Meeting Report

Workshop on Ensuring Access to Priority Medicines for Mothers and Children

15–17 August 2011
Manila, Philippines
WORKSHOP ON ENSURING ACCESS TO PRIORITY MEDICINES FOR MOTHERS AND CHILDREN

Convened by:

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
15 to 17 August 2011

Not for sale

Printed and distributed by:
World Health Organization
Western Pacific Regional Office
Manila, Philippines
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**Keywords:** Drugs, Essential – supply and distribution / Pharmaceutical preparations – supply and distribution / Maternal health services / Child health services
The Workshop on Ensuring Access to Priority Medicines for Mothers and Children was held in Manila, Philippines, from 15 to 17 August 2011.

The objectives of the workshop were:

(1) to review the current status of service delivery for maternal and child health as related to access to priority medicines for mothers and children;

(2) to analyse the existing financing and supply system for essential medicines and to identify bottlenecks for access to priority medicines for mothers and children; and

(3) to define country-specific feasible options and next steps to improve access to and use of priority medicines for mothers and children at national and subnational/district levels.

The 27 participants in the workshop came from Cambodia, China, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines and Viet Nam. There were also representatives from partner organization UNFPA, observers and a WHO secretariat from the Western Pacific Regional Office, WHO country offices in Cambodia, China, Laos, South Pacific, Viet Nam, Philippines, Papua New Guinea, and WHO Headquarters (Annex 1).

The programme consisted of plenary presentations and discussions together with group work to define country-feasible options and next steps to improve access to and use of priority medicines for mothers and children at national and subnational/district levels.

Participants of the Workshop on Ensuring Access to Priority Medicines for Mothers and Children discussed the services delivery of maternal and child health indifferent countries, especially on the access and availability of the medicines in different levels of health facilities. The bottlenecks for access, availability, quality as well as proper usage by providers and consumers were reviewed and practical options for improvements were proposed.

Participants also discussed the progress and challenges of the Millennium Development Goals 4 (reducing child mortality) and 5 (improving maternal health). There is indeed notable progress in some countries despite serious challenges in other countries. Follow up actions at different levels of services delivery were proposed to improve access and availability of the priority medicines, from selections, pricing, financing and streamlining the procurement, supply and management as part of the essential medicines in general. The importance of monitoring and supervision and the need for effective back up system for supply and for proper usage is underlined. There is a need for a mechanism for exchange of information, sharing of experiences and collaboration to cross fertilize the success to other countries in need.
Following were the recommendations:

WHO, UNFPA and partners

(1) WHO and UNFPA should closely collaborate to follow up the joint assessment and to provide technical support in improving the logistics supply distribution and monitoring of priority medicines for mothers and children.

(2) WHO, UNFPA and partners should facilitate effective intercountry exchange of experiences, cross fertilization, and collaboration in relation to access to priority medicines and the achievement of health outcome to reduce mortality.

(3) WHO, UNFPA and partners should collaborate to devise a mechanism for locating available stocks and rapid delivery of resupply of the priority medicines for emergency care such as oxytocin.

(4) WHO should facilitate, advocate and provide technical support for improving the availability and production of quality paediatric formulation.

(5) WHO should facilitate the documentation and publication of success in ensuring access to the priority medicines and the progress towards the achievement of the Millennium Development Goals.

Member States:

(1) a translation of Priority Medicines for Mothers and Children 2011 should be made available in the local language;

(2) a (national) workplan for improving access and availability to priority medicines through the existing delivery system should be devised, if possible as part of the bigger national strategy on maternal and child health. Proper advocacies and training of providers should be part of the plan. The plan should also include ways of ensuring access in remote places. The implementation of the action plan can be started in a particular area, e.g. provinces or districts, and scale up with a step wise approach;

(3) adequate financing of essential medicines for mothers and children should be ensured by inserting the priority medicines, as published in WHO's list as "Priority medicines for mothers and children 2011", on the list of reimbursable items of national health insurance schemes. Costing of standard treatment courses for health problems facing mothers and children, should be based on the Priority medicines' list and on WHO's standardized costing methodologies;

(4) relevant follow up actions should be initiated within six months to one year at the national and subnational levels to address the bottle neck for access and availability of priority medicines for mothers and children;

(5) the implementation for monitoring and back up support for the availability, supply management and use of priority medicines should be developed and initiated; and a pilot area for implementation should be identified. A baseline on availability and affordability of the medicines can serve as an evidence for advocacy and a basis for
measuring progress. Track availability of a small set of selected medicines from the list "Priority Medicines for Mothers and Children 2011".

(6) effective mechanism for intercountry cross fertilization and collaboration in ensuring access to priority medicines and achievement of health outcome should be pursued to reduce child and maternal mortality. Document success stories towards the achievement of millennium Development Goals and share with other countries.
1. INTRODUCTION

The Workshop on Ensuring Access to Priority Medicines for Mothers and Children was held in Manila, Philippines, from 15 to 17 August 2011.

1.1 Background information

Universal access to good quality essential medicines for childhood illnesses and maternal health is one of the critical elements to improve service delivery for achieving Millennium Development Goals 4 (to reduce child mortality) and 5 (to improve maternal health). Yet lack of access to essential medicines for maternal and child health remains a major challenge in many developing countries and areas in the Western Pacific Region. This will inevitably constrain efforts to reduce mortality and improve the health of children and mothers.

Recently, the United Nations Population Fund, the United Nations Children's Fund and WHO launched the global list of Priority Medicines for Mothers and Children 2011. This list aims to help countries and partners select and make available those medicines that will have the biggest impact on reducing maternal, newborn and child morbidity and mortality. Improving access to these medicines is a priority for the Western Pacific Region.

This workshop, involving responsible officers from high burden countries, will identify bottlenecks in the medicine financing and supply system in the overall context of health service delivery for women and children at the national and subnational levels, and will identify feasible options for improvement.

1.2 Objectives

The objectives of the workshop were:

1. to review the current status of service delivery for maternal and child health as related to access to priority medicines for mothers and children;

2. to analyze the existing financing and supply system for essential medicines and to identify bottlenecks for access to priority medicines for mothers and children; and

3. to define country-specific feasible options and next steps to improve access to and use of priority medicines for mothers and children at national and subnational/district levels.

1.3 Participants

The 27 participants in the workshop came from Cambodia, China, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines and Viet Nam. There were also representatives from partner organization UNFPA, observers and a WHO secretariat from the Western Pacific Regional Office, WHO country office in Cambodia, China, Laos, South Pacific, Viet Nam, Philippines, Papua New Guinea, and WHO Headquarters (Annex 1).
1.4 Organization and content of the workshop

The workshop elected Dr Lahui Geita from Papua New Guinea as Chairperson, Dr Lamphone Syhakhang from Lao People's Democratic Republic as Vice-chairperson and Ms Angelina del Mundo from the Philippines as Rapporteur.

The workshop timetable is in Annex 2. The participants were provided with background and discussion papers related to the subjects, and a complete set of all country presentations, in hardcopy as well as on USB, with all the workshop presentations in Powerpoint® format.

1.5 Opening session

Dr Hans Troedsson, Director, Programme Management, WHO Western Pacific Region, delivered the opening address on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific Region.

Dr Troedsson referred to Millennium Development Goal (MDG) 4 that calls for a reduction in child mortality and MDG 5 that seeks a reduction in maternal mortality. He emphasized that there are three key factors for achieving MDGs 4 and 5. These are: (1) appropriate health care seeking behaviour, (2) availability of qualified and skilled health workers and birth attendants, and (3) access to essential medicines. All three are important, though this workshop will focus on the third element.

He underscored that priority medicines for mothers and children should always be available at all levels of health care facilities. Henceforth, the bottlenecks relative to access to a core set of critical and life-saving medicines for mothers and children ought to be identified and addressed. He furthermore warned that it can be tempting to design "perfect" solutions that are too complex to be implemented; instead, the focus should be on what is feasible, practical and doable.

