Procurement and Supply Management Workshop for HIV, TB and Malaria

25 – 30 July 2005

Siam City Hotel, Bangkok, Thailand
Acknowledgements

This workshop was a result of a joint effort involving several partners, namely WPRO, SEARO, Esther, JSI, IDA Foundation, Management Sciences for Health, the World Bank, UNICEF, UNDP, the Stop TB Partnership, Roll Back Malaria as well as from different departments and offices of the WHO. Funding for the workshop was provided by the GFATM, through its Principal Recipient organizations, and by Johnson and Johnson Family of Companies Contribution Fund, through the UN Foundation.

The WHO Representative Office in Thailand has hosted the workshop and kindly provided the logistic support. Other WHO partners contributed materials, expert time as required.
# Table of Contents

**Background, objective, and expected results** 3  
**Selection of participating countries** 4  
**Partner involvement and workshop contents** 5  

**Presentations and discussions**  
1) PSM plan: key principles and overview of PSM template 6  
2) Product selection of HIV, TB and Malaria: An overview of selection principles and HIV medicines recommended in the WHO treatment guidelines 6  
3) Product selection for opportunistic infections 7  
4) Product selection for TB 7  
5) Product selection for Malaria: Anti-malaria drugs 8  
6) Product selection for Malaria: Long lasting insecticidal net (LLIN) 8  
7) Understanding basic drug management elements for proposal writing 9  
8) Forecasting: preparing a PSM plan, tool and process for forecasting for HIV drugs 10  
9) Procurement planning: policies, systems, capacity, price monitoring 10  
10) Procurement & supply management session 11  
11) Inventory control and management information system: storage, cold chain, loss and wastage 11  
12) Rational drug use 13  
13) Pharmacovigilance 14  
14) QA/QC including issues related to GF policies and pre-qualifications: general principles with focus on HIV drugs 15  
15) TB Drugs QA perspective 16  
16) Intellectual properties: international and national laws 16  
17) Planning laboratory support for HIV, TB and Malaria 18  
18) National PSM coordination mechanism 18  
19) Expectations 19  

Overview of PSM plans 21  
Next steps 23  

**Annexes**  
1. Final Agenda 25  
2. List of participants 30  
3. Address by Dr. Samlee Plianbangchang, Regional Director, WHO South-East Asia Region 38  
4. Sources of technical support for PSM planning implementation 42  
5. Summary of Group Discussion on PSM plans and review of implementation 44
Background

The international community has expressed its commitment to fight HIV/AIDS, TB and Malaria particularly in the most affected countries, through the Global Fund, which has provided grants to most countries in need. The challenge of these countries is the capacity to effectively implement their proposals. WHO and other partners are working together to provide effective implementation of the GFATM proposals. It is in this spirit that WHO, the GFATM and their partners developed the present workshop. The urgent need for countries to prepare their PSM Plans to "unlock" GFATM funds, and their current problems in doing so in a timely and acceptable manner, offers a great opportunity for WHO, the GFATM and their partners to provide assistance in getting PSM Plans prepared, submitted and approved, to release the GFATM funds required to scale-up access to treatments & care of people suffering from HIV/AIDS, TB and Malaria.

The proposed PSM Plan development process adds to the range of PSM training and capacity building initiatives already being planned and implemented by WHO and its partners.

Objectives

1) To provide technical knowledge and skills in various areas of the PSM cycle and to give opportunities for trouble shooting through exchange of experiences among participants.
2) Assist countries with approved GFATM proposals in the development of their PSM Plans so that they are ready for assessment by the GFATM. This provides as well the opportunity to strengthen their skills in developing PSM plans
3) Assist countries in developing the work-plan for direct in-country technical assistance required to strengthen their national PSM system and to effectively implement their plans.

Specific Objectives for each session

Each presentation as outlined in the agenda will have its specific objectives set up front by the presenter. Training materials that we have used for previous workshops will be shared to facilitate the work of the presenter.

Expected results

1) Increased knowledge and skills in the development and the implementation of PSM plans.
2) HIV/AIDS, TB, Malaria PSM plans developed to a level ready for submission to the GFATM
3) Technical assistance plans developed for participating countries
Desired additional outputs

- A PSM information package for HIV, TB and Malaria commodities, developed and available in the public domain.
- National experts with newly-gained experience in PSM planning, who are identified as a technical resource for the region.
- Cooperation fostered between principal recipients, government departments responsible for procurement and supply management, and WHO partner organizations.
- Regional cooperation fostered between national and international experts in PSM planning and implementation.

Approach

Methodology (interactive approach): Topics will be covered briefly for 15-30 minutes, then followed by discussion of issues from the participants (interactive method) in order to improve their knowledge, their skills in the development and implementation of their PSM plans. The references and other resource materials are very useful as sources of technical information once the participants are back home but some copies in the back of the meeting room for consultation only are useful. After this discussion, countries will move on refining their PSM plan or continue implementation issues in small groups with case study for exercise whenever possible for the rest of the day.

Selection of participating countries

Selection criteria

The Principal Recipient (PR) in collaboration with the WHO Representative and the Government will work together to select the right people as suggested below:

1) A PR representative who has the responsibility of writing/implementing the Procurement and Supply Management (PSM) plan for the GFATM.
2) His national counterpart who is directly involved in the writing and/or the implementation of the PSM Plan for the GFATM.
3) A WHO staff in the country office who is responsible of procurement and supply management of medicines.

Suggested participants

The following countries have been selected by the GFATM Secretariat based on the need for technical assistance and capacity building:

1. Bangladesh
2. Bhutan
3. Cambodia
4. China
Partner involvement
This workshop was a result of a joint effort involving several partners, namely WPRO, SEARO, Esther, JSI, IDA Foundation, Management Sciences for Health, the World Bank, UNICEF, UNDP, the Stop TB Partnership, Roll Back Malaria as well as from different departments and offices of the WHO. Funding for the workshop was provided by the GFATM, through its Principal Recipient organizations, and by Johnson and Johnson Family of Companies Contribution Fund, through the UN Foundation.

The WHO Representative Office in Thailand has hosted the workshop and kindly provided the logistic support. Other WHO partners contributed materials, expert time as required.

Content of the workshop:
The content follows the structure and requirements of the GFATM PSM plan template and includes the components of the drug supply cycle as outlined in the GFATM PSM plan. Details are found in the agenda.
Summary of presentations and discussions

1) The PSM plan: key principles and overview of the PSM plan template
   (Luca Li. Bassi, GFATM)

   It was emphasized that the workshop would provide an opportunity to share knowledge and to
   learn from other participants and partners on what is happening in the region regarding
   procurement and supply management, particularly in the implementation of Global Fund
   proposals. The workshop would focus on the critical elements in the writing of PSM plans and
   the individual concerns of each country would be covered according to the individual situation to
   be addressed during the development of the plan.

   The key components of a PSM plan and the various sections of the template would be discussed
   in details during the workshop. Specific topics would be presented by resource persons who are
   experts in their respective field. GFATM encouraged everyone to comment or suggest for the
   improvement of the template.

2) Product selection of HIV, TB and Malaria: An overview of selection principles and HIV
   medicines recommended in the WHO treatment guidelines
   (Mary Couper, WHO/QSM)

   The general principles for selection of medicines and the criteria for product selection, including
   the HIV medicines used in the WHO treatment guidelines1 and the major toxicities of ARVs
   were presented.

   Key topics covered by the presentation:

   • Criteria for product selection
   • Prevalence of HIV/AIDS
   • Goals in HIV/AIDS treatment
   • Efficacy, quality and safety
   • Cost effectiveness and availability
   • Special population
   • Other factors influencing selection
   • Anti-retroviral drugs on WHO’s model list of essential medicines

   Issues
   The participants were advised that in product selection:
   - WHO has recommended a list of first and second line ARV regimens for HIV treatment
     in adults/adolescents and simplified guidelines for ARV treatment (HIV-1 Infection)
     (with list of essential medicines).

1 Please refer to list of documents and publications issued by World Health Organization.
- Factors influencing change in the treatment depends on toxicity and treatment failures (adverse reaction, absence of cold chain, storage conditions, affordability/availability).

3) Product selection for opportunistic infections (Connie Van Marrewijk, IDA)

An overview of the product types to be used in treating opportunistic infections (OI) was presented.

It was briefly explained how people with advanced HIV/AIDS were vulnerable to infections or malignancies that are called “opportunistic infections” because they took advantage of the opportunity offered by weakened immune system. The sequential loss of CD4 cells accounts for progressive immunosuppression and subsequent manifestations of OIs.

Access to drugs for the treatment of OIs (antibacterial, anti/protozoa agents, anti-viral and anti-cancer agents) was very critical in the planning programs at lower level of care.

The procurement of drugs against OIs, preferably generic products, is less expensive with shorter delivery time compared to branded products. The names of various types of infections and the various drugs for treatment were listed in the handouts given to participants.2

4) Product selection for TB (Hugo Vrakking, WHO/STB)

It was explained that tuberculosis is a disease that usually attacks the lung but can affect any part of the body. A person infected with TB does not necessarily feel ill. When the lung disease is active, the symptoms include cough, weight loss, loss of appetite, fever and night sweats. TB is spread through the air.

Tuberculosis can be controlled and cured with the right strategy and selection of appropriate formulation of essential tuberculosis medicines. WHO promotes the implementation of DOTS strategy and the use of fixed-dose combination (FDC) anti-TB drugs in the treatment of tuberculosis.3

The following briefly summarized the process of selecting TB drug medicines:

- Review patterns of TB morbidity, drug resistance and population affected.
- Identify standard treatments for TB program of patients (e.g. DOTS regimens).
- Develop a list of essential medicines and supplies to standardize availability.
- Select specific 1st line TB medicines
- Select specific 2nd line medicines for drug resistant TB.

