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PROGRESS REPORTS ON TECHNICAL PROGRAMMES

As a follow-up to discussions at previous sessions of the Regional Committee, progress reports on the following technical programmes are presented in this document:

(1) *Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015)*;

(2) Dengue fever and dengue haemorrhagic fever prevention and control;

(3) Mental health;

(4) Action Framework on Essential Medicines;

(5) Asia Pacific Observatory on Health Systems and Policies;

(6) *Regional Strategy on Human Resources for Health (2006–2015)*; and

(7) Expanded Programme on Immunization.

In addition, this document briefly reports on the outcome of the Pacific Health Ministers Meeting held on 28–30 June 2011.

The Regional Committee is requested to note the progress made and the main activities undertaken.

REGIONAL ACTION PLAN FOR MALARIA CONTROL AND ELIMINATION IN THE WESTERN PACIFIC (2010–2015)

1. BACKGROUND AND ISSUES

The sixtieth session of the Regional Committee for the Western Pacific in 2009 endorsed the *Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015)* through resolution WPR/RC60.R5, as a road map to guide national malaria programmes, as well as a programme monitoring framework and an advocacy and resource mobilization tool. Since then, remarkable progress has been made by most Member States to reduce malaria mortality and morbidity and to move towards elimination. However, malaria remains a significant public health problem in the Region, with continued transmission in "hot spots" in many endemic countries, malaria epidemics and a high burden of malaria existing in Papua New Guinea.

While coverage with malaria interventions has increased, universal access of populations at risk to malaria diagnosis, artemisinin-based combination therapy (ACT) and preventive measures, including long-lasting insecticidal bednets (LLIN), is yet to be achieved. This is especially so for vulnerable groups, such as mobile and migrant populations. In some countries, the private commercial sector is still a major provider of treatment services and often poorly regulated, leading to increased risks of counterfeit and substandard medicines and of the irrational use of artemisinin derivatives and other antimalarials. These factors are major contributors to artemisinin resistance of falciparum malaria, which has emerged in this Region—notably on the Cambodia-Thailand border—and which poses a major threat to malaria control and elimination in the Region and beyond.

Vivax malaria is prevalent in 10 malaria-endemic countries in the Region and predominant in four, with a large subregional variation. Primaquine for radical cure is not implemented in all countries due to safety concerns given the high prevalence of glucose-6-phosphate-dehydrogenase (G6PD) deficiency and the lack of a G6PD rapid test for use at the level of primary health .

Malaria control as a part of health systems strengthening is desirable, but implementation of cross-cutting interventions, such as the strengthening of laboratories, health information systems, mother and child health programmes and human resources for health, remains challenging.

2. ACTIONS TAKEN

2.1 Five out of 10 malaria-endemic Member States used the *Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015)* to update their national malaria strategic plans, and four other Member States newly incorporated a malaria elimination goal in their national plans. All malaria-endemic countries in the Region, except Papua New Guinea, now aim for malaria elimination. Five countries updated their national malaria monitoring and evaluation plans based on the malaria indicator framework, which is part of the Regional Action Plan. Most countries used the *Regional Action Plan* to mobilize additional internal and external resources, including sizable grants from major donors such as AusAID, the United States Agency for International Development and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

2.2 Eight out of 10 malaria-endemic countries have expressed a strong commitment to malaria elimination and have intensified control. Most have increased their manpower at all levels to scale up their programmes. The Asian Collaborative Training Network for Malaria (ACTMalaria) continued to play a major role in capacity-building, such as training for middle-level programme managers on all malaria interventions. Malaria resources are being used to strengthen key components of the health system tailored to country needs, including health systems strengthening support through the Global Fund to Fight AIDS, Tuberculosis and Malaria and other donors. The commitment was also reflected in vivid annual World Malaria Day commemorations in each country.

2.3 Universal access (greater than 80% coverage) of at-risk populations to appropriate and effective vector-control measures (insecticide-treated bed nets and/or LLINs) has been achieved by three Member States, while others have scaled up malaria prevention appreciably. Six endemic countries are using indoor residual spraying (IRS)—especially in the malaria elimination context. IRS has been strengthened through training and the provision of standard operational procedures.

Access to parasite-based diagnosis (microscopy and malaria rapid tests) increased significantly in most countries: 20% more malaria tests were carried out in 2009 compared to 2008 and 88% of suspected malaria cases in the Region were laboratory tested that year. To assure quality of malaria diagnosis, WHO in the Western Pacific, working jointly with partners and WHO Collaborating Centres continued to provide batch testing of malaria rapid tests in two regional laboratories, conducted external competency assessments of microscopists in most countries.

2.4 Access to effective malaria treatment also increased in the Region. All countries are using WHO-recommended artemisinin-based combination therapy; malaria treatment guidelines were reviewed in Cambodia to take into account the severe drug resistance situation; and community-based

malaria diagnosis and treatment is part of the programmes in all countries. Cooperation with the private sector for diagnosis and treatment was piloted in Cambodia and the Lao People's Democratic Republic. In Cambodia, outreach to migrant and mobile populations was intensified through innovative interventions, including at border crossings. Services utilization was maximized through intensified communication and community mobilization.

2.5 Cambodia and the Lao People's Democratic Republic issued a government decree to ban the marketing of artemisinin-based monotherapy and take action to enforce it. Operations to contain artemisinin-resistant falciparum malaria on the Cambodia-Thailand border continued, and as a result malaria cases were reduced to pre-elimination levels in target areas. Resources to sustain these efforts have been secured, aiming at elimination of these parasites. New suspected foci of artemisinin resistance have been identified in the Greater Mekong Subregion, and a South-East Asia regional containment effort is currently being initiated.

The problem of substandard and counterfeit medicines is being addressed in some countries through continued monitoring of the medicines quality, increased public awareness, and regulatory and enforcement actions involving medicines regulatory authorities, drug inspectors, intersectoral committees, customs authorities and police, including Interpol.

2.6 To fill knowledge gaps to improve treatment of vivax malaria, research is being conducted to evaluate a new rapid test for diagnosis of G6PD deficiency as well as a clinical trial to assess the sensitivity to primaquine among people with G6PD deficiency. *Plasmodium knowlesi*, a monkey malaria parasite, affects humans in South-East Asia, and as a result a priority research agenda and recommendations on a public health response have been established during an expert consultation.

2.7 National malaria surveillance and monitoring and evaluation systems are being strengthened based on an assessment of the capacity of those systems in nine countries, through training, guidance on the regional indicator framework and surveys. All Member States reported on malaria trends and programme impact. While malaria deaths in 2010 decreased by 15% (from 1031 in 2009 to 899 in 2010), confirmed malaria cases increased by 6% in 2010 compared to 2009 (262 474 versus 247 669 cases), which may be due to improved diagnosis and surveillance. Malaria risk stratification was updated in several countries. Antimalarial drug resistance surveillance has been intensified in the Greater Mekong Subregion, and is being strengthened in the Pacific through a new network. For monitoring insecticide resistance of mosquito vectors, an Asia Pacific web-based system is being established, coordinated by ACTMalaria.

3. ACTIONS PROPOSED

The Regional Committee is invited to discuss the issues and challenges associated with the implementation of malaria control and elimination in the Western Pacific Region.

Member States are requested to accelerate implementation of activities leading to elimination or intensified control of malaria and to strengthen their commitment to all elements of the *Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015)*.

DENGUE FEVER AND DENGUE HAEMORRHAGIC FEVER PREVENTION AND CONTROL

1. BACKGROUND AND ISSUES

Dengue remains a serious public health problem in the Western Pacific Region. Outbreaks and deaths continue to be reported in increasing numbers. In 2010, Member States reported a total of 353 907 dengue cases, with 1075 deaths. The countries in the Region with the highest number of reported cases were Australia, Cambodia, the Lao People's Democratic Republic, Malaysia, the Philippines, Singapore and Viet Nam. Those countries, except for Australia, reported an increase in the number of reported cases compared with 2009. So far, in 2011, the dengue situation in some countries continues to show high activity.

During its fifty-ninth session in 2009, the WHO Regional Committee for the Western Pacific endorsed the *Dengue Strategic Plan for the Asia Pacific Region (2008–2015)* in resolution WPR/RC59.R6. Member States were urged to: (1) strengthen their health systems to improve diagnosis and case management and to strengthen national surveillance; and (2) foster and support inter-programme, interagency, intersectoral and intercountry collaboration for outbreak response and greater community involvement, early recognition of dengue complications, and timely referral of cases.

In 2010, Member States expressed the need for technical assistance from WHO in the practical application of the 2009 WHO guidelines for dengue prevention and control, particularly in the areas of strengthened surveillance and use of the new case definition and adjustment of International Statistical Classification of Diseases and Related Health Problems, 10th Revision, (ICD-10 Codes).

It was felt that a lack of consensus on the use of the new case classification may affect data interpretation and intercountry comparison.

Dengue prevention and control is an intersectoral issue requiring national resources to be mobilized, with better regional collaboration.

2. ACTIONS TAKEN

The Emerging Disease Surveillance and Response unit of the Regional Office's Division of Health Security and Emergencies collects and collates dengue data from the Region to monitor regional epidemiological trends. To address the issue of early diagnosis and case management, the Regional Clinical Network on Infectious Diseases discussed the current case definition. A dengue case-management curriculum is under development and, once ready, will be piloted in selected countries. It is proposed to undertake a dengue death study to retrospectively review the progression of the disease. The Malaria and Other Vectorborne and Parasitic Diseases unit of the Regional Office's Division of Combating Communicable Diseases is supporting integrated vector management (IVM) training and policy development in countries in the Association of Southeast Asian Nations (ASEAN) countries and establishing a web-based Insecticide Resistance Monitoring Network.

ASEAN Health Ministers demonstrated strong political commitment in their designation of 15 June 2011 as Dengue Day. The first such Dengue Day was observed in 2011, launching what will become an annual advocacy campaign for the prevention and control of dengue at regional and national levels. WHO and the ASEAN Secretariat combined efforts to ensure the successful launching of ASEAN Dengue Day, at the same time using the day as an opportunity to consolidate prevention and control measures. The Dengue Strategic Plan was used as a starting point to develop key messages for advocacy use by health ministers on ASEAN Dengue Day and for use by programme managers.

3. ACTIONS PROPOSED

In response to concerns from Member States during the sixty-first session of the WHO Regional Committee for the Western Pacific, dengue is being used as a pathfinder for strengthening of national and regional alert and response capacities. Member States are being encouraged to integrate dengue surveillance into their existing indicator-based surveillance under APSED. Dengue is one of the priority diseases for laboratory strengthening, and laboratory capacity is being strengthened under APSED and in conjunction with ASEAN +3 Partnership Laboratories. Regional information-sharing was an issue raised among participants during a WHO/ASEAN workshop. Neighbouring countries stated the benefits to be derived from the timely sharing of data on the dengue situation in countries nearby. WHO is also providing support to Member States in using the IVM principle in dengue prevention and control.

MENTAL HEALTH

1. BACKGROUND AND ISSUES

An estimated 100 million people in the Western Pacific Region suffer from mental and neurological disorders, which affect people of all ages, classes and cultures. Surveys estimate that at least 2% of the population suffer from the most severe forms of mental disorder, including schizophrenia, dementia, severe mental retardation and the consequences of brain injuries. Less severe, but still disabling conditions, such as depressive disorders, anxiety and obsessive-compulsive disorders, affect a further 3%–4% of the population. The disease burden from mental health is expected to increase greatly in the future as a result of such factors as dramatic social changes, rapid population ageing, increased gaps between social and economic classes, etc.

Many barriers prevent the successful implementation of mental health programmes, as well as preventing people from receiving the effective treatment they need. The perception of mental illness is often still contaminated with images of violence, sin and laziness. In addition, most general health workers are unfamiliar with modern methods of treatment for mental illness and often do not have the necessary skills to deal with patients. More efforts are needed to explore innovative approaches to enhance political commitment, raise public awareness, and motivate and empower health professionals to provide much needed mental health services.

2. ACTIONS TAKEN

2.1 Partnerships for mental health

The Pacific Islands Mental Health Network (PIMHnet) has, since its launch in 2007, been a successful vehicle for delivery of a range of interventions across the Pacific, such as updated and improved mental health policies and legislation, and increased workforce capacity to deliver quality services. Human resource development plans have been developed in all PIMHnet countries. PIMHnet has often utilized innovative approaches, such as on-the-job mentoring by volunteer experts. Currently, 19 countries and areas in the Pacific are members of the Network.

Other partnerships include a network for suicide prevention, which has, in recent years, had a number of meetings and workshops in Brisbane, Australia; Hong Kong (China) and Beijing, China.

Close collaboration also exists with the World Organization of Family Doctors (WONCA), the Royal College of Psychiatrists and the Asia Federation of Psychiatric Associations.

2.2 Strengthening integrated and systematic prevention and management

Mental health policies and legislation are essential, not only to coordinate all programmes and services related to mental health, but also to protect the human rights of people with mental disorders. A number of countries in the Region have been supported to assess their existing mental health systems and to update or develop national policies and legislation.

In order to reduce the treatment gap, continuous efforts have been made to strengthen mental health education and training for medical and nursing students, health professionals in general practice, and programme managers at national and local levels. An approach of combining domestic and international fellowships, short-term training courses and development of a psychiatric resident programme to build capacity for mental health has been supported in a number of countries, including China, the Lao People's Democratic Republic, Mongolia, Solomon Islands and Vanuatu. In the Lao People's Democratic Republic, national workshops and training sessions for provincial heads of health authorities and provincial hospitals have also been organized as a first step in establishment of mental health units in all provincial hospitals throughout the country. Globally, the Mental Health Gap Action Programme (mhGAP) is providing a useful instrument for integrating mental health into different levels of health care in Member States.

Natural disasters and other emergency situations cause significant psychological and social suffering in affected populations. Since 2003, WHO has been working closely with China, Mongolia and the Philippines to improve and integrate mental health and psychosocial support into disaster preparedness, response and rehabilitation.

2.3 Evidence and information for action

WHO-AIMS (Assessment Instrument for Mental Health Systems) has been carried out in China, Fiji, the Lao People's Democratic Republic, Mongolia, the Philippines, the Republic of Korea and Viet Nam, and the results will act as a baseline to monitor improvement in their mental health systems. All countries of the Region have participated in the mental health ATLAS survey, which globally maps all mental health sources, and specific mental health epidemiological surveys have been supported in China and Mongolia.

The Suicide Trends in At-Risk Territories (START) project has been running for the past few years in a number of countries. Besides improving the recording of both fatal and non-fatal suicidal

behaviours, the project also aims to develop flexible and cross-culturally appropriate interventions for suicidal behaviours.

2.4 Innovative approaches and initiatives

The Patient at the Centre of Care Initiative, a patient-centred and rights-based approach to health care, has evolved from extensive consultations establishing a policy framework reflecting the psychosocial factors affecting health outcomes into development of indicators to assess health care systems.

The project, Epilepsy Management at a Primary Health Level, implemented in rural China under the aegis of WHO and the Ministry of Health, has successfully reduced the epilepsy treatment gap in demonstration sites and has been expanded to cover rural areas of 13 provinces in the country. The experiences and lessons learnt from the project are shedding light on development of an effective and sustainable strategy to scale up treatment of mental and neurological disorders in resource-poor settings.

In response to concerns about the impact of the mass media on suicidal behaviours, a review was carried out to assess the effect of media-centred interventions on suicide prevention. Following the review, consultations were held in high-burden countries to engage media professionals and other stakeholders in discussions about suicide, and to mobilize the media to actively promote suicide prevention.

3. ACTIONS PROPOSED

The Regional Committee is invited to note the fact that, during the last decade, there has been no substantial progress in mental health care in many low- and middle-income countries, while increasing trends of depression and suicide are occurring in many countries. More efforts are needed to explore innovative approaches to enhance political commitment, raise public awareness, and motivate and empower health professionals to provide much-needed mental health services.

The Regional Committee is also requested to take note that, with an increasingly ageing population in the Western Pacific Region, rates of dementia are expected to increase substantially. In 2010, 36 million people globally lived with dementia, and that number is projected to increase to 66 million by 2030. Two thirds of those people live in low- and middle-income countries, where the increases in numbers are set to occur. The societal cost to health and social systems, and to families, is

substantial. Member States should be supported to develop plans for dealing with the emerging need for long-term care that take social and demographic needs into consideration and focus on supporting family caregivers through, for example networks of caregiver nongovernmental organizations, and also offer social protection for vulnerable people with dementia.

ACTION FRAMEWORK ON ESSENTIAL MEDICINES

1. BACKGROUND AND ISSUES

The original *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region* covered the period from 2005 to 2010, providing guidance to Member States and WHO on improving access to essential medicines and strengthening pharmaceutical systems. Access to essential medicines of assured quality remains a problem in a number of countries in the Region. Evaluations of the implementation of the Regional Strategy (see below) show that the strategies and actions outlined in the Strategy still remain valid. In order to ensure continued success and address new or emerging issues and challenges (e.g. related to adequate financing for medicines), the *Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016)* was developed (Annex 1). The Framework will provide strategic direction for WHO collaboration with Member States and will enable WHO to respond to country needs and challenges in the development and implementation of actions.

2. ACTIONS TAKEN

The development of the *Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016)* started in 2008 with an evaluation of progress in implementation of the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* through in-depth reviews undertaken in six countries, not including the Pacific. In the Pacific island countries, implementation of the Strategy was evaluated in 2010 as part of the European Community/WHO partnership on pharmaceutical policies. Those evaluations concluded that the Strategy "has met, and still meets many of the needs as a guide for improving access to essential medicines".[1]

The Framework takes into consideration the findings from those evaluations, as well as data on the medicine situation in the Region, comments from Member States and input from the expert consultation held from 18 to 20 November 2009 in Manila, Philippines. Moreover, the Framework has been aligned with the *WHO Global Medicines Strategy*.

[1] Helling-Borda M, Eriksen T, *Review of the Implementation of the Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010).*

In September 2010, the Framework was finalized during a consultation to which all Member States in the Western Pacific had been invited. Among the more salient outcomes of that consultation was an agreement to set specific targets for the indicators and to introduce a "traffic light" system to provide quick feedback and alert countries to areas requiring more attention

3. ACTIONS PROPOSED

The Regional Committee is invited to take note of the *Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016)* (Annex 1).