Finally, he noted that attending the workshop is not an objective in its own right, and that the success of this workshop will be measured by how much increase in access will be achieved.

2. PROCEEDINGS

2.1 Introduction to the consultation

Dr Santoso Budiono explained the objectives of the consultation. The methodology would be in the form of plenary presentations and discussions together with group work to identify bottlenecks and challenges and options for improving access to priority medicines for mothers and children. The output would include recommendations for follow up action, both at national levels and sub-national levels, to improve access to priority medicines for mothers and children.
2.2 Maternal and child health in the Western Pacific Region (Dr Marianna Trias)

Significant progress has been made towards MDG 4 (reduce child mortality) and MDG 5 (improve maternal health) in the Western Pacific Region. The overall under-five mortality rate has declined by 50% and maternal mortality ratio by almost 60% between 1990 and 2008, though geographical and geographical inequities exist. In 2008, 527 000 children under five still died - often due to neonatal conditions (prematurity, asphyxia and severe infections) and major communicable diseases (post-neonatal pneumonia, diarrhoea and malaria). More than 50% of the 13 000 maternal deaths were due to haemorrhage and hypertension.

Although cost-effective maternal and child health interventions exist along with technical guidelines for their implementation, huge coverage gaps persist along the continuum of care. For example, in four countries with the highest under-five mortality, only 40% to 65% of children under five with suspected pneumonia received appropriate antibiotics, while oral rehydration therapy (ORT) coverage for diarrhoea varied from as low as 15% to around 60%. Furthermore, quality of care remained an issue particularly in antibiotic prescriptions.

In a responsive health system, care is provided along the continuum of care across the life-course and all levels of care, and proven evidence-based interventions are delivered as packages in an integrated manner, and supported by appropriate policies and country-led health plans. Improving equity and reaching universal access to maternal and child health services are important goals for the Region, which requires higher investments in health and reducing out-of-pocket payments and other barriers to maternal and child health services. Skilled health workers with the necessary infrastructure, drugs, equipment and regulations play a major role. Collaborative approach to maternal and child health (MCH) and health systems strengthening including improving access to priority medicines is necessary as better health requires coherent policies and efficient planning and organization of financial and human resources.

2.3 Improving service delivery for maternal and child health (Ms Laura Hawken)

In order to improve service delivery, it is important to take a whole system approach, for all components or building blocks of the health system (leadership and governance; health care financing; health workforce; medical products and technologies; information and research; and service delivery) are interconnected. The weakest part of the system will determine its output; thus, all parts should be balanced and coordinated.

Similarly, values of health as a human right, participation, quality and equity are all important in relation to health system design and objectives of accessibility, affordability, acceptability and accountability.

A service delivery model outlines:

- how the community enters and interacts with the health system;
- what types of facilities and services are available at each level;
- when facilities or services are open, e.g. 24 hours per day, 7 days per week;
the number and mix of staff at each level, what they can and should do, and how they work together;

- the referral system and the controls on access to higher level, specialist and expensive services, including the incentives to providers and patients to comply;

- the linkages between levels of service, e.g. communication, transport, supervision, specialist visiting, financial linkages; and

- the role of non-state providers and how they interact with state services to support reaching national and local health goals.

These aspects were discussed in relation to the service packages for MCH, service management and scaling up services. Strategies and plans for scaling up services may include the use of feasible, integrated packages that have potential for being delivered universally.

2.4 Intervention packages for maternal and child health (Dr Ardi Kaptiningsih and Dr Emmalita Mañalac)

Dr Ardi Kaptiningsih, Regional Adviser for Making Pregnancy Safer/Women and Reproductive Health, and Dr Emmalita Mañalac, Medical Officer for Child and Adolescent Health presented the Packages of interventions for family planning, safe abortion care, maternal, newborn and child health. The intervention packages for MCH across the continuum of care were described. The adequacy, accessibility and good quality of the interventions are crucial. The interventions need to be adapted according to country needs and delivered in an enabling environment, and in consideration of the prevailing socio-economic milieu and relevant socio-economic interventions.

The guiding principles in delivering the interventions include universal access with a special attention to the needs of underserved and vulnerable groups; address inequity, gender and cultural sensitivity and human rights; integration of health services and women and community participation. The presentation moved on to the specific packages of interventions for family planning, safe abortion/post-abortion care; pregnancy, childbirth and postpartum care; newborn, infant and child care. For each intervention package, elaborations were made on the components of services, benefits and indicators used. Further, components of services at various levels, namely at home and community, primary care and referral facility, were explained. Medicines that are lifesaving at crucial life stages are covered in a subsequent presentation on priority medicines for mothers and children.
2.5 Priority medicines for mothers and children (Dr Krisantha Weerasuriya)

The Priority Medicines List for mothers and children was developed from the WHO Model List of Essential Medicines – it is a subset that will have biggest impact on reducing maternal, newborn and child morbidity and mortality. It addresses the Millennium Development Goal 4 (Reduce Child Mortality) and 5 (Improve Maternal Health). The number of medicines relevant to each of the countries varies (depending on the disease pattern) but is around 25. The challenge is to have these medicines available 24 hours per day, seven days per week, 52 weeks per year.

The medicines are ones that health care workers are familiar with: oxytocin, magnesium sulphate, ampicillin injections, amoxicillin dispersible tablets, Oral Rehydration Salts and Zinc tablets are some examples from the list. The reasons for these medicines not being available runs right throughout the chain – the medicine may not be in the National Essential Medicines List, may not be registered in the country, may not have suppliers carrying the product, may not have been ordered although being available in the Central Medical Store – and when available in the health care facility, may not be used.

The questions that should be asked are: 1) Are the priority medicines in national treatment guidelines and essential medicines lists? 2) Is there a supplier of a quality product? 3) Are the priority medicines licensed? 4) Are the priority medicines being supplied? 5) Do the health professionals know how to use the priority medicines? and 6) Is there consumer demand for medicines such as ORS and zinc tablets? The answers to these questions will provide information to tackle the issue of the availability of priority medicines for mothers and children.

2.6 Financing options for maternal and child health services (Dr Chris James)

Millions of people around the world still cannot use needed health services because they are unavailable or are too expensive. Millions more suffer financial ruin each year because they must pay for the health services they use at the time they receive them. There are three fundamental health financing challenges countries must address if they are to move closer to universal coverage whereby all people can use services without the risk of financial ruin. These are:

(1) Raising sufficient funds for health to ensure the provision of priority maternal and child health (MCH) medicines and other commodities. The main options are to increase the priority given to health in government budget allocations (for countries where the current priority to health is relatively low); to raise revenues more efficiently (for example by minimizing tax evasion); to find new or more diversified sources of revenue, such as 'sin' taxes on tobacco, alcohol and unhealthy foodstuffs, or specific levies on large profitable companies and tourists; and more, and more predictable, external funds for health (for low-income countries).

(2) Minimizing the reliance on direct out-of-pocket payments implies that priority MCH commodities are provided for free or low cost at the point of use. This requires increased prepayment and risk pooling through taxes and/or social health insurance. Reducing or eliminating charges in government health facilities is another policy option, and specific attention should be given to the poor and vulnerable. At the same time it is important to note that universal coverage is difficult unless contributions are compulsory.
Making best use of available resources requires that public budgets and/or health insurance subsidize the most cost-effective MCH commodities. Essential packages of care, such as the Partnership for Maternal, Newborn & Child Health essential package, can help guide this prioritization process. Efficiency gains are also possible through other supply-side policies. This involves increasing the use of generic medicines, reducing prices through better procurement policies, improving supply chain management, and reducing inappropriate use of commodities by modifying the incentives faced by health providers.