2 Please refer to the handout “Product selection for opportunistic infections, Connie van Marrewijk, IDA Foundation”.
Challenges/issues:

Among the challenges in the country, is the absence (or lack) of person or body authorized to select TB medicines or lack of TB drug registration in the country.

5) Product selection for Malaria: anti-malaria drugs (Remy Prohom, WHO/RBM)

Remy Prohom highlighted the use of mosquito-treated net considered as one of the cheapest and best way to prevent mosquito bites that infects people with malaria.

It was noted that there are many challenges involved in the battle against malaria and solutions have been identified to overcome them. For example, drug resistance has been a serious obstacle to malaria control. Chloroquine, the cheapest and most widely used antimalarial drug, has lost its clinical effectiveness in most parts of the world. But the next generation of antimalarial drugs – artemisinin-based combination therapies (ACTs) – are highly effective and life saving. A work is under way to make these new drugs widely available, and more countries are changing their national drug policies and adopting ACTs as the first choice of treatment.\(^4\) The choice of antimalarial drugs depends on different clinical needs, i.e. presence of P. Falciparum vs P. Vvax virus, and the extent of resistance to malarial drugs.

Participants were advised that during the selection process, to consider the advantages of ACTs and compare with different combinations in response to increasing resistance. WHO has recommended combination therapy. However, ACTs are more expensive and beyond the reach of many of the households where the need is greatest, short shelf life (24 months), and longer lead time for delivery. Concerns about the delay of malaria drug delivery were expressed by the Philippines and close review of delivery was requested.

6) Product selection for Malaria: Long lasting insecticidal nets (LLIN)
(Lorenzo Witherspoon, WHO/RBM)

Lorenzo Witherspoon mentioned that the insecticide-treatment of the nets has major benefits, especially in the context of high population coverage. LLIN is more beneficial because it does require regular re-treatment with insecticide.

Further, LLIN are widely used in Africa because they were simple, safe and cost effective. It was estimated that 50 million ITN nets would need re-treatment by 2007 (upgrading to LLINs more desirable) and another 50 million worn nets will have to be replaced.

Comparison of the two (2) types of nets:

<table>
<thead>
<tr>
<th></th>
<th>ITN</th>
<th>LLIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy</td>
<td>6 months/treatment</td>
<td>3 to 5 years</td>
</tr>
</tbody>
</table>

\(^4\) World Malaria Report, WHO and UNICEF
Indicative cost | $2 | $5

Issues/recommendation:

In the selection of product to be purchased, LLIN would be more economical in the long run than ITN. However, it was suggested that the high costs of shipment and distribution of nets that may cost, between 45% and 65% of net cost, should be taken into consideration..

7) Understanding basic drug management elements for proposal writing  
(Thomas Moore, MSH)

It was explained by Thomas Moore that the key elements in the drafting PSM proposals and described the drug management system, which included the following six (6) basic elements of pharmaceuticals and the gaps within each of the elements.5

- Policy and legal framework
- Selection
- Procurement
- Distribution
- Use
- Management support

He added that with the support from Global Fund, there would be improvement in the basic elements and closure of the gap in the drug management system by reinforcing drug regulatory capacity, establishment of expert committee, reinforced capacity and infrastructure, improvement of drug management information system, strengthening of quality assurance.

He also stressed the need to establish working M&E policy, procurement quantification/forecasting and the various options for quantifications (i.e. morbidity based, consumption based or adjusted-consumption based).

8) Forecasting: preparing a PSM plan, tool and process for forecasting for HIV drugs  
(Helene Moller, UNICEF)

It was explained that forecasting and estimating requirements for the procurement of HIV related supplies is a very important element in the preparation of PSM plan. She also described the forecasting process in determining quantity of products required, and by which method applied in forecasting product requirements. Forecasting consisted of estimating the overall requirements for drugs taking into account various factors such as availability of funds, number of cases & morbidity, consumption, health service capacity, population including pediatric needs.

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The most common were anti-retroviral drugs and anti-malarial and TB drugs. Prices of ARVs vary substantially over time given the improvements in production and competition.

Quantification starts with: (1) defining patients profile at sites of service delivery (2) the growth in number of patients on treatment, and (3) number of requirements.

**Recommendation:** The participants were advised that in the development of PSM plan on subject of forecasting, they should consider lead times, re-order levels and buffer stocks.

To assist in the selection of ARVs, the WHO has produced a set of guidelines that address ART regimen.\(^6\)

**Specific issues experienced by various countries concerning procurement:**

(a) Delay in the procurement of drugs due to prolonged lead-times from manufacturers (Philippines)
(b) Taxation problem of some donor funded projects (Philippines, Indonesia and India)
(c) Poor quality of equipments purchased (Indonesia and Nepal)
(d) Procurement by one specific agency. Requested to do own procurement in order to develop capacity (Bhutan)
(e) Difficulty in implementation because of less collaboration with PR (Myanmar)

**9) Procurement planning: policies, systems, capacity, price monitoring**

(Philippines)

Helene Moller presented the operational principles for good pharmaceutical procurement and key consideration in planning the procurement of HIV related supplies. She also encouraged the participants to read the book on procurement included in the materials given to the participants at the beginning of the workshop.\(^7\)

She also stressed the need to understand which good and services to be purchased, when, who will purchase, procedures to be used and what would be the expected cost of the procurement with the most efficacious and cost effective medicines.

**Group discussion**


\(^7\) Battling HIV/AIDS a decision maker;s guide to the procurement of medicines and related supplies, World Bank, 2004; Sources and Prices of Selected Products for the prevention, diagnosis and treatment of Malaria, a joint WHO, RBM, UNICEF, PSI, MSH Project, September 2004.
In the group discussion, participants were asked to review the current system for procurement of essential supplies applicable in the country. The following were among the various feedbacks received from the participants:

- List of pre-qualified suppliers
- Develop capacity of country to undertake own procurement
- Lack of clear regulation
- Tax levy on donor funded projects
- Weak monitoring system
- Long lead time
- Program support cost being charged by agencies doing procurement
- Assistance from Governments in the immediate release of goods from custom.

10) Procurement & supply management session
(Krishan Batra, UNDP)

Krishan Batra presented an overview of UNDP’s procurement procedures and shared his experience as procurement officer. He also mentioned about the major challenges in the area of procurement. The topic generated a dynamic discussion particularly concerning the roles of procurements agents (PA’s).

Issues

Some participants argued that Procurement Agent (PA) performing dual roles as supplier (example IDA and UNICEF) are perceived as having potential conflict of interest. It was also commented that MOU’s executed with UN agencies may not be legally enforceable. However, they are valid agreements that could be followed-up by agency concerned with suppliers.

Mr Luca Li Bassi clarified that UN agencies acting as PA’s serve only in countries where there is lack of national capacity in procurement. PA’s are accountable to Global Fund. Whatever option chosen by the PR, it must be done on a transparent and competitive basis as possible.

Mr Luca Li Bassi added that in cases of urgent purchase of mosquito nets, and if no available stock of LLIN’s (due to long lead time), he recommended that orders should still be placed for LLIN even if it would take long. The gap can be covered with normal non-LLIN nets.

11) Inventory control and management information of information system: storage, cold chain, loss and wastage (Daniel Thompson, John Snow Inc.)

Daniel Thompson summarized the critical elements of logistic as essential part of a PSM plan. He pointed out that a system must be in place in the country before any procurement has to be made, i.e. from the time order is made up to the time when the product has arrived and distributed.
He mentioned that the purpose of logistic was to plan ahead of time with proper Logistic Management Information System (LMIS), that included the control on quantity, which should not be too much or too little depending on the availability of adequate storage facilities.

He stressed the following points order to maintain the integrity of the product and reach the patient at its best condition:

1. How frequently the products are distributed from the warehouse to the regional/district level and the conditions of existing health facilities.
2. The adequacy of human resource at all levels and the training required for the personnel working at storage facilities.

Key topics discussed:
(a) Storage
(b) LMIS
(c) Inventory

Storage

The key issue in inventory management is whether sufficient storage space was available at all levels of distribution chain, in order to quality of the product and make product available when needed. In keeping the products in good condition, the following points have to be considered: 
Humidity/climate (are cold chain facilities available?); storage area; personnel; security (reducing loss due to theft); shelf life; expiration dates and cold chain requirements.

Coordination among procurement and technical staff was essential in order to have an efficient procurement system and guidelines in the disposal of expired products should be available at country level.

Mr Thompson suggested that for additional information regarding guidelines on disposal/storage of medicines, consult WHO Guidelines for Storage of Medicines and Health Commodity

Logistic Management Information System (LMIS)

LMIS was a central issue in logistic. Without an effective LMIS, management cannot make correct decision.

The following are important logistic information:
(a) availability of stock
(b) rate of consumption
(c) losses/adjustments

Mr Thomson gave the participants some examples of LMIS forms being used in Kenya, Ghana and Uganda. The forms summarize the activities at various facilities and are very useful in

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Guidelines for the Storage of Essential Medicines and Other Health Commodities. 2003, Arlington VA, John Snow Inc./DELIVER, in collaboration with WHO, USAID, and UNICEF.
determining consumptions, stock levels and lead time. Furthermore, it is essential that whatever forms to be used they should be filled-up completely as they provide useful information for decision making.