ASIA PACIFIC OBSERVATORY ON HEALTH SYSTEMS AND POLICIES

1. BACKGROUND AND ISSUES

At its fifty-ninth session in 2008, the WHO Regional Committee for the Western Pacific adopted a resolution on health systems strengthening and primary health care (WPR/RC59.R4) that, among other things, urged Member States "to collaborate in efforts to increase the capacity in the Region to analyse country-specific health system issues and challenges and assess health systems performance through a mechanism such as an Asia Pacific Observatory on Health Systems and Policies". This report provides an update on progress towards that objective.

2. ACTIONS TAKEN

Over the last two years, WHO has led a series of consultations on the Asia Pacific Observatory on Health Systems and Policies, with participation of Member States, development organizations and the academic and research communities. These stakeholder consultations culminated in the official launch of the Observatory in June 2011 and agreement on its two founding documents: the Statement of Intent, in which signatories pledge financial support to the Observatory and endorse its goals, objectives and guiding principles; and, the Terms of Reference, which set out the Observatory's day-to-day management arrangements.

2.1 Institutional arrangements

The Observatory is a collaborative partnership of interested governments, international agencies, foundations, civil society and the research community, based within WHO and run as a WHO programme. The Secretariat of the Observatory will initially be based in the WHO Regional Office for the Western Pacific.

A Steering Committee, comprising signatories to the Statement of Intent, guides the strategic direction of the Observatory and monitors the implementation of its workplan. The Observatory is a biregional initiative, covering Member States of both the South-East Asia and Western Pacific Regions of WHO, thereby encompassing the entire Asia Pacific region.

2.2 Products

The purpose of the Observatory is to support and promote evidence-based health policy-making by linking systematic and scientific analysis of health systems with the decision-makers who shape policy and practice. To this end, it will provide policy-makers with comparative evidence and other information relevant to strategic policy decisions on health systems in the Asia Pacific region, primarily through three types of product:

1. **Country profiles**, using the Health Systems in Transition (HiT) template, developed by the European Observatory on Health Systems and Policies and adapted for the Asia Pacific region.

2. **Thematic studies with cross-country analysis**, aiming to provide in-depth and impartial evidence on key health systems issues that policy-makers in the Region have identified as being of concern to them.

3. **Policy dialogue events**, at which the Observatory will facilitate access to tailored evidence and expertise on specific issues, as requested by Member States.

These products will be developed by academic and research institutions based in the Asia Pacific region. In addition, a research advisory group, comprising individuals with health systems expertise, will be appointed to provide advice on the quality and relevance of Observatory products.

3. ACTIONS PROPOSED

Once the Observatory has been in operation for three years, the Secretariat will commission an independent review of its performance.

A number of products are already in the pipeline and will be published by the Observatory over coming months. These include HiTS in Fiji, Hong Kong (China), Malaysia, Mongolia, the Philippines, Singapore and Solomon Islands, as well as policy briefs on human resources for health and health financing.

REGIONAL STRATEGY ON HUMAN RESOURCES FOR HEALTH (2006–2015)

1. BACKGROUND AND ISSUES

The *Regional Strategy on Human Resources for Health (2006–2015)*, endorsed by the WHO Regional Committee for the Western Pacific in 2006, provides a range of policy options and practical guidance for developing and sustaining a sufficient, competent, responsive and adequately supported health workforce. Recent global and regional developments have further guided work in the area of human resources for health (HRH) in the Region, such as the *World Health Report 2006: Working together for health*; the strengthening of human resource planning and information systems; reviews and updating of regulatory systems; reviews of the quality and relevance of education; research and recommendations on rural and remote retention; and dissemination of codes of practice for recruitment of health workers.

2. ACTIONS TAKEN

Three WHO meetings have been held to review progress in implementation of the Regional Strategy, which is considered to be still very relevant. However, there is a need to better reflect action points to assist Member States in the area of HRH. A proposed action framework to direct and scale up implementation has been drafted, incorporating recent trends and developments in HRH (Annex 2). The framework is based on comprehensive regional HRH situation analyses conducted by experts in 2009, as well as on country consultations in 2011, including a meeting of Pacific island countries.

Most countries now recognize the importance of the health workforce in achieving population health goals. There is increasing impetus on resolving HRH challenges at the highest levels of government, as evidenced by the formation of high-level, multisectoral committees and issuance of HRH decrees. Countries are responding by strengthening health workforce strategic planning; implementing human resource management systems; improving the collection and sharing of data; improving the linkage of workforce planning with service and education; reorienting health services towards primary health care, health promotion and integrated care across the continuum; and testing strategies to reduce access barriers for disadvantaged groups.

Countries have intensified their efforts to improve HRH production and development, including concerted interventions to strengthen the quality and relevance of education and training. There have been improvements in the geographical distribution of health workers, as well as evidence-based interventions to increase retention and motivation and to better manage performance. There are ongoing activities to review the skills mix, roles and functional requirements, as well as strategies to mitigate the effects of migration.

Intensified strategic actions are required to address absolute shortages of qualified health workers; the unbalanced distribution of workers and an inefficient skills mix; inappropriate training and education—not matched to patient and population needs; and poor motivation and retention in most lesser-resourced countries. The need for increased, sustainable HRH financing also needs to be met.

Workforce shortages and maldistribution of health workers are still shared problems, although the seriousness of the situation varies from country to country, as do the availability and reliability of workforce information. In many countries, most health workers are found in urban areas, leaving rural areas underserved. Cross-sectoral planning and coherent policy alignment across sectors are currently lacking. Databases and HRH information management systems, even if they exist, do not provide policy-makers and planners with the necessary data to enable workforce analyses by sex, age, location and ethnicity.

3. ACTIONS PROPOSED

The *Human Resources for Health Action Framework for the Western Pacific Region (2011–2015)* is proposed to better inform and guide WHO, Member States and partners in concerted actions to address the challenge of developing and sustaining a health workforce that is adequate, competent, productive and supported, to meet population health needs.

The Regional Committee is invited to take note of the *Human Resources for Health Action Framework for the Western Pacific Region (2011–2015)* (Annex 2).

EXPANDED PROGRAMME ON IMMUNIZATION

1. BACKGROUND AND ISSUES

Resolution WPR/RC61.R7, adopted by the Regional Committee at its sixty-first session in 2010, reaffirmed the 2012 measles elimination and hepatitis B control milestone and maintenance of poliomyelitis-free status. It urged Member States to commit the human and financial resources necessary to achieve the high immunization coverage and sensitive and timely surveillance needed to achieve those goals and to accelerate control of rubella, and to establish an independent verification process for measles elimination.

Progress towards measles elimination and hepatitis B control continues. Annualized measles incidence for 2011, as of April 2011, stands at 14 per million population, down from 34 and 27 per million in 2009 and 2010, respectively; 25 countries and areas may already have achieved the elimination goal. The remaining countries have only 15 months to stop endemic measles virus transmission. The hepatitis B milestone of less than 2% chronic hepatitis B infection among 5-year-old children is likely to be achieved in 27 countries and areas by 2012, representing 88% of the Region's population. However, many of these countries and areas have not conducted serological studies to measure prevalence rates and/or have not initiated the verification process. Nine priority countries need to further improve routine immunization coverage to the levels needed to reduce chronic hepatitis B infection rates to target levels. Although wild poliovirus importations caused outbreaks in several countries in the WHO European Region in 2010 (eight years after the Region was certified poliomyelitis-free), the Western Pacific Region has remained poliomyelitis-free. Surveillance quality for acute flaccid paralysis (AFP), as well as measles, remains a challenge, and does not meet several indicator targets of performance in many Member States, particularly at subnational levels.

2. ACTIONS TAKEN

Nationwide measles supplementary immunization activities (SIAs) reached 130 million children in five priority countries (Cambodia, China, Papua New Guinea, the Philippines and Viet Nam) from September 2010 to June 2011. The Lao People's Democratic Republic will target three million people aged 9 months to 19 years with measles and rubella vaccine and will introduce rubella-containing vaccine into its immunization schedule thereafter. The burden of congenital

rubella syndrome (CRS) is, or will soon be, monitored in the above six countries through development or enhancement of CRS surveillance. Members have been designated for the Western Pacific Regional Verification Commission for Measles Elimination, which will hold its inaugural meeting soon. The Hepatitis B Expert Resource Panel has convened and established a simplified process and plan for verification of countries that have likely achieved the hepatitis B milestone. Technical assistance and resource mobilization for increasing immunization coverage in priority countries has been provided. A poliomyelitis risk assessment tool was developed by the WHO Regional Office for the Western Pacific in 2010, and identified three countries at high risk and four countries at medium risk for the spread of imported wild poliovirus because of subnational performance gaps in immunization and/or AFP surveillance. Subsequent poliomyelitis SIAs have been conducted or are planned. Both measles and poliomyelitis SIAs are conducted as far as possible in combination with other EPI and child health activities (tetanus toxoid SIAs, child health days, vitamin A weeks, deworming initiatives, etc.) to improve operational efficiencies and strengthen health systems. Measles and AFP surveillance and laboratory performance are being strengthened through a series of training sessions, feedback mechanisms and supplemental surveillance activities (e.g., environmental and enterovirus surveillance for poliovirus). The measles/rubella and poliomyelitis laboratory networks continue to be strengthened by hands-on-training workshops and are regularly assessed by on-site review to maintain their accreditation status. Joint resource mobilization initiatives have been undertaken for all targeted vaccine-preventable disease initiatives.

3. ACTIONS PROPOSED

To eliminate measles regionally by 2012 and reduce the threat of importation and subsequent spread, countries and areas will need to identify and respond to any residual chains of measles virus transmission. This will require: (1) an implementable action plan to interrupt measles virus transmission in remaining groups at risk; and (2) improvement of surveillance performance to ensure timely laboratory or epidemiological confirmation of cases, measles virus identification, periodic epidemiological analysis and, ultimately, verification of measles elimination. High-level political commitment will be critical to ensure the human and financial resources necessary to achieve the goal. Measles elimination activities may simultaneously address rubella control whenever possible, and countries and areas that have not yet introduced rubella-containing vaccine should consider doing so, in line with the recent WHO position paper. Achieving regional hepatitis B control will require increasing coverage with three timely doses of hepatitis B vaccine (HepB), including a dose within 24 hours of birth, in the nine countries that will not achieve the 2012 milestone. The need to increase

timely HepB birth dose coverage offers an opportunity to simultaneously strengthen neonatal and maternal health care. Countries and areas that have achieved adequate HepB coverage during the past five years should conduct serological surveys to measure the impact and should initiate the regional process of verifying reduced chronic infection rates among children. All countries and areas must remain vigilant to identify and respond to the threat of poliovirus importations. Poliomyelitis risk assessments should be conducted regularly at the subnational level, and actions should be taken to ensure adequate levels of population immunity and surveillance performance. WHO will continue to provide technical support and seek additional financial support on behalf of Member States for these and other needs of the Expanded Programme on Immunization.

PACIFIC HEALTH MINISTERS MEETING

1. BACKGROUND AND ISSUES

The first Meeting of Ministers of Health for the Pacific Island Countries was convened in Fiji in 1995. The meeting adopted the Yanuca Declaration, advancing the concept of Healthy Islands as the unifying theme for health promotion and health protection. Seven biennial meetings of the Ministers of Health for the Pacific island countries and areas in the ensuing years have further developed a consensus view of health in the Pacific and identified follow-up actions necessary to build Healthy Islands.

The Ninth Meeting of Ministers of Health for the Pacific Island Countries was jointly organized by WHO and SPC and held 28–30 June 2011 in Honiara, Solomon Islands. Forty-five representatives, including special participants from 21 Pacific island countries and areas, took part in the meeting. In addition, there were 11 representatives from United Nations offices, specialized agencies and related organizations, as well as 20 observers.

Among the various health topics considered, grave concern was expressed over the rapid increase in the incidence and prevalence of NCD in the Pacific, where NCD risk factors are among the highest in the world—up to three of every four adults are obese and up to four of every five adults smoke.

2. ACTIONS TAKEN

2.1 Agenda setting through the Ministers Open Forum

The Open Forum was a new addition to the meeting, allowing the Ministers to table priority issues for ministerial deliberation and discussion, with no specific agenda set in advance. Following identification of issues by the Ministers, development partners and technical agencies also were given an opportunity to propose priority issues to be included for discussion. This resulted in agreement on 10 dominant themes: (1) mental health; (2) social determinants of health; (3) health information systems, evidence, epidemiology and statistics; (4) human resources for health; (5) clinical care and clinical governance; (6) diseases, including emerging and neglected diseases; (7) disaster risk

management; (8) laboratories; (9) health care financing, health leadership and governance; and 10) new technologies.

After further prioritization through a ranking process, five discussion groups were formed—one each for the four highest-ranking areas (mental health, social determinants of health, health information systems, evidence, epidemiology and statistics, and human resources for health) and the fifth group to cover the remaining six areas. The groups deliberated on the situation and issues of the 10 identified areas and proposed actions to overcome the challenges. It is anticipated that progress on some of the priority areas will be further tabled and discussed during the next biennial meeting.

2.2 NCD Communiqué

The Honiara Communiqué on NCD (Annex 3) was developed through a drafting group selected at the beginning of the meeting.

The Communiqué highlighted the burden of NCD in the Pacific, where it is responsible for up to 75% of all deaths and a similar percentage of long-term illness and disability. It called on the leaders of the Pacific Islands Forum to give the highest priority to the issue by declaring NCD as a health and development crisis and by driving a whole-of-government and whole-of-society response involving all sectors.

It also called upon the United Nations General Assembly High-level Meeting on NCD in New York in September 2011 to address the need for better information and guidance on cost-effective interventions in resource-limited settings, and to ensure sustainable resources for NCD prevention, treatment and control.

This was further discussed and endorsed by the Ministers for tabling at the meeting of leaders of the Pacific Islands Forum in New Zealand in September 2011, as well as at the United Nations General Assembly High-Level Meeting on NCD in New York the same month.

2.3 Other Topics

In addition to the 10 priority issues identified during the Open Forum, the meeting also addressed four areas already identified as priorities for the Pacific.

(1) *Healthy Islands: Framework of Action for Revitalization of Healthy Islands in the Pacific*

At the 2009 Meeting of Ministers of Health for the Pacific Island Countries in Madang, Papua New Guinea, there was a call by Ministers to renew the commitment to the vision of Healthy Islands

and primary health care in line with the principles contained in the Declaration of Alma-Ata. At the Honiara meeting, a draft Framework of Action, which encompasses a bottom-up approach, was endorsed and will provide further guidance to the Member States for revitalization of Healthy Islands in the Pacific.

During the meeting, four winners were recognized for their submissions for Best Practices and Best Proposals as part of the WHO's Healthy Islands Recognition Programme. The programme is intended to encourage Pacific island countries and areas, as well as communities, to continue to innovate and demonstrate effective and efficient ways of promoting and protecting the health of their populations.

(2) The other three areas were presented as a panel discussion.

- Improving performance: strengthening national health planning and monitoring and evaluation

  There was a consensus from the meeting that an effective and robust national health planning process is necessary to achieve the Millennium Development Goals and positive health outcomes, and it also is important that planning extend beyond the health sector to encompass the broader public health agenda.

- Strengthening food security in the Pacific: Pacific Food Summit and beyond

  The meeting looked at the progress of the implementation of the Framework for Action on Food Security in the Pacific and also on outcomes of the Food Summit.

- Achieving MDGs 4 and 5: Pacific strategy for scaling-up action on women's and children's health

  The status of the Pacific with respect to MDGs 4 (child health) and 5 (maternal health) were presented and discussed. Recommended actions include making use of health system and country-specific approaches that are evidence-based and strengthening the monitoring of MDGs 4 and 5.

3. ACTIONS PROPOSED

The Regional Committee is invited to take note of this report and the issues that were identified as priorities for the Pacific island countries and areas.

ANNEX 1

Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016) (Draft)

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EXECUTIVE SUMMARY

In 2004, the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* was endorsed by Member States to provide practical and evidence-based guidance for developing actions to improve access to essential medicines and strengthen pharmaceutical systems.[1] Depending on the local context, countries chose specific areas on which to focus and adapted their implementation plans according to their national objectives.

In spite of the progress made over the years, access to essential medicines of assured quality still poses problems for countries in the Western Pacific Region. In high-income countries, problems are related to rational use and cost containment, while in low- and most middle-income countries, ensuring access to essential medicines, especially for the poor and the vulnerable, remains a major public health problem. After food, medicines account for the second-largest household expenditure. A substantial portion of the population in low- and lower-middle-income countries may have to make difficult choices as they have to pay out of pocket for their vital medicines.[2] In the Western Pacific Region, catastrophic medicine payments can entrench individuals and families in poverty.[3] Recent price surveys show that even the lowest-priced generics are often unaffordable for the poor.[4]

The increasing need for essential medicines due to the growing burden of diseases is stretching country pharmaceutical systems and budgets. Thus, more resources are required for reliable and timely delivery of quality assured medicines as well as their appropriate utilization. To address the growing need, governments must ensure efficient use of resources that the system and the people can afford. They should protect the public from substandard and counterfeit medicines, increase access to medicines while containing costs, ensure efficiency of supply chains and ensure rational use of medicines.

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[1] *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)*. Manila, World Health Organization, 2009 (http://www.wpro.who.int/sites/emp/regional_strategy/regional_strategy.htm)

[2] Equitable Access to Essential Medicines: a Framework for Collective Action. Geneva, World Health Organization, 2004. (WHO policy perspectives on medicines, No.8). See also Chan M. Opening remarks on creating synergies between intellectual property rights and public health, delivered at a joint technical symposium by WHO, WIPO and WTO on Access to Medicines: lessons from procurement practices, 16 July 2010, Geneva (http://www.who.int/dg/speeches/2010/access_medicines_20100716/en/index.html)

[3] *Health Financing Strategy for the Asia Pacific Region (2010–2015).* Manila, World Health Organization, 2009 (http://www.wpro.who.int/internet/resources.ashx/HCF/HCF+strategy+2010-2015.pdf

[4] Cameron A et al. Medicine prices, availability, and affordability in 36 developing and middle-income countries: a secondary analysis. *The Lancet*, 2009, 373: 240–249.

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Countries in the Western Pacific Region have taken a comprehensive approach to prioritizing goals for the pharmaceutical sector and identifying strategies to attain them. They have used the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* as a practical guide for developing and implementing actions in a synergistic way.

To ensure continuation of the strategies and actions outlined in the Regional Strategy and to include issues that need reinforcement, the *Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016)*, hereafter the Framework for Action, was developed through a consultative process with the following objectives:

(1) to provide strategic direction and guidance for WHO collaboration with Member States;
(2) to ensure continuation of the actions outlined in the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* and include issues that need to be reinforced; and
(3) to respond to country needs and challenges in the development and implementation of actions, based on agreed principles.

The Framework for Action will serve as a basis for country collaboration in improving access to essential medicines. The Framework is organized under the following headings:

(1) policy and access to essential medicines;
(2) regulation and quality assurance; and
(3) rational selection and use of medicines.

The first component on policy and access to essential medicines addresses issues of medicines policy and coordination, adequate financing, affordable prices, procurement and supply management, and intellectual property rights and international trade agreements.

The second component on quality assurance addresses issues of regulatory control, substandard medicines and counterfeit medicines.

The third component on rational selection and use of medicines addresses the issues of evidence-based selection of essential medicines and rational use of medicines.

A set of core indicators are proposed which countries can adapt to their context to monitor implementation and evaluate progress. Along with these indicators, a "traffic light" system has been

devised to provide "feedback at a glance" and to alert Member States to areas that may require more attention. This system is being introduced on a pilot basis; it is anticipated that it will be refined in the future.

WHO in the Western Pacific Region will use the Framework for Action to guide its work at the regional level as well as its collaborative work with countries and partners for the period 2011–2016. Simultaneously, based on the national context, countries may wish to consider using the Framework for Action options to guide their strategic planning and collaboration with WHO.

Annex 1

1. BACKGROUND

1.1 Access to essential medicines in the Western Pacific Region

Sustainable and effective pharmaceutical systems are crucial for health service delivery and primary health care. These are complex systems which must ensure that medicines are of good quality, safe and effective, that they are available at all times in all levels of health care, are affordable and are properly used by providers and consumers.

In the Western Pacific Region, access to essential medicines of assured quality still poses problems for many countries. In high-income countries, problems are related to rational use and cost containment, while in low- and most middle-income countries, ensuring access to essential medicines, especially for the poor and the vulnerable, remains a major public health problem. After food, medicines account for the second-largest household expenditure. A substantial portion of the population in low- and lower-middle-income countries may have to make difficult choices as they have to pay out of pocket for their vital medicines.[5] In the Western Pacific Region, catastrophic medicine payments can entrench individuals and families into poverty.[6] Recent price surveys show that even the lowest-priced generics are often unaffordable for the poor. [7]

Access to essential medicines is a key development challenge. Despite the progress made in achieving health-related Millennium Development Goals (MDG), around 1500 children under the age of 5 die every day of illnesses that are easily treatable with a low-cost basic range of essential paediatric medicines. Almost 95% of these deaths occur in six countries in the Region (Cambodia, China, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and Viet Nam).[8] Around 100 maternal deaths occur every day in the Region with huge disparities across and within countries (urban-rural, rich-poor). Postpartum haemorrhage, the main cause of maternal death, could be prevented with the proper administration of oxytocin, a low-cost essential medicine. While the Region is likely to achieve the MDG targets related to tuberculosis, access to antiretroviral treatment for HIV/AIDS is still around 31% despite a fast scale-up in recent years. Access to medicines for chronic diseases also remains a major problem. Collectively, noncommunicable diseases—cardiovascular diseases, cancers, diabetes and chronic respiratory diseases—have

[5] *Op cit*. Ref 2.
[6] World Health Organization. Op cit. Ref 3.
[7] Cameron A. Op cit. Ref 4.
[8] *Child health*. Manila, World Health Regional Office, 2010 (http://www.wpro.who.int/health_topics/child_health/ , accessed 20 July 2010).

overtaken communicable diseases as the leading health burden in the Region. Of the estimated 26 500 people in the Region who die every day from noncommunicable diseases, 20 000come from developing countries.[9] Considering that the majority of the population in low- and most middle-income countries do not have any social health protection and have to pay out of pocket for their medicines, control of chronic diseases is beyond the reach of those most in need.

The increasing need for essential medicines due to the growing burden of diseases is stretching country pharmaceutical systems and budgets. More resources are required for reliable and timely delivery of quality assured medicines as well as their appropriate utilization. To address this need, governments must ensure efficient use of resources that the system and the people can afford. They should protect the public from substandard and counterfeit medicines, increase access to medicines while containing costs, ensure efficiency of supply chains and ensure rational use of medicines.

Countries in the Western Pacific Region have taken a comprehensive approach to prioritizing goals for the pharmaceutical sector and identifying strategies to attain them. They have used the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* as a practical guide for developing and implementing actions in a synergistic way.

1.2 Issues and challenges

A few countries in the Region are successfully implementing pharmaceutical policies and regulatory systems, thus setting some of the best examples in the world. However, many still lag behind in applying basic standards and face many challenges in improving access to quality-assured medicines. Support is still needed to accelerate the efforts in addressing issues in the areas of policy and access, quality assurance and rational selection and use of medicines.

Policy and access — In the last 10 years, most countries in the Region have taken a comprehensive and systematic approach to guide their actions by developing and/or revising their National Medicines Policy (NMP). Of the 25 countries from the Region that participated in the WHO Country Pharmaceutical Situation Survey in 2007, 14 had official NMP documents, four had a NMP in draft form and seven had no NMP (Table 1, Figure 1). Eight countries had revised their NMP in the last five

[9] Broad support needed to fight rising noncommunicable diseases. Press release for the sixtieth session of the Regional Committee for the Western Pacific, 21–25 September 2009, Hong Kong (China). Manila, World Health Organization 2009 (http://www.wpro.who.int/media_centre/press_releases/pr_20090924_NCDs.htm).

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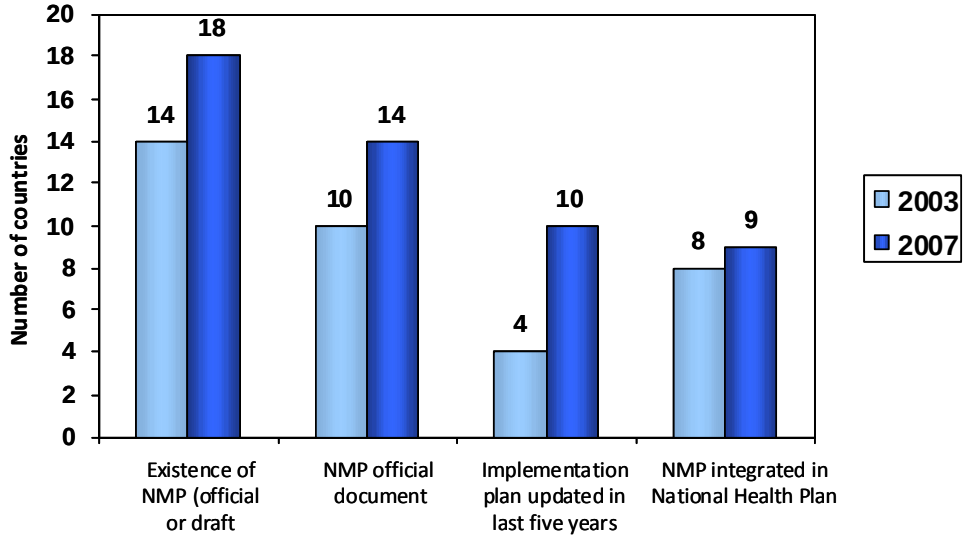
years.[10] However, existence of a NMP does not mean much if it is not implemented. Many countries in the Region still strive to implement a NMP in a coherent way. Availability of sufficient and adequately trained human resources to implement activities remains a challenge especially in low- and most middle-income countries. Harmonizing and coordinating activities related to implementation of NMP with other health systems building blocks are essential to augment the implementation.

Table 1. National Medicines Policy in the Western Pacific Region (2007)

Status of National Medicines Policy (NMP) document	Low-income countries	Middle-income countries	High-income countries	Total number of countries
Official NMP document	Cambodia, Lao People's Democratic Republic, Mongolia, Solomon Islands, Papua New Guinea, Viet Nam	Fiji, Malaysia, Philippines, Tonga, Samoa	Australia, Japan, Republic of Korea	14
NMP updated in last five years	Lao People's Democratic Republic, Solomon Islands	Fiji, Malaysia, Philippines, Samoa	Japan, Republic of Korea	8
Draft document	Cook Islands	Kiribati, Palau	New Zealand,	4
No document	Nauru	China, Marshall Islands, Niue, Vanuatu	Brunei Darussalam, Singapore	7

Figure 1. Progress in the development and/or revision of National Medicine Policy in the Western Pacific Region, 2003–2007



[10] Regional analysis: WPRO 2007 level I indicators: structure and process indicators on pharmaceutical situation. Geneva, World Health Organization, 2009 (unpublished document).

Out-of-pocket payments for health in the Asia Pacific region are much higher than in other parts of the world.[11] Without adequate financing for procurement and distribution of medicines, availability of essential medicines cannot be ensured. Public funding of medicines per capita varies between countries and between country income levels (Table 2). In some low- and middle-income countries, public spending on medicines is extremely low. A price survey conducted from 2004 to 2006 revealed that, in five countries in the Western Pacific Region, the mean availability of 15 medicines surveyed was only 43% in the public sector. Low availability of essential medicines in the public sector, where medicines are generally provided at a low cost or free of charge, means that basic needs of patients cannot be met; as a consequence patients have to purchase higher-priced medicines from the private sector, most often paying out of pocket. [12]

Table 2. Public spending on medicines per person per year (2007)

High income (data from 5 countries)	***average:***		**147.04**	
	range:	38.8		331
Middle-income (data from 10 countries)	***average:***		**20.41**	
	range:	4.4		63.9
Low-income (data from 8 countries)	***average:***		**14.11**	
	range:	0		45.3

Availability of medicines in the public sector is influenced also by procurement practices and the supply management system. The Price Information Exchange for Selected Medicines (www.piemeds.org), a web-based tool established by the WHO Western Pacific Regional Office, provides comparative information on procurement prices that countries can use when negotiating with suppliers. This information-sharing platform has revealed great variability in procurement prices in the public sector even when medicines were sourced from the same suppliers. National centralized procurement systems generally yield better prices than fragmented procurement systems. Some models of decentralized government systems in the Region have been reported to negatively affect medicines financing and procurement. In many countries in the Region, weak infrastructure and verticalization of supply systems based on narrowly funded projects continue to

[11] World Health Organization. Op cit. Ref 3.
[12] Cameron A. Op cit. Ref 4.

disrupt timely delivery of essential medicines in health facilities. Although outdated, a few countries in the Region still use revolving funds as a strategy to cover medicines costs and generate revenue.

The number of countries in the Region that have developed policies to promote the use of generic medicines has increased. By 2007, most of the countries in the Region were regulating generic substitution in the public and private sectors and some had made it an obligatory requirement (Figures 2 and 3). However, preference for using branded medicines still remains high, which has cost implications. Policies to promote generics are difficult to implement if there is no incentive for prescribing and dispensing low-cost generic medicines. Such incentives are relatively common in high-income countries where they are found in both the public and private sectors, but more needs to be done in low- and middle-income countries.

Figure 2. Number of countries regulating prescription of generic medicines in the public sector, 2003–2007

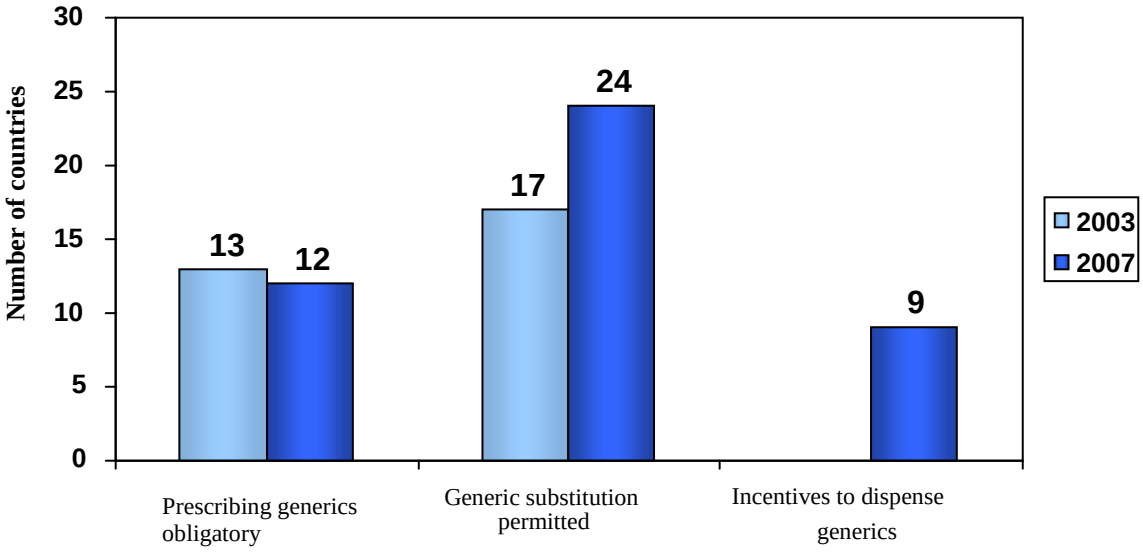
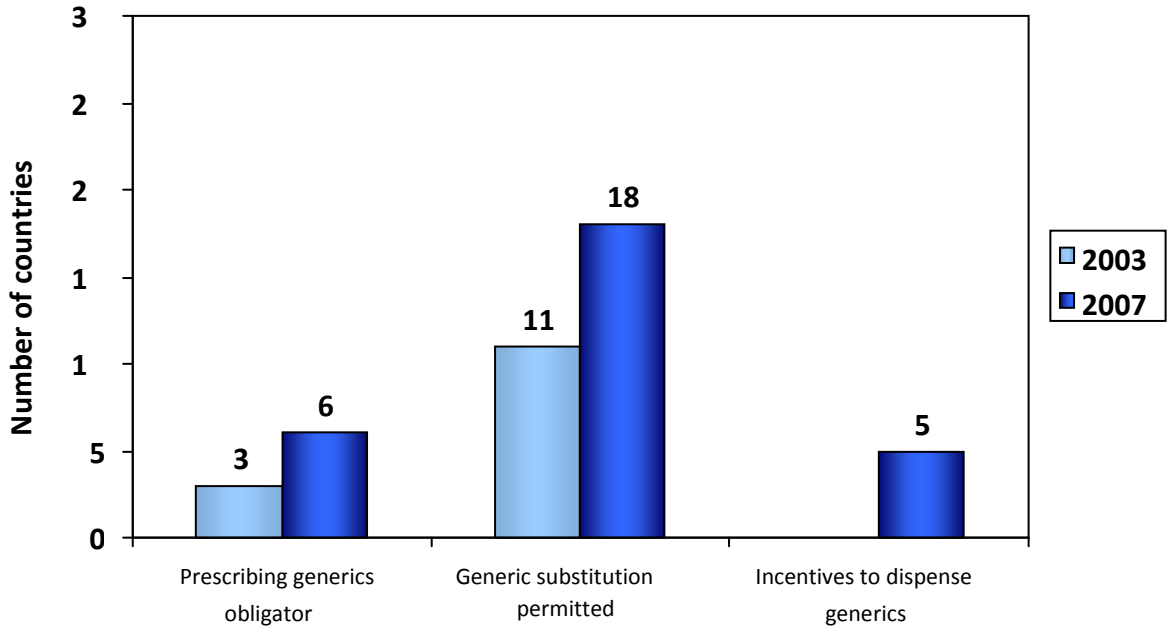


Figure 3. Number of countries regulating prescription of generic medicines in the private sector, 2003–2007.



International agreements related to intellectual property rights can have a negative impact on access to medicines. Policy-makers often have insufficient understanding of the flexibilities and safeguards that can be used to protect access to medicines. This is further aggravated by the rapidly changing global intellectual property environment.

Countries in the Region have taken actions to promote transparency in the pharmaceutical sector. Through Good Governance for Medicines (GGM) they are raising awareness on the risk of abuse in the public pharmaceutical sector and promoting good governance and transparency to ensure that medicines reach the people. Six countries in the Region are taking up the challenge to improve transparency. Malaysia, Mongolia and the Philippines have made significant progress.

Quality assurance — With the expansion of the burden of diseases, the increasing need for access to treatment and the significant number of suppliers in the global medicines market, countries continue to face challenges to regulate the pharmaceutical sector. Most countries in the Region have established medicines regulatory authorities and quality assurance systems. In fact, with the exception of a majority of Pacific island countries, all countries in the Region have mechanisms for marketing authorization in place (Figure 4, Table 3).