Discussion

During the ensuing discussions, the following issues were raised:

In the past, due to consistent advocacy, the utilization of ORS has been a success (nearly 90% utilization rate). However, with the introduction of zinc, which needs to be utilized together with ORS, utilization of ORS has dropped to between 50%-60%. So there is a need to adapt the advocacy: where zinc is available, it should be used together with the ORS. However, where zinc is not available, the use of ORS alone should continue to be encouraged.

The existence of perverse incentives for prescribers, such as doctors in hospitals (in some countries) who receive payments for prescribing certain medicines, can increase costs dramatically.

Sum of the “Out of Pocket Expenses” by patients and government expenditure on drugs is high. A high proportion of these drugs are used irrationally, often leading to additional cost of managing drug resistance.

Cost-containment is equally important in ensuring cost-effective use of resources, and should be considered as critical for sustainable financing or health insurance coverage.

The lack of controls on type and the prices of medicines that are reimbursed may lead to cost escalation and high expenditures for the health insurance. It is therefore important to analyze the expenditures on and the consumption of medicines at the facility level. High procurement prices incurred by hospitals are secondary to inefficient procurement system. Inefficient procurement systems and irrational use of medicines increase costs to hospitals/health services. Increases in expenditures will limit the health insurance capacity to increase the breadth of its coverage and the extent of the benefits that it can provide.

Furthermore, the importance of increasing the focus on pre-service training was raised. The availability of competent human resources is a pre-condition to enable the MOH to staff the health system with providers that are capable of responding, timely and efficiently, to the needs of the patients and of putting into practice national health policies and strategies. It should be recognized that vertical systems focusing on a particular disease contribute to the fragmentation of the health care system.

Finally, the need to involve men in MCH programs was stressed; it is of paramount importance for the success of any MCH interventions.
2.7 Country presentations - delivery of MCH services and challenges for access, availability and quality of priority medicines

2.7.1 Cambodia

In Cambodia, the leading causes for maternal mortality are haemorrhage during or after delivery, pre-eclampsia, infection, unsafe abortion and obstructive labour. The main causes of under five mortality are respiratory infections, diarrhoea, premature birth, neonatal infections and asphyxia.

Maternal and child health services are delivered at community level, where traditional birth attendants are the main provider of services (though MoH is discouraging delivery services at this level), at the primary care level (Health Centers), where midwives and nurses are the main service providers, and at referral level. The latter refers to district hospitals, provincial hospitals or national hospital. Physicians, midwives and nurses are the main providers of services at this level.

Some of the priority medicines for mothers and children have not been included in the Essential Medicines List (EML). Compliance with Standard Treatment Guidelines (STGs) is ensured through training, supervision and by supplying only those medicines in the EML and STGs.

MCH medicines are procured, along with other essential medicines, through centralized procurement. From the central store, they are distributed to district stores, from where facilities collect their orders. They are provided free of charge to patients.

Generally, priority medicines for MCH are available in Cambodia. Supply chain challenges include late delivery of orders, inadequate quantity supplied and stock management issues.

Comments and discussion:

It was noted that Cambodia has made good progress regarding the availability of zinc tablets. This was attributed to two main factors: the training on health professionals on rational use and proper medicine management. The zinc tablets come from donation and it is recommended that donor should not only donate medicines but also provide supplementary fund for training the prescribers.

The importance of monitoring medicine supply and use was mentioned; Cambodia has quite an extensive monitoring system that works well (see also under 4.4).

2.7.2 China

The leading causes for maternal death in China are obstetric haemorrhage, pregnancy-induced hypertension syndrome, heart disease, amniotic fluid embolism, pneumonia.

The leading causes for under five death in China are: preterm or low birth weight, pneumonia, birth asphyxia, congenital heart disease, accidental asphyxia.

There are three levels of service delivery for maternal and child health: community level (village), primary care level (township) and referral level (county/district and above).
The main medicines used for maternal and child health in the country are amoxicillin, Cefuroxime, Azithromycin, anti-TB, Amobroxol. There is no formal list of maternal and child medicines. Most of maternal and child medicines are registered in China and included in the 2009 National Essential Medicine List (NEML) for primary level.

(1) Standard treatment guidelines and rational use of medicines

Nearly all standard treatment guidelines (STGs) for maternal/child health are available. For ensuring the compliance with STGs, the training and supervision are applied and in addition, the Standard prescription for children is being developed.

(2) Medicines supply system

In China, a decentralized procurement mechanism is applied for the essential medicines with MCH medicine included. Each province is responsible for the procurement of the essential medicine for the health facilities in its own region.

(3) Availability of medicines

- The maternal/child health medicines generally available at the primary care level (public sector) and first referral level (public sector)
- The MCH medicine that is frequently not available is Erythromycin

(4) Funding for medicines

- The Health Insurance, Public expenditure and out-of-pocket payment consist of funding source for MCH medicines
- Some medicines are free-of-charge, such as anti-TB, Anti-AIDS, Vaccine

(5) Achievements and challenges:

The key achievements regarding ensuring access to maternal/child health medicines: the issuance of NEML including the necessary medicines for maternal/child health. The fast track registration mechanism is in place for children's medicines.

Comments and discussion:

Reference was made to the ongoing hospital reform in China, which is very successful; hospitals see many outpatients and sell medicines. However, the question was raised whether that creates challenges for following STGs and promoting rational use of medicines. To address this, several aspects will need to be considered, such as regulating the behaviour of prescribers to ensure rational prescription and educating consumers to not demand medicines that do not have clear value. It was also suggested that perhaps more outpatients should be directed to the primary facilities where medicines are free and services very good.
2.7.3 **Lao People's Democratic Republic**

According to Census in 2005, the Maternal Mortality Rate and the Under Five Mortality Rate of Laos are 405 per 100 000 live births and 98 per 1000 live births respectively. Data on leading causes of death are not available. Maternal and child health services are provided at community, primary care and referral level. Maternal health service includes non-pregnancy RH care, pregnancy care, intrapartum care and post natal care, while child health services includes new born and under five cares.

Most medicines used for mothers and children are in the National Essential Medicines List and registered. The medicine list and guideline on treatment and care specific for mothers and children exist. Medicines for mothers and children are quantified based on past consumption and the medicines are procured and supplied through the provincial health authority using tendering or price negotiations. Most medicines for mothers and children are available at primary health care, and referral level. However, there are some medicines which are not frequently available such as magnesium sulphate, oxytocin, benzathyl penicillin and zinc. Medicines are funded through health care facility revolving fund, initiatively started by government fund or donors.

The main achievements include the availability of a national essential medicine list, a guideline on treatment and care for mothers and children and the availability of a training guideline on treatment and care. Besides the achievements, there are some main challenges, such as, uncontrolled prices of medicines, no specific national essential medicine list for MCH services, irrational uses of medicines and insufficient drug supply at different level of facilities.

**Comments and discussion:**

The importance of monitoring procurement prices, and sharing this information, was mentioned. Prices are monitored at province and hospital level, but only in certain pilot provinces. Efforts are underway to harmonize procurement systems.

Suggestions were made about integrating supply systems and pooling procurement, to achieve economies of scale. However, if the budget is insufficient to purchase a large volume of medicines, then there is no point. Moreover, nationwide pooled or centralized procurement requires sufficient storage space and staff that is capable of handling this. Thus, instead, Laos is pooling procurement at the provincial level, not at the national level.

2.7.4 **Mongolia**

Health service delivery is organized under three levels based on the administrative structure of the country: national, aimag and soum levels. Primary health care services are provided by health care workers and feldshers in soum and bagh and by general practitioners in urban family clinics.