*Inventory record*

Inventory record is essential in maintaining appropriate level of all products, avoiding shortages and over-supply taking into account availability of adequate storage facilities.

*Delivery*

In order to shorten lead times, the distribution of products be planned ahead of time, preferably delivered directly to beneficiaries, if possible.

Thailand shared its experience about the use of Vendor Managed Inventory (VMI) system.

**12) Rational Drug Use** (Andrew Barracclough, MSH)

Andrew Barracclough remarked that rational drug use (RDU) was often neglected in the supply management. He explained that rational use of drug requires that patients receive medication appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time and at the lowest cost possible.

Furthermore, without RDU there could be a risk of treatment failure, rapid development of drug resistance, increase toxicity risk and wastage of money.

Factors that may lead to irrational drug use:

(a) diagnosis  
(b) Prescription  
(c) Incorrect dispensing of drug

*Highly Active Antiretroviral Therapy (HAART)*

He mentioned that adherence to HAART is very critical in suppressing viral load in the blood to undetectable level. High adherence is essential in order to make the program successful. Poor adherence will result to treatment failure and drug resistance. He said that from the public health perspective, the prevention of transmission of resistant virus would be a major concerned subsequent to HAART failure.

Also mentioned are the other barriers to adherence such as communication, literacy, knowledge, lack of social support, etc. In order for adherence to work under multi-disciplinary roles, the message (or story) to the patient must be the same at all levels of society from doctors to family and friends.

*Nutrition and ART*
HIV affects nutrition. Poor nutrition reduces ability to fight HIV and OIs and nutritional problems can affect drug compliance. Some food interacts with ARVs which may either increase or decrease absorption.

*Pediatric ART*

HIV/AIDS in children is not the same as in adults due to immature immune system of children. Infants have a substantial risk of developing AIDS even with high CD4 values. Treatment of children with HIV/AIDS could be complex and expensive.

He emphasized that the most critical issue was whether there was a system of monitoring adverse drug reaction and drug resistance in the country.

13) Pharmacovigilance (Mary Couper, WHO)

Mary Cooper reported that Pharmacovigilance is still at its early stage and involves detection, assessment, understanding and prevention of adverse effects or any other medicine related problem. It is essential that new drugs are monitored for their effectiveness and safety under real-life conditions post release. Notably about the drug use in specific population groups such as children, pregnant women and the elderly, and about efficacy and safety of chronic use.

The management of risks associated with use of medicine requires collaboration and commitment of various sectors involved in pharmacovigilance. WHO's programme for international monitoring includes policy development, exchange of information, technical support and advisory committee on safety of medicinal products.

The subject was very much linked with rational drug use, whose major aim was the early detection of unknown safety problems. All countries were suggested to establish their own ADR monitoring committee and report on ADR to share with other countries in the regions.

It was reported that the following countries have existing national Pharmacovigilance centers:

- China
- India
- Indonesia
- Philippines
- Sri Lanka
- Thailand
- Vietnam
- Pakistan
- Nepal

Notes: The following are available reference materials on Pharmacovigilance

• Guidelines for good clinical practice (GCP) for trials on pharmaceutical products, WHO, Annex 3 (http://193.231.189.110:8080/gsdl/cgi-bin/edmweb/library.fcgi?e=d-0edmweb---00-1-0--010---4---0-0-10l--len-5000---50-about-0---01131-0011iMcN%2asok9ee84d6400001008433158ab-0utfZz-8-0-0&a=d&c=edmweb&cl=CL2.1.2&d=jwhozip13e)

• Effective Communications in Pharmacovigilance http://www.who-umc.org/index2.html

• The Erice Report, Uppsala http://www.who-umc.org/index2.html

• Safety monitoring of medicines. Guidelines for setting up and running a pharmacovigilance centre, WHO, 2000 http://193.231.189.110:8080/gsdl/cgi-bin/edmweb/library.fcgi?e=d-0edmweb---00-1-0--010---4---0-0-10l--len-5000---50-about-0---01131-0011iMcN%2asok9ee84d6400001008433158ab-0utfZz-8-0-0&a=d&c=edmweb&cl=CL2.1.5&d=jh2934e


14) QA/QC including issues related to GF policies and pre-qualifications: general principles with focus on HIV drugs (Truls Eriksen, WHO/WPRO)

Truls Eriksen explained that quality assurance (QA) was basically about getting it right from the very beginning. QA refers to management activity required to ensure that the medicines (or other health products) reaching patients were safe, effective and acceptable. The activities may include, but not limited to, (drug) registration, pre-qualification and quality control.

Low cost pharmaceutical products of assured quality have the greatest potential of maximizing impact of effort to combat communicable disease. Without a quality assurance system organizations risk sourcing substandard, counterfeit and contaminated pharmaceutical products leading to product complaints and product recalls, waste of money and health risk to patients.9

As from January 2005, Principal Recipients (PR’s) of the Global Fund, as a requirement, may only purchase WHO pre-qualified commodities with GFATM funds as well as commodities approved by Stringent Regulatory Authority. The availability of quality, safe and efficacious medicines was a major concern.

Classification: (a) pre-qualified (b) authorized by Stringent Regulatory Authority, and (c) authorized by NDRA.

Issues and comments:

9 Model Quality Assurance System (MQAS). MQAS is intended to assist procurement organizations to establish quality assurance systems to enable them procure safe, effective, quality pharmaceuticals.
1. Some countries raised concerns about choosing of drugs only from pre-qualified suppliers, or from those approved by Stringent Regulatory Authority. In some cases, this process could be burdensome.

2. It was noted that products from India source have double standards. Goods for local consumption have lower standard whereas goods for export have higher standards which was not the case in European countries.

3. Countries who have existing contracts with single and limited source pharmaceutical products authorized by NDRA have only up to 30 April 2005. After April 2005, PR may not enter into new contract previously qualified under clause C.

4. PR’s were requested to notify Global Fund of any procurement being processed under option C.

5. Countries with manufacturer not registered can be helped to obtain GMP compliance.

6. In case of de-listed products from list of qualified products, the advice was to discontinue immediately and switch to other qualified products.

7. PRs are responsible to ensure that products being purchased with Global Fund meet the standard required.

8. India is one of the biggest generic drug producing countries, but is not regarded as the country with a stringent regulatory authority.

15) TB Drugs QA perspective (Hugo Vrakking, WHO/STB)

Hugo Vrakking briefly mentioned that the purpose of QA in the supply of TB drugs was to ensure that each medicine reaching the patient was safe, effective and of standard quality.

Key issues discussed:
- Determinants of pharmaceutical product
- Actions to obtain good-quality products
- Actions to verify the quality of shipped medicines
- Actions to verify product quality

Participants were provided with Forms: Checklist QA/QC system for anti-TB medicines and Example of Quality requirements in a Tender Letter.

Participants were also advised that when purchasing generic drugs, be sure that they contained generic name, manufacturing date, name of manufacturer and do not buy products without labels.

16) Intellectual properties: international and national laws (Karin Timmerman, WHO/Indonesia)

Karin Timmerman explained that intellectual property rights include patents, trademarks and copyrights, but presentation would be more focus on patent. A *patent* is granted to an inventor of a product or process and gives the inventor the right to exclude others from making, using, selling, offering for sale, and importing a product covered by a “product” patent. Patents
situation varies widely across countries, affected by such international agreements as the Agreement on Trade Related Aspects of International Property Rights (TRIPS).

She added that in the Doha Declaration on the TRIPS agreement and public health, recognized that while intellectual property protection is important for the development of medicines, there were concerns about the effects on prices. To this end, the Members are not be prevented from taking measures to protect public health and hence the Agreement should be executed with the right of members to support such protection and promote access to medicines to all.\(^\text{10}\)

Key issues discussed:

1. TRIPS had harmonized standards for patents. 20 years requirement for patent was longer for most developing countries.
2. Most important safeguards: compulsory licensing and parallel importation. The safeguards can only be used when incorporated in national laws.
3. The DOHA declaration on TRIPS and public health
4. TRIPS requirement. During the exclusivity period, generic manufacturers would have to submit their own data to prove safety and efficacy.
5. Recent development in India. The production and sale of generic drugs that were already on the market in India can continue but only if significant investment and royalties is paid.
6. Medicines are subject to two sets of rules: Intellectual property rights (the right to exclude but not the right to market or to use) and Registration requirements (authorization to put a medicine on the market)

*Patent laws applicable in other countries:*

- Cambodia – Patent law in place which specifies that no patent for pharmaceuticals until 2016.
- Brazil – Generic production of ARVs not patented in Brazil. Negotiating price reductions of ARVs that are patented using the “threat” of compulsory licensing.
- Thailand – Generic production of ARVs not patented in Thailand.
- Malaysia and Indonesia- Government use (Malaysia for importation and Indonesia (mainly) for local production.

- Countries currently revising their patents laws include China and other 5 countries.

*Issues/challenges*

PRs are responsible for adhering to international and national laws, in particular with regard to intellectual property rights or patent.

Participants interested to know if there is any existing databank (or web sites) that compiles various information about prevailing patent laws in various countries, may check for information in the web or with the originator/supplier.

\(^{10}\) Battling HIV/AIDS a decision maker’s guide to the procurement of medicines and related supplies, The World Bank, 2004, Annex B.
17) Planning laboratory support for HIV. TB and Malaria (Anthony Gomes, WHO PNG)

Anthony Gomes explained that the objective of his presentation is to provide guidance for planning and strengthening of laboratory support including technical information and guidance on quantification and selection criteria for lab supplies and equipment.

He highlighted the importance of laboratory services in the diagnosis and treatment of diseases.