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Figure 4. Progress in medicines registration in the Western Pacific Region, 2003–2007

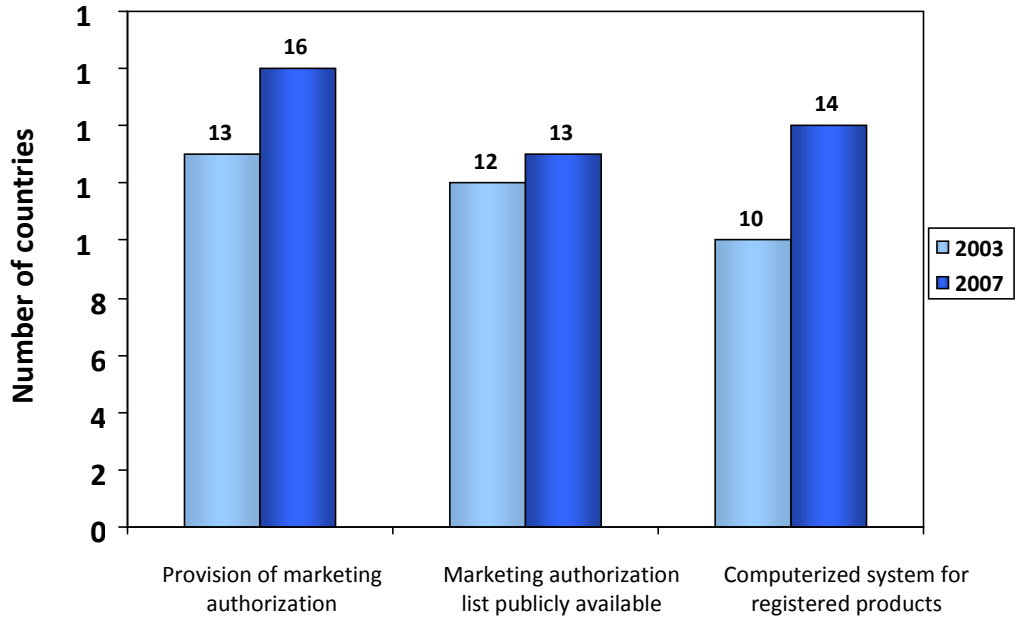

Table 3. Quality assurance in the Western Pacific Region (2007)

Countries	*Low-income countries*	*Middle-income countries*	*High-income countries*	*Total number of countries*
Provision of marketing authorization	*Cambodia, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Viet Nam*	*China, Kiribati, Malaysia, Philippines, Tonga*	*Australia, Brunei Darussalam, Japan, New Zealand, Republic of Korea, Singapore*	*16*
Marketing authorization list publicly available	*Cambodia, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Viet Nam*	*China, Kiribati, Malaysia, Philippines*	*Australia, Brunei Darussalam, Republic of Korea, Singapore*	*13*
Computerized system for registered products	*Cambodia, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Viet Nam*	*China, Malaysia, Philippines*	*Australia, Brunei Darussalam, Japan, New Zealand, Republic of Korea, Singapore*	*14*
Number of products with marketing authorization (2007)	*Median [25th, 75th percentile] 4508 1624 9666 Cambodia, Lao People's Democratic Republic, Mongolia, Viet Nam*	*Median [25th, 75th percentile] 14 547 1000 36 899 China, Kiribati, Malaysia, Philippines, Tonga*	*Median [25th, 75th percentile] 9431 7602 30 647 Australia, Brunei Darussalam, New Zealand, Republic of Korea, Singapore*	*14*
Adverse drug reactions (ADR) monitored	*Mongolia, Viet Nam*	*China, Fiji, Malaysia, Philippines*	*Australia, Brunei Darussalam, Japan, New Zealand, Republic of Korea, Singapore*	*12*

Even though most countries in the Region have medicines regulatory authorities, their levels of functionality differ greatly. Weak regulatory systems coupled with weak and nontransparent enforcement may result in the production, distribution and sale of medicines of doubtful efficacy, safety and substandard quality that can endanger the public. Products contaminated with diethylene-glycol, melamine and contaminated heparin are examples of substandard products that have penetrated the global market. Countries need to strengthen their capacity to safeguard public health by enforcing regulations in the pharmaceutical sector.

In spite of intensified collaboration between the medicines regulatory authorities and law enforcement agencies at national and international levels, the production, distribution and sale of counterfeit medicines continue in the Region. Apart from being a major public health problem, counterfeiting is a serious criminal act. Yet only few criminals are effectively prosecuted as law enforcement is weak. Samples of artesunate collected in remote Mekong areas were found to be counterfeits, without active ingredients, causing catastrophic effects on the poor and rural populations.[13] International and national actions so far have not been able to deal adequately with the problem. A mechanism was established at the regional level to exchange information among countries and to alert them of detected cases of counterfeit medicines. Collaboration between regulatory and law enforcement agencies in Mekong areas has resulted in the confiscation of millions of counterfeited tablets. However, as these types of criminal acts continue, often moving counterfeit products across national boundaries, more action is needed throughout the Region to address this complex issue.

Evidence-based selection and use — Efforts to improve access to essential medicines are hampered if medicines are not selected, prescribed and used rationally. Overuse, underuse and misuse of medicines undermine therapeutic benefits and waste scarce resources. Evidence has shown that using a variety of simple methods to guide and monitor the use of medicines results in better medicines use, more efficient use of resources and better management, which ultimately leads to better health outcomes.[14]

[13] Dondrop AM et al. Fake antimalarials in South East Asia are a major impediment to malaria control: multinational cross-sectional survey on the prevalence of fake antimalarials. *Tropical Medicine and International Health*, 2004, 9(12):1241–1246.

[14] Laing R, Hogerzeil H, Ross-Degnan D. Ten recommendations to improve use of medicines in developing countries. *Health Policy and Planning*, 2001, 16(1):13–20.

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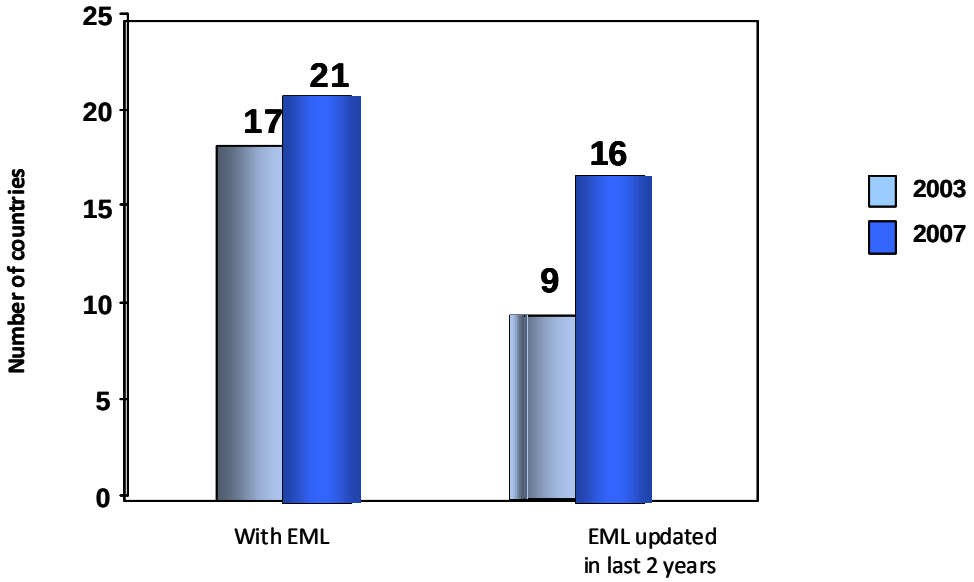
Almost all countries in the Region have Essential Medicines Lists (EMLs). National EMLs need to be updated regularly to reflect changing therapeutic needs and options for treating the majority of diseases with essential medicines. Essential medicines should be selected based on evidence of comparative efficacy, safety, effectiveness and cost, and through a transparent process. Figure 5 shows the progress that countries have made since 2003 in updating their EMLs.

Figure 5. Essential medicines list in countries in the Western Pacific Region, 2003–2007



EMLs must also include paediatric formulations (Table 4). There is a global need for safe, effective and accessible children's medicines, without which Millennium Development Goals 4 and 6 cannot be achieved. This is particularly important in the Western Pacific Region where around 1500 children die every day of diseases that can be treated by low-cost, effective essential medicines. Countries must ensure not only that paediatric formulations are included on their national EMLs, but also that systems are in place to make paediatric medicines available and properly used.

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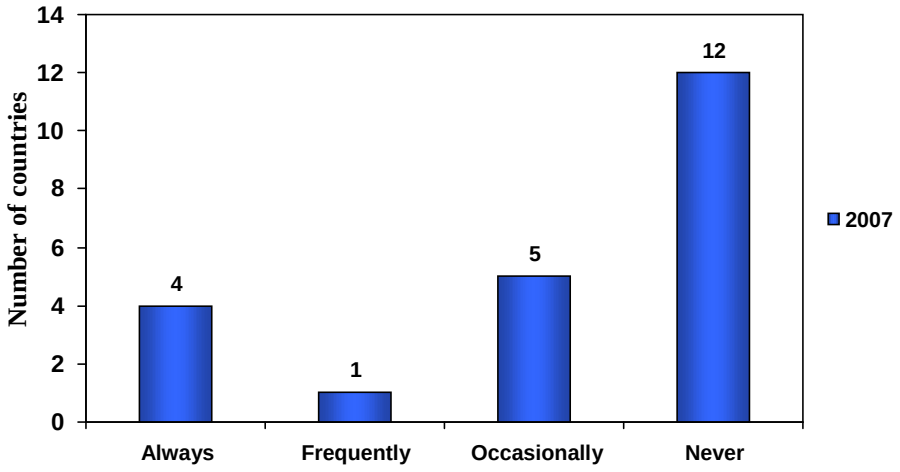
Table 4. Essential Medicines List in the Western Pacific Region, 2003–2007

EML	Low-income countries	Middle-income countries	High-income countries
Number of medicines in EML	Median [25th, 75th percentile] **355** 344 366.5 Cambodia, Cook Islands, Lao People's Democratic Republic, Mongolia, Nauru, Solomon Islands, Viet Nam	Median [25th, 75th percentile] **352** 320 1145 China, Kiribati, Malaysia, Niue, Palau, Philippines, Vanuatu	Median [25th, 75th percentile] **1201** 923 1453.5 Australia, Brunei Darussalam, Singapore
Paediatric formulations in EML	Median [25th, 75th percentile] **22.5** 15.25 31.25 Cambodia, Cook Islands, Lao People's Democratic Republic, Mongolia, Nauru, Solomon Islands	Median [25th, 75th percentile] **58.5** 26.25 60 Kiribati, Malaysia, Niue, Palau, Philippines, Vanuatu	Median [25th, 75th percentile] **76** 63 91.5 Australia, Brunei Darussalam, Singapore

EMLs are generally used as a basis for public procurement and guidance for prescribing. However, they are often not harmonized with treatment guidelines. Quality prescribing must be based on evidence of safety, efficacy and cost. In some cases, less than half of patients are treated according to the treatment guidelines for the common diseases seen in primary care settings. Provider payment schemes often create incentives for irrational prescribing and excessive prescribing (Figure 6).

Figure 6. Revenue from sales of medicines used to pay salaries (2007)



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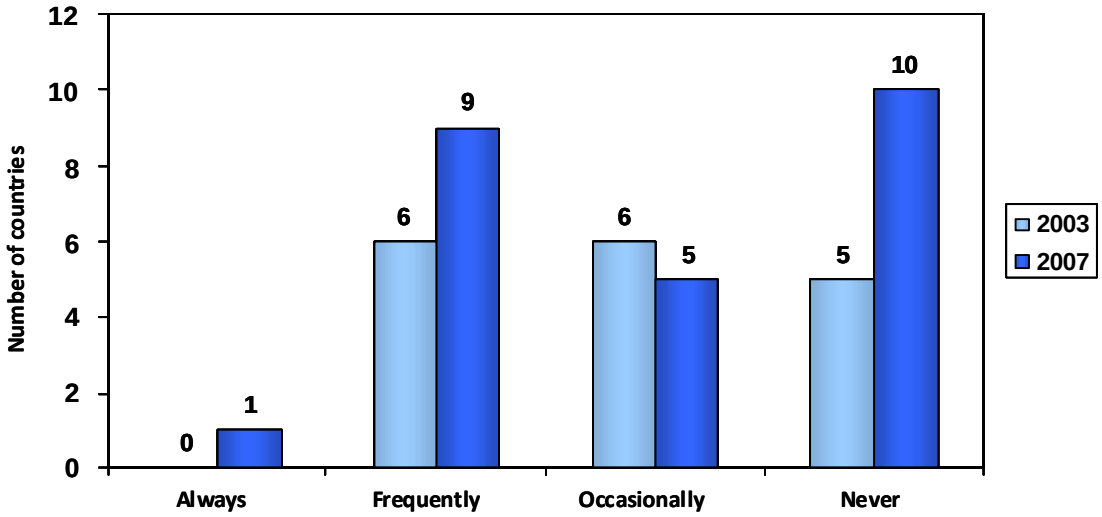
Objective information on medicines for providers and consumers is generally lacking and unethical practices in medicines promotion continue. Serious antimicrobial resistance may emerge in many countries in the Region. By 2007, only nine countries reported to have a national strategy for containment of antimicrobial resistance. Antibiotics continue to be sold over the counter in 15 countries in the Region, mostly in low-income countries (Figure 7).

Figure 7. Number of countries in the Western Pacific Region where antibiotics are sold without a prescription, 2003–2007



To promote regional collaboration, more effective ways of sharing experiences and information between countries are needed. Data are generally lacking for making informed decisions, developing interventions and implementing effective changes in the pharmaceutical system. To obtain such data, specific operational research is needed, in addition to effective monitoring systems using indicators. Most countries have not yet developed monitoring systems and indicators for measuring improvement of access to essential medicines. However, both WHO and countries need to measure progress and impact of interventions, a challenge that needs immediate attention.

The Framework for Action proposes a set of core indicators to monitor implementation and evaluate progress. Along with these indicators, a "traffic light" system has been devised to provide "feedback at a glance" and to alert Member States to areas that may require more attention. This system is being introduced on a pilot basis; it is anticipated that it will be refined in future.

2. Purpose and development of the Framework for Action

2.1 Purpose of the Framework for Action

In 2004, the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)*, hereafter the Regional Strategy, was endorsed by Member States to provide practical guidance for developing actions to improve access to essential medicines and to strengthen pharmaceutical systems. Depending on the local context, countries chose specific areas on which to focus and adapted their implementation plans according to their national objectives.

The Regional Strategy covered the period from 2005 to 2010. To ensure continuation of the strategies and actions outlined in the Regional Strategy and to include new issues and areas that need reinforcement, the *Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016)*, hereafter the Framework for Action, was developed. Issues that emerged after the introduction of the Regional Strategy and that the Framework for Action now seeks to address include the following: (1) essential medicines as a core building block of health systems strengthening for renewed primary health care; (2) essential medicines benefits as part of health insurance and social protection; (3) rights-based approach to improving access to essential medicines; (4) better medicines for children; (5) intercountry information sharing to promote regional collaboration; and (6) transparency and good governance.

The objectives of the Framework for Action are:

(1) to provide strategic direction and guidance for WHO collaboration with Member States;
(2) to ensure continuation of the actions outlined in the *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* and include issues that need to be reinforced; and
(3) to respond to country needs and challenges in the development and implementation of actions, based on agreed principles.

WHO in the Western Pacific Region will use the Framework for Action to guide its work at the regional level as well as its collaborative work with countries and partners for the period 2011–2016. Simultaneously, based on the national context, countries should consider using the Framework for Action options to guide their strategic planning and collaboration with WHO.

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2.2 Development of the Framework for Action

The Framework for Action has been developed in the context of promoting stronger collaboration between WHO and its Member States; thus, it does not separate actions for WHO and for countries as was done in the Regional Strategy. Instead, it builds on shared principles and recommended actions.

WHO and countries are expected to align their collaboration and identify their joint actions based on the stated principles.

The Framework for Action is organized under the following headings:

(1) Policy and access to essential medicines
(2) Regulation and quality assurance
(3) Rational selection and use of medicines.

The three technical components introduced in the Framework for Action are consistent with those in the *WHO Global Medicines Strategy (2008–2013)* and in WHO Strategic Objective 11, "Access, quality and rational use of medical products and essential health technologies", by which WHO's work is guided and managed at the global, regional and country levels. Activities specified under the components are relevant to the regional context.[15]

The Framework for Action takes into consideration findings from in-depth reviews undertaken in six countries in 2008;[16] country situation reports using level I and level II indicators;[17] comments from Member States; and input from an expert consultation held in November 2009 in Manila.[18] It reflects on the health-related MDG where access to essential medicines is a target in itself.[19] This implies a strong emphasis on principles of equity and sustainability, the needs of the poor and disadvantaged, and the attainment of the highest possible standard of health as a fundamental right. It draws on actions based on the priorities set by the WHO Director-General on health development,

[15] *Continuity and Change: Implementing the third WHO Medicines Strategy 2008-2010*. Geneva, World Health Organization, 2009. Available at http://www.who.int/medicines/publications/medstrategy08_13/en/index.html
[16] Helling-Borda M, Eriksen T. Review implementation of the Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region, 2005-2010. Manila: World Health Organization, 2008 (unpublished mission report).
[17] World Health Organization. Op cit. Ref 10.
[18] *Expert consultation on the regional framework for action on access to essential medicine in the Western Pacific, 18–20 November 2009*. Manila, World Health Organization, 2009 (unpublished meeting report).
[19] United Nations. *Delivering on the Global Partnership for Achieving the Millennium Development Goals, MDG Gap Task Force Report*. United Nations, New York, 2008.

health security, and strengthening health systems through primary care.[20] The Framework for Action also synchronizes actions with other strategies such as the *Regional Strategy on Health Systems Based on the Values of Primary Health Care* (where medicines are one of the six building blocks);[21] and the *Health Financing Strategy for the Asia Pacific Region (2010–2015)*.[22]

[20] *The World Health Report 2008. Primary health care: now more than ever.* Geneva, World Health Organization, 2008:XV (http://www.who.int/whr/2008/whr08_en.pdf).
[21] *Regional strategy on health systems based on the values of primary health care*. Manila, World Health Organization, 2010 (draft).
[22] World Health Organization. Op cit. Ref 3.

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3. Components

3.1 Policy and access to essential medicines

WHO will continue to support effective promotion, development, revision and implementation of policies to improve access to medicines. In line with the needs identified by countries, new developments in global health, MDGs 4, 5, 6 and 8, and the Director-General's priorities, WHO will promote a new focus to:

- emphasize the integration of National Medicines Policy within health systems and health financing policies;
- promote access to essential medicines as part of the fulfilment of the right to health;
- increase affordability of medicines through expansion of prepayment and other risk pooling mechanisms (thus reducing high out-of-pocket expenditures), and through appropriate pricing and taxation policies;
- promote strategic planning for procurement and supply management of medicines and strengthen coordination with disease-specific programmes;
- strengthen capacity to manage the implications of trade agreements on access to essential medicines; and
- promote transparency and good governance in the pharmaceutical sector.