The Government of Mongolia has placed a high priority on achieving MDGs 4 and 5. There are a number of government policies, legislation and programmes on maternal and child health such as the National Strategy for Reducing the Maternal Mortality Rate (MMR) 2005-2010 and the National Strategy for Maternal and Newborn’s health 2011-2015.
The MDG target for the under-five year mortality rate (21.0 by 2015) is on track. Vaccination of measles for child less than one year is 99%. The National Programme for Children 2002-2010 was ratified in 2002 by Government Resolution No. 245. The priorities are: improvement of fetal and newborn care; nationwide implementation of IMCI; promotion of breastfeeding practice; immunization for vulnerable and unregistered children; increase capacity building of human resources for child health and expand adolescent friendly health service. A number of standards and guidelines are in place to guide and facilitate quality child care services.

The MMR has declined steadily from 200 (1990) to 49.9 (2008). A reverse trend was observed for MMR in 2009 (81.9) and then it declined again in 2010 (45.5). The sustainability is a challenge due to a number of factors such as: lack of modern equipment for early detection and treatment of the complications of pregnancy, childbirth and postpartum period, congenital abnormalities; and lack of health professionals in rural areas.

Most priority medicines for mothers and children are included in the national essential medicines list and they are registered. A joint assessment of availability, accessibility of life-saving maternal medicines was carried out in 2009 by UNFPA, WHO and the government. Overstocks or stockouts of some medicines (like ergometrine, oxytocin, metronidazole, ampicillin) was observed in some sites. Overall the storage conditions at both public and private facilities and pharmacies are good. However, inappropriate condition of oxytocin was observed in some places (issue is the labelling construction which is in English).

Medicines procurement is decentralized. Most oxytocin and all ergometrine is provided by UNFPA. Estimating or forecasting requirements for RH essential medicines needs to be improved at all levels.

Future plans include: to improve availability of essential equipment and medicines according to structural and operational standards of each health facility, to allocate appropriate funds for MCH services, and to strengthen human resource capacity for MCH service delivery.

Comments and discussion:

Inappropriate storage, for instance of oxytocin, is caused by lack of clear instructions and labels in a foreign language which is understood. Now, it is required that all medicines instructions should be in Mongolian or Russian languages.

Other countries can learn from Mongolia's experience in reducing MMR. The main factors that contributed to the decline of maternal mortality rate (MMR), infant mortality rate (IMR) and child mortality rate (CMR) were strong government commitment, an enabling legal and policy environment, an increased budget allocation and dedicated human resources. The translation of WHO guidelines and training materials, the referral strategy (developed in 2000) and the fact that an essential medicine policy was in place have also contributed. But all this was underpinned by government commitment.

It is challenging to deliver care to a dispersed rural population. In Mongolia, two weeks before delivery, pregnant women are expected go to a maternal care home and wait there; once delivery starts, they are taken to a nearby hospital. In Mongolia, there has not been much resistance to these "delivery houses", since people know the risks of home delivery.
Facilitating factors are the relatively high level of education of the population, and the fact that maternal and child services are provided for free.

2.7.5 Papua New Guinea

Papua New Guinea has the highest MMR amongst the countries participating in the workshop: 733/100 000 (DHS 2006). The main causes of mortality are postpartum haemorrhage, sepsis, malaria and anaemia. Papua New Guinea can learn from Mongolia, which has achieved a significant reduction in maternal mortality. For example, with support from UNICEF, waiting houses for pregnant women are being tried out on a small scale, to gain experience and test acceptability.

MCH medicines are not registered. The regulatory system is weak and drug registration is very slow. However, the national medicines regulatory authority can prioritize and fast track the registration of MCH medicines in the future.

Papua New Guinea has a challenging geography which, together with a weak supply chain, contributes to low availability of critical MCH medicines. Oxytocics are distributed and stored without temperature-monitoring, which may compromise efficacy. There is an obstacle in sharing fridges with the expanded programme on immunization (EPI) as there is great fear of health workers confusing different drugs. However, MCH and EPI programme managers will discuss further about sharing the limited resources. Also, at the regional level, MCH and EPI programmes are convening to seek collaboration.

Paediatric formulations of TB drugs run out quickly and it is difficult to use adult doses for children. More attention should be given to TB drugs for children.

Comments and discussion:

In addition to the issue of storage of oxytocin in "EPI fridges", there are other products where cooperation between the EPI and MCH programmes would be desirable, such as hepatitis vaccine and maternal/neonatal tetanus.

Like Mongolia, Papua New Guinea has a dispersed rural population and a challenging geography; collaboration between the two countries in for example the area of drug supply could be explored.

2.7.6 Philippines

With the rate the country is going (maternal mortality rate changed from 209 per 100 000 live births in 1990 to 162 in 2006, NDHS), it is unlikely that the MDG target for MMR in the Philippines (52 by 2015) will be reached. However programs to rapidly reduce MMR, such as Maternal, New Born, Child Health and Nutrition Strategy (MNCHN), are already underway. Leading causes of maternal deaths include post-partum hemorrhage, pregnancy-related hypertension, infection, and dystocia.

Under-five mortality rate is 34 per 1000 live births (NDHS, 2008). This is attributed to the following lead causes: neonatal death, pneumonia, NCD, diarrhea, injury, meningitis, and other infections. There is little improvement in child mortality despite changes implemented. Specifically neonatal mortality is caused by prematurity, pneumonia/sepsis, asphyxia, and
congenital abnormality (CHERG, 2008). NMR and IMR are 17 and 9.3 per 1000 live births respectively (NDHS, 2008).

MCH services are provided at the: (1) community level (trained volunteer health workers); (2) primary level (rural health unit staff); and (3) referral facility (district and provincial hospitals, specialty hospitals or medical centers). Standard treatment protocols are followed with special emphasis on rational drug use (such as IMCI, WHO). Medical treatment is governed by the List of Essential Women’s Health and Safe Motherhood and Child Survival Drugs and Supplies complied by both DOH and PhilHealth, and the PHL National Drug Formulary (PNDF). All drugs included at the PNDF are registered with DOH Food and Drug Administration.

While the majority of medicines is obtained out-of-pocket, the government procures a part of the total essential drug requirement based on budget and priority (20% in 2010 and 75% in 2011 for the MCH programme). All local government health facilities are required to have appropriate essential medicines at all levels.

The government supports MDG 4 and 5 through policies such as the Formula One for health and the Aquino Health Agenda, although political issues, financial matters, and availability of skilled professionals still threatens its sustainability. The country plans to improve access to healthcare through implementing new legislations, reforms in logistics management, optimization and creation of treatment guidelines, and strengthening the government programs.

Comments and discussion:

Misoprostol is not on the essential medicines list in the Philippines since abortion is illegal and oxytocin is considered safer for non-abortion purposes.

2.7.7 Viet Nam

A steady decline in MMR is observed in Viet Nam, from 130 per 100 000 live births (1992) to 69 (2009). Although disparities between mountainous and plane regions are large, with an observed MMR of 411 in Cao Bang compared to 45 in Binh Duong (2000-2001 data). Leading causes of maternal mortality are haemorrhage, eclampsia, infection, abortion, ectopic, and uterus rupture.

There is substantial reduction of child mortality, with a significant disparity between rural and urban deaths. Neonatal mortality accounts for 57% of under-five year old deaths. Other leading causes include: pneumonia, diarrhea, accidents, measles, and HIV/AIDS.

MCH services are provided at commune level and district/provincial level through home-based maternal and child care and district/provincial hospitals, respectively. Medicines used for MCH are included in the current 5th list of essential drugs of Viet Nam (MOH, 2005) and a standard treatment guideline for diarrhea in children is in existence (MOH, 2009). Additionally, there are plans to update both the EML and treatment guidelines to strengthen the country’s MCH policy.

Local pharmaceutical manufacturers supply basic medicines in Viet Nam (49% of demand), while specialized drugs are imported. The drug distribution network is developed
and covers almost all areas of the country including remote areas. Medicine expenditure is mainly out-of-pocket with only 18% of total health expenditure funded by the government (National Health Account, 2008).