Key issues discussed in the presentation:

- Laboratory system/network
- Human resources
- Appropriate technology – affordable price
- Supply management – quality supplies
- Capacity building

Comments/recommendation

1. Microscopic diagnosis was recommended as the best choice for the diagnosis of TB and Malaria considering the accuracy and lower costs. Despite higher costs, RDT – ICT for the diagnosis of malaria were also recommended for peripheral laboratories or health facilities in remote areas without a lab.
2. HIV tests kits including other laboratory tests kits for serological tests should meet WHO criteria for quality and must have a sensitivity of >99% and specificity >98%.
3. In the quantification and forecasting of supplies/test kits, buffer stock must be considered including requirements for Quality Assurance Program.
5. Consider bulk procurement scheme that provides lower price.
6. Proper maintenance of equipment; especially the microscope which a very important piece of equipment.

18) National PSM coordination mechanism (Vincent Habiyambere, WHO/AMDS)

Vincent Habiyambere remarked that significant progress in scaling-up the number of people on ART was made possible through the partnership of various UN agencies, partners and NGO’s. In order to sustain the treatment, this would need a collective approach. At the global level, AMDS partners consisting of UN agencies, technical organizations and donor agencies lead the campaign in combating the disease with AMDS/HIV Department/Geneva as secretariat. AMDS operated as a clearinghouse for global information.

Further, AMDS operates as a network. It maps and publicizes the capacity and availability of technical assistance of partner organizations to support capacity building for procurement and
supply management, and brokers cooperation between technical partners, funding agencies, manufacturing companies and organizations.

**Recommendation to establish National PSM coordination Body** -

Similarly, in order to harmonize the implementation and reporting mechanism at country level, he recommended that National PSM Coordination Body be established at country level consisting of partners and NGO’s who would be addressing procurement issues in the country. The body would have its own guidelines and procedures.

The support of the Regional Offices of WHO would be requested in order to support the creation of such body. He expects that the body would be able to solve most of the problems associated with the implementation of the PSM plans through a common agenda in addressing capacity gap in the pharmaceutical sector, sharing information and coordination of training activities.

He also stressed the importance of partnership, particularly among NGO’s but need to identify the collaboration whether it need to be strengthened.

**19) Expectations**

**Review of Expectations** (Patrick Osewe, World Bank)

Patrick Osewe facilitated this exercise. At the start of the workshop (Day 1), the participants have been asked about their expectations from the workshop. The following were the various responses/indicators received from the participants:

**Workshop Expectations**

1. Rules and regulations of the GFATM regarding PSM plan
2. Choices for supplier after bidding (lowest price= lowest quality product)
3. Does GF has a pre-qualified supplier list?
4. If we spent 75% of the budget on supply of product, can we spend 75% the next year?
5. Share of knowledge and experience from the other countries
6. Global Fund product specification
7. PSM cycle, system and plan
8. Storage management
9. Learn from other country experience (Challenge, limitation, advantage)
10. GF Policy & Direction (Updated)
11. Selection of suppliers
12. UN agencies – too long time
13. Other suppliers – how about quality?
14. Assisting local manufacturers to obtain pre-qualification
15. Funding timing
16. Too late for SRs
17. Pricing information
18. Products available at UN agencies (Stockpiles)
19. Standardization of PSM plans - effective and cost effective
20. Factors/ effective tools in monitoring and evaluation of PSM plans
21. Intellectual property rights
22. Effective procurement policy (includes logistics)
23. Procurement for services
24. Suppliers/bidders accreditation
25. Solution to implement bottlenecks
26. Networking with other countries with GF grants
27. Clarifications/ concerns with partner agencies (WHO, UNICEF, etc.)
28. Ensuring: Quality, safety efficacy of medicine for ATM Medicine
29. Ensuring: Distribution at service unit, timely, quantity ATM
30. Ensuring: PSM plan on the right way (recording of the GFATM Standard/ procedure)
31. Learn more about MIS from the workshop
32. Better understanding of PSM procedures
33. Problem solving in PSM
34. PSM Planning
35. Steps in getting GF approval of PSM plan
36. Better understanding of drug supply and management
37. Better understanding of procurement agencies’ (WHO, UNICEF, UNDP, etc) to which PR outsource its procurement.
38. How to ensure quality of procured drugs
39. How to get best price/ high quality
40. How to improve disbursements from GF grants
41. Better understanding of international bidding procedure.
42. Forecasting of drugs
43. Distribution and storage at local level (grassroot)
44. Pediatrics Formulation
45. Information Management System
46. To know participants from different countries
47. To get knowledge and skills on how to develop PSM Plans and experience with PSM implementation in different countries.
48. How to source and finance technical assistance
49. To understand the expectations of Global Fund from the PR on PSM
50. To define and clarify the GF procurement
51. Is it drugs, related supplies, or does it include works and services
52. Sharing good experiences from other countries
53. Challenges with quantification and how to resolve them
54. Defining requirements for procurement issues
55. Storage & distribution
56. Solutions to challenge in country
57. Human resources/manpower
58. Technical Assistance
59. Resources

Facilitator’s Expectation
1. Learn about country’s issues with PSM – writing plan and implementing
2. Provide viable tools for quantification and procurement of HIV, TB and Malaria drugs
3. Address the need for improved coordination among donors and programs
4. Learn about successes in implementing PSM activities
5. Develop a network to strengthen communication among countries

The participants agreed that most of the expectations have been met or addressed during the workshop. The following require follow-up actions:

- Preparation of pre-qualified list of products. Currently, Global Fund has no list of qualified suppliers but it would soon be developed and be made available in the web. However, WHO has developed such lists which can be found on: http://mednet3.who.int/prequal/……
- In response to the comments from the Philippines regarding excess drugs, it was recommended to just allow the drugs to expire and not to encourage re-exportation. Poor procurement planning, or donations done at a higher level could have caused the excess drugs. However, the cause of oversupply should be investigated, if warranted.
- Assisting local manufacturers to obtain prequalification. It was noted that no shortcut in compliance with GMP. In order for a manufacturer to obtain accreditation this would require significant investment on the part of the manufacturer to comply with the infrastructure required. Any country that wishes to be assisted on prequalification, they can always enquire with local WHO country office. They can also check the WHO web site.

Conclusions and overview of PSM plans

Mr. Li Bassi expressed his appreciation and congratulated everyone for the very significant achievements during the workshop. The workshop achieved excellent results and he recognized how difficult to come up with good PSM plans at such short period of time.

He commended the participants for working very hard up to late at night in order to complete the PSM plans. Please refer to Table 1 for Status of various countries PSM plans.

There were 14 PSM plans developed from 7 countries. Overall the total value of all product categories was $160 million, which was an important contribution in accelerating the release of urgent funds to PR’s.

He thanks the facilitators, WHO and other partners in addressing the technical issues.
Table 1 - Status of various countries PSM plans

The following countries will develop their PSM plans during the workshop: LAO PDR, Pakistan and Papua New Guinea.

PSM Plans for HIV, TB, and Malaria
(As of 31 July 2005)

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>HIV/AIDS</th>
<th>TB</th>
<th>MALARIA</th>
</tr>
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<tbody>
<tr>
<td>1. BANGLADESH</td>
<td>√</td>
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</tr>
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<td>3. CAMBODIA</td>
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<td>4. CHINA</td>
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<tr>
<td>5. INDIA</td>
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<tr>
<td>6. INDONESIA</td>
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</tr>
<tr>
<td>7. LAO PDR</td>
<td>DEVELOP</td>
<td>DEVELOP</td>
<td>DEVELOP</td>
</tr>
<tr>
<td>8. MONGOLIA</td>
<td>√</td>
<td>√</td>
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<td>11. PAKISTAN</td>
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<td>12. PNG</td>
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<td>13. PHILIPPINES</td>
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<td>16. TIMOR LESTE</td>
<td></td>
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<td>17. VIETNAM</td>
<td>√</td>
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<tr>
<td>Total PSM Plans to be developed</td>
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</table>
What is the next step

Mr. Habiyambere in his concluding remarks mentioned that the workshop has brought together partners and people that served as powerful tool in assisting the formulation of PSM plans, even if the workshop took very long which started with a lengthy process of collaboration between partners and different countries.

He added that any other issues not addressed during the workshop, would be dealt with during the next step:

- WHO (Regional offices in collaboration with HQ relevant programmes: HIV, TB, Malaria) will follow-up with the WR country office to have confirmation regarding specific terms of reference, the duration, the period, expected outputs, the type of expert required and funding sources confirmation the TA expressed by each country (estimated by mid-August 2005).
- Countries with good practice to share are advised to send it to the Regional Office and Dr Kenji Tamura who will put them on the AMDS website or send them to TB or MMSS (continuous process).
- Share any issue by email and addresses informally (e.g. technical advise, publication identification of a consultant, etc), unless the solution requires formal procedures (continuous process).
- Countries who would like to have in-country PSM workshop to increase the number of professionals who are familiar with the PSM issues can be assisted in the organization by WHO, the GFATM and their partners. (continuous process).
- E-discussion will be set-up to continue this exchange of experiences and raise/address implementation of PSM issues.
- Suggestions to participants:
  - Lessons learned to be shared among various countries (from bad experience)
  - Communication could be made to Roll Back Malaria on issues relating to Malaria as well as to GFATM (through web site)
  - UN agencies can also provide support in defining the TORS when needed by the country
  - Email – an inexpensive process to share knowledge, participants remains connected with email.

Mr. Habiyambere also reported that more than 100 people from 17 different countries have participated in the workshop.