3.1.1 National Medicines Policy

Guiding principles

(1) National Medicines Policy should emphasize principles of equity and sustainability in access to essential medicines as a fundamental human right to health.
(2) Countries should strive for universal access to essential medicines.
(3) National Medicines Policy should be developed through a consultative process that ensures the participation of a wide spectrum of stakeholders, partners, civil society and academia.

(4) National Medicines Policy should be an integral part of the national health policy and plan.[23]

(5) National Medicines Policy should be linked to all health systems building blocks: service delivery, health workforce, information, financing and leadership and governance.

Recommended actions

(1) Plan, develop and revise National Medicines Policy to identify national goals, commitments and actions based on a country's needs, priorities and resources.

(2) Synchronize National Medicines Policy with health financing policy and other health systems strengthening building blocks.

(3) Strengthen institutional capacity for national coordination of partners and development agencies to align technical assistance with national medicines goals.

(4) Establish and strengthen monitoring and evaluation of actions in implementing National Medicines Policy.

(5) Promote a synergistic approach with disease-specific, reproductive and child health programmes on the selection of essential medicines, quality assurance, procurement and supply management and rational medicines use.

(6) Foster collaboration with relevant professional organizations, partners, civil society and the private sector on promoting and implementing National Medicines Policy.

(7) Promote information sharing among countries through interregional meetings, conferences and projects, web-based communication, and printed technical materials.

(8) Promote coordination and information sharing between national and local levels in decentralized systems.

3.1.2 Affordable prices

Guiding principles

(1) Medicines should be available at a cost that the health system (both public and private) and patients can afford.

(2) Transparent competition will help to improve availability and affordability of medicines.

(3) Import duty and tariffs should not represent barriers to access to essential medicines.

[23] The Country Health Planning Cycle database is available at http://creator.zoho.com/downeyc/countryplanningdb/view-perma/Country_Planning_Cycle_DB/

(4) Generic competition is an effective mechanism to increase affordability. Policies that encourage generic prescription and generic substitution should be implemented.

Recommended actions

(1) Exchange information and evidence on mechanisms for and impact of price-setting and on direct and indirect price-control policies.
(2) When appropriate, assess interventions to regulate mark-ups at the ex-factory level, or at the level of importers, wholesalers and retailers.
(3) Increase efficiencies in public sector procurement by applying good procurement practices, purchasing generics and aggregating volumes to negotiate better prices.
(4) Implement policies that encourage generic prescription and generic substitution, including financial incentives, in both the public and private sectors.
(5) Support efforts to increase the awareness of health professionals and the public about potential cost-savings when using generics and provide information on medicines prices.
(6) Exchange information on medicines prices among countries in the Region and encourage cross-country comparative information sharing on price trends (e.g. regional Price Information Exchange at www.piemed.com).
(7) Support mechanisms that contribute to reducing prices of branded medicines.

3.1.3 Adequate financing

Guiding principles

(1) Countries should strive for universal access to essential medicines.
(2) Medicines financing policies should be synchronized with national health financing policies.
(3) Out-of-pocket payments for essential medicines should not be used as the main mechanism for financing medicines, for replenishing revolving funds or for financing other parts of the health system.
(4) Essential medicines should be part of the basic package for health care.
(5) Health and medicines financing policies must provide the poor and other vulnerable groups with full or partial protection against the costs of essential medicines, especially medicines for chronic diseases.

(6) Medicines financing mechanisms should not create incentives that lead to prescriber-induced demand.

Recommended actions

(1) As part of National Medicines Policy, review essential medicines financing strategies based on the principles of equity to access, affordability, cost-containment and sustainability.
(2) Develop and implement strategies that reduce out-of-pocket payments for essential medicines.
(3) Establish information systems to monitor medicine expenditures, disaggregated by sources, building on existing national health accounts.
(4) Provide technical support and training on medicine financing systems.
(5) Advise on policies that can contain costs by applying a combination of measures that influence the supply side (e.g. evidence-based essential medicines selection and formulary development, use of EML for procurement and reimbursement based on generics) and the demand side (e.g. treatment guidelines harmonized with EML/formulary, generic prescription policies and control of inappropriate medicines promotion and unethical marketing practices).

3.1.4 Medicines procurement and supply system

Guiding principles

(1) Disease-specific medicines supply systems should be coordinated and where possible integrated into one essential medicines supply system.
(2) Assessments of supply systems by donors and development partners should be harmonized with the national monitoring and evaluation system to reduce unnecessary duplications.
(3) Training activities and efforts to evaluate their impact on the efficiency of the medicines supply system should be coordinated.
(4) Medicines procurement should follow the national EML and treatment guidelines.
(5) Public medicines procurement systems should follow transparent processes.
(6) Medicines procurement and distribution systems should ensure continuous availability of medicines at all levels of the health care.

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Recommended actions

(1) Strengthen collaboration and information sharing between those responsible for medicines supply management and those responsible for disease-specific programmes to increase efficiencies in demand forecasting and to ensure that adequate supplies are provided at all levels of health care.
(2) Synchronize public medicines procurement with the national EML and treatment guidelines.
(3) Strengthen capacity of medicines procurement authorities to apply transparent and good procurement practices and to monitor availability and prices of medicines.
(4) When feasible, increase efficiencies in procurement by aggregating volumes to negotiate better prices.
(5) Support the development of human resources, infrastructure and logistics capacity to ensure appropriate management of the medicines supply system at all levels of health care.
(6) Strengthen collaboration between the national medicines procurement agency and the medicines regulatory agency to reduce the risk of sourcing medicines of poor quality.
(7) Strengthen information systems to improve planning, monitoring of suppliers' performance and evaluation of efficiency in procurement and supply chain management.
(8) Integrate data collection for indicators about the medicines supply system into the routine health management information system.

3.1.5 Intellectual property rights and international trade agreements

Guiding principle

Trade agreements and intellectual property rights should not be an impediment to access to essential medicines and achievement of public health goals.

Recommended actions

(1) Disseminate information on international developments related to intellectual property rights and trade globalization and their impacts, and facilitate the exchange of country experiences.
(2) Advocate the inclusion of the public health safeguards of the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) in national intellectual property laws and regulations and support countries to amend legislation accordingly.

(3) Advocate and facilitate collaboration between the health sector, the trade sector and other sectors, as well as nongovernmental organizations, in preparing domestic policies to ensure that national health objectives are taken into account when multilateral, regional and bilateral agreements are negotiated, or when national legislation related to trade, health and intellectual property is drafted.

(4) Support national workshops and training on trade globalization and access to medicines for health and trade policy-makers.

(5) Promote and support national and regional institutions in their efforts to build and strengthen capacity to manage and apply intellectual property in a manner oriented to public health needs and priorities of developing countries.

(6) Advocate for countries to learn how to use the "TRIPS flexibilities" in order to protect access to medicines and, upon request, support countries' efforts to use these flexibilities.

(7) Disseminate information on the potential negative implications for access to medicines of "TRIPS-plus" provisions (notably data exclusivity and "linkage" between patent and registration status); where necessary, also support countries in identifying strategies to mitigate their negative impact.

3.2 Regulation and quality assurance

WHO will continue to support medicines regulatory authorities in improving legal frameworks and implementing norms and standards to assure that the production, import, export, distribution, sale and use of medicines are regulated effectively to protect public health; it will continue to strengthen collaboration between regulatory authorities in combating counterfeit and substandard medicines and improve intercountry information sharing. In line with the needs identified by countries, new developments in the field, and MDG 8, WHO will pay more attention to:

- improving medicines safety through an effective post-marketing surveillance system;
- increasing effectiveness in detecting and addressing problems of substandard medicines; and
- strengthening collaboration between medicines regulatory authorities and law enforcement agencies in combating counterfeit medicines.

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3.2.1 Medicines regulation

Guiding principles

(1) The medicines market should be effectively regulated and regulations should be actively enforced.
(2) Transparency, good governance and disclosure of conflicts of interest should be key principles of the medicines regulatory authority.
(3) Medicines promotion should be regulated and guided by codes of conduct.

Recommended actions

(1) Strengthen the legal framework to assure that medicines production, import, export, distribution, dispensing, sale use, promotion and clinical trials follow internationally accepted standards.
(2) Increase national technical capacity and knowledge sharing in implementing norms and standards in medicines regulation.
(3) Strengthen monitoring of compliance with good practices in production, distribution, storage and dispensing, to ensure the quality of medicines.
(4) Advocate and support the independence of regulatory decision-making to strengthen the capacity for effective enforcement of laws and regulations.
(5) Support the application of internationally accepted standards in licensing, inspection, quality control and product evaluation to ensure medicines quality.
(6) Support the establishment of functional mechanisms to monitor adverse medicine reactions, and encourage the establishment of medicine safety networks and warning/recall systems in countries to ensure the safety of medicines.
(7) Promote ethical conduct in the promotion and marketing of medicines.
(8) Ensure the availability of independent, unbiased, correct, updated and accessible information on medicines to prescribers and consumers.
(9) Strengthen mechanisms for collaboration with regional and international bodies on medicines regulation.
(10) Support medicines regulatory authorities in providing access to accurate and timely information on licensed manufacturers, suppliers and pharmacies.

3.2.2 Substandard medicines

Guiding principle

All medicines in the market should meet internationally accepted quality standards.

Recommended actions

(1) Provide guidance on procedures and sampling methods for collecting samples for routine detection of substandard medicines.
(2) Support continuous surveillance of the extent of substandard medicines in national and regional markets.
(3) Conduct training and capacity-building for implementation of pharmaceutical norms (particularly good manufacturing practices [GMP]) to reduce the risk of substandard production.
(4) Train staff involved in medicines supply management, prescribers and dispensers on product integrity issues and procedures for detecting and reporting suspected substandard (or counterfeit) medicines.
(5) Develop advocacy materials to increase consumer awareness of substandard medicines and to describe mechanisms for reporting suspected cases.
(6) Provide guidance on establishing an effective system for rapid recall/withdrawal of medicines that are suspected or confirmed to be substandard.
(7) Develop country guidelines for donations, product return and safe disposal of unwanted, damaged and/or expired medicines.

3.2.3 Counterfeit medicines[24]

Guiding principles

(1) Systems should be established for regular surveillance of counterfeit medicines and for timely reporting of counterfeit medicines to national, regional and international monitoring systems to safeguard public health.

[24] For the purpose of this Framework, a counterfeit medicine is one that is deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient (inadequate quantities of) active ingredient(s) or with fake packaging.

(2) Countries should establish a legal framework to combat counterfeit medicines and implement appropriate sanctions against counterfeiting of medicines.

Recommended actions

(1) Develop and implement a national action plan on combating counterfeit medicines, involving multiple stakeholders, which includes effective legislation.
(2) Develop advocacy materials for providers and consumers to increase their awareness of counterfeit medicines and the associated risks.
(3) Encourage the development of innovative technology for the prevention of counterfeit medicines.
(4) Support continuous surveillance of counterfeit medicines in national and regional markets.
(5) Strengthen capacities of laboratory staff, inspectors and law enforcement agents to detect counterfeit medicines.
(6) Strengthen collaboration between medicines regulatory authorities and law enforcement agencies to enforce appropriate laws.
(7) Develop and implement guidelines for rapid recall/withdrawal of medicines suspected or confirmed to be counterfeits.
(8) Facilitate collaboration with international agencies, manufacturers and professional associations on synergizing actions to combat counterfeit medicines and to exchange experiences and best practices.
(9) Support the use of a regional/global reporting system to rapidly alert national medicines regulatory authorities of counterfeit medicines in the Region.

3.3 Rational selection and use of medicines

WHO will continue to support the essential medicines concept, which incorporates regular and evidence-based revisions of national EMLs, reflecting new, safe and cost-effective therapeutic options, and will continue to advocate for rational use of medicines. In line with the needs identified by countries, new sector developments, MDGs 4, 5, 6 and 8, World Health Assembly resolutions and the Director-General's priorities, in this process, WHO will promote a new focus to:

- prioritize inclusion of children’s medicines in national EMLs;
- provide methodological guidance on evidence-based selection;

- promote transparency in selection of essential medicines;
- promote innovative approaches to improve rational use of medicines.

3.3.1 Evidence-based selection of essential medicines

Guiding principles

(1) The role of the EML should be clearly defined in the National Medicines Policy.
(2) The EML should be part of the basic package for universal health care.
(3) The EML should be available, accepted and used at all levels of health care.
(4) Transparent processes should be used in selecting essential medicines.
(5) Children's medicines should be included on the EML.
(6) The EML should be harmonized with evidenced-based national standard treatment guidelines.

Recommended actions

(1) Build national capacity to promote essential medicines as a cost-effective component of health care and a means to promote health equity.
(2) Provide tools for applying evidence-based methodologies for development or revision of the EML.
(3) Promote and support regular revision and distribution of the EML to incorporate evidence on efficacy, safety, cost, effectiveness, and new therapeutic options.
(4) Advocate for the distribution and use of the EML for public procurement, reimbursement and prescribing at all levels of health care.
(5) Provide guidance for including children's medicines on the EML and advocate for availability of children's medicines in the market.
(6) Advise on strategies to engage educational institutions in promoting the essential medicines concept in undergraduate and continuing education programmes.

3.3.2 Rational use of medicines

Guiding principles

(1) Rational use of medicines should be integrated with the national goal of universal access to essential medicines.

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(2) Quality prescribing should be based on need, evidence of safety, efficacy and cost.

(3) National strategies and regulations should be developed to contain antibiotic use and resistance.

(4) Policies should be implemented to promote rational and safe use of medicines for children.

(5) Policies should be implemented to improve patient adherence to therapies for chronic diseases.

(6) Medicines prescribing and use should not be adversely influenced by financial interest. Provider payment schemes should not create incentives for irrational prescribing of medicines.

Recommended actions

(1) Support the development of a system and building of capacities to promote rational use of medicines at all levels of health care within the framework of national medicines and health policy.

(2) Support the review and reform of provider payment mechanisms such that health care workers are not influenced by incentives to prescribe medicines inappropriately.

(3) Support studies to generate evidence on the health and economic impacts of irrational prescribing and on the effectiveness of interventions.

(4) Encourage the sharing of information and experiences among countries on successful interventions to promote rational use of medicines.

(5) Support the development and updating of evidence-based treatment guidelines and their harmonization with the EML.

(6) Support the development and testing of interventions that address appropriate and safe use of medicines, especially for maternal and child health, adherence to medicines for chronic illness and antibiotic use.

(7) Support the monitoring of prescribing practices in health facilities.

(8) Promote strengthening of the performance of Drug and Therapeutic Committees or their equivalent in health care centres, especially in hospitals.

(9) Support the strengthening of mechanisms for medicines' information sharing.

(10) Advocate for the incorporation of training modules on rational use of medicines in undergraduate and continuing education programmes for health care workers.

(11) Support the development and application of tools to promote the rational use of medicines by consumers and in the community.

(12) Support the development, implementation and monitoring of regulations on ethical promotion of medicines.

4. Monitoring and evaluation

WHO will continue to support countries to regularly monitor and evaluate implementation of National Medicines Policies and access to essential medicines.

Guiding principles

(1) Countries should implement an indicator-based monitoring of pharmaceutical system structures, processes, outcomes, and impacts.
(2) Countries should use monitoring data to refine approaches in implementing National Medicines Policies.

Recommended actions

(1) Advise on the development and adoption of indicator-based tools to monitor the implementation of National Medicines Policy and strengthen national technical capacities for conducting monitoring.
(2) Support periodical assessments of the national pharmaceutical situation – and advise on their frequency – to measure the impact of interventions on access, quality and rational use of essential medicines.
(3) Support dissemination of, and provide feedback on, assessment results to national policy-makers, health workers, consumer groups and other stakeholders.
(4) Support the sharing of pharmaceutical situation reports at national, regional and global levels.