Challenges in infrastructure and resources have been identified. And in addition to legislation and policy development, the country also plans to improve the quality of MCH care through capacity and skill improvement for health care providers.

Comments and discussion:

It was suggested that the therapy in provincial level should be monitored to ensure rational prescription and use.

2.8 Improving access, availability and rational use of priority medicines for mothers and children

2.8.1 Framework for improving access to medicines (Ms Karin Timmermans)

From a public health perspective, the overarching objective in the area of pharmaceuticals is to ensure equitable access to good quality essential medicines and to ensure their rational use by providers and consumers, in order to improve health outcomes. While the main focus of this presentation is access, ensuring quality and rational use are equally important. Moreover, there are linkages between the strategies to ensure access, quality and rational use.

Access to medicines depends on:

- **Rational selection.** Selection of a limited number of essential medicines is the basis for optimizing supply, financing and use. Selection should be evidence-based and take cost-effectiveness into account. The EML and STGs should be harmonized, and essential medicines should be registered.

- **Adequate and sustainable financing.** Available funds should be spent on cost-effective products. Public financing for MCH medicines may have to be increased.

- **Affordable prices** can be achieved by using measures such as reducing taxes, tariffs and margins. Regressive mark-ups or fixed dispensing fees can reduce prices as well as perverse incentives. The use of INN (international non-proprietor names) or generic names during procurement enables competition, which can drive prices down. Alternatively, prices could be negotiated based on reference prices etc. It may also be important to make price information public and comparable.

- **Reliable supply systems.** There are two significant challenges related to medicines supply. Firstly, in many countries, multiple 'vertical' supply systems for medicines co-exist. Yet there is no dedicated supply system for MCH medicines. The unintended result is insufficient attention for and supply of MCH medicines. Secondly, several countries have decentralized medicines supply systems, which results in a loss of economies of scale. Nevertheless,
other factors such as access to market intelligence and up-to-date price information, and a reliable payment record also are important factors in obtaining good prices; thus, even in a decentralized system it is possible to obtain reasonable prices.

Attention was drawn to the importance of proper quantification, procurement procedures that give due attention to product quality, storage, inventory control and distribution. Systems for emergency supply and redistribution of excess stock may need to be put in place. In addition, there is a need for a comprehensive generic policy, policies to manage conflicts of interest as well as regular monitoring and evaluation to identify and address problems in a timely manner.

Comments and discussion:

Procurement and supply management systems should be tailored to country's situation and needs; there is no one-size-fits-all solution.

In terms of procurement, not only the quality and price should be considered, but also the performance of suppliers; for example if suppliers fail to deliver on time, cost could be enormous.

It can be challenging to get prescribers to prescribe rationally. Some governments have put in place systems of financial rewards (in the United Kingdom, savings will flow back to the prescriber's practice) or punishments (Germany: if physicians surpass their allocated prescription budget, they will be asked to reimburse the surplus) to increase compliance with STGs.

2.8.2 Efficient procurement, supply and management (Dr Socorro Escalante)

Procurement, supply and management of essential medicines directly affect health outcomes because they impact on the availability and affordability of medicines that combat diseases and save lives. The goal of efficient procurement therefore is to ensure that:

- Essential medicines are at all times available in health facilities
- Are of assured quality, procured from reliable sources and at competitive prices
- Provided to the intended patients in a timely and appropriate manner

The evidence collected from various WHO studies undertaken in several African countries show that the average availability of essential medicines is consistently low, most especially for ORS and zinc. The latest survey in Viet Nam covering 29 selected medicines for mothers and children showed a mean availability of 13.6%. When procurement systems are inefficient, the same medicines may be obtained from different suppliers at different prices. This can result in wasting government resources and may needlessly complicate the supply management system.
A comprehensive assessment of procurement and supply systems should cover all levels (from manufacturing or import to delivery at health facilities), and should consider the following:

(1) Get an overall view of the supply system. This involves an assessment of the overall availability of essential medicines in the country. When the availability is low, the government must conduct national advocacy to improve the availability of medicines and may encourage local production of generic medicines.

(2) Secure the public sector supply. The availability of MCH medicines is consistently low in the public sector. It is important that the government should ensure an adequate supply system in the public sector. This is critical, as the public health facilities usually are the first point of contact, especially for poor patients.

(3) Reduce regulatory and policy barriers. Some interventions to address this include: a) facilitate registration of priority medicines for mothers and children; b) ensure their inclusion in the EML; 3) ensure their inclusion in the re-imbursement list; and 4) make these medicines a priority for entitlements.

(4) Address operational barriers: good planning, quantification and transparent and accountable procurement systems can ensure the availability of medicines at the facility level. Drug and therapeutic committees must be involved in the selection and provide technical support in the efficient utilization of medicines.

Countries may consider the establishment of a National Medicines Facility (NMF) that rationalizes, oversees and supports local governments and health facilities in medicines procurement. Specifically, a NMF shall: a) conduct a national tendering system or provide support to health authorities and facilities to conduct tendering; b) outsource procurement of medicines which have very low availability and high prices from international and local sources; c) prequalify and accredit suppliers to ensure quality assurance in procurement; and d) monitor and disseminate medicines prices.

Comments and discussion:

Ensuring quality of the medicines procured and supplied is of utmost importance. Strategies to ensure quality include purchasing from preselected/prequalified suppliers, or purchasing prequalified products. Nevertheless, all medicines need to be registered at the national Medicines Regulatory Authority, including imported and/or prequalified medicines. It is also important to encourage regular sampling for quality testing, and to make the results publicly available; among others, this can enhance confidence in the procurement system and in the medicines supplied.

2.8.3 Rational use of priority medicines for mothers and children (Dr Budiono Santoso)

The relevance of promoting rational use of medicines in improving access to essential medicines for mothers and children towards improved health outcome was illustrated. Without rational use, improving access to essential medicines will not bring about impact on health outcome. The presentation started with the definition of rational use as defined by WHO Conference of Experts in 1985. Rational use of drugs requires that patients receive medicines appropriate to their clinical needs, in doses that meet their individual requirements,
for an adequate period of time and at the lowest cost for them and their community. Some specific examples of irrational use of medicines, affecting mothers and children were provided. Overuse of antimicrobials and injections are common examples of irrational use of medicines. While progress in reducing the over use and misuse of injectable products has been observed over the years, such success has not been demonstrated in dealing with the over use of antimicrobials.

The presentation also highlighted some indicators of usage from the WHO Medicines 2011 databases, including the use of antibiotics and oral rehydration therapy in acute diarrhoeas, the use of antibiotics in non pneumonia and pneumonia acute respiratory infections. The data basically show that indeed irrational use of medicines is still commonly encountered in health facilities jeopardising the quality of medical care and wasting resources for health in many developing countries. Specific challenges in promoting rational use, particularly in the region, were the fact that in many countries medicines sales have been used for revenue generation and for incentives to the providers. The major proportion of medicines expenditure is from the patient and paid out of their pocket. This poses serious barriers for promoting rational use of medicines.

After explaining the common factors influencing the use of medicines, which include those deriving from providers themselves, from the social and cultural environment, from the work group, from the work place environment, and from the information, strategies for promoting rational use of medicines were highlighted. The strategies include the educational intervention, behavioural intervention, managerial intervention, financing intervention and regulatory intervention. The nature of these interventions was explained and examples were presented. Some specific targeted interventions which had been implemented in some countries in the Asia Pacific region, were presented, including the interactive group discussion (IGD) – a behavioural intervention (implemented in Indonesia and China), monitoring training and planning (MTP) intervention (implemented in Indonesia, Laos and Cambodia), a small group active learning for consumers (Indonesia) and a small group intervention to improve rational use of medicines in acute diarrhoea (Indonesia).