He thanked the staff from WR’s Office/Thailand for spending long hours and ensuring that everything was smooth and all the partners which involved a number of Organizations
harmonizing major challenges and are all key players in all aspect of collaboration, especially the Global Fund.
ANNEX 1

Procurement and Supply Management Workshop for HIV, TB and Malaria
Bangkok, Thailand, Siam City Hotel: 25 - 30 July 2005

Final Agenda

DAY 1: Monday 25 July 2005

SESSION I: 08:30 – 18:00

08:30 – 09:00 Registration/Administrative / Housekeeping

09:00 – 09:30 Introduction (Tamura Kenji, WHO/AMDS)
Welcome remarks on behalf of AMDS partners: Vincent Habiyambere
Remarks from the GFATM Secretariat: Luca Li Bassi
Opening: WHO Representative, Thailand (Annex 2)

09:30 – 10:30 Review of meeting agenda and small group discussion on participants expectations (Patrick Osewe, World Bank)

10:45 – 11:00 1) The PSM plan: Key principles and overview of the PSM plan template: (Luca Li Bassi, GFATM)

11:10 – 13:00 2) Product Selection for HIV, TB, and Malaria: Overview of selection principles and HIV medicines recommended in the WHO treatment guidelines (Mary Couper, WHO/PSM/QSM)
3) Drugs for opportunistic infections (Ms Connie van Marrewijk, IDA Foundation)
4) Product selection for TB (Hugo Vrakking WHO/STB)
5) Product selection for Malaria: Anti-Malaria drugs (Remy Prohom WHO/RBM)
6) Product selection for Malaria: Long lasting insecticidal net (Lorenzo Witherspoon, WHO/RBM)
7) Understanding basic drug management elements for proposal writing (Thomas Moore, MSH)

13:00 – 14:00 LUNCH

14:00 – 15:30 8) Forecasting : preparing a PSM plan, tool and process for forecasting for HIV drugs (Helene Moller, UNICEF)

15:30 – 15:45 Tea/Coffee break
15:45 – 17:00 Identification of PRs that need to develop their PSM plans and those that have presentation on PSM implementation issues.

17:00 – 18:00 Facilitators meeting

**DAY 2:**

**Tuesday 26 July 2005**

**SESSION II:**

08:30 – 19:00

08:00 – 09:00 Administrative / Housekeeping and feedback report on the previous day session

09:00 – 10:30 9) Procurement and Planning; policies, systems, capacity and price monitoring (Helene Moller, UNICEF)

10:30 – 10:45 Tea/Coffee break

10:45 – 12:15 10) Procurement & Supply Management Session (Krishan Batra, UNDP)

12:15 – 13:30 LUNCH

13:30 – 15:00 Review of implementation status and identify successes, challenges and solutions for HIV, TB and Malaria groups

Preliminary review of draft PSM plans by the GFATM.

15:00 – 15:30 Tea/Coffee break

15:30 – 17:00 Review of implementation status and identify successes, challenges and solutions for HIV, TB and Malaria groups

Preliminary review of draft PSM plans by the GFATM.

17:00 – 19:00 Facilitators meeting and work on PSM plans: PRs and facilitators working together on the development of PSM plans.

**DAY 3:**

**Wednesday, 27 July 2005**

**SESSION III:**

08:30 – 19:00

08:30 – 09:30 Administrative / Housekeeping and feedback report on the previous day session

09:30 – 10:45 11) Inventory control and management information of information system: storage, cold chain, loss and wastage (Daniel Thompson, John Snow Inc.)
10:45 – 11:00  Tea/Coffee break

11:00 – 12:30  12) Rational drug use (Andrew Barraclough, MSH/RPM Plus)

12:30 – 13:30  LUNCH

13:30 – 14:45  13) Pharmaco-vigilance (Mary Couper, WHO/PSM/QSM)

15:30 – 17:00  Review of implementation status and identify successes, challenges and solutions for HIV, TB and Malaria groups

Preliminary review of draft PSM plans by the GFATM.

17:00 – 19:00  PRs and facilitators working together on the development of PSM plans.

**DAY 4:**  Thursday 28 July 2005

**SESSION IV:** 08:30 – 16:30

08:30 – 09:30  Recap of Previous Day - Reynaldo Pangan

09:30 – 10:30  14) QA/QC including issues related to prequalification; general principles with focus on HIV drugs (Truls Eriksen, WHO/WPRO)

15) TB drugs QA perspective (Hugo Vrakking, WHO/STB)

10:30 – 10:45  Tea/Coffee break

10:45 – 12:30  16) Intellectual Properties: International and national laws (patents) (Karin Timmerman, WHO Indonesia)

12:30 – 13:30  LUNCH

14:45 – 15:30  (1) Identification of TA needs by HIV, TB and Malaria groups

(2) For PRs which need to develop their PSM plans, PSM plan writing: Sections..

15:30 – 15:45  Tea/Coffee break

15:45 – 17:00  (1) Identification of TA needs by HIV, TB and Malaria groups

(2) For PRs which need to develop their PSM plans, PSM plan writing.

**DAY 5:**  Friday 29 July 2005

28
SESSION V: 08:45 – 17:45

08:30 – 09:00 Recap of Previous day: Reynaldo Pangan
9:00 – 10:45 Review of participants expectations: Patrick Osewe
10:45 -- – 11:00 Tea/Coffee Break
11:00 – 12:00 17) Planning Laboratory Support for HIV, TB and Malaria (Anthony Gomes, WHO, Papua New Guinea)
12:00 – 12:45 18) Coordination: multiple donors and supplies, national PSM Coordination Mechanism (Vincent Habiyambere, WHO/AMDS)
12:15 – 13:30 LUNCH
13:30 – 16:00 (1) Discussions to cover the unmet expectations (ex. Presentation on Procurement by Krishan Batra, UNDP).
(2) For PRs which need to develop their PSM plans, PSM plan writing.
16:00 – 16:30 Tea/Coffee break
16:30 – 18:00 For PRs which need to develop their PSM plans, PSM plan writing.

DAY 6: Saturday 30 July 2005

Session VI: 09:00 – 13:00

09:00 – 09:30 Demonstration of the AMDS website: Tamura Kenji, WHO/AMDS
09:30 – 10:00 Recap of Previous day – Reynaldo Pangan, WHO/PNG
10:00 – 10:45 Group work on finalization of plan of action for in-country technical assistance (Patrick Osewe, World Bank)
10:45 – 11:00 Tea/Coffee break
11:00 – 13:00 (1) Finalization of PSM plans with various PRs
(2) Overview of progress made on the development of PSM Plans: Luca Li Bassi, the GFATM
(3) Next steps following the PSM workshop and a word of thanks to participants and partner organizations: Vincent Habiyambere, WHO/AMDS

(4) Concluding remarks and a word of gratitude do all involved parties: Patrick Osewe, World Bank Institute.

13:00 – 14:30 LUNCH

13:00 – 14:00 Facilitator meeting: Dr Vincent Habiyambere, WHO/AMDS
## ANNEX 2

### PSM WORKSHOP for HIV, TB and Malaria

**Bangkok, Thailand 25 - 30 July 2005**

**List of Participants**

<table>
<thead>
<tr>
<th>Country</th>
<th>Name &amp; Title</th>
<th>Organization &amp; Address</th>
<th>Program (HIV/TB/Mal)</th>
</tr>
</thead>
</table>
| **Bangladesh** | **Susanto K Dobey**  
Grants Manager | Save the Children-USA  
House # 1A (2) Rd. No. 91  
Gulshan-2, Dhaka | HIV                              |
|             | **Mr Arif Kibria**  
Coordinator | BRAC  
75, Moha Khali  
Dhaka 1212 | TB                               |
|             | **Mr Fazlul Haque**  
Programme Coordinator,  
Procurement | BRAC  
BRAC Centre, 75 Mohukhali  
Dhaka 1212 | TB                               |
| **Bhutan** | **Mr Nado Dukpa** | Ministry of Health  
Royal Govt. of Bhutan  
Thimphu, Bhutan, |                                |
|             | **Mr Kaka** | Ministry of Health  
Royal Govt. of Bhutan  
Thimphu, Bhutan |                                |
| **Cambodia** | **Sok Khim**  
Procurement Officer | The Principal Recipient  
Ministry of Health  
No 151-153,  
Kampuchea Krom Street  
Sangkat Veal Vong,  
Khan 7 Makara  
Phnom Penh, Cambodia | HIV, TB and Malaria |
|             | **Hok Chantheasy**  
Procurement Officer | The Principal Recipient  
Ministry of Health  
No 151-153,  
Kampuchea Krom Street  
Sangkat Veal Vong,  
Khan 7 Makara  
Phnom Penh, Cambodia | HIV, TB and Malaria |
| **China** | **Du Cheng Gang**  
Program Coordinator,  
Procurement Department | China CDC | HIV, TB and Malaria |
|             | **Wang Xing Jun**  
Program Manager | Program Office of GFATM TB  
Program in China  
National Center for TB Control and Prevention, China CDC  
27 Nan Wei Road, Xuan Wu District,  
Beijing 10050 | TB                               |
|             | **Wang Ni** | China CDC | TB                               |
### Procurement and Supply Management Workshop for HIV, TB and Malaria, Bangkok, Thailand, July 2005