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Annex 1: Proposed indicators

	Indicator	Type	Target 2015		Progress in countries			Importance of the indicator	How to measure	Frequency
			Regional	Country	[illegible]	Needs further improvement/support	Good progress			
Policy and Access										
1	Medicines policy and implementation mechanism in place									
	a. NMP official document exists. Write the year of the most recent revision		at least 80% of countries	revised in last 5 years	[illegible]	Yes but document older than 5 years	Yes, document revised at least once in last 5 years	Commitment to universal access to essential medicines	collect information from the MOH	every two years
	b. NMP implementation plan exists. Write the year of the most recent revision			revised in last two years	[illegible]	Yes but plan older than 2 years	Yes, plan revised in last 2 years			
	c. NMP implementation regularly monitored/assessed			regular monitoring	[illegible]	Yes, once in 2 years	Yes, more frequently than 2 years			
2	Availability of 30 essential medicines in public and private sector	Y/N	70% of countries	at least 80% availability in both sectors	[illegible]	availability 80-95%	availability above 95%	Availability of medicines	use 15 global/regional core medicines and 15 country specific. Allow flexibility at the country level to subsitute for similar items within the therapeutic class i.e. Ranitidine vs. Famotidine	Decide on a representative sample, collect once by visiting sites, follow-up by phone once a year
3	Public procurement prices for selected medicines in comparison to international reference price	Ratio to international reference price	80% of countries	below 3x world market reference price	[illegible]	between 3-5x world market reference price	below 3x world market reference price	Efficiency in procurement	use information that is collected for Price Information Exchange for Selected Medicines in the Western Pacific Region	Countries submit data at the Regional level. WPRO will analyze data as part of the PIEmeds project (once a year)
4	Total pharmaceutical expenditure per capita (public and private)	$ value						Expenditure on medicines	NHA	baseline and 2015
5	Total pharmaceutical expenditure as a % of total health expenditure	%	70% of countries	15-20% of THE	[illegible]	20% - 25%	[illegible]	Expenditure on medicines	NHA	baseline and 2015
6	Public expenditure (including public health/social insurance) on pharmaceuticals as % of total pharmaceutical expenditure	%	70% of countries	above 50%	[illegible]	30% - 50%	[illegible]	Expenditure on medicines	NHA	baseline and 2015
7	Private out-of-pocket expenditure as % of total health expenditure	%	70% of countries	less than 50% out-of-pocket	[illegible]	50% - 70%	30% and below	Affordability	NHA	baseline and 2015
8	Does a public health service, public health insurance, social insurance or other sickness fund provide partial or full coverage for medicines that are on the EML for **outpatients** (write % of coverage and % reimbursement)	Y/N	70% of countries	all EML	[illegible]	Yes but not for all medicines in the EML	[illegible]	Affordability	collect information from the MOH	every two years
9	Does a public health service, public health insurance, social insurance or other sickness fund provide partial or full coverage for medicines that are on the EML for **inpatients** (write % of coverage and % reimbursement)	Y/N	70% of countries	all EML	[illegible]	Yes but not for all medicines in the EML	[illegible]	Affordability	collect information from the MOH	every two years
10	Is revenue from the sale of medicines used to pay the salaries or supplement the income of public health personnel in the same facility	Y/N	80% of countries	no	[illegible]	Yes but this system is in the process of phasing out	[illegible]	Medicines financing/RMU	collect information from the MOH	baseline and 2015
Quality Assurance										
11	An assessment of the mediciens regulatory system has been conducted in the last five years?	Y/N	50% of countries	conducted in last 5 years	[illegible]	Yes but five or more years ago	[illegible]	medicines regulation and quality assurance	collect information from MRA	baseline and 2015
12	Legal provisions exist permitting inspectors to inspect premises where pharmaceutical activities are performed	Y/N	100% of countries	complete legal framework	[illegible]	Partially	[illegible]	regulation of pharmaceutical activities/inspection	collect information from MRA	every two years
13	Legal provisions exist requiring manufacturers, wholesalers, distributors and dispensers to be licensed	Y/N	100% of countries	complete legal framework	[illegible]	Partially	[illegible]	regulation of pharmaceutical activities	collect information from MRA	every two years

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	Indicator	Type	Target 2015		Progress in countries			Importance of the indicator	How to measure	Frequency
			Regional	Country	Action is needed	Needs further improvement/support	Good progress			
14	Antibiotics are dispensed over the counter without a prescription	Y/N	70% of countries	in zero outlets	Licensed pharmacies and drug sellers	Licensed pharmacies but not drug sellers	None	regulation enforcement (licensing, inspection, dispensation)	collect information from MRA	every two years
Rational Selection and Use										
15	EML updated in the last three years	Y/N	80% of countries	updated in last 3 years	EML updated more than three years ago	EML updated three years ago	EML updated less than three years ago	Rational Selection	collect information from the MOH	every two years
16	A survey on rational use of medicines has been conducted. Write the year of the survey.	Y/N, year	80% of countries	conducted in last 5 years	No	Yes more than 5 years ago	Yes in less than 5 years ago	Prescribing practices	collect information from the MOH	baseline and 2015
	a. Average number of medicines prescribed per patient (outpatient)	nr	80% of countries	2.5 or less	More than 3	2.5-3	2.5 or less	Prescribing practices	as in "How to investigate RDU in health facilities"	baseline and 2015
	b. % of patients in outpatient public health care facilities receiving antibiotics	%	80% of countries	below 10%	More than 20%	Between 10-20%	Below 10%	Prescribing practices	as in "How to investigate RDU in health facilities"	baseline and 2015
	c. % of medicines in outpatient public health care facilities that are prescribed by INN (generic) name	%	80% of countries	above 80%	Less than 50%	50-80%	80% and above	Prescribing practices	as in "How to investigate RDU in health facilities"	baseline and 2015
	d. % of medicines prescribed in outpatient public health care facilities that are in the EML	%	80% of countries	above 90%	Less than 70%	70-90%	90% and above	Prescribing practices and rational selection	as in "How to investigate RDU in health facilities"	baseline and 2015
17	% of prescriptions complying with the standard treatment guidelines	%	80% of countries	at least 80%	Less than 50%	50-80%	80% and above	Prescribing practices and rational selection	as in "How to investigate RDU in health facilities"	every two years
18	A national programme or committee (involving government, civil society and professional bodies) exists to monitor and promote rational use of medicines	Y/N	100% of countries	government and partners involved	No	Yes, only government members	Yes composed of government and other partners	System to promote RMU	collect information from the MOH	every two years

APPENDIX 2

Annex 2: Suggested reading materials

1. *How to develop and implement a national drug policy, second edition*. Geneva, WHO, 2001 http://whqlibdoc.who.int/publications/924154547X.pdf

2. *Equitable access to essential medicines: a framework for collective action* (WHO policy perspectives on medicines, No. 8). Geneva, WHO, 2004 http://whqlibdoc.who.int/hq/2004/WHO_EDM_2004.4.pdf

3. *International Health Partnership, country planning cycle database* http://creator.zoho.com/downeyc/countryplanningdb/view-perma/Country_Planning_Cycle_DB/

4. *OECD health policy studies: pharmaceutical pricing policies in a global market.* OECD, 2008 http://www.centad.org/seminar/2. Price regulation/OECD Pharma pricing policies.pdf.

5. *Price Information Exchange for Selected Medicines in the Western Pacific Region* www.piemeds.com

6. *Guidelines for price discounts of single-source pharmaceuticals*. Geneva, WHO, 2003 http://apps.who.int/medicinedocs/en/d/Js4884e/

7. Dukes M et al. *Drugs and money prices, affordability and cost containment, seventh edition*. Geneva, WHO, 2003, http://apps.who.int/medicinedocs/en/d/Js4912e/

8. *Operational principles for good pharmaceutical procurement*. Geneva, WHO, 1999 http://apps.who.int/medicinedocs/en/d/Jwhozip49e/4.html

9. *A model quality assurance system for procurement agencies*. Geneva, WHO, 2007 http://www.who.int/medicines/publications/ModelQualityAssurance.pdf

10. *Practical guidelines on pharmaceutical procurement for countries with small procurement agencies*. Manila, WHO, 2002, http://www.wpro.who.int/NR/rdonlyres/7D1B522D-DEB1-48CB-88A7-68DEB599CCE1/0/PharmaProcurementGuide.pdf

11. *Procurement and Supply Management Toolbox* www.psmtoolbox.org

12. Briefing notes on Intellectual Property Rights and Access to Medicines http://www.wpro.who.int/sites/emp/documents/sample.htm

13. *WHO medicines regulatory package* http://www.who.int/medicines/areas/quality_safety/regulation_legislation/reginfo/en/index.html

14. *Resources on good governance for medicines* http://www.who.int/medicines/areas/policy/goodgovernance/documents/en/index.html

15. *Resources on quality assurance* http://www.who.int/medicines/areas/quality_safety/quality_assurance/en/index.html

16. *Quality assurance terminology database, list of terms and related guidelines* http://www.who.int/medicines/services/expertcommittees/pharmprep/TermListcategory.pdf

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17. *Rapid Alert System* http://www.counterfeitmedalert.info/

18. *Resources on combating counterfeit medicines*
http://www.who.int/medicines/services/counterfeit/en/index.html

19. *WHO Essential Medicines List and Model Formulary*. Geneva, WHO, 2010
http://www.who.int/selection_medicines/list/en/

20. *WHO Model List of Essential Medicines for Children*. Geneva, WHO, 2010
http://www.who.int/medicines/publications/essentialmedicines/Updated_second_children_list_en.pdf

21. *Promoting rational drug use: course material and other documents*. Geneva, WHO, 2008
http://archives.who.int/PRDUC2004/RDUCD/RDUCD.htm.

22. Resolution WHA60.16. *Progress in the rational use of medicines*. Geneva, World Health Organization, 2007 http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/reso-60-en.pdf#page=27.

23. *Antimicrobial Resistance Document Centre*
http://www.who.int/drugresistance/documents/en/index.html

24. *The World Medicines Situation.* Geneva, WHO, 2004.
http://apps.who.int/medicinedocs/en/d/Js6160e/

25. *WHO operational package for assessing, monitoring and evaluating country pharmaceutical situations: guide for coordinators and data collectors*. Geneva, WHO, 2008
http://apps.who.int/medicinedocs/index/assoc/s14877e/s14877e.pdf

ANNEX 2

HUMAN RESOURCES FOR HEALTH ACTION FRAMEWORK for the Western Pacific Region (2011–2015) (Draft)

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1. BACKGROUND

1.1 Purpose

Many health systems in the Western Pacific Region remain beset by a health workforce crisis: absolute shortages of qualified health workers; inequitable distribution of workers and inefficient skill mix; training and education poorly matched to patient and population needs; and financial constraints with poor motivation and retention in most lesser-resourced countries.

The *Regional Strategy on Human Resources for Health (2006–2015)*, endorsed in resolution WPR/RC57.R7 by the WHO Regional Committee in 2006, guided the collaborative actions of WHO and Member States in strengthening health workforce responsiveness to population health needs through enhanced health system performance and service quality.

These actions included strengthening of national human resource strategic planning and human resources for health (HRH) information systems; reviews and updating of regulatory systems; initiatives addressing the quality and relevance of health professionals education; analyses of policy options for rural and remote retention in selected countries, along with publication of global evidence-based policy recommendations on the same issue; and the formulation and dissemination of subregional and global codes of practice for the international recruitment of health workers.

Despite this progress, there remains an urgent need for intensified, collaborative and multisectoral HRH actions to improve universal coverage and access to quality health services in order to reduce population health inequities and achieve better health outcomes for all.

1.2 Global and regional context

Many countries face similar challenges in providing equitable access to quality health services for all and improving health outcomes. A sufficient health workforce, adequately prepared and equitably distributed, is necessary for creating strong health systems. However, developing and maintaining an equitably distributed, competent and effective health workforce is an ongoing struggle for many countries, requiring innovative, collaborative and comprehensive national and international planning and strategic actions.

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The Western Pacific Region is making better progress towards the health-related Millennium Development Goals (MDG) than other WHO regions. However, progress is unequally spread within and between countries, with rural and poor populations lagging behind. Progress towards achievement of MDG 4 and 5 targets, reduced child mortality and improved maternal health, requires a multi-dimensional approach to service delivery, incorporating core HRH elements, integrated with information management systems, essential medicines, equipment and technologies, financing, service delivery, leadership and governance.[1,2]

The Region also grapples with mounting negative effects of climate change, health risks, ongoing natural disasters and other public health emergencies. While globalization is accelerating worldwide transmission of communicable diseases, health disparities are widening, populations including health workers are aging, and the burden of chronic conditions is increasing. Estimates suggest that the older population in this Region will grow faster than in any other WHO region.[3]

Four out of every five deaths in the Western Pacific Region are due to the most common noncommunicable diseases (NCD)—cancer, cardiovascular disease, chronic respiratory conditions and diabetes.[4] The poorest people have the highest burden of NCD, as they have greater exposure to risk factors and less access to preventive and therapeutic services. Health systems in the Region are developing more integrated and comprehensive models of prevention, risk reduction and care provision that use available resources more efficiently and reduce disease complications.

1.3 Primary health care, now more than ever

A resolution to strengthen health systems based on the values and principles of primary health care (PHC) was endorsed at the fifty-ninth session of the WHO Regional Committee for the Western Pacific. The resolution (WPR/RC59.R4) urges Member States to develop and implement strategies for health systems strengthening and PHC to achieve improved health outcomes for their people, especially those who are poor or otherwise most vulnerable. The common values of PHC and the right to health underpin the *Western Pacific Regional Strategy for Health Systems Based on the*

[1] *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care*. Manila, World Health Organization, 2010.
[2] Dawson A. Towards a comprehensive approach to enhancing the performance of health workers in maternal, neonatal and reproductive health at community level: Learning from experiences in the Asia and Pacific regions. Discussion paper 2. Sydney, Human Resources for Health Knowledge Hub, 2010.
[3] *Gender, Health and Ageing*. Geneva, World Health Organization, 2003.
[4] *Seoul Declaration on Noncommunicable Disease Prevention and Control in the Western Pacific Region*. Seoul, World Health Organization, 2011.

Values of Primary Health Care as well as the *Regional Health Financing Strategy for the Asia Pacific Region (2010–2015)*, which aims for universal coverage by quality health services without excessive household financial burden.

The crucial role of HRH in the context of health systems strengthening, primary health care renewal, universal access and equity was the focus of a mid-term review of the *Regional Strategy on Human Resources for Health (2006–2015)*. Technical norms at global and regional levels have also been recently developed to further support countries in addressing the challenges of health workforce strengthening, and implementing the agreed regional resolutions. These norms include global evidence-based guidelines on increasing access to health workers in remote and rural areas,[5] a global code of practice for the international recruitment of health personnel,[6] and a Pacific code for the migration of health workers.[7]

1.4 Regional progress in strengthening human resources for health

Three WHO meetings have been organized to review challenges and progress in implementing the *Regional Strategy on Human Resources for Health (2006–2015)* and to propose an action framework to further guide and scale up implementation.[8,9,10] Consultations during these meetings, technical reviews of national progress by key strategic result areas in 2009, and a mid-term review of the strategy in 2011 provided the basis for a fairly comprehensive assessment of the current situation of HRH in the Region and the identification of priority issues. The assessment was also informed by reports from Member States, project documents and numerous other publications.

Recognizing the importance of the health workforce in achieving population health goals and the links these have to broader socioeconomic goals, national governments are stepping up efforts to resolve HRH challenges, as evidenced by the formation of high-level, multisectoral committees or taskforces and the issuance of HRH decrees in many countries.

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[5] *Global policy recommendations: increasing access to health workers in remote and rural areas through improved retention*. Geneva, World Health Organization, 2010.
[6] *WHO Global Code of Practice on the International Recruitment of Health Personnel*. Geneva, World Health Organization, 2010 (http://www.who.int/hrh/migration/code/code_en.pdf, accessed 6 June 2011).
[7] *Pacific Code of Practice for Recruitment of Health Workers and Compendium*. Endorsed at the Seventh Meeting of Ministers of Health for Pacific Island Countries, Port Vila, Vanuatu, 12 to 15 March 2007 (http://www.wpro.who.int/NR/rdonlyres/6B618EAA-B30B-4CFA-8038-A9F145174895/0/Pacificcodeofpractice.pdf, accessed 6 June 2011).
[8] Meeting on the Regional Strategy and Initiatives on Human Resources for Health, Manila, Philippines, 24–26 August 2009.
[9] Meeting on Nursing Education and Human Resources for Health, Nadi, Fiji, 7–11 February 2011.
[10] Meeting on an Action Framework fro the Regional Strategy on Human Resources for Health, Manila, Philippines, 4–6 April 2011.

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Across the Region, countries have been responding to the HRH challenges by strengthening health workforce strategic planning and human resource management systems. Actions taken include improvements in the collection and sharing of population and health data; better links between workforce planning and health service and educational sector planning; steps to reorient health services towards primary health care, health promotion and integrated care provision across the continuum of care; and the testing of strategies to reduce access barriers for disadvantaged groups.

Countries have intensified efforts to improve human resources production and development. Examples include increased participation of minority groups in the health workforce; and concerted interventions in multiple countries to strengthen the quality and relevance of education and training. Evaluations of such interventions are limited.

Improved HRH management practices have resulted in reviews of skills-mix, roles and functional requirements of health workers, with the aim of improving their motivation and performance. Implementation of evidence-based interventions to increase retention in rural and remote areas, as well as strategies to mitigate effects of migration, have resulted in some improvements to the geographic distribution of health workers.

Governance, leadership and partnerships have been addressed through the introduction, review and/or strengthening of legislative and regulatory frameworks and improved coordination of stakeholders and partners; capacity-building in HRH strategic planning and management; improving the quality and safety of service delivery; and the establishment and sustaining of regional HRH, nursing and midwifery networks.

Despite these efforts, insufficient progress has been made in the delivery of universally accessible quality health services.

2. CRITICAL GAPS AND CHALLENGES

Intensified strategic actions are required to address absolute shortages of qualified health workers; unbalanced distribution of workers and inefficient skill mix; training and education poorly matched to patient and population needs; and lack of motivation and retention in most lesser-resourced countries. Increased sustainable financing of HRH is imperative for workforce strengthening and scaling up.

2.1 Cross-sectoral planning and policy alignment

Health workforce planning and policy alignment across sectors, including health, education, finance and labour, are currently lacking in many countries. More attention must be spent on facilitating policy dialogue and joint decision-making across sectors with multiple stakeholders, including all relevant ministries, the public–private service delivery sector, professional associations, nongovernmental and faith-based organizations, consumers and communities, and technical and donor partners.

2.2 Health sector financing and governance

HRH policies, plans and interventions call for strong political commitment and sustained financial investments to support workforce scaling up in areas of greatest need, i.e. employment costs and pre-service education.[11] In the Western Pacific Region, little has been done to increase health sector funding even though the consequences of inadequate investment are widely recognized. As such, many countries are struggling to improve the recruitment, deployment, retention and performance of the health workforce. In countries with chronically under-resourced health facilities, the salaries of health workers are significantly lower than the cost of living and payment is sometimes delayed. Government resource constraints, as well as inadequate investments and inefficient resource mobilization, including insufficient use of fiscal space,[12] are factors that make it difficult for countries to achieve universal access to quality health services. Reductions in out-of-pocket payments for health services and improved financial risk protection and safety nets, especially for the poor and

[11] *Efficiency and effectiveness of aid flows towards health workforce development: Exploratory study based on four case studies from Ethiopia, the Lao People's Democratic Republic, Liberia and Mozambique*. Geneva, World Health Organization, 2011.

[12] Fiscal space is defined as room in the government's budget that allows it to provide resources for desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.

vulnerable population segments, are essential in overcoming financial barriers to access to quality services.

2.3 HRH databases, information management systems and strategic plans

In most lesser-resourced countries, databases and other data sources, as well as HRH information management systems (IMS), even if they exist, do not provide policy-makers and planners with the necessary minimum data sets (MDS) to enable full workforce analyses by sex, age, location (rural or urban) and ethnicity. Furthermore, governments have not completely or consistently identified health service priorities, or delineated the functions and staffing norms for different facilities or services, further limiting the effectiveness of workforce planning efforts.