The presentation proposed that efforts to promote rational use of medicines for mothers and children should focus on those interventions that have a direct impact on health outcomes, such as the lack of use of oral rehydration in acute diarrhoea, the use of antimicrobials in children, inappropriate use of uterine stimulants etc. It was concluded that monitoring of medicines use and availability in health facilities, and providing back up support for supervision and for resupply, is extremely important for improving rational use of medicines. Furthermore, a combination of different interventions is needed, as a single intervention alone rarely works.

Comments and discussion:

The presentation was followed by a discussion on the role of regulation vs. education. Examples of regulatory interventions include the withdrawal of artemisinin monotherapy from the market in Viet Nam and the ban on the sale of TB drugs in the private sector in Cambodia.

It was also noted that scaling up of interventions to promote rational use of medicines is not always easy.
2.8.4 Monitoring and supervision of medicines management and use in health facilities in Cambodia (Mr William Mfuko)

Cambodia has implemented a “supervision and monitoring” program for more than 16 years, since 1995. Implementation was initially supported by WHO and UNICEF. Supervision and monitoring activities were intensified in 2007, when several other partners, including the GF (HSS grants), the Health Sector Support (HSSP) program and KfW (Germany Development Bank) joined hands to support the program. The main objective has been, and continues to be, to improve and ensure the availability of essential medicines in health facilities at all times, through the regular collection of data for selected drug management indicators. Among others, agreed indicators include the number or the proportion of facilities: with accurate inventory records; found with sufficient stock levels; found with overstocks; that experienced stock out and stock out rates; with expired medicines; that stocked medicines that are not in the National Essential Medicines List (NEML).

Monitoring and supervision visits to collect data on these indicators and to provide the needed support are conducted by either a team from central level (the DDF), provincial (PHD) or district (OD). NGOs supporting drug supply management in Cambodia also participate in the program. During these visits, previously trained pharmaceutical staff working in health facilities stores are interviewed and assessed on their ability to manage health commodities in their respective stores. Appropriate hands-on support is given as needed where short-fall or under performance is observed. Results presented in the form of graphical trend analysis were shared with the participants for each of the indicators monitored. Drug management indicators showed notable achievements, including increased availability of essential medicines during the last 3-4 years of the project. Currently the availability of essential medicines in health facilities in Cambodia is nearly 98% (or 2% stock out rates).

Cambodia's experience shows that regular and timely monitoring and support supervision visits to health facilities' pharmacy stores have the potential of improving drug supply management and, most importantly, of reducing the level of stock out and consequently improving the availability of and access to essential medicines. However, this outcome can only be achieved with sustainable sources of funding for the purchase of essential medicines, efficient procurement and distribution procedures.

2.8.5 WHO/HAI survey on access, availability and affordability of priority medicines for mothers and children (Dr Richard Laing)

MDG target 8E aims to provide access to affordable essential drugs in developing countries. Data from HAI/WHO surveys conducted in 50 countries show insufficient availability of the most affordable versions of selected essential medicines: their availability varied from 28-42% in the public sector. Low public sector availability could be due to lack of resources or under-budgeting, to inaccurate forecasting or inefficient procurement and distribution, or to low demand for slow-moving products. High private sector prices could furthermore be due to high manufacturer’s selling prices or high import costs or taxes and tariffs and /or high mark-ups.

The policy options to address these problems include measures to improve procurement efficiency, or to ensure adequate, equitable, and sustainable financing, through health
insurance systems that cover essential medicines. There is also a need to prioritize the medicine budget, i.e. target widespread access to priority medicines for mothers and children.

A key policy action to improve access would be to facilitate and promote generic use through preferential registration procedures (e.g. fast-tracking, lower fees), by ensuring the quality of generic products, and by permitting generic substitution and providing incentives for the dispensing of generics. In addition, there is a need to educate doctors and consumers on the quality, availability and acceptability of generic medicines.

Additional policy initiatives to separate prescribing and dispensing as well as controlling import, wholesale and/or retail mark-ups through regressive mark-up schemes may also be necessary. There is also a need to provide tax exemptions for medicines. Where there is little competition, it may be necessary to consider regulating prices. For patented medicines it may be necessary to use the flexibilities of trade agreements to introduce generics while a patent is in force and to promote differential pricing schemes whereby prices are lowered, in line with the purchasing power of governments and households in poorer countries. However, one should be cautious about introducing price controls for generic medicines when competition exists.

The WHO/HAI pricing policy papers available at http://www.haiweb.org/medicineprices/ may be a useful resource.

Comments and discussion:

There was some discussion on bioavailability and bio-equivalence. It was pointed out that bioavailability studies are not needed for vast majority of essential medicines. WHO has specified which essential medicines require bioavailability studies (technical report series).

If originator companies break the rules regarding advertising and promotion, e.g. if they make false statements that a generic product is not bioequivalent or is of lower quality, they should be fined.

2.8.6 UNFPA-WHO Collaborative Initiative to Review the Current Status of Access to a Core Set of Critical Life Saving Maternal/RH Medicines in Asia Pacific Countries

UNFPA and WHO conducted a joint review of access to selected, life-saving maternal and reproductive health medicines in Lao PDR (2008), Mongolia (2009), Philippines (2009), Solomon Islands (2010) and Vanuatu (2009).

The main objectives were to:

- obtain a ‘snapshot’ of the current status of access, supply and rational use;
- develop a harmonized approach for performing rapid assessments of critical maternal/reproductive health medicines;
- guide institutional support and capacity building in commodity security; and
suggest ways forward for consideration by the governments and key stakeholders.

The studies were conducted based on a toll developed by a core team from UNFPA and WHO. Document review, key informant interviews and consultations with key stakeholders were used, as well as visits to warehouses, health facilities, pharmacies at central, regional, district level and below. Public, private and nongovernmental organization sectors were included.

The studies were not based on representative samples; thus, the findings cannot be generalized. Nevertheless, they do provide valuable insights and are useful for raising awareness. The findings also supplement the findings of other studies and surveys.

It was found that, though the key medicines for maternal and reproductive health were mostly available, there were nevertheless incidences of stock out or overstock, due to inadequate knowledge of and guidelines on quantification, procurement and/or storage. Other issues that surfaced included the fact that the essential medicines list was outdated, absence of STGs, or a mismatch between STGs and the medicines that are actually available. In some instances, unregistered or expired medicines were in stock. It was also found that while prescribers knowledge is usually good at teaching facilities and academic institutions, there is a gap between knowledge and practice; thus, ultimately irrational use of medicines occurs at all levels. Inadequate dispensing skills were also observed. Wide variation in prices, donor-dependent supply chains and lack of quality control facilities pose further challenges. Finally, the maintenance of equipment (such as the fridge) may pose challenges.

Proposals to address this include in-service training, supportive supervision, strengthening of capacities for storekeeping and inventory management, forecasting, procurement and supply management. Ways need to be found to make these topics more interesting, especially for staff in health facilities. It also would be useful to harmonize approaches among UN agencies.

Comments and discussion:

The joint assessments brought to light that at times products are being stuck at central level. This may need to be looked into further; it is suggested that UNFPA and WHO can jointly do some follow-up work on this.

There has been an instance of adverse reactions to oxytocin related to a quality problem. This resulted in the withdrawal of the product. Such instances highlight the need to have resupply/emergency supply systems in place.

The "one UN" process could help to improve coordination between UN agencies.

2.9 Barriers to and options for improving access to priority medicines at national, sub national, facilities and community levels

The first part of this session consisted of group work; individual country groups identified country-specific feasible options and possible next steps to improve access to MCH medicines. A summary of the priority follow up actions can be found in Annex 3.
Subsequently, the proposed follow up actions were presented and discussed. Issues raised during these presentations (either by the presenting country itself or by other participants) are summarized below.