<table>
<thead>
<tr>
<th>Country</th>
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<tr>
<td><strong>India</strong></td>
<td>Wang Yu</td>
<td>Procurement Department China CDC</td>
<td>HIV, TB and Malaria</td>
</tr>
<tr>
<td></td>
<td>Wang Dou</td>
<td>The Global Fund China AIDS Program (R3) Office Roo 7, No 42 Donging Rd. Xian wu District, Beijing</td>
<td>HIV</td>
</tr>
<tr>
<td></td>
<td>Liu Shiliang</td>
<td>NCAIDS China CDC No 27 Nam Wei Road, Xuan Wu District, Beijing P R China 100050</td>
<td>HIV</td>
</tr>
<tr>
<td></td>
<td>S. Vijayakumar</td>
<td>Population Foundation of India B-28, Qutab Institutional Area Tara Crescent, New Delhi 110 016</td>
<td>HIV</td>
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<tr>
<td></td>
<td>C.S. Aggarwal</td>
<td>National Vector Borne Disease Control Programme 22-Shamnath Marg New Delhi 110 054</td>
<td>Malaria</td>
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<tr>
<td></td>
<td>Virender Singh Salhotra</td>
<td>Central TB Division/Directorate General of Health Services Ministry of Health &amp; Family Welfare R No 532, C-Wing, Nirman Bhawan, New Delhi 110011</td>
<td>TB</td>
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<tr>
<td></td>
<td>Anil Kumar</td>
<td>National AIDS Control Organization 9th Floor, Chanderlok Building, (Ministry of Health &amp; F W) Janpath, New Delhi 110 001</td>
<td>HIV</td>
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<tr>
<td><strong>Indonesia</strong></td>
<td>Nyoman Suesen</td>
<td>GFATM Project, AIDS Component DG of CDC/EH Ministry of Public Health JL Percetakan Negara 29 Jakarta</td>
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<td></td>
<td>Dr Slamet</td>
<td>CDC-MOF Ministry of Health Indonesia JL. Percetakan Negara No 29, Jakarta</td>
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<td></td>
<td>Dr Zaenal Komar</td>
<td>Ministry of Health Indonesia DG Pharmacy Services &amp; Medical Devices JL HR Rasuna Said Blok. X-5 Kav 4-9 - Jakarta</td>
<td>HIV, TB and Malaria</td>
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<tr>
<td></td>
<td>Budi Pramono</td>
<td>Implementation Program Ministry of Health Indonesia, CDC DG JL Percetakan Negara, No. 29, Jakarta</td>
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<td></td>
<td>Sudarman Sumrah</td>
<td>Directorate General of CDC Ministry of Health</td>
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<tr>
<td>Lao PDR</td>
<td>Mrs Sengchoy Panayavong</td>
<td>Global Fund of Laos Ministry of Health</td>
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<td></td>
<td>Dr Luanglath Phonepaseuth</td>
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<td>Dr Khamxeng Bannarath</td>
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<td>Mr Tavagnutti Nicolas</td>
<td>Ministry of Health GF</td>
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<tr>
<td>Mongolia</td>
<td>Avirmed Bayar Engineer</td>
<td>National Center for Health Development, Mongolia</td>
<td>HIV</td>
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<tr>
<td>Myanmar</td>
<td>Dr Tint Maw Medical Officer</td>
<td>National AIDS Control Program Department of Health</td>
<td>HIV</td>
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<td></td>
<td>Dr Kyaw Lin Deputy Director</td>
<td>Department of Health (CMSD)</td>
<td>HIV, TB and Malaria</td>
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<tr>
<td>Nepal</td>
<td>Dr Mahendra K Chhetri Director</td>
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<td>Indra Mani Pokharel Account Officer</td>
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<td>Purna B Maharjan</td>
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| Government Service
(Store Keeper) |                                |                                                                                        |                        |
| **Pawan Koirala**
Procurement Officer | Ministry of Health & Population
Department of Health Services,
Logistics Mgmt Division
Teku, Kathmandu | Malaria                      |                        |
| **Pakistan**     | **Awais Saleem.**               | National AIDS Control Programme
National Institute of Health
Chan Shahzad, Islamabad | HIV                     |
| **Papua New Guinea** | **Vali Karo**
Principal Advisor
Pharmaceuticals | Department of Health
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| **Philippines**  | **Norma G. Miranda**
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| **Normita D Leyesa**
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| **Ianne F Mencidor**
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| **Sri Lanka**    | **Mr.Siripala Uduwanage**
Financial Consultant | Lanka Jathika Sarrodaye Sharmdeu
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98 Rawatawhtra Road
Morathw Sri Lanka |                        |
| **Dr W Punsiri Fernando**
Consultant on GFATM Projects | Ministry of Health
555/5 Elvitigala Road
Colombo 5 | Malaria                      |                        |
| **Thailand**     | **Chitra Niweswan**             | Bureau of AIDS, TB and STIs                                                             | HIV, TB and Malaria |
| **Gonzague Jourdain** | 29/7-8 Sanlan Road
Soi 1 Prasing
Chiang Mai 50200 | HIV                                      |                        |
| **Intira Colling** | 29/7-8 Sanlan Road
Soi 1 Prasing
Chiang Mai 50200 | HIV                                      |                        |
| **Thongphit Pinyosinwat**
Chief of Program
Development and Monitoring Unit | Raks Thai Foundation
185 Pradipat Road, Soi 6
Phayathai, Bangkok 10400 |                        |                        |
| **Pornsinee Amornwichet**
Technical Public Health | Department of Health
Ministry of Public Health | HIV                                      |                        |
<table>
<thead>
<tr>
<th>Country</th>
<th>Name &amp; Title</th>
<th>Organization &amp; Address</th>
<th>Program (HIV/TB/Mal)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Officer</strong></td>
<td>Tiwanon Road Muang, Nontaburi 11000</td>
<td></td>
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<tr>
<td>Thailand</td>
<td><strong>Thidaporn Jirawattananapisal</strong> Pharmacist</td>
<td>Bureau of AIDS, TB and STI, Department of Disease Control Ministry of Public Health Tiwanond Road, Muang Nonthaburi 11000</td>
<td>HIV</td>
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<tr>
<td>Thailand</td>
<td><strong>Suthasinee Panya</strong> Procurement and Supply Chain Management</td>
<td>Principal Recipient Office Department of Disease Control Ministry of Public Health Tiwanond Road, Muang Nonthaburi 11000</td>
<td>HIV, TB and Malaria</td>
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<tr>
<td>Thailand</td>
<td><strong>Pornsak Khortwong</strong> Program Specialist in TB</td>
<td>Principal Recipient Office Department of Disease Control Ministry of Public Health Tiwanond Road, Muang Nonthaburi 11000</td>
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<td><strong>Pimjai Satasit</strong> Program Specialist on HIV/AIDS, General Manager</td>
<td>Principal Recipient Office Department of Disease Control Ministry of Public Health Tiwanond Road, Muang Nonthaburi 11000</td>
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<tr>
<td>Thailand</td>
<td><strong>Piriya Worakasemsuk</strong></td>
<td>Bureau of Aids, TB &amp; STIs, Department of Diseases Control 3331/116 Suprasert Road, Bangklo, Bang Ko Laem, Bangkok 10120</td>
<td>TB</td>
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<tr>
<td>Thailand</td>
<td><strong>Atiporn Silkanoklert</strong></td>
<td>AIDS Care Unit, Bureau of Aids TB &amp; STIs, Diseases Control Department of Public health Tiwanon Road, Muang Nonthaburi 11000</td>
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<tr>
<td>Thailand</td>
<td><strong>Booncherd Kladphuang</strong> TB Cluster</td>
<td>TB Cluster, Bureau of AIDS, TB and STIs, Department of Disease Control Ministry of Public Health 3331/116 Suprasert Road, Bangklo, Bang Ko Laem, Bangkok 10120</td>
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<td><strong>Sanitchai Suwanaratana</strong> Finance &amp; Administration Director</td>
<td>Raks Thai Foundation 185 Pradipat Road, Soi 6 Phayathai, Bangkok 10400</td>
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<td>Thailand</td>
<td><strong>Kesanee Kladphuang</strong> Bureau of Vector Borne Disease</td>
<td>Bureau of Vector Borne Disease Department of Disease Control Ministry of Public Health Tiwanon Road, Muang Nonthaburi 11000</td>
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<tr>
<td>Vietnam</td>
<td><strong>Nguyen Viet Nhung</strong> National Hospital of TB and Respiratory Diseases</td>
<td>463 Hoang Hoa Tham, Hanoi</td>
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<td>Vietnam</td>
<td><strong>Nguyen Thi Quynh Oanh</strong> National Hospital of Tuberculosis and Respiratory Diseases</td>
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<td></td>
<td>Nguyen van Hieu</td>
<td>Vietnam Global Fund Malaria Control Project</td>
<td>Malaria</td>
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<tr>
<td></td>
<td>Finance Officer, Planning &amp;</td>
<td>245 Luong The Vinh Street, Tuliem Dist. Hanoi, Vietnam</td>
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<td></td>
<td>Procurement Assistant</td>
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<td>Le Trung Kien</td>
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<td>245 Luong The Vinh Street, Tuliem District, Hanoi</td>
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<tr>
<td>coachingplatform Inc.,</td>
<td>Gunnar Bruckner</td>
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</tr>
<tr>
<td>Germany</td>
<td>Chief Executive Officer</td>
<td>Elsholz str. 4 10781 Berlin Germany</td>
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</tr>
<tr>
<td>MSH</td>
<td>Thomas Moore</td>
<td>MSH 4301, N. Fairfax Drive Suite 400 Arlington, VA 22203 USA</td>
<td>TB</td>
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<tr>
<td>Rima Shretta</td>
<td>Senior Program Associate</td>
<td>Management Sciences for Health (MSH) 4301 N. Fairfax Drive Suite 400 Arlington VA 22203 USA</td>
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<tr>
<td>Andy Barrachough</td>
<td>Principal Program Associate</td>
<td>MSH 203, 30 Nguyen Du, Hanoi, Vietnam</td>
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<tr>
<td>World Bank</td>
<td>Patrick Osewe</td>
<td>1818 H street N.W. Washington DC 20433</td>
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<tr>
<td>UNICEF</td>
<td>Helene Moller</td>
<td>UNICEF Pladz Copenhagen DK2100 Denmark</td>
<td>HIV</td>
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<td>UNICEF Supply Division</td>
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<tr>
<td>Arjan De Wagt</td>
<td>Project Officer PMTOT</td>
<td>UNICEF EAPRO 19 Phra Atit Road Bangkok</td>
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<tr>
<td>Global Fund</td>
<td>Luca Li Bassi</td>
<td>Global Fund 8Ch. Des Blandonnet Verin – Geneva</td>
<td>HIV, TB and Malaria</td>
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<tr>
<td>John Snow Inc., USA</td>
<td>Daniel Thompson</td>
<td>John Snow Inc. 1616 N. PT Myer Drive 11th Floor Arlington UA 22209 USA</td>
<td>HIV and TB</td>
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<tr>
<td></td>
<td>Senior Advisor</td>
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<tr>
<td></td>
<td>Yasmin Chandani</td>
<td>John Snow Inc. 1616 N. PT Myer Drive 11th Floor Arlington UA 22209 USA</td>
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<tr>
<td></td>
<td>HIV/AIDS Coordinator</td>
<td></td>
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<tr>
<td>UNDP</td>
<td>Jacqueline Pee Guaw</td>
<td>UNDP No. 6 Natmaku Road P.O. Box 650, Yangon</td>
<td>HIV, TB and Malaria</td>
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<tr>
<td>Myanmar</td>
<td>Mr Htun Min Maw, Procurement Officer</td>
<td>No. 6 Natmauk Road, P.O. Box 650, Yangon, Myanmar</td>
<td>HIV, TB and Malaria</td>
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<td></td>
<td>Krishan Batra, Senior Adviser</td>
<td>New York, USA</td>
<td>HIV, TB and Malaria</td>
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<td>IDA Foundation</td>
<td>Connie van Marrewijk</td>
<td>IDA Foundation</td>
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<tr>
<td>Esther</td>
<td>Dubreuil Muriel, Project Manager</td>
<td>Esther, 36 rue de Charenton, 75012 Paris, France</td>
<td>HIV</td>
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<tr>
<td>MMSS</td>
<td>Mr Lorenzo Witherspoon, Technical Officer</td>
<td>RBM partnership Secretariat (MMSS)</td>
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<td>WHO</td>
<td>Dr Vincent Habiymambere, HIV Dept.</td>
<td>WHO – HIV Dept.</td>
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<tr>
<td></td>
<td>Dr Françoise Renaud-Théry, HIV</td>
<td>WHO HIV AIDS Medicine &amp; Diagnostics Services</td>
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<td></td>
<td>Mr Hugo Vrakking</td>
<td>WHO/GDF</td>
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<td>Prohomme Remy, Technical Officer</td>
<td>RBM Partnership Secretariat</td>
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<td></td>
<td>Dr Kenji Tamura</td>
<td>WHO/HIV/AMDS</td>
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<tr>
<td>WHO</td>
<td>Jing Sun, National Technical Officer in PHA</td>
<td>WHO Representative Office China 401 Diplomatic Office Building 23 Dongzhinenwai Ave 100600, Beijing, PR China</td>
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<tr>
<td></td>
<td>Kanokporn Coninx, Technical Officer</td>
<td>WHO Representative Office Myanmar</td>
<td>HIV/AID</td>
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<tr>
<td></td>
<td>Truls Eriksen, Technical Officer</td>
<td>WPRO WHO Western Pacific Regional Office P.O. Box 2932, Manila Philippines</td>
<td>HIV/AID</td>
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<tr>
<td></td>
<td>Stéphane Rousseau, Regional coordinator for GFATM issues</td>
<td>WPRO WHO Western Pacific Regional Office P.O. Box 2932, Manila Philippines</td>
<td>HIV, TB and Malaria</td>
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<tr>
<td></td>
<td>Anthony Louis Gomes, Health Laboratory Specialist</td>
<td>WHO PNG P.O. Box 5896 Boroko, NCD Papua New Guinea</td>
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<td></td>
<td>Reynaldo Pangan, Program and Admin.</td>
<td>WHO PNG P.O. Box 5896</td>
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<td>Country</td>
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<td>Program (HIV/TB/Mal)</td>
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<tr>
<td>Officer</td>
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<td>Papua New Guinea</td>
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<tr>
<td>Karin Timmermans</td>
<td>WHO Indonesia</td>
<td>P.O. Box 1302 Jakarta 10350 Indonesia</td>
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</tr>
</tbody>
</table>
Distinguished participants, ladies and gentlemen,