2.4 Workforce shortages and maldistribution

Workforce shortages and maldistribution of health workers are problems shared throughout the Region, though the seriousness of the problems varies from country to country. Cambodia, the Lao People's Democratic Republic, Papua New Guinea, Solomon Islands, Samoa, Vanuatu and Viet Nam continue to face acute overall shortages of health workers (doctors, nurses and midwives), with a density of less than 2.3 per 1000 population.[13,14] Overall, the Region has insufficient numbers of essential groups of health personnel, including: qualified tutors/faculty for education and training; mental health personnel; community-based nurses and midwives and selected categories of medical specialists; adequately trained health facility and equipment engineers and maintenance personnel; and, in the Pacific islands, local, low-cost prosthetic makers. All countries also have workforce distribution inequities with most health workers found in urban areas, leaving rural areas underserved.

2.5 Implementation of HRH plans

While many countries have HRH plans in place to address workforce issues, it is clear that implementation is not easy. Even when HRH priorities are clearly delineated, there may still be inadequate strategic action planning and budgetary support to adequately address urgent HRH needs. Disconnects still exist between health services and educational and workforce planning,

[13] *Human Resources for Health Forum Discussion Papers*. Port Moresby, National Department of Health, Papua New Guinea, 2008.
[14] *Country Health Information Profiles*. Manila, World Health Organization, 2010.

contributing to inefficiencies and misalignment in training, deployment and uptake into the workforce. Limited capacity for human resource management at the national, provincial and facility levels, limited cross-sectoral and multi-stakeholder involvement and other underlying, constraining health system factors all contribute to the difficulties countries have in following through on policy-level commitments, and implementing strategies and plans.

2.6 Education and training

The standards and quality of education and training of health professionals remain below par in many countries, resulting in a health workforce that is ill-prepared to effectively respond to rapidly changing, complex health systems and population health challenges surrounding ageing and the growing burden of noncommunicable diseases. Faculty in lesser-resourced countries typically lack clinical expertise as well as formal preparation in education, teaching and learning. They tend to impart knowledge, interpersonal skills and clinical practices that are outdated and not evidence-based. As such, students do not acquire the necessary clinical reasoning skills for safe practice. Basic entry-to-practice competencies of new graduates are negatively influenced by gaps between classroom learning and mentored clinical learning as well as inadequate clinical supervision and role-modelling. Safe and quality services are continually eroded by shortages of formally prepared educators as well as multiple inadequacies in the promotion of student-centred, experiential learning, problem-solving and critical thinking within the clinical context. Though the production of the health workforce requires scaling up, educational institutions in most lesser-resourced countries are ill-equipped to do so due to human and other resource constraints, without severe compromises in educational quality.

2.7 Informal health workers

Informal health workers, including community health workers, traditional practitioners and lay caregivers, are playing increasingly important roles in the primary health care systems of most countries to compensate for workforce shortages. The HRH challenges of the formal workforce apply to the informal workforce, to an even greater extent, as many informal health workers do not receive salaries or supervision. Insufficient comparative and analytical data exist regarding their education, deployment, utilization, retention and effectiveness in the Region. While informal health workers have multiple titles and varying types and depth of training, studies and experience have shown that they can play important roles in child survival, maternal health and management of

infectious diseases,[15,16] as well as health literacy, community empowerment and resilience, all of which contribute to improved health. There is a potential for better primary health care system coverage through the use of adequately trained and supported community or informal health workers, who are deployed to complement the work of health professionals but not to serve as direct substitutes for health professionals.[17]

2.8 Research, analysis, monitoring and evaluation

The growing amount of analysis and research being undertaken throughout the Region will inform policy development and planning, but more is needed to capture the unique characteristics of each country and its health workforce. To date, much of the research has been directed at better understanding the workforce situation, and the underlying causes of particular problems. There has been little investigation of the impact of interventions taken to resolve problems; however, in many countries, not enough time has passed for such impacts to be felt, and resources for monitoring or independent analysis are limited.

[15] Haines A. et al. Achieving child survival goals: potential contribution of community health workers. *The Lancet*, 2007, 369:2121.
[16] Lewin S. et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. Cochrane Database of Systematic Reviews, 2005.
[17] Lin V., Ridoutt L. and Hollingsworth B. What incentives are effective in improving the deployment of health workers in primary health care settings in Asia and the Pacific? Manila, World Health Organization, [not yet published].

3. HUMAN RESOURCES FOR HEALTH ACTION FRAMEWORK (2011–2015)

Countries in the Western Pacific Region are working hard to address the challenges of developing and sustaining a health workforce that is sufficient, competent, responsive and adequately supported to meet population health needs. Although many workforce challenges are common to all countries, their unique health systems and political, socioeconomic and topographical situations necessitate workforce policies and strategic interventions specific to each country context. As countries address these challenges, they are guided by a universal vision.

3.1 HRH Vision 2020

> "Universal coverage for access to quality health services, particularly for the most vulnerable and excluded groups, with improved patient and community health outcomes, through a balanced distribution and efficient skill mix of a multi-professional, motivated workforce able to prevent and manage a full range of conditions and empower people and communities to manage their own health needs as fully as possible."

3.2 HRH Action Framework

The HRH Action Framework, depicted in Figure 1, was designed to achieve the HRH Vision 2020. The Framework's six interlinked action fields—human resource management systems, policy, finance, education, partnership and leadership—must all be taken into account in health workforce development and overall health system improvement. The Framework highlights the need for multisectoral and multi-stakeholder collaboration and other factors critical for sustainable HRH and health service improvements.[18]

While the HRH Action Framework is applicable in all countries, the way it is used is influenced by the elements specific to the country context, including the labour market. The outcomes of applying the Framework are also influenced by the strength of other components in the health system (e.g. availability of medical products and equipment, health care financing and health information).

[18] *World Health Report 2006: Working together for health*. [Adapted from the Human Resources for Health Technical Framework: achieving a sustainable health workforce, p. 137]. Geneva, World Health Organization, 2006 (http://www.who.int/hrh/tools/en/index.html, accessed 14 May 2011).

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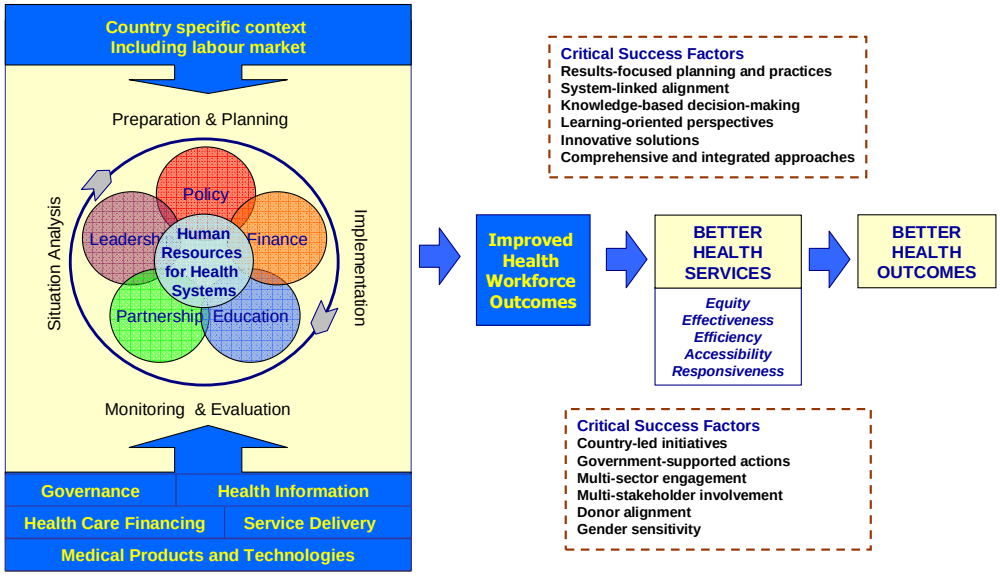
Figure 1: HRH Action Framework for WHO Western Pacific Region



The revised HRH Action Framework (2011–2015) serves as a guide for WHO, governments and partners as they plan and implement concerted actions for health workforce development based on analysis of current and future needs.

3.3 Key result areas, strategic objectives and core indicators

The HRH Action Framework was revised to take into account increasing health system complexities, changing health needs and system demands posed by ageing populations and noncommunicable diseases, and the corresponding growing need for scaled-up health workforce education and training to maintain competencies. As such, the revised Framework is comprised of four key result areas, rather than the three identified in the original version,[19,20] as well as corresponding strategic objectives and core monitoring and evaluation indicators guiding the implementation of actions.

[19] *Regional Strategy on Human Resources for Health (2006–2015)*. Manila, World Health Organization, 2007.
[20] Workforce management is addressed with workforce utilization and retention as it lays the foundation for improved retention. Partnerships have been more fully addressed in key result area 4, in recognition of the need for coordinated, collaborative and sustained action in support of the HRH Vision 2020.

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Key Result Area 1		Core monitoring and evaluation indicators
Health workforce strategic response to evolving and unmet population health and health service needs		• Existence of a funded human resources plan addressing population needs and priority HRH areas • Number of health workers overall per 10 000 population as well as number of doctors, nurses and midwives per 10 000 population • Distribution of health workers by rural and urban location (as defined by country official documents)
Strategic objective	Ensure that health workforce plans and strategies respond to population and service needs, particularly those of the most vulnerable and excluded groups, evolving health worker functions, and technological advances.	

Strengthening of HRH minimum data sets is required for workforce production and effective deployment. Analysing policy options and implementing more efficient and effective HRH skill mix, aligned with minimum packages of service delivery at all levels are important areas that need to be strengthened to better inform the policy-making process. Reporting on and analysing trends, using agreed-upon sets of core monitoring and evaluation indicators, are essential in monitoring the implementation of plans. Furthering the consistent and systematic dissemination of research findings and application of evidence to policy-formulation and practice is of utmost importance.

Key Result Area 2		Core monitoring and evaluation indicators
Health workforce education, training and continuing competence[21]		• Annual number of graduates of health training institutions, broken down by category of health professional • Percentage of health professional graduates employed in the health sector within 12 months after graduation • Evidence of implementation of national or standardized institutional competency examination for each health professional cadre. • Percentage of graduates in each health professional cadre passing the national competency examination on the first attempt
Strategic objective	Develop and continually upskill an inter-professional, flexible, competent workforce able to prevent and manage a full range of conditions and empower people and communities to manage their own health needs as fully as possible.	

[21] "Continuing competence" is a newer version of the concept of "professional development" that ensures individual as well as collaborative/team learning to enable "all health professionals to engage effectively in a process of lifelong learning aimed squarely at improving patient care and population health." *The Future of Nursing: Leading Change, Advancing Health, 2011.* Institute of Medicine, 2009.

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Establishing and applying academic standards, entry-to-practice competencies and faculty development initiatives, with continual strengthening of regulatory frameworks and the operational work of regulatory bodies, are important actions to improve quality education, practice standards and accreditation capacities in Member States. Subsequent to a global analysis of the current state of health professional education, the independent Commission on Education of Health Professionals has called for all health professionals in all countries to "be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams … to assure universal coverage of the high-quality comprehensive services that are essential to advance opportunity for health equity within and between countries."[22]

<table>
<tr><th colspan="2">Key Result Area 3</th><th>Core monitoring and evaluation indicators</th></tr>
<tr><td colspan="2">Health workforce utilization, management and retention.</td><td rowspan="2">Management
• Number of countries with evidence of formulation or implementation of professional competencies and standards and of quality assurance mechanisms to ensure competence of health professionals
• Number of countries with evidence of a performance appraisal system in place
Skill mix
• Births attended by trained health personnel/ total births
Recruitment and rural/remote retention
• Percentage of vacant posts annually as a percentage of all recruits and/or total number of vacant posts, broken down by geographical location (rural, urban)
• Total number of health workers recruited to rural, underserved areas annually
Migration
• Annual attrition rate of health workers by cadre or percentage of health workers leaving the health sector</td></tr>
<tr><td>Strategic objective</td><td>Maximize functions of the health workforce, staff and skill mix efficiency and management and retention to improve service delivery in terms of equity, universal access, quality and effectiveness.</td></tr>
</table>

Improving the management, retention, participation and motivation of the health workforce requires application and testing of innovative interventions including bundled packages of incentives, other effective retention strategies, effective performance management at all levels, and an

[22] Bhutta Z et. al. Education of health professionals for the 21st century: a global independent commission. *The Lancet*, 2010, 375:1137–1138.

adequate skill mix, as countries struggle to achieve better health outcomes using their existing workforce.

Key Result Area 4		**Core monitoring and evaluation indicators**
Health workforce governance, leadership and partnerships for sustained HRH contributions to improved population health outcomes.		• Number of countries with evidence of existing, active HRH partnerships and networks with products/outputs addressing workforce efficiency and effectiveness • Evidence of nationally enacted policies addressing terms and conditions of work. • Evidence of nationally enacted policies addressing quality, including infection control. • Evidence of up-to-date, reliable health workforce registration databases
Strategic objective	Strengthen health workforce cross-sectoral planning, policy coherence, regulations and partnerships to ensure the delivery of universally accessible, effective, evidence-based, quality and safe services.	

Government-wide, multi-stakeholder approaches are required to address the contextual labour market and health systems strengthening issues underlying HRH shortages, particularly those in rural, remote and other underserved areas.

Sustainable workforce investments require prioritized and costed human resource plans addressing resources required; necessary increased investments; analysis of improved fiscal space utilization as well as taking into account the timeline and the predictability of external funding.

Integrated, coordinated donor support is essential to avoid fragmented, donor-driven or other potentially disruptive support that greatly impairs healthy system functioning. Multiple types of donor support could be applied in the following ways: strengthening of the HRH IMS; infrastructure strengthening or rebuilding of educational institutions; faculty development; innovative curricular changes; and ongoing technical support in lieu of financial contributions.

Unless adequate resources are secured, lack of investment will continue to be a major barrier to resolving many of the key HRH challenges, regardless of the appropriateness of other actions taken by governments and development partners.

3.4 Expected results

Concerted action by WHO and Member States, in close collaboration with stakeholders, partners and donors, can be expected to result in some key achievements, including:

- increased numbers of countries with strengthened, costed and implemented national HRH plans and HRH management capacities;
- improved HRH information systems and minimum data sets supported by a growing body of regional shared databases;
- scaled up investments in pre-service education and continuing competence;
- regulatory and policy analysis and updates enabling full functional utilization of all cadres of health workers, including policies and interventions addressing rural and remote recruitment and retention;
- growing body of literature and research, as well as application of evidence to planning, policy-formulation and practice; and
- improved and expanded cross-sectoral partnerships and dialogue for more coherent planning, policy-making and more sustainable HRH financing

3.5 Results-based HRH Action Framework

The strategic actions chosen to address priority HRH challenges in the next five years are clustered within the four key result areas. The actions are further categorized into macro-level structural input, operational or organizational actions, processes or steps, expected outputs, outcomes and impacts. Thus the results-based action framework serves as a stepwise approach to changes and an overall assessment of progress and performance in the four key HRH domains or key result areas, within the context of national health system strengthening.

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Key result area 1: **Health workforce strategic response to evolving and unmet population health and health service needs**
Strategic objective: Ensure that health workforce plans and strategies respond to population and service needs, particularly those of the most vulnerable and excluded groups, evolving health worker functions, and technological advances.

Macro-level structural input →	Operational processes →	Outputs →	Outcomes →	Impact
HRH strategic plans • HRH plan based on sound situation analysis using workforce planning models and tools • Workforce policy or strategy addresses population needs and workforce response in terms of gender, equity, vulnerability • HRH plan integrated into national health plan **Information management systems (IMS)** • Established focal point for HRH IMS for data collection, dissemination and analysis • Information systems for policy and planning in place • Action plan, timeline and targets in place for strengthening HRS IMS • Minimum HRH data sets established, linked to definitions, data sources • Number of health workers per 10 000 population as well as number of doctors, nurses and midwives per 10 000 population for both the public and private sectors	• Formation, operation and funding of a distinct team or unit responsible for analysis, HRH planning • Provision of cost estimates and input into overall HRH cost estimates by all levels of the health system • Prioritization of HRH plan, with costing at individual element levels inclusive of: immediate training costs, longer-term employment costs, and broader health system costs • Prioritized HRH action plan detailed with workforce targets by national minimum data set categories and time frame • Formal government endorsement/approval of HRH plan • Operational implementation of the HRH plan • Regular review and revision of HRH plan based on ongoing evaluation and operational research • Established mechanisms for transparency in information sharing • Continued and improved evidence-based decision-making in HRH analysis and reporting • Increased knowledge, data acquisition from the private sector and the labour force and market • Increased accessibility and sharing of workforce data bases across departments, levels and sectors	• Existence of a funded prioritized HRH plan addressing population needs and identified priority HRH areas: o National HRH plan integrated into national policies and plans o Projected HRH needs for public and private sectors included in HRH plan • Implementation of national HRH plan with monitoring and evaluation mechanisms and development of national evaluation plan; preparation of reports based on evaluations • Application of HRH information for decision-making and policy formulation at all levels • Private sector workforce data integrated into national IMS • Easily accessible, shared workforce databases used for workforce analyses and planning • Number of national data points on the stock and distribution of health workers produced within past three years • Current number and distribution of health workers	• Increased population access to an adequate, competent, productive and supported workforce for quality health care	• Increased life-expectancy • Increased equity, responsiveness of health services • Reduced mortality and burden of disease as measured by: - under-5 mortality - maternal mortality ratio - mortality by cause of death by sex and age - TB prevalence • Reduction in cause-specific mortality and morbidity

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Key result area 2: Health workforce education, training and continuing competence **Strategic objective**: Develop and continually upskill an inter-professional, flexible, competent workforce able to prevent and manage a full range of conditions and empower people and communities to manage their own health needs as fully as possible.				
Macro-level structural inputs →	**Operational processes →**	**Outputs →**	**Outcomes →**	**Impact**
Cross-sectoral policy-making, planning • Formation of high-level cross-sectoral working group or stakeholder committee tasked with policy analysis and planning to ensure that universally accessible, quality services are delivered and population health needs are met through health worker education and continued capacity-building • Policy analysis carried out and strategic plans developed to improve primary and secondary education and to ensure that health professional applicants and students meet entry requirements and successfully complete programmes • Academic accreditation body and regulatory systems established to ensure quality, quantity, relevance and competencies for work positions • Established core competencies[23] for all cadres of health professionals • Academic quality standards and indicators established, applying international standards/guidelines to assess: o programme graduates o programme development and revision, including resources o programme curriculum o academic faculty and staff o programme admission • Faculty development programme established for continued professional growth and number of qualified, skilled educators increased, including clinical educators/preceptors • Mechanisms put in place for mentoring and coaching faculty, staff and students	• Formal endorsement/recognition of national cross-sectoral stakeholder committee • Evidence of active engagement of relevant sectors, consumers, communities and professional organizations in developing and improving competency-based health professions education • Review and periodic updating of entry-to-practice competencies, practice standards to meet newly emerging roles, and changing population needs • Regular academic quality improvement meetings; actions taken, evaluated and recorded; and internal and external assessments benchmarked against established national and global academic quality standards • Implementation of regular faculty appraisals, faculty development and reporting of progress • Data reveal increased faculty retention, increased number of educators, and improved competencies • Curricular content, community rotations, service arrangements and student assessments reflect capacity development in rural and vulnerable population health • Ratio of staff (faculty, preceptors) to	• Available data on estimates of total cost of education per cadre • Innovative models of educational delivery and quality improvement evaluated and reported on, involving: resource sharing, clinically contextualized learning, inter-professional education and/or education/practice models of service delivery • Evidence of scaling up and evaluation, application of lessons learnt from educational production and quality initiatives • Adequate number of health professional educational institutions with development needs receiving technical and financial support for faculty and programme strengthening • Increased budgetary allocations and financial support for health professional educational institutions • Annual number of graduates of health training institutions broken by category of health worker • National or standardized institutional competency examination in place for each health professional cadre • Percentage of graduates in each cadre passing national competency examination	• Increased population access to an adequate, competent, productive and supported workforce for quality health care	• Increased life expectancy • Increased equity and responsiveness of health services • Reduced mortality and burden of disease as measured by: - under-5 child mortality - maternal mortality ratio - mortality by major cause of death by sex and age - TB prevalence • Reduction in cause-specific mortality and morbidity

[23] "Competencies" do not represent tasks, but rather higher-level competencies (applied knowledge; attitudes; skills; clinical decision-making processes) essential for the provision of safe care in clinical situations across all care settings.

[24] "Continuing competence" is a newer version of the concept of professional development that ensures individual as well as collaborative, team learning to enable "all health professionals to engage effectively in a process of lifelong learning aimed squarely at improving patient care and population health." Institute of Medicine, 2009; *The Future of Nursing: Leading Change, Advancing Health, 2011.*

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Key result area 2: Health workforce education, training and continuing competence
Strategic objective: Develop and continually upskill an inter-professional, flexible, competent workforce able to prevent and manage a full range of conditions and empower people and communities to manage their own health needs as fully as possible.

Macro-level structural inputs →	Operational processes →	Outputs →	Outcomes →	Impact
• HRH tracking of number of entrants into health professional training programmes (with nationally approved curriculum) within last three years, with trend analysis and policy options • Number of students in medical, nursing and midwifery pre-service education programmes, per qualified instructor monitored, with policy interventions to ensure quality **Continuing competence**[24] • Establishment of integrated coordinated programme for continuing competence and lifelong learning of all health professionals	student • Annual training budget per worker • Annual number of days for continuing professional development (CPD) • Percentage of staff receiving CPD **Continuing competence** • Scaling up integrated, competency-based continued learning programmes for individuals and teams	on the first attempt (data monitored, reported and evaluated to ensure quality, safe competencies for practice) • Policies and processes in place that support the continuing competence of individuals and teams, with accompanying evaluation data		

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Key result area 3: Health workforce utilization, management and retention
Strategic objective: Maximize health workforce utilization, management, skill mix, recruitment and retention to improve service delivery in terms of equity, universal access, quality and effectiveness.

Macro-level structural input →	Operational processes →	Outputs →	Outcomes →	Impact
Management • Comprehensive, coherent macro-level human resource management (HRM) strategy, policies and plan as part of the overall national HRH plan, addressing: o staff supply, recruitment needs, processes o working conditions, health, safety o setting pay levels and incentive packages o harmonizing relations between staff, and teamwork/inter-professional teamwork o labour relations, skills-requirements and skill mix o performance management—optimizing production and quality of care, supervision, professional career development, job descriptions, and performance appraisal. • Established policies and training programme for all senior staff for HRM skill development and updating **Staff and skill-mix efficiency**[25] • HRH analyses of options for improved efficiency and effectiveness, within local context of population needs, alternative models of service provision, evolving skills/competencies and assurance of quality, and safety **Recruitment** policy frameworks address: • recruitment of students from rural, underserved areas; and • obligatory service agreements and/or other incentives for mandatory practice rotations in rural or underserved areas.	**Management** • Participatory staff involvement in planning and changing HRM at facility level • Strong, active HRM and leadership skill development at all levels supporting productivity, competence, responsiveness, team work and problem-solving • Institutional policies that are gender-specific; plans addressing satisfactory, favourable working conditions: equipment and supplies; infrastructure; support services; regulations of work, lines of authority, decision-making; accountability, ethical and unethical behaviour, recognition. **Skill mix and efficiency** • Institutional/facility skill mix analyses, adjustments or new introductions which maximize health benefits, outcomes while maintaining or reducing costs. **Recruitment and retention** • Workload and other studies implemented to address and rectify HRH imbalances between levels of care and urban and rural areas. • Data availability of distribution of health workers (by occupation/specialization, region, place of work and sex) • Policies analysed, implemented and evaluated for obligatory community service to rural and/or urban underserved areas and populations • Bundled packages of incentives to support deployment, recruitment and retention being implemented and evaluated • Number of health workers newly recruited at primary health care facilities in the past 12 months (as percentage of planned recruitment target)	**Management** • Number of senior staff at primary health care facilities who received in-service management training (with nationally approved curriculum) in past 12 months. • Percentage of health service providers at primary health care facilities who received personal supervision a minimum of every six months. **Staff and skill-mix efficiency** • Analysis, evaluation of interventions matching staff skill, competency mix to care needs of specific populations. **Recruitment to rural, remote, underserved areas and retention** • Increase in stated preferences for working in rural/remote, underserved areas • Total number of health workers recruited to rural, underserved areas • Proportion of new graduates entering into practice in rural, remote or underserved areas • Proportion of health workers staying in rural areas (stability index or retention rate) in past 12 months • Length of service in rural areas	• Increased population access to an adequate, competent, **productive and supported** workforce for quality health care.	• Increased life expectancy • Increased equity and responsiveness of health services *(health worker, patient, community satisfaction surveys)* • Health outcomes *(urban as compared to rural, impoverished areas):* • Reduced mortality and burden of disease as measured by: - under-5 child mortality - maternal mortality ratio - mortality by major cause of death by sex and age - TB prevalence • Reduction in cause-specific mortality and morbidity

[25] Skill mix usually refers to the mix of posts, grades or occupations in an organization. It may also refer to the combination of activities or skills needed for each job in the organization. (Buchan J. and Dal Poz M. Skill mix in the health care workforce: reviewing the evidence. *Bulletin of the World Health Organization*, 2002, 80:575–580.

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Key result area 3: Health workforce utilization, management and retention
Strategic objective: Maximize health workforce utilization, management, skill mix, recruitment and retention to improve service delivery in terms of equity, universal access, quality and effectiveness.

Macro-level structural input →	Operational processes →	Outputs →	Outcomes →	Impact
Retention • Career pathway frameworks in place linked to continued competency development, performance assessment, quality and financial, non-financial incentives • Succession planning policies, plans for leadership development, mobility, rotation • Retention policies and programmes addressing: o salary standards o conditions of service o incentives, rewards linked to performance o favourable work environments aimed at increasing satisfaction retention **Transitions, attritions and exits (migration** HRH minimum data sets contain essential data elements, in shared database • Coherent, cross-sectoral HRH policies addressing cross-border recruitment, migration, return migration	• Number of days of health worker **absenteeism** relative to the total number of scheduled working days over a given period among staff at PHC facilities • Percent of health workers with intention to stay in or leave the rural areas **Data showing increased motivation and intention to remain in workplace** • Job satisfaction of rural and urban health workers • Patient satisfaction (and analysis of rural as compared to urban satisfaction) **Transition, attritions and exits (migration)** • Increased tracking and analysis of all elements of HRH minimum data sets • Number of doctors, nurses and midwives produced or graduated in a year • Number of doctors, nurses, midwives immigrating internationally in a year, as share of total number in each workforce category. • Proportion of nationally trained health workers as compared to foreign-trained health workers entering the country annually	• Density of health workers in rural areas compared to urban areas **Transition, attritions and exits (migration)** • Stocks and flows of health workers—data availability and trend analysis based on HRH minimum data sets • Strengthened policy coherence addressing international recruitment and in-country health system, population health needs • Regularly updated and available HRH MDS data, reporting on number of health workers trained abroad entering country annually, relative to number of nationally trained graduates		

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Key result area 4: Health workforce, governance, leadership and partnerships for sustained HRH contributions to improved population health outcomes
Strategic objective: Strengthen health workforce cross-sectoral planning, policy coherence, regulations and partnerships to ensure the delivery of universally accessible, effective, evidence-based, quality and safe services.

Macro-level structural input →	Operational processes →	Outputs →	Outcomes →	Impact
Governance • Existence of a cross-sectoral national coordination body (including health, planning, education, finance, labour, public or civil service commission) or formal mechanisms for HRH strategic planning, including application of labour market data, stakeholder coordination, and HRH sustained investments • Coherent cross-sectoral HRH policies developed and implemented for production, distribution, utilization and issues surrounding migration • Ongoing evaluation of policies and outcomes to ensure HRH responsiveness to evolving population health needs within PHC context and changing models of health service delivery • Policy and mechanisms established for donor and partner support **Leadership and partnerships** • Leadership capacity-building policies and structures in place • Establishment of networks and partnerships of relevant committed leaders and stakeholders **Regulation and safety** • Existence of national policy framework for workforce health and safety; quality improvement, including infection control; safe, improved working conditions • Regulatory bodies established for regulation and oversight mechanisms, with flexibility • Review and updating of regulatory	• Multi-stakeholder involvement in HRH planning, evaluation and policy-making (including public and private sectors, international and national NGOs, faith-based organizations, civil society, professional associations, multinational and bilateral development partners, global health initiatives) • Innovative intervention models evaluated and reported on; policy briefs issued on HRH priority issues/needs • Donors forum conducted for alignment and harmonized activities • Mechanisms to ensure certain level of local autonomy over HRH financial, material, human resources for locally developed strategies, matching health worker needs and essentials packages of care delivery at all levels **Leadership and partnerships** • Mechanisms for capacity-building and upgrading in place at all levels • Strengthened capacities in: o data literacy, analysis, reporting skills; o analysis, generation and application of evidence and research; o use of tools and techniques for HRH system, o institutional economic, quality and equity assessments and overall policy analysis; o generation, analysis, dissemination and application of evidence • Networks and partnerships have formal aims, objectives, operating procedures, workplans, monitoring and evaluation of work. • Network expansion, strengthening, sustainability, increased collaboration and	**Governance** • HRH plan developed and evaluated with participation of various stakeholders and sectors • HRH policy integration into other sector policies and programmes • Commitment of national government and international community to HRH plan implementation and sustainability: o costed HRH plan; o commitment to appropriate or increased allocation from national sources; o receipt of donor funding o data availability: HRH expenditures as % of public expenditures and GDP. **Leadership and partnerships** • Operational research and evaluation studies implemented and reported on • Evidence and research applied to changes in HRH policies, practices, service delivery models, skill, staff mix, etc. • Policy recommendations adapted and implemented by government • Dissemination and publication of outputs and technical work products resulting from networks and partnerships **Regulation and safety** • Health professional registration system data up to date and accurate for both private and public sectors • Increasing number of public and private facilities with policies, systems for quality	• Increased population access to an adequate, competent, productive and **supported** workforce for quality health care.	• Increased life expectancy • Increased equity, responsiveness of health services • Reduced mortality and burden of disease as measured by: - under-5 child mortality - maternal mortality ratio - mortality by major cause of death by sex and age - TB prevalence • Reduction in cause-specific mortality and morbidity

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Key result area 4: Health workforce, governance, leadership and partnerships for sustained HRH contributions to improved population health outcomes **Strategic objective:** Strengthen health workforce cross-sectoral planning, policy coherence, regulations and partnerships to ensure the delivery of universally accessible, effective, evidence-based, quality and safe services.				
Macro-level structural input →	**Operational processes →**	**Outputs →**	**Outcomes →**	**Impact**
framework to enable all cadres to work to full functional capacities while maintaining safety of the public • Health worker registration system and full database established	productivity **Regulation and safety** • Policy enactment for improved working conditions at all levels, in all facilities • Systems, monitoring, evaluation and accountability mechanisms for quality improvement, health and safety, improved working conditions at facility level for public and private facilities	improvement (including infection control), health and safety, and improved working conditions • Public access and transparency in workforce registration, licensure, disciplinary data • Regular surveys and reporting of facility quality and safety data benchmarked with national, regulatory and/or accreditation standards and indicators		

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ANNEX 3

30 June 2011

Honiara Communiqué on the Pacific Noncommunicable Disease Crisis

9th Meeting of Ministers of Health for the Pacific Island Countries

Ministers of Health for the Pacific island countries are gravely concerned that the rapid increase in the incidence and prevalence of noncommunicable disease (NCD) in the Pacific island countries and areas over the past decade is responsible for up to 75% of all deaths and a similar percentage of long-term illness and disability, and declared at their 9th Meeting in Honiara, Solomon Islands, on 28–30 June 2011 that the Pacific island countries and areas are in an NCD crisis requiring urgent attention.

Pacific island countries and areas are in crisis due to an epidemic of noncommunicable disease (NCD) such as heart disease, cancer and diabetes. The burden of NCD in the region is already extremely high, causing up to 75% of deaths and much long-term illness and disability. Our prevalence of NCD risk factors are among the highest in the world—up to three of every four adults are obese and up to four of every five adults smoke—meaning that without real action things will only get worse.

The Pacific NCD crisis is not just a concern for the health of our people. It drains limited national budgets, reduces worker productivity, separates families, and robs communities of leadership and wisdom, as adults suffer long-term illness and die early. While adult NCD rates continue to rise, the next generation—more overweight and less active than any other Pacific generation in history—is the tsunami of the future. High childhood obesity rates in the Pacific, if left unchecked, suggest that a true health catastrophe is just a generation away.

There is hope, however. There has been some early progress in the fight against NCD, and effective actions are available across a spectrum ranging from prevention to early detection and treatment. But what is missing is a sense of urgency in the region, and the recognition among Pacific island countries and areas that a whole-of-government and whole-of-society approach is needed to tackle this health and development crisis.

There is a great opportunity this year with the United Nations General Assembly holding a High-level Meeting on the Prevention and Control of Noncommunicable Diseases from 19–20 September 2011 in New York. In the lead-up to this meeting, there have already been a number of key regional and global meetings that have considered the NCD crisis. The resulting Nadi Statement and Moscow Declaration made important recommendations on

ways forward and this communiqué builds on those important initiatives. We have an opportunity to address this crisis if we act now.

Recognizing the fundamental importance of the upcoming United Nations High-level Meeting in tackling this crisis at the global level, and the need for the outcomes of this meeting to reflect Pacific realities, we call on the outcome document of the High-level Meeting to include the following:

- recognize NCD as a crisis in the Pacific to be addressed with the utmost urgency;
- address the need for better information and guidance on cost-effective interventions in resource-limited settings;
- initiate and sustain effective action across the life-course;
- ensure sustainable resourcing for NCD prevention, treatment and control;
- adopt a small number of global and publicly reported targets for NCD that can be adapted to national context; and
- initiate multisectoral action at the international level to complement national level action, and make an explicit expectation that international organizations will work together in a coordinated way to tackle NCD.

And in support of these recommendations, consistent with the Pacific Plan endorsed by the leaders of the Pacific Islands Forum at their October 2005 meeting and in support of our goal of Healthy Islands, we, the **Ministers of Health for the Pacific island countries and areas,** declare our commitment to the following critical actions:

(1) provide strong and sustained leadership and support for NCD prevention and control;

(2) lead the advocacy for a whole-of-government and whole-of-society response and a coordinating mechanism to mainstream the response to NCD;

(3) ensure implementation of evidence-based initiatives to reduce the common modifiable NCD risk factors across the life-course, and address the social determinants of health, including leveraging the power of local government and civil society, with a focus on interventions across the life-course;

(4) strengthen health systems, based on primary health care, to ensure that effective NCD prevention and control is funded and part of a coherent, balanced, realistic and comprehensive programme of health services as reflected in a costed national health plan;

(5) ensure monitoring and accountability systems are in place, along with a small number of quantified and timed national targets, with progress to be reported publicly; and

(6) fully implement the WHO Framework Convention on Tobacco Control as a critical step in reducing the impact of tobacco use on the prevalence of NCD.

Recognizing that many of the factors underlying this pandemic are outside the control of the health sector, and that as a result a whole-of-government, whole-of-society and whole-of-region response is needed, we also call on the **Pacific Forum Leaders** to give the highest priority to NCD, and to lead and champion tackling the crisis in the Pacific by:

(1) declaring NCD as a health and development crisis;

(2) driving a whole-of-government and whole-of-society response involving all sectors;

(3) integrating NCD prevention and control into national development agendas;

(4) mobilizing additional resources locally and internationally to support the fight against NCD;

(5) setting national targets for NCD and regularly and publicly reporting results;

(6) calling on all Council of Regional Organizations in the Pacific (CROP) agencies and regional health agencies to play an active part in a coordinated regional response to the crisis, and to report back every two years to Pacific Islands Forum Leaders on actions and progress;

(7) considering setting an ambitious regional tobacco elimination target, inspired by New Zealand's smoke-free by 2025 goal; and

(8) championing the cause of prevention and control of this NCD epidemic.