Questions and discussion about Viet Nam

Many plans are for the mid- to long-term. For immediate action, already existing clinical guidelines can be collated together to form a national standard treatment guideline. Another area of immediate focus should be to ensure that medicines are available in the health centres.

It is critical to strengthen clinicians’ declaration of conflict of interest. It is common in Asia that influential clinicians are often supported by pharmaceutical companies. It would be a good idea to adopt what US and Italy have done to control drug promotion in the private sector. In the US, all payments made to doctors need to be reported by the pharmaceutical companies. Italy levies 5% tax on all marketing activities and the money generated are used for research in neglected diseases and generic medicines.

Reimbursement of all medicines by the national insurance scheme drains the budget and is not sustainable. However, reimbursement costs for MCH services and medicines are low. Increase in reimbursement rate for MCH would stimulate increased utilization of services.

It is costly to carry out quality testing of drugs, however, the information is not shared. As Global Fund publishes quality control results on their website, sharing information would enhance better quality of drugs.

Questions and discussion about the Philippines

The Philippines already has guidelines and benchmarks for the use of MCH medicines in place. A list of essential MCH medicines exists, as an annex to the relevant treatment guidelines.

Some MCH medicines are included in the medicines provided by the botika barangay, for example ORS and certain antibiotics are included. The intention is to expand the range, but there is a temporary moratorium, for some of these botikas were found to operate outside their license.

Previously, different strengths of oxytocin were available, this has been standardized; currently only 10 IU should be available.

Previously, midwives were not allowed to use oxytocin, to protect them from being sued in case of unexpected side effects that they cannot handle. Now there is an administrative order that allows them to administer oxytocin, but there should be a doctor in reasonably near distance. This is however mainly an issue in the private sector.

Questions and discussion about Papua New Guinea

Public-private partnership should be encouraged. For-profit sector is not very big but faith-based organizations are very active providing half the health care services in the country.
Though private sector is profit-driven, some private organizations are interested in promoting the public good.

Intervention studies in other countries can be benchmarked to promote ORS sales and free distribution of family planning commodities through private outlets.

Papua New Guinea is interested in carrying out pricing survey. Faith-based organizations (FBOs) can be included as a third sector. The experience from East African countries is that FBOs procure medicines at low public prices, however sell at a private sector price making a big profit.

Quality control of medicines is a major concern. Though most vertical programs procure from WHO-prequalified suppliers, general supplies are procured from developing countries with weak regulation. Absence of quality testing lab makes it difficult to filter substandard medicines entering the country.

Questions and discussion about Lao People's Democratic Republic

Procurement is decentralized in Laos. The government is trying to centralize the system as the decentralization has led to problems of inconsistent quality of drugs and varying prices across the country. Centralized system already exists for certain vertical program commodities such as contraceptives and vaccines. Though centralization cannot be done at once, MCH commodities could be prioritized.

Vertical programs have a parallel supply chain. It would not be encouraged that MCH set up another parallel system. Hence, it was suggested that strengthening one standardized guideline on supply chain management would be useful. However, SOPs already exist in Laos. The document itself is not enough to ensure compliance without monitoring activities.

Countries are encouraged to run drug use surveys. Laos has carried out one in 2005 and plans to do level II survey this year.

Laos expressed an interest in exploring the use of regular monitoring (MTP), as in Cambodia.

Questions and discussion about China

One challenge in China is the under-utilization of primary facilities; patients have a tendency to go for "the best doctor".

The question was raised how useful it is to have a separate list of MCH medicines. Would it be better to have them in the regular EML? Perhaps it is useful to have the separate list ready and advocate for including those medicines in EML once the next revision is due. I.e. a separate list is not an end in itself (but a means to make progress). It was noted that some countries (e.g. Cambodia) have an EML which has a section where the medicines are listed per program; this makes it easy for each programme to review "their" part once revision is due.

The process for updating the WHO Model List of Essential Medicines was changed from selection by a committee of experts to a process based on applications and evidence.
It is important that treatment guidelines are formally endorsed by MOH and widely distributed, including by uploading on websites.

Questions and discussion and Cambodia

Cambodia raised the question whether macronutrients for the treatment of malnutrition could be included in EML. Inclusion of macronutrients in WHO model list is unlikely. By contrast, micronutrients are part of WHO model list as they have pharmaceutical standards which do not exist for macronutrients. However, it could be tried through WHO model list application process.

Inclusion in the WHO model list can have a great impact on availability of certain medicines. For example, inclusion of fixed dose combination therapy for TB increased its market share to 90%.

Common use of multi-dose injectables in Cambodia causes risk of contamination. Single dose is preferred, however, manufacturing cost of a multi-dose vial are often lower than or not too different from single dose. Hence, it may be more economical to use multi-dose vial for single usage.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

Participants of the Workshop on Ensuring Access to Priority Medicines for Mothers and Children discussed the services delivery of maternal and child health in different countries, especially on the access and availability of the medicines in different levels of health facilities. The bottlenecks for access, availability, quality as well as proper usage by providers and consumers were reviewed and practical options for improvements were proposed.

Participants also discussed the progress and challenges of the Millennium Development Goals 4 (reducing child mortality) and 5 (improving maternal health). There are indeed notable progress in some countries despite serious challenges in other countries. Follow up actions at different levels of services delivery were proposed to improve access and availability of the priority medicines, from selections, pricing, financing and streamlining the procurement, supply and management as part of the essential medicines in general. The importance of monitoring and supervision and the need for effective back up system for supply and for proper usage is underlined. There is a need for a mechanism for exchange of information, sharing of experiences and collaboration to cross fertilize the success to other countries in need.
3.2 Recommendations

**WHO, UNFPA and partners**

(1) WHO and UNFPA should closely collaborate to follow up the joint assessment and to provide technical support in improving the logistics supply distribution and monitoring of priority medicines for mothers and children.

(2) WHO, UNFPA and partners should facilitate effective intercountry exchange of experiences, cross fertilization, and collaboration in relation to access to priority medicines and the achievement of health outcome to reduce mortality.

(3) WHO, UNFPA and partners should collaborate to devise a mechanism for locating available stocks and rapid delivery of resupply of the priority medicines for emergency care such as oxytocin.

(4) WHO should facilitate, advocate and provide technical support for improving the availability and production of quality paediatric formulation.

(5) WHO should facilitate the documentation and publication of success in ensuring access to the priority medicines and the progress towards the achievement of the Millennium Development Goals.

**Member States:**

(1) A translation of Priority Medicines for Mothers and Children 2011 should be made available in the local language.

(2) A (national) workplan for improving access and availability to priority medicines through the existing delivery system should be devised, if possible as part of the bigger national strategy on maternal and child health. Proper advocacies and training of providers should be part of the plan. The plan should also include ways of ensuring access in remote places. The implementation of the action plan can be started in a particular area, e.g. provinces or districts, and scale up with a step wise approach.

(3) Adequate financing of essential medicines for mothers and children should be ensured by inserting the priority medicines, as published in WHO’s list as "Priority medicines for mothers and children 2011", on the list of reimbursable items of national health insurance schemes. Costing of standard treatment courses for health problems facing mothers and children, should be based on the Priority medicines" list and on WHO's standardized costing methodologies.

(4) Relevant follow up actions should be initiated within six months to one year at the national and subnational levels to address the bottle neck for access and availability of priority medicines for mothers and children.

(5) The implementation for monitoring and back up support for the availability, supply management and use of priority medicines should be developed and initiated; and a pilot area for implementation should be identified. A baseline on availability and affordability of the medicines can serve as an evidence for advocacy and a basis for
measuring progress. Track availability of a small set of selected medicines from the list "Priority Medicines for Mothers and Children 2011"

(6) Effective mechanism for intercountry cross fertilization and collaboration in ensuring access to priority medicines and achievement of health outcome should be pursued to reduce child and maternal mortality. Document success stories towards the achievement of millennium Development Goals and share with other countries.
ANNEX 1

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## WORKSHOP ON ENSURING ACCESS TO PRIORITY MEDICINES FOR MOTHERS AND CHILDREN
15 to 17 August 2011, Manila, Philippines

### TIMETABLE

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday, 15 August 2011</th>
<th>Time</th>
<th>Tuesday, 16 August 2011</th>
<th>Time</th>
<th>Wednesday, 17 August 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>Registration</td>
<td>08:00</td>
<td>10. Improving access, availability and rational use of priority medicines for mothers and children</td>
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<tr>
<td>08:30</td>
<td>1. Opening ceremony</td>
<td></td>
<td>• Framework for improving access (Karin Timmermans)</td>
<td>08:00</td>
<td>11. Plenary presentations &amp; discussions — Barriers and options for improving access to priority medicines — national, subnational, facilities and community levels.</td>
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<tr>
<td></td>
<td></td>
<td>09:30</td>
<td>• Efficient procurement, supply and management (Socorro Escalante)</td>
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<td>10:00</td>
<td>2. Introduction of the workshop (Budiono Santoso)</td>
<td>10:00</td>
<td>12. Follow up plan</td>
</tr>
<tr>
<td>09:30</td>
<td></td>
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<td>3. Maternal and child health in the Western Pacific Region (Marianna Trias)</td>
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<td>• National level</td>
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<td>10:00</td>
<td>4. Improving service delivery for maternal and child health (Laura Hawken)</td>
<td></td>
<td>• Subnational level (province, district)</td>
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<td></td>
<td>10:00</td>
<td>5. Intervention packages for maternal and child health (Ardi Kapinggisih, Emma Maricac)</td>
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<td>• Facilities</td>
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<td></td>
<td></td>
<td>10:00</td>
<td>6. Priority medicines for mothers and children (Kulisanta, Weerasuriya)</td>
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<td>• Community levels</td>
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<tr>
<td></td>
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<td>10:00</td>
<td>7. Financing options for maternal and child health services (Chris James)</td>
<td></td>
<td>Discussions</td>
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<td></td>
<td></td>
<td>12:30</td>
<td>Discussions</td>
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<td></td>
<td></td>
<td>13:30</td>
<td>8. Country presentations - delivery of MCH services and challenges for access, availability and quality of priority medicines.</td>
<td></td>
<td>13. Conclusion and recommendations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15:00</td>
<td>Group work — barriers to and options for improving access to priority medicines — national, subnational, facilities and community levels.</td>
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<tr>
<td></td>
<td></td>
<td>15:30</td>
<td>(Cont.) Group work — barriers to and options for improving access to priority medicines — national, subnational, facilities and community levels.</td>
<td></td>
<td>14. Closing session</td>
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<tr>
<td></td>
<td></td>
<td>17:00</td>
<td>Country presentations — brief overview on access to priority medicines for mothers and children.</td>
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<td>Country presentations — brief overview on access to priority medicines for mothers and children.</td>
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<td></td>
<td>17:30</td>
<td>Cocktails</td>
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</tbody>
</table>

### Coffee Break

- 09:30
- 12:30
- 15:00
- 15:30
- 17:00
### PRIORITY FOLLOW UP ACTIONS IDENTIFIED BY WORKSHOP PARTICIPANTS

<table>
<thead>
<tr>
<th>National level</th>
<th>Sub-national level</th>
<th>Facility</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAMBODIA</strong></td>
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<tr>
<td>• Prepare a separate list of priority medicines for MCH.</td>
<td>• Continue the utilization of existing back-up systems, such as stock transfers and supplementary orders, to meet program scale-up needs.</td>
<td>• Strengthen reporting of medicines use.</td>
<td>Strengthen Village Health Volunteers groups.</td>
</tr>
<tr>
<td>• Include additional priority medicines for mothers and children, including F75, F100 and BP100 for treatment of acute malnutrition, in the national EML.</td>
<td>• Continue the expansion of the MTP approach to improve rational drug use.</td>
<td>• Continue training and implementation of drug management guidelines.</td>
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<tr>
<td>• MoH/Govt to look for alternative sources of funding for contraceptive commodities after 2012.</td>
<td>• Strengthen DTCs at all referral hospitals.</td>
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<tr>
<td>• Conduct storage needs assessment and seek funding for identified gaps.</td>
<td>• Continue to promote Public-Private Mix Strategy.</td>
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<tr>
<td>• Continue to promote Public-Private Mix Strategy.</td>
<td>• Continue the expansion of the MTP approach to improve rational drug use.</td>
<td>• Develop guidelines for prescription audits and education.</td>
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<tr>
<td><strong>CHINA</strong></td>
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<tr>
<td>• Compare the WHO Priority list with the Chinese EML, identify gaps and consider inclusion of &quot;missing&quot; medicines in Chinese EML.</td>
<td>• Implementation of Health Reform Policy.</td>
<td>• Cut the link between prescription and income; compensation should be provided by government.</td>
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</tr>
<tr>
<td>• Set up database on supply management and use of medicines for maternal and children health</td>
<td>• Increase government investment for the provision of MCH medicines.</td>
<td>• Conduct performance evaluation with comprehensive indicators, such as rational prescription, patient satisfaction.</td>
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<tr>
<td>• Apply fast track registration for pediatric dosage forms.</td>
<td>• Integrate the 3 separate insurance systems</td>
<td></td>
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<tr>
<td>• Increase government investment for the provision of MCH medicines.</td>
<td>• Set up an integrated information system (including health facilities) for collecting the information on medicine requirements efficiently and transparently.</td>
<td></td>
<td></td>
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<tr>
<td>• Integrate the 3 separate insurance systems.</td>
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</table>
### Laos

- Develop a clear policy on procurement for MCH medicines.
- Develop a detailed plan to implement the policy of free health services for mothers and children.
- Include pediatric formulations in the EML.
- Facilitate registration of needed MCH medicines.
- Disseminate the EML for MCH to all health facilities.
- Centralize procurement for essential medicines.
- Introduce Unified logistic system for supplying medicines including MCH medicines.
- Provide guideline on storage of essential medicines for all levels.
- Train health providers on rational prescription.
- Use MTP for improvement of rational use of medicines.

### Mongolia

- Renew reproductive health programme.
- Renew national programme for children's health.
- Price assessment of essential medicine.
- Conduct refresher training for service providers.

- Provide drug information to patients when dispensing drugs.
- Only registered medicines should be procured (self-management by pharmacists at all levels).
- Educate the community on the rational use of medicines.
<table>
<thead>
<tr>
<th><strong>P A P U A N E W G U I N E A</strong></th>
<th><strong>P H I L I P P I N E S</strong></th>
<th><strong>V I E T N A M</strong></th>
</tr>
</thead>
</table>
| • National Quantification study.  
• Increase manpower number & skills. | • Establish provincial transit stores to strengthen supply chain.  
• Increase and training of appropriate manpower. | • Review operational procedures for procurement and supply of medicines.  
• Strengthen post-marketing surveillance  
• Develop local level capacity for medicines management. |
| | | • Strengthen drug therapeutic committees and drug information units to provide independent information on medicines.  
• Introduce prescription audits and utilization analysis for medicines. |
| • Assured funding support by incorporating as budget line item  
• Financial risk protection by expanding PhilHealth benefits  
• Universal coverage of PhilHealth enrolment and increased utilization thru social marketing and information dissemination  
• Increase functionality of health facilities  
• Assist CHD regional offices in operationalization of universal health care (UHC) | • Alignment of priorities with the Aquino Health Agenda through localization of national policies and guidelines. |  |
| | | • Advocacy for increased utilization / access to essential basic health services  
• Close follow-up and monitoring of clients  
• Functional community health teams |
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