I am very happy to convey greetings from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, to the distinguished participants and guests. As Dr Samlee is unable to attend due to prior commitments, I have the honour to deliver his address. And I quote:

- It gives me great pleasure to welcome you all to this fifth Procurement and Supply Management Workshop organized for countries having Global Fund grants. This is the first such workshop for countries of the Western Pacific and South-East Asia regions.

- The three diseases targeted by the Global Fund viz. HIV/AIDS, TB and malaria, are also high priorities for WHO. Fighting them will help to alleviate poverty and reach the Millennium Development Goals. In recent years, WHO has launched the 3 by 5 initiative, Stop TB and Roll Back Malaria initiatives to address them.

- The Global Fund to Fight AIDS, Tuberculosis and Malaria is currently the most important source of funding for the fight against these diseases. Global Fund grants not only help to strengthen health systems, but also pay for drugs, diagnostics, mosquito nets and other supplies.
• An estimated 49% of Global Fund grants will be expended on drugs and related supplies. Thus efficient systems and plans for procurement and supply management are vital to their success. Lack of such systems have considerably delayed the implementation of projects in as many as 13 countries in the two regions.

• Procurement and supply management is a complex process. It requires expertise in logistics, finance, health, global supply situation, donor policies and intellectual property rights related to drugs. Such expertise is rare in our countries. I hope that this workshop will help countries in bridging some of these gaps.

• Beyond this immediate requirement, I also encourage national governments and their Country Coordinating Mechanisms to make use of expertise of WHO and other agencies. WHO has undertaken a wide range of activities to support Member States in this area. These include, the AIDS Medicines and Diagnostics Services (AMDS) established to advise countries on supply management, regulatory issues and intellectual property rights.

• WHO and partners have also undertaken pre-qualification of anti-retroviral products and manufacturers to guide Member States in selecting products and suppliers.

• WHO can also work with countries to help achieve lower prices, for example, through bulk purchasing and sharing of information on medicine prices. Countries are encouraged to participate in existing pooling mechanisms like the Global Drug Facility for TB drugs and diagnostics. Similarly, WHO and partners have facilitated groups of countries in negotiating with the pharmaceutical industry for lowering HIV/AIDS drug prices.
WHO is also supporting Member States in facing complex challenges arising from the implementation of the WTO/TRIPS Agreement. This includes support in reviewing and amending national patent legislation in such a way as to best utilize the public health safeguards of the agreement.

The Regional Committee for the Western Pacific endorsed in September 2004 a Regional Strategy for Improving Access to Essential Medicines. In the SEA Region we hope to achieve this by supporting Member States in developing their national drug policies based on the WHO Medicines Strategy.

Activities financed by the Global Fund focus on priorities set by the Roll Back Malaria Partnership. The largest part of the Global Fund investment is being used to roll out new, effective malaria drugs, as well as to provide insecticide-impregnated mosquito nets to families in high-prevalence areas.

Through the Pesticide Evaluation Scheme (WHOPES), WHO provides information on specifications for insecticide-treated nets (ITNs) and insecticides used in malaria control. Along with UNICEF, WHO is also working with countries and manufacturers of bed nets to achieve economies of scale through forecasting requirements.

Significant progress has been achieved towards the global tuberculosis control targets for 2005 following the establishment of the Stop Tuberculosis Initiative. Global Fund grants have facilitated high-burden countries in achieving the global targets for TB case detection and successful treatment through the DOTS strategy. Global Fund grants have also provided access to treatment of multidrug-resistant tuberculosis.
• Along with the Stop TB partnership, WHO has initiated the Global Drug Facility (GDF) in order to increase access to high quality tuberculosis (TB) drugs for DOTS implementation. GDF aims to provide TB drugs to treat up to 10 million patients, and to help countries to reach the WHO global TB control targets by 2005.

• I am glad to see that so many of you could come to this workshop, despite your busy schedule. I would also like to extend my gratitude to all the guests and facilitators from other UN agencies, the Global Fund and various government and non-governmental agencies for their support and contribution to this workshop.

• Finally, I wish you all a pleasant stay in Thailand. Unquote

I will, apprise the Regional Director of the outcome of this workshop. I too take this opportunity of welcoming you all and wishing you fruitful interaction and a pleasant stay.

Thank you
### ANNEX 4
#### Sourcing technical Assistance

**Countries requiring technical assistance**

<table>
<thead>
<tr>
<th>Country</th>
<th>Element</th>
<th>National/International</th>
<th>Duration</th>
<th>Source of Funding</th>
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<td>TB</td>
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<td>Cambodia</td>
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<td>China</td>
<td>TB</td>
<td>MIS assessment (Drug Management)</td>
<td>End of 2005</td>
<td>Gov +WHO</td>
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<td>HIV</td>
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<td>Revision &amp; training of ARV’S management guideline</td>
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<td>Malaria, HIV and TB</td>
<td>Training on PSM, preferably separately.</td>
<td>2-3months</td>
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<td>-Ensuring pre-qualification process for local FDC manufac.</td>
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<td>QA, QC, LMIS and PSM on medical devices</td>
<td>Minimum 1 year or more</td>
<td>WHO, UNICEF, UNDP and GF</td>
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<td>Myanmar</td>
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<td>Supply management, LMIS and ensuring drug use.</td>
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<td>(3) QA/QC</td>
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<td>Forecasting, LMIS, Patents, rational drug use.</td>
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<td>(depending on subject)</td>
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<td>Papua New Guinea</td>
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<td>Inventory management, distribution, Management</td>
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<td>and information system (national &amp; international)</td>
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<td>Philippines</td>
<td>HIV, TB and</td>
<td>Forecasting (Int), 1 week Nov2005 for TB&amp;HIV</td>
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<td>Ext. eval. (Int), 1 mo. Sep06 (TB), Oct06 for Mal &amp; HIV</td>
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<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>HIV, TB Malaria</td>
<td>QA (nat)</td>
<td>2 weeks each</td>
<td>GF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>QC (nat)</td>
<td>(Sep05) on CB</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inventory Mgt. (nat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patent (nat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MIS system (nat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>HIV</td>
<td>PSM plan</td>
<td>Aug05</td>
<td>GF + WHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Price negotiation for imported drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TB</td>
<td>QA/QC of drug</td>
<td>Phase II</td>
<td>WHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MIS</td>
<td>Oct05</td>
<td>WHO + RBM</td>
</tr>
<tr>
<td></td>
<td>Malaria</td>
<td>Product specification of RDT</td>
<td>Oct.05</td>
<td></td>
</tr>
</tbody>
</table>

Vietnam

| Vietnam       | Malaria           | Product selection- NA (CP/T)                                               | 2 mos (Feb-Mar 2006).         | GF                      |
|               |                   | Forecasting NA (CP/T)                                                       | 3 mos (Apr-Jun 2006).         |                         |
|               |                   | Patents (CP)                                                                | 1 mo. (Aug 06)                |                         |
|               |                   | External evaluation                                                         | 1 mo Dec 05)                  |                         |
|               | TB                | QA/QC (Int)                                                                 | 1 month each                   | GF and other sources   |
|               |                   | MIS (Int)                                                                   | (in 2007)                     |                         |
|               |                   | Product selection (Int)                                                     |                                |                         |
|               |                   | Patent                                                                     |                                |                         |
|               |                   | External evaluation (Int)                                                   |                                |                         |
ANNEX 5

Table 2 - Summary of Group Discussions on PSM plans and review of implementation

<table>
<thead>
<tr>
<th>Country</th>
<th>Issues/Challenges</th>
<th>Response to issues/challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>Medication selection:</td>
<td>• Drugs availability – forecast and notify the supplier in advance.</td>
</tr>
<tr>
<td></td>
<td>• 2\textsuperscript{ND} (availability, sustainability and affordability)</td>
<td>• OI prophylaxis – cotrimoxazole cheap option.</td>
</tr>
<tr>
<td></td>
<td>• OI prophylaxis (GF procurement policy, HW)</td>
<td>• QA/QC – GF guidelines, QC – local lab.</td>
</tr>
<tr>
<td></td>
<td>• Pediatric formulation</td>
<td>• Management</td>
</tr>
<tr>
<td></td>
<td>QA/QC</td>
<td>• Rational drug use/adherence/education/counseling</td>
</tr>
<tr>
<td></td>
<td>• Needs for training/international assistance.</td>
<td>• Costly viral load – consider CD4</td>
</tr>
<tr>
<td></td>
<td>• Capacity building for provincial/ prefecture level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coordination: consolidating with National plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Programme management agent/implementer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rational use and containment resistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adherence issue (patient education/ support/ formulation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Introduction of viral load (GF policy/HW capacity / 2\textsuperscript{nd} line</td>
<td></td>
</tr>
<tr>
<td></td>
<td>drugs)</td>
<td></td>
</tr>
<tr>
<td>Philippines</td>
<td>Problems/concerns:</td>
<td>• Delay in delivery of drugs – small quantity</td>
</tr>
<tr>
<td></td>
<td>• Delay in delivery of drugs – hence implementation delayed.</td>
<td>• Specification of drug &amp; supplies – WHO criteria</td>
</tr>
<tr>
<td></td>
<td>• Specification of drugs and supplies.</td>
<td>• Prequalification – WHO assistance available through the web.</td>
</tr>
<tr>
<td></td>
<td>• Prequalification.</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Issues/Challenges</td>
<td>Response to issues/challenges</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| (General comments from country representatives) | • Technical specs for vehicle  
• Delayed supplier deliveries  
• Too few HIV patients  
• No local pharma industry  
• Lack of training and H.R.  
• GF slow to TA request  
• GF slow in release of funds  
• Taxes and clearing  
• No budget for inland drug distribution  
• No NTP manager, lack of supervisory capacity.  
• Long lead time for drugs  
• Prequalification limits procurement capacity  
• No paediatric formulations  
• Short shelf life  
• No prequalification done  
• Poor quality on arrival of drugs after prequalification  
• 2\textsuperscript{nd} line drugs from GLC too expensive  
• PR too slow in proving budget for PSM  
• PR too slow to approve reports. | • Steering committees: MoF, MoF, Health Services, Public Health, NTP, Logistics.  
• T.A. for Distribution and MIS  
• Capacity building and Training  
• Appoint NTP manager  
• Frequent in-country deliveries  
• Conducting PMTB assessment  
• Conducting external evaluation  
• Assess/ pilot test 4-FDCs  
• Emergency purchases  
• Can procure MDR Tb drugs cheaper than GLC  
• TA in project management incl. M&E  
• TA in QA  
• Hire international TA for pharmaceutical management  
• Hire local TA for distribution  
• Specialist to troubleshoot quality problems and donor co-ordination. |

<table>
<thead>
<tr>
<th>Country</th>
<th>Issues/Challenges</th>
<th>Response to issues/challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia</td>
<td>Poor communication between PR &amp; PA; delivery delay and quality control and after sale service</td>
<td>TA: help PR handle the relationship between procurement agency. (Indo.)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Poor communication between PR &amp; MOH</td>
<td>TA: help PR handle the relationship between MOH.</td>
</tr>
<tr>
<td>Thailand</td>
<td>Poor communication between PR &amp; LFA</td>
<td>TA: specification writing</td>
</tr>
<tr>
<td>China, Indonesia and Vietnam</td>
<td>Prequalification, limit number of suppliers and increase the price.</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>HR: lack of people with malaria background</td>
<td>TA: training/program management (China) TA: specification writing</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Time difference between workplan * procurement plan.</td>
<td>TA: monitoring and evaluation</td>
</tr>
</tbody>
</table>
### Malaria Group (summary of group discussion on 27 July 2005)

<table>
<thead>
<tr>
<th>Logistic cycles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three ways of delivery</td>
</tr>
<tr>
<td>(1) Government system</td>
</tr>
<tr>
<td>Government system – Cambodia: Has problem in inventory control. Some time the central level is over stock and the country level is out of stock due Government’s capacity for distribution not enough.</td>
</tr>
</tbody>
</table>

*Recommendation:* include in the budget the strengthening of distribution capacity in the PSM plan, such as vehicles, motorcycles, etc.

(2) Private system

Sri Lanka’s practice:
(a) There is a list of end users name, address, and contact person in the tender documents. The suppliers will add the distribution fee in the price and will deliver.
(b) The supplier get receipt document from end users and get money base on it.
(c) In some urgent situation, use the Government system.

(3) The mix system

Vietnam’s practice:
(a) Government system – Government has a schedule of bed net distribution yearly, the end-users get information to go to central level to get the bed net themselves.
(b) Private system – Contract with supplier with list of users and deliver to them directly.

### Rational drug use and pharmacovigilance

All countries in the Malaria Group have no problem with this topic.
**HIV/AIDS Group (summary of group discussion 28 July 2005)**

**General consensus:**
- Very useful and productive information and experience sharing as well as networking
- Most expectations have been met.

**Issues discussed in details:**

**Distribution system – experience in Asia**
- China – direct distribution from supplier to provinces
- Thailand – Vendor Managed Inventory (VMI)
  - agreement with GPO (in advance for 3-6 months)
  - hospitals develop plan and monitor the amount of each ARV.
  - hospitals set time of re-order: not more than 1-2 months of stock at the hospital.
  - Regional Disease Control Office verify the plan/re-order time.
  - GPO follow hospitals’ plan and re-order.
  - GPO submitted the invoice periodically and paid.
- India – direct suppliers to hospitals
- Flexibility of shifting suppliers from one province/district to another to solver over and under supply.

**Development of PSM plan:**
- Need example of good PSM plan.
- Template available
- Suggestion for next workshop – case study of what is perceived as a good PSM plan, case study in implementation strategies.
- JSI diagram for supply management for TB.

**Data collection and LMIS training and curriculums**
- Existing courses available i.e. WHO/IDA or JSI and MSH/WHO/IDA
- Handbook “IMAI Handbook of supply management at first line health facilities – under developed (to be available soon).
- Suggestions for countries to organize workshops (TA) to build local capacity.
- CD rom available.

**Other area:** Myanmar participants need clarification on country with additional safeguard policy and zero cash flow management (to meet with GFATM).