Goal 3

Target number: 3.b

Indicator Number and Name: 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis.

Agency: World Health Organization

Has work for the development of this indicator begun? Yes

Who are the entities, including national and international experts, directly involved and consulted in developing the methodology/and or data collection tools?
After the initial proposal for indicator 3.b.3 was discussed at the IAEG meeting in November 2016, WHO began convening key stakeholders to discuss the measurement of this indicator, proposing a draft methodology for consideration. As the draft proposed methodology has been pilot tested in February 2016 in 19 countries, those governments and WHO country offices where the pilot took place have substantially contributed to the development so far of the draft proposed methodology.
The first stakeholders meeting in December 2016 has included all members of the Interagency Pharmaceutical Coordination Group (IPC), an informal group of international agencies involved in the development and implementation of medicines and health products' policies and programmes. The entities that participate in this group are: United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Industrial Development Organization (UNIDO), Joint United Nations Programme of HIV/AIDS (UNAIDS), the Global Fund to Fight AIDS, the Global Alliance for Vaccines and Immunization (GAVI), UNITAID, the Stop TB Partnership, the World Bank and the International Pharmaceutical Federation (FIP).
The following stakeholders meetings that included all members of the Interagency Pharmaceutical Coordination Group (IPC) took place in June 2017, December 2017and June 2018. Over these meetings the methodology of the indicator was presented and discussed with the members.
An information sharing session was held with all the WHO regional offices in January 2017.
One country, Kenya, is in the process of conducting a Service Availability and Readiness Assessment (SARA) and will provide the data to calculate the indicator.

What is the involvement of or how do you plan to involve National Statistical Systems in the development of the methodology?

The development of the methodology will draw from existing and well-established methodologies, used widely by international agencies and national institutions: the WHO/HAI methodology created in 2003, the Service Availability and Readiness Assessment (SARA) methodology and the WHO 2007 Children's Medicines Survey.
WHO has also been developing a data collection tool, the EMP Price and Availability Monitoring Mobile App, to collect data on essential medicines that can be used to measure this indicator as it supports collection of information at facility level on availability and price of the agreed core basket of medicines.
The first pilot of the data collection tool occurred in February 2016, in collaboration with WHO regional and country offices in 19 countries with the involvement of national Ministry of Health officers that reviewed the raw data and the analysis results and helped in the refinement of the mechanism.
The final version of the methodology was disseminated to WHO Regional Offices and the above-mentioned IPC Members for further comments in June 2018. The comments were then analysed and implemented.

In June 2018 WHO requested to its Member States the identification of a national focal point to start consulting on the methodology as well as to consult and review the individual country estimates. By end of July the detailed Concept Note on the methodology accompanied with the example of the computed indicator based on an anonymized country will be shared with these focal points and the NSOs that are SDG focal points. Countries that participated in the pilot data collection (with EMP Price and Availability Monitoring Mobile App) will be additionally contacted and the computed indicator based on their national data will be shared. The feedback and comments are expected to be received by 15 September 2018.

Please briefly describe the process of developing the methodology for the indicator

Given that the methodology is derived from well-established ones that international agencies and national institutions have been using regularly for more than a decade, WHO has focused on agreeing on the core set of medicines to be monitored regularly. During the December 2016 meeting of the IPC group, WHO presented the draft proposed methodology and data collection tool and initiated discussions for their refinement.
Consultations with WHO Regional offices were initiated in January 2017 and continued until the next meeting of the IPC group that took place in June 2017, during which a final methodology, data collection tool and core set of medicines to be monitored were introduced.
The basket of medicines was presented and discussed during multiple occasions, including the latest IPC meeting in June 2018 as well as with WHO regional advisers on medicines. All comments and suggestions on the medicines' inclusion/exclusion were taken into consideration.
In February 2016 the data collection tool was piloted in 19 countries by WHO country offices in collaboration with national Ministry of Health officials. Through the feedback from national officials to that pilot, the data collection tool was further refined and the results of the analysis of the collected data shared with national governments officials.
Since December 2016, once the indicator was agreed by the IAEG, WHO started consultations with the above mentioned stakeholders (IPC members and WHO regional offices) on the basis of the results of the pilot in February 2016.
The analysis of the indicator will be computed based on 19 countries from a pilot survey and will be shared to receive the feedback from national Ministry of Health officials and WHO country offices of these countries to help the identification of possible remaining issues to be addressed. Other Member States (not involved in the pilot data collection survey) that have submitted the nomination of the national focal point will be reached as well and the Concept Note on the methodology together with an example of the computed indicator based on an anonymized country will be shared for feedback by the end of July 2018.

Please indicate new international standards that will need to be proposed and approved by an intergovernmental process (such as UNSC) for this methodology.

None

When do you expect the methodological work on this indicator to be completed?

The final version of the methodology will be available after receiving the feedback and comments from WHO Member States in September 2018.

Are data and metadata already being collected from the National Statistical System for one or more components of this indicator?

Data on price and availability of medicines should be collected through the national Logistics Management Information System (LMIS), national health insurance schemes, national pharmaceutical regulatory institutions, etc. However, many low income and lower middle income countries have less mature systems for data collection and are unable to collect data for this indicator regularly through existing systems. Thus, WHO will be using data collected through the well-established Service

Availability and Readiness Assessment (SARA) surveys. Furthermore, WHO has developed a data collection tool (the EMP Price and Availability Monitoring Mobile App) that can be used by national institutions to conduct surveys to obtain these types of data.
During a pilot data collection in 2016 the main point of contact in the 19 countries where the pilot took place was the WHO country office in strong connection with national Ministry of Health officials.

If yes, please describe:

See above

How do you plan to collect the data?

Data will be collected through the Service Availability and Readiness Assessment (SARA) surveys that countries conduct regularly. However, the process used during the 2016 pilot will also be repeated: WHO, through its country offices, will make available a data collection tool (the EMP Price and Availability Monitoring Mobile App) for local staff to use in the selected facilities to conduct a survey on price and availability. The survey will focus on a core set of medicines for inclusion in the indicator.

If the indicator involves multiple components from different data sources, please describe how each individual component of the indicator will be collected here.

The affordability component is the only component that will require data collected from several sources. In particular, except for the medicine price data that will be collected from the EMP Price and Availability Monitoring Mobile App, data on the lowest paid unskilled government worker (LPGW) wage and National Poverty Lines (NPLs) is needed to compute the affordability component.
Data on the LPGW wage will be collected from the ILOSTAT database.
Information for NPLs will be collected from the Poverty reports that are produced by the National Statistical Departments of the countries.
To weight medicines in the basket according to the prevalence of the diseases that these medicines are used to treat/cure/control, data from the WHO Global Burden of Disease (regional information) will be used.
Other data sources could be used to compare the price of the core set of medicines collected through the WHO data collection tool with other available prices for the same medicines.

With what frequency is data expected to be collected?

We expect each country to collect data every 2-3 years.

Is there a process of data validation by countries in place or planned for this indicator?

As during the pilot in February 2016, countries are able to review the raw data after data collection is completed and provide comments. Moreover, the Ministry of Health will be requested to approve the information before making it publicly available.

If yes, please briefly describe:
The raw data is shared with the country (WHO country office and Ministry of Health official, when involved in the survey process) before the data analysis starts to allow for major issues to be corrected (missing information, data inconsistencies, etc.).
Once the data is analysed, the information will be shared again with the same counterparts and approval for its publication will be sought.

(as of July/August 2018)