Reproductive Health Supplies Coalition
2010 Membership Meeting

Meeting Report
May 27–28, 2010
Kampala, Uganda

Table of Contents

Day 1

1. Welcome and Introduction……………………………………………………………….......1
2. Executive Committee report………………………………………………………….........1
3. State of the Coalition……………………………………………………………….........2
4. Keynote speech...3
5. Advocating for supplies..4
6. Special interest topics (parallel sessions):
    - Pledge Guarantee for Health mechanism..6
    - Market segmentation and Total Market Initiative–Honduras............................6
    - Maternal health supplies...6
    - Country showcase–Ethiopia...6
7. Importance of quality for RH supplies..7
8. Day 1: Wrap-up..9

Day 2

9. Welcome and Introduction..10
10. Contraceptive security and long-acting methods...10
11. Professionalizing supply chain management...11
12. Caucus reports..12
13. Working group updates (parallel sessions)
    - Systems Strengthening Working Group...13
    - Resource Mobilization and Awareness Working Group...............................13
    - Market Development Approaches Working Group..13
14. Contraceptive security country showcase...13
    - Tanzania
    - Ghana
15. Private-sector financing projects that work: Contribution to development and supplies.....13
16. AccessRH and RH Interchange...16
17. New RH Strategy for the World Bank..17
18. Coalition activities and continuing Innovation Fund projects...............................17
19. Closing remarks...18

Day 1: May 27, 2010[1]

1. Welcome and Introduction
Speaker:

- Julia Bunting, Team Leader, AIDS and Reproductive Health Team, UK Department for International Development (DFID), and Chair, Reproductive Health Supplies Coalition Executive Committee
- Anthony Mbonye, Commissioner of Health Services, Ministry of Health, Uganda

Julia Bunting welcomed attendees to the 11th membership meeting of the Reproductive Health Supplies Coalition. Ms. Bunting noted that she will be co-chairing the meeting with colleagues from the Government of Uganda. Today, she will be co-chairing with Anthony Mbonye from the Ministry of Health, and tomorrow with Jotham Musingusi from Partners for Population and Development (PPD).

In September, world leaders will gather to assess achievement towards the Millennium Development Goals (MDGs). Progress has been slow, particularly towards MDG 5 and MDG 5b (Improve Maternal Health and Achieve Universal Access to Reproductive Health). People are starting to remember the cost-effectiveness and benefits of investing in reproductive health (RH) and family planning (FP). Recognition of the value of FP is growing around the world, including within the new government of the United Kingdom. Now, we must seize the opportunity and demonstrate what can be achieved and what more can be done. Over the next few days, we must listen and learn, and share our successes and failures. Ms. Bunting hopes we go away reinvigorated with the possibility of what we can achieve.

Dr. Mbonye welcomed all attendees to Uganda and to the meeting. One year ago, the government of Uganda became a member of the Coalition. Uganda has poor RH indicators, low contraceptive prevalence rates, and high unmet need. Poor supply chain mechanisms contribute to these indicators. Reproductive health commodity security (RHCS) is a challenge to Uganda, especially in rural areas. There are large gaps between supply and demand for RH commodities. Studies conducted in Uganda show that addressing the unmet need for FP would save US$101 million annually. The country has a roadmap for addressing RH. Projections suggest that US$12 million is needed to meet contraceptive needs. In 2010 alone, Uganda will have a $4 million shortfall for contraceptive supplies. DFID has generously offered to provide £3 million to support procurement of contraceptives through the United Nations Population Fund (UNFPA). This will help to avoid shortfalls in supplies, and ensure women are able to access family planning.

2. Executive Committee Report
Speaker:

- Julia Bunting, Team Leader, AIDS and Reproductive Health Team, DFID, and Chair, Reproductive Health Supplies Coalition Executive Committee

Ms. Bunting provided attendees with an update on the Executive Committee (EC) meeting held yesterday, May 26, at the Kampala office of UNFPA (many thanks to Janet Jackson and her colleagues at UNFPA for hosting the EC). She reported that that Coalition's Secretariat now has core funding for the next three years, which gives us stability to move forward with plans. The EC received updates from the Secretariat leadership and the leaders of the Coalition's three Working Groups. The EC approved workplans for the next year for the Secretariat, Systems Strengthening Working Group (SSWG), and Market Development Working Group (MDA WG). The EC will approve the workplan for the Resource

[1] To view presentations, including the Keynote and State of the Coalition speeches, please click here.

Mobilization and Awareness Working Group (RMA WG) once it is presented. Over the summer, the Secretariat will review the Coalition's focus countries and assure they still meet our current priorities. This will be part of a broader review of the Coalition's Strategic Plan. The EC will discuss recommendations at the next meeting in late autumn.

3. State of the Coalition
Speaker:

- John Skibiak, Director, Reproductive Health Supplies Coalition

John Skibiak welcomed all attendees to the 11th membership meeting of the Reproductive Health Supplies Coalition. The Coalition is honoured to be here at the invitation of the Ministry of Health (MOH) and PPD, both of whom are not only hosts, but active members of the Coalition. There are many new faces in the audience today, welcome. We are all here today because many who want to plan their families will fail to do so because their method of choice is unavailable, unaffordable, or their method of choice does not meet international standards of quality. We are here because none of us, acting alone, can grab the world's attention. No single technical agency has all the knowledge and tools to address supply chain issues. No single donor could, or should, foot the bill for supplies that countries ought to be buying themselves. The Coalition was formed in 2001 to ensure access to a broad range of RH supplies and methods. The last three years have seen increases in donor willingness to include supplies in their scope and financing for supplies. Among the Coalition's 14 focus countries, funding for RH increased by 55 percent.

Since our last meeting in 2009, both the AccessRH and Pledge Guarantee for Health financing mechanisms were launched, promising drastic reductions in the lead time for procurement of commodities and the possibility for procurers to turn promises of donor support into cash for commodities. The Coordinated Assistance for RH Supplies group (CARhs) meets monthly to address supply issues in many countries, including our host country Uganda. In 2009, we noted that the Coalition's priority would be to engage members at the country level. Membership has grown to 114, with the largest growth coming from organizations in low- and middle-income countries. We have become a trilingual organization, with our website, newsletter, and other key documents being produced in English, Spanish, and French. Through the Innovation Fund, the Coalition disbursed US$761,000 to member organizations implementing activities under the Coalition's three Working Groups. In addition to the many advances in the past year, one highly successful project has come to a close. Project RMA played a critical role in raising the profile of the supplies issue at the global level.

Yesterday, the EC approved the Secretariat's workplan for the coming year. The Secretariat will work to highlight the successes and challenges of our members since the 2001 conference "Meeting the Reproductive Health Challenge" in Istanbul. This initiative, called Istanbul +10, seeks to reinforce global attention on the need for RHCS. The Secretariat will also conduct a three-year review of the Coalition's Strategic Plan. We will continue to engage with representatives of countries from the Global South. We hope to replicate the Latin American Forum with other regions throughout the year. We will also pursue replenishment of the Innovation Fund so it can continue past its current end date of 2012.

We hope that the coming days will inspire us to meet the global RH needs of women and men worldwide.

(Full speech available online)

4. Keynote speech
Speaker:

- The Hon. James Kakooza, State Minister for Health (Primary Care), on behalf of Hon. Dr. Stephen Malinga, Minister of Health

Dr. Mbonye introduced the Hon. James Kakooza, who presented the keynote speech on behalf of the Hon. Dr. Stephen Malinga, Minister of Health, who was unable to attend the meeting. Mr. Kakooza announced that on behalf of the government of Uganda and the MOH, he would like to welcome members of the Coalition to Uganda. Uganda was the first country to join the Coalition and it is a great honour for us to host this meeting. It is also an opportunity as it puts our country in the spotlight, highlighting our strengths, accomplishments, and our shortfalls. The concept of commodity security did not easily find its way into the national planning process. In the International Conference on Population and Development Plan of Action, the cornerstone of the RH movement, the word "supplies" is mentioned only three times. Today, commodity security has become an integral part of the RH equation. No national RH strategy would be appropriate without RHCS and the work of many of you in this room today. It is true that there are many funding shortfalls, poor outcomes, and stock-outs of drugs and commodities in health facilities.

To achieve contraceptive security, the MOH has conducted a situation analysis of RHCS that culminated in a five-year strategic development plan for 2010-2015. This will be used to improve RHCS for Uganda and will cost approximately US$530 million over the next five years, a large challenge for Uganda requiring fundamental changes in procurement and the MOH. This calls for increased funding to supply chain systems and strengthening/establishing a strong coordination mechanism.

The Coalition, through the RMA WG and Project RMA, has played a key role in highlighting the need for RHCS. We look to the Coalition as a critical source of information, guidance, and solidarity as we move forward toward achieving RHCS. The Minister congratulates the Coalition for putting its weight behind prequalification and other mechanisms. Once again, congratulations on this auspicious occasion where RH supplies take the place they deserve at centre stage. By working together, we can achieve our objective to ensure every person living in Uganda can obtain and use the RH supplies he or she needs.

Julia thanked the Minister for addressing the membership and his leadership on this issue. She noted her delight in hearing that the MOH has allocated funding for RH, and that the IDA grant allocated funding for RH commodities specifically. Thank you again for addressing us and continuing to advocate for this very important issue.

(Full speech available online)

5. Advocating for supplies
Speakers:

- Chair: Moses Muwonge
- Sarah Shaw, International Planned Parenthood Federation (IPPF)
- Jackson Chekweko, Reproductive Health Uganda (RHU)
- Christa Cepuch, Health Action International (HAI) Africa
- Dennis Kibera, Coalition for Health Promotion and Social Development (HEPS) Uganda
- Wendy Turnbull, Population Action International (PAI)

(All presentations available online)

Sarah Shaw—Overview of Project RMA:

Family planning must be regarded as a political and development priority at country level in order to achieve the necessary funding. IPPF responded to advocate for increased resources at country level. Project RMA, in collaboration with DSW and Population Action International (PAI), was developed to create advocacy resources, convene civil society partners, and create nationally owned and led networks. Using evidence-based messages and research, we identified champions who used their access and position of influence to promote the issue. Project RMA had four indicators telling us where we wanted to go, and an advocacy model telling us how to get there.

Work began in earnest in 2008. There was an overall increase of US$5.5 million in funding of supplies at country level in five of the countries between 2008–09. In Nicaragua, the majority of increases came from USAID and UNFPA; the government's allocation has decreased due to political instability and the H1N1 response, in addition to an overall budget decrease. In Bangladesh, we needed an evidence base, so we commissioned an innovative research study. Membership had to be diverse to have teeth; we included parliamentary groups, donors, and networks of parliamentarians.

Regarding messaging, in some cases ministers and local leaders lacked information, or we found that a lot of policy makers were not aware of connections between FP and increased economic output and other development goals. Messages had to be developed with a very specific ask and had to be audience specific: Ministry of Finance, MOH, media, etc. For champions, you need movers (top level) and shakers (behind the scenes people who affect what the movers see).

Jackson Chekweko—RHU Advocating for RH Supplies:

Increase funding for RH and save lives. The cost of meeting unmet need is increasing in Uganda. RHU started the RH Supplies Advocacy Network with a diverse membership. The constituent- and district-level mobilization was a collaborative effort with the government. The Advance Family Planning project will be providing advocacy input in the future. One of the challenges so far has been that the private sector was left out of the National Medical Stores (NMS) policy, and yet the private sector plays a significant role in providing FP services in Uganda. Other problems are that actual expenditures in the allocated budget are very low, and although there is a plan for outreach efforts, there are not enough supplies. Another central medical store may need to be established to serve the private sector specifically, if they cannot access the government stores.

Christa Cepuch—HAI, Stop Stock-outs, Access to Medicines:

There is a huge disconnect between the definition of essential medicines and actual access. Rural populations are always at risk of lower availability of essential medicines. Barriers to access led to launch of the Stop Stock-outs (SSO) campaign. If there is political will and financial support, systems can work, as evidenced by Global Fund (GFATM) support for commodities in Kenya. SSO engages people on their human right to access medicines, raising awareness in the first phase of the campaign that medicines should be on shelves and that it is the responsibility of governments. Pill Check Week was conducted in June 2009 in five countries. People checked availability of essential medicines at their local public health facilities and sent an SMS text message when medicines were out of stock. They mapped stock-out problems, raising awareness and making the media aware of stock-out issues. The outcome was a huge media response; this innovative project was well received. Governments were asked to respond to the issues raised.

Dennis Kibera—Coalition for Health Promotion and Social Development (HEPS): Case Study on SSO Campaign in Uganda:

SSO alliances and members trained on the concept of essential medicines. The private sector proved to be very important; they provided a lot of information and backing for the campaign, which relied on evidence-based advocacy, using MOH surveys on medicines availability. The public sector is regularly the poorest performer. Pill Check Week was very successful and created a good picture for policy makers. NMS reacted strongly to media coverage and therefore opened their doors to civil society. NMS is now directly funded by the government, getting almost 100% of money designated for medicines. The Drug Monitoring Unit is looking for medicine theft.

Wendy Turnbull—Empty-handed, responding to the demand for contraceptive:

Wendy Turnbull introduced a new video from PAI, created with support from the Coalition's Innovation Fund. The goal of the film was to put a face on the more technical aspects of supplies. The film is 8.5 minutes long, which is a tested length to deliver messages to policymakers and other non-governmental organizations (NGOs). The advocacy message at the end is open-ended, which was intentional. The video was filmed in Uganda and is meant to be useful for the entire continent. Next steps include marketing and dissemination, as well as working with partners in Europe and Africa to get this in the hands of advocates. We hope to create regional films for Asia and Latin American/the Caribbean. View the film here.

Discussion:

- Questions were raised as to the feasibility and viability of a proposed network of Ugandan NGOs aimed at ensuring access to RH commodities in light of new government plans to channel all procurement through NMS and require local NGOs to procure through local health districts.
  - The Executive Director of NMS informed participants that the new supply scheme would not exclude NGOs in any way. The proposed changes were designed to ensure that all groups requesting supplies truly are legitimate and working in the areas for which they seek supplies. Participants asked the Executive Director for NMS to disseminate in writing the new policy to the district level because reports suggest that in some districts supplies are only going to public, not non-governmental, facilities, while many of them were previously listed as beneficiaries of supplies in the districts.
- The message from attendees is not the same message NMS hears from government. Maybe someone from government can speak to the situation in Uganda.
  - The Uganda MOH (Executive Director of NMS): The issue is one of coordination, transparency, and accountability. NMS has moved away from system where facilities would come to NMS, because they did not know if medicines were actually reaching people. Now they require any NGO to present a signed order by the District Health Officer of the district to NMS clarifying they are, in fact, delivering services.

6. Special Interest Topics—parallel breakout sessions were held on the following topics:

- *Pledge Guarantee for Health Mechanism*—Kevin Starace, UN Foundation
- *Market Segmentation and Total Market Initiative: Honduras*—Pam Riley, Abt Associates
- *Maternal Health Supplies*—Elizabeth Leahy Madsen, PAI; Shanaz Shabnam, Pathfinder International, Bangladesh
- *Country Showcase: Tanzania*—Edgar Basheka, MOH, Tanzania; Tim Rosche, DELIVER; Arthur Jason, UMATI; Catherine Slater, Marie Stopes International/Tanzania

Members broke out for simultaneous panel discussions. During the first session, members could attend presentations on either the Pledge Guarantee for Health or the Total Market Initiative in Honduras. The second session offered the opportunity for members to learn more about work on maternal health supplies or attend a country showcase on Tanzania. Presentations are available online.

7. Importance of quality for RH supplies
Speakers:

- Chair: David Smith, UNFPA
- Peter Hall, Concept Foundation
- Hans Hogerzeil, World Health Organization (WHO)
- Sophie Logez, Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM)
- Hans Vemer, Consultant
- Ben Light, UNFPA

(All presentations are available online)

Peter Hall—Does Quality Matter: Does quality matter to the people that use products? For hormonal contraceptives (HC), we counsel women to put up with side effects, so there is an issue in measurement. Many companies never considered regulatory approval outside of their home markets. There is a very small amount of active ingredients in oral contraceptive pills. It is not always possible to inspect a functioning facility; manufacturers often only produce product during a short "campaign" period for the year's supply. Every key issue under good manufacturing policies (GMP) has different results and must be looked at individually.

Hans Hogerzeil—Quality RH Supplies: WHO is the gold standard for prequalification. Prequalified products are those that people want to process or sell through the UN. Prequalification has been open to HCs for four years. The real benefit of prequalification is identifying products not normally marketed in Europe or the US and that are good enough for UN procurement. After products have been prequalified, it hopefully leads to faster regulatory approval in developing countries. Applications for RH growing, but there are still not very many, and some are definitely not good enough. Manufacturers are trained together with the inspectors. Trainings show where companies have failed so far. 1,600 people trained in 2009 alone. The WHO has held a large number of trainings in Africa, specifically trying to bring African manufacturers on board with prequalification. The Bill & Melinda Gates Foundation funding specifically for prequalification of RH medicines ends May 31, 2010. Some products may achieve prequalification, but registration in country can also take a long time, and WHO is working to overcome this.

India, the United States, Hungary, and Argentina have pending products. Indonesia submitted a number of applications, but all were rejected. There is huge potential there, but they need training. Generic manufacturers fail more often than R&D manufacturers because bioequivalence data is often missing, essentially because most regulatory agencies never asked for it or the GMP standard was unacceptable. There is a general lack of experience, skills, and cooperation among generic manufacturers. Five of 10 workshops in the last four years were aimed at RH products, really trying to get them on board. As long as they can sell their product as it is, manufacturers may not be interested in making prequalification investments. Tuberculosis had the same problem, and it took a great deal of time to convince tuberculosis procurers to stop buying substandard products. WHO only publishes the names of companies that have achieved prequalification. We need very specifically trained people in procurement systems to ensure quality.

Sophie Logez—Quality for medicines, the Global Fund approach: Experience in defining, implementing, and reviewing the GFATM approach for quality medicines procurement. GFATM conducted a thorough review of policies to ensure we procured only quality medicines, without affecting the availability of medicines. Establishment of an external review panel (ERP) would ensure you have a good and adequate supply and could incentivize manufacturers to pursue prequalification. GFATM set up the mechanism with technical assistance from WHO. Transparency is key—publishing results allows seeing every transaction and how much was spent from which manufacturer/country. Quality control results are available online for more than 200 medicines. A number of the products approved by the ERP were prequalified within a year; it represents a step toward prequalification. The key point is discussion and collaboration with manufacturers. Quality control labs need a more reliable global network.

Hans Vemer—Quality FP products, the view of the pharmaceutical industry: Pharmaceutical manufacturers do see importance in both the public and private sectors. Including all costs, there is very often no profit for the private sector in prequalification. Quality is important because clients are consumers, not patients. Quality should be the same everywhere, and pharmaceutical companies believe in that. Companies are committed to building capacity in lower-income countries. Follow up is a big issue—do products go where they're supposed to, to well-trained providers, to users who know what they're getting and are accessing on a voluntary basis? Companies are committed to checking this. Companies try to make sure women can have products they want now and in the future. Pharmaceutical companies are committed to long-term partnerships with all players in the field, based on trust.

Ben Light—Ensuring access to quality RH medicines (particularly generic products): Mr. Light provided feedback on a recent Washington, DC, meeting of procurers. In the meeting, there was a realization that some of the goals could be pursued using the AccessRH mechanism. Accessing Quality Assured Supplies (AQAS) runs out relatively soon and we need to consider that. At the end of the meeting, there was consensus on moving forward, and the group agreed to complete a framework strategy by the end of July 2010. This will be undertaken by a sub-committee of the MDA and SSWG working groups.

Discussion:

- John Gerofi: do inspectors have to be from domicile of company? Hans Hogerzeil replied that one should come from WHO, one from a Stringent Regulatory Authority (SRA), and at least one from a developing country. Local inspectors can participate, but only as observers, they can't vote. Seen as conflict of interest.

8. Day 1 Wrap-up

Ms. Bunting closed the first day of the Coalition's membership meeting by thanking all of the speakers. She remarked that she learned a lot from the morning advocacy session, which set the context for what we're all about: it's not just about numbers and PowerPoint's and drugs and supplies, but about people having access.

Day 2: May 29, 2010

9. Welcome and Introduction
Speakers:

- Julia Bunting, Team Leader, AIDS and Reproductive Health Team, Department for International Development (DFID), and Chair, Reproductive Health Supplies Coalition Executive Committee
- Jotham Musingusi, Regional Director, Partners in Population and Development - Africa (PPD)

Ms. Bunting and Mr. Musingusi welcomed all attendees to the second day of the Coalition's 11th membership meeting. Mr. Musingusi noted that he felt energized and motivated after seeing the fruits of the Coalition's efforts presented yesterday. The advocacy testimony from yesterday demonstrates the breadth of the Coalition's global engagement. In Uganda, many developments have occurred, but the country is not yet meeting its contraceptive security needs. Globally, PPD wants to energize efforts in developing countries. He thanked everyone for attending today.

10. Contraceptive security and long-acting methods
Speaker:

- Dr. Roy Jacobstein, Clinical Director, RESPOND Project, EngenderHealth

(Presentation available online)

Dr. Jacobstein gave a presentation on the need to ensure inclusion of long-acting and permanent methods (LAPM) in order to achieve contraceptive security. The RESPOND Project is tasked with improving knowledge of LAPMs.

He noted the need to be more precise in our use of terminology in the supplies field. For instance, we use the term "long-acting" not "long-term" because we want to focus on the characteristic of the methods, not how long they're used. In the field, misunderstandings may arise. "Long-term" may be interpreted as meaning women cannot use that particular method if they don't intend to use it for the full length of efficacy.

Discussion of LAPM is growing within the field. Dr. Jacobstein hopes this is the beginning of a catalyst to bring more attention to LAPMs in subsequent years. Existing contraceptive security planning tools are inadequate for LAPMs. Better indicators are needed. The implants toolkit on the Knowledge for Health (K4H) website is very useful and contains a logistics section. The intrauterine device (IUD) toolkit is an equally useful resource. The many different documents on LAPMs create ambiguity, lack of specificity, and imprecision.

The language of contraceptive security causes a bias against LAPMs. If we are talking about family planning, we should say "family planning", not "reproductive health". This is the same with "contraception". What does the term "supplies" mean? We risk leaving it up to people's imaginations if we don't define it. The definition of contraceptive security equates it to supplies, but Dr. Jacobstein noted his belief that contraceptive security is about more than supplies. Contraceptive=something you can hold; contraceptive method=includes sterilization. Just by saying "contraceptive" instead of "contraceptive method," you exclude LAPMs. The Coalition's Strategic Plan states "all materials and consumables." Isn't a consumable a material? Additionally, it says "contraceptives and FP supplies." Isn't a contraceptive an FP supply? Dr. Jacobstein thinks this is something we can improve, and would be happy to be part of that

effort. “Product” is a term we use often, but not one you hear in clinical settings; no clinician says “sterilization products.” This applies to the term “commodities” as well.

Supplies alone do not equal contraceptive security; we also need services to achieve contraceptive security. Just getting money for FP doesn’t mean we’ve done the job. Use of IUDs or implants to space and/or delay conception is very low. Part of the reason for this is the history of FP services; clinicians generally don’t think about giving an IUD to a woman who hasn’t had a child. We’re only beginning to think of delivering these products to youth. Women in the South deserve the same mortality rates and choices as women in the West. In the UK, 31 percent of all women, not just limiters, are using LAPMs. There is disconnect between what people want and where we’re putting most of our effort. Malawi has been very successful in the equitable provision of LAPMs through MSI. South Africa refutes the idea that women in Africa are different from women in the rest of the world. In the UK, male involvement is very high; there is a high vasectomy rate. We can learn much from the private sector. The Coalition offers an opportunity to discuss these topics with private-sector members. Access means psycho-social and cognitive access, in the absence of myths and rumours. Dr. Jacobstein is confident we’ll see community health workers providing implants in next 10–20 years. Our highest priority needs to be a woman’s right not to die in childbirth.

Discussion:

- Frank Roijmans: This is a very interesting presentation. Companies need to bring products to market in a way that they are used and followed up appropriately; this will ensure contraceptive security in the long-term.
- In Kenya, IPPF is promoting LAPM and wrestling with the interest in and use of LAPMs among youth populations. It is often the first question our member associations ask. The key question is: are our audiences going to be interested? Dr. Jacobstein responded that there is experience giving LAPM to younger women, and they are equally efficacious. The IUD is a little more practical than other LAPMs for younger populations.
- Access issues increase the popularity of LAPMs in sub-Saharan Africa. Youth in sub-Saharan Africa need limiting and spacing earlier than youth in the western world because they start childbearing earlier.

11. Professionalizing Supply Chain Management
Speaker:

- Tracey Brett, Head of Procurement and Logistics, Marie Stopes International

(Presentation available online)

Ms. Brett noted that she is presenting on behalf of Kevin Pilz, who led this initiative and did a tremendous amount of work. Ensuring senior leadership to understand supply chains improves the functionality of the entire office. Supply chains are led by people, from great leadership down. Poor supply chain performance results in part from insufficient technical skills and a lack of empowerment on the part of supply chain managers. We need to recruit, train, and retain skilled managers and acknowledge this need. We hope to broaden membership to include non-RHSC members and other sectors. Kevin is meeting with UK-based agencies in the coming months. In the private sector, we now see supply chain managers at the director level; this shift needs to happen in the public sector. There is a marked lack of awareness amongst leaders and decision makers. The White Paper developed on this topic is a good read and can be downloaded from the Coalition’s website. A Global Positioning Meeting is planned for early 2011. We hope to establish policy and technical committees. Ms. Brett noted that she sees the greatest benefit of this work in that products get down to the client level and none go home empty

handed. We would love more Coalition members, especially country members, to become active members of this workstream, express support, and attend the global meeting in 2011. This is not just for logisticians and procurers, but all those engaged in and concerned with getting essential products to those who need them (programmers, funders, etc).

12. Caucus Reports
Speakers:

- Ian Askew, Population Council, on behalf of the Caucus on New and Underused RH Technologies
- Maria Cristina, International Planned Parenthood Federation, on behalf of the Latin America and Caribbean Forum on Assuring Reproductive Health

(Presentations are available online)

Ian Askew presented an update to the membership from the Caucus on New and Underused RH Technologies (the Caucus) meeting held earlier in the week. Dr. Askew noted that the Caucus is working on better publicizing what the Caucus is about and why it exists. The Caucus offers an opportunity to keep a focus on the concept of choice, which is central to the Coalition's existence. At the same time, the group provides a forum for discussion around methods that are new, or are underused. The Caucus is a place where issues for these methods can be raised and addressed. The Caucus was established as a caucus and not a Working Group as the issues cut across Working Groups. The group is open to anyone interested in those issues. Dr. Jacobstein's earlier presentation demonstrates a great example of what the Caucus could discuss. The objective of Monday's meeting was to reaffirm whether there was a purpose and a need for the Caucus. The group has achieved publication of a list of technical briefs on new and underused methods. Those of you interested in these technologies, please visit the Caucus website to access them. During Monday's meeting, the group discussed the outcomes of an electronic survey sent to members, discussing where the Caucus can go and how it can operate. The group agreed that to be effective, the Caucus really needs to emphasize access to choice at the country level. However, there is a need to develop realistic activities given what the Caucus can achieve as it is not a Working Group, but rather a community of the willing. A Caucus teleconference will be held in mid-summer, which will launch quarterly meetings of the group. The name of the group was also much discussed and maligned. The tricky word is "underused"; the group universally felt it wasn't a good concept, what's underused in one setting may be overused in another. However, no conclusions were reached on a new name. Thoughts and suggestions are most welcome.

Maria Cristina presented an update on the recently formed Latin America and Caribbean Forum on Assuring Reproductive Health (LAC Forum). Ms. Cristina discussed the inaugural meeting of the group in Panama in February 2010. The group was formed to discuss key issues in LAC, coordinate activities, and work to increase the effectiveness of the public sector. More information on the LAC Forum is available on the Coalition's website.

13. Working Group Updates—Parallel breakout sessions
Speakers:

- Neil Datta, Resource Mobilization and Awareness Working Group Leader and from the Inter European Parliamentary Forum on Population and Development (IEPFPD)
- Sandra Jordan, Resource Mobilization and Awareness Working Group Leader and Director of Communications and Outreach, USAID, Bureau for Global Health
- Ben Light, Market Development Approaches Working Group Leader and Technical Advisor, UNFPA

- David Smith, Systems Strengthening Working Group Leader and Chief, Procurement Services Section, UNFPA

During this session, attendees had the option to listen to updates from the Coalition's three Working Groups (Market Development Approaches; Systems Strengthening; Resource Mobilization and Awareness). Working Group Leaders presented workplan changes and developments since the 2010 meeting. All Working Group workplans can be viewed on the respective Working Group web pages.

14. Contraceptive Security Country Showcase—Parallel breakout sessions were held on the following topics:

- *Ethiopia*
- *Ghana*

Members broke up for simultaneous panel discussions highlighting country developments in contraceptive supplies and commodity security. Members had the option of attending a presentation on either Ethiopia or Ghana. Presentations are available online.

15. Private-sector financing projects that work: contribution to development and supplies Speakers:

- Chair: Julia Bunting
- Klaus Brill, Vice President, Corporate Commercial Relations, Bayer-Schering Pharma
- Emily Katarikawe, Managing Director, Uganda Health Marketing Group (UHMG)
- Christine Namanyanja, Marie Stopes Uganda

(All presentations are available online)

Klaus Brill—BSP Contraceptive Initiative: The initiative is in alignment with USAID. Improving logistics capacity at the receiving end is critical. Research and development companies are keen to put support into this to make it happen. So many funds are going to HIV; we must find a way to connect with them and raise awareness about contraceptive needs. Ensure access to medicines in developing countries and emerging markets. Noristerat submitted for prequalification in the first quarter of 2010. They hope to introduce Microgynon Fe in the first quarter of 2011 in Ethiopia, through a pilot approach. Contract with USAID, all roles are clear and defined, responsibilities laid out, work and financial plans agreed with USAID. Hold regular feedback meetings with USAID.

Emily Katarikawe—RH Supplies in the Private Sector: Promote demand creation both above and below the line. The Uganda Health Marketing Group (UHMG) has a well equipped warehouse, as well as relationships with 300 pharmacies, more than 1,000 drug shops, 200 clinics, and partnerships with civil society and corporate organizations. UHMG directs consumers to the outlets that stock the products through demand creation activities (mass media, etc). We are establishing five pharmacy models in the country at district level through rural pharmacies. One is operational; two others are opening in the coming months. The focus is on training private-sector providers, profit and non-profit. Work with civil-society organizations with networks and communities. The majority of the population expects RH commodities to be free, so it's a challenge to change mindsets among users, providers, and other partners. The marketing of RH commodities is not yet very attractive to the private sector. We are working with partners to help them see the potential for business growth. Since 2009, we have established a large network of corporate social responsibility partners. Wholesale facilities procure commodities also on behalf of other partners.

Christine Namanyanja—Voucher scheme in Uganda: The presentation will show how the private sector can provide services and eliminate stock-outs through a voucher program. This access to health services for the poorest through output-based aid (OBA) focuses on reimbursing providers after getting results and rewarding them after a performance has been achieved. Contrast with input based aid, public subsidies injected at beginning of program/activity. In Uganda, a voucher project is being funded by KfW and global partnership on OBA (WB funded). MSI contracts with providers, mapping providers in specific areas, promote vouchers in western Uganda, map areas to find suitable providers who meet the quality standards required by MSI. MSI contracts providers and then defines the package of services. Mothers don't pay for any service, but do have to present their vouchers at time of service. Sexually transmitted disease (STD) clients receive diagnosis; lab tests are required so you can be sure of what they are suffering from. Clients receive medicine and have four follow-up visits. The voucher scheme is underway in six districts for STD treatment and 20 districts in western Uganda for safe delivery. Vouchers are delivered by community distribution networks, and sold in pharmacies and drug shops, all of which are managed by MSI.

Providers are trained on medical services and the voucher system/program. They must sign a contract to provide services in exchange for voucher repayment. A system is in place to authenticate claims. Quality is very important, external audits are conducted. Look at dispensaries and make sure required drugs are in dispensaries. If not, the contract is terminated. Emphasis is on qualified staff. Conduct client visits, monitoring and evaluation to see if she accessed voucher, got the services providers are claiming to have provided.

Key lessons: Services are increased, especially if the target group is well defined and addressed. Many women who previously delivered babies at home without services were brought in to the participating providers. The system emphasizes good health practices; women who used vouchers for pregnancy care will likely bring children back for immunizations and other treatments. Unfortunately, some think the voucher covers these services and it does not, so this is a gap. We have seen the private sector invest in services they know are actually reaching the poor. Private providers expand facilities because their clientele increased; some cover emergency transport for pregnant women, linking to transport systems or hospitals. They receive income from this project and reinvest into improved services. Working together with providers to ensure vouchers are used by the women who really need them. Make sure communication does not stigmatize those who use them. Must have providers in areas where you want to work and must have enough providers...is private sector well developed in area where you want to work? Monitoring and improving client records, lab records, etc. Private providers know you're paying them back, so services may become fragmented. Must be careful this doesn't happen. Also the project must be well funded because monitoring costs can be high.

Discussion:

- For MSI: How are the poor identified? Is there a system? Hard to do without people who specialize in this.
    - Don't know any organization going into the depth that MSI does. At the beginning, we did a lot of work with the Ministries of Health and Finance, using national indicators for regional poverty, used existing poverty mapping study. The easiest targeting has been geographical.
- For Bayer: in a country like Uganda where a large percentage of the population is considered poor, how will this program affect the majority of Ugandans who are very poor? How will new Microgynon Fe be positioned against regular Microgynon?

  - We will conduct a price analysis for the existing market. What is done in private markets anywhere, we have a great deal of experience in this and think it's both realistic and achievable. Target countries already have been analyzed. Competition is always a good thing; it enlarges markets and increases quality. Each new method offers the opportunity to increase market and acceptance.
- For OBA: what mechanisms are in place to sustain the OBA system? Systems to monitor if access and quality of services improved?
  - Sustainability is a challenge. User fees not sustainable. Women contribute $1.50 to access services, but it is very low. Not sustainable, costs about $30–58 for a normal delivery, $80–140 for a complicated delivery depending on number of visits and complications.
  - 1.5 years into program implementation. Monitoring changes. Seeing increased clientele, most who never accessed facilities before. We are working with the RH Division to access statistics. Only have data from facilities and numbers from them have increased.

16. AccessRH and RH Interchange
Speaker:

- Morten Sørensen, Deputy Chief, Procurement Services Branch, UNFPA

Mr. Sørensen provided an update of the integration of AccessRH and the RH Interchange (RHI). The initial idea was that it AccessRH would entail online ordering, and this is the cornerstone of the IT platform. We want it to be very intuitive and easy to use, little training required; want everyone to use it like with other training platforms. Will be very transparent system, where you can see your orders and where researchers can access information. The RHI team is now integrated with UNFPA's Procurement Services Branch (PSB) in Copenhagen. Outreach and computer programmers will join the team, externally. This will be a very phased approach, starting with condoms and gradually adding one product after another. A small fee may be incurred. RHI will be fully integrated into AccessRH; users can use it to make informed decisions before placing an order. Mr. Sorensen asked all members to get the message out about AccessRH and act as ambassadors.

Discussion:

- Suggest next items in AccessRH procurement should be the three prequalified HCs. This would boost the prequalification system and motivate other suppliers.
  - Mr. Sorensen responded and stated that sounds promising and in line with current thinking.
- What will be the fee? Who will pay, etc.?
  - Need to ensure sustainability. Haven't worked it out yet, but the aim is to be substantially below the 5% UNFPA currently charges for third-party procurement
- Competitive tender rules?
  - As the number of prequalified supplies increases, procurement would need to follow competitive tendering practices.
- Can private for-profits use?
  - As of now, no. Social marketing organizations may be able to use it.
- How are you conducting demand planning?
  - Initial stock, looking at historic procurement by UNFPA, manage inventory that will be ordered and determine how much stock needed on hand at any part throughout the year. Hope to continue to engage those who will order to get better advance order information as time goes on. Initial inventory is based on historic information.
- Is there linkage with the UNICEF ordering facility?

- No. They have an online catalogue, not really an online ordering system as this is envisioned.

17. New RH strategy for the World Bank

Speaker:

- Sadia Chowdhury, Coordinator, Reproductive and Child Health, World Bank, and member of the Coalition's Executive Committee

The World Bank (WB) has supported RH since 1970 in a substantive way. We have action plans on malaria, HIV, nutrition, and now RH. This strategy was specifically developed on the request of Bank's Board of Directors. The Bank approved a US$130 million load to Uganda for health systems strengthening, preceded by two pieces of work: fiscal space analysis, comparison between Uganda, Kenya and Tanzania; another showing impact of high fertility on households and women. The first was presented to the Governments. The comparison between the three countries was very stark; it got people thinking, and was taken up at presidential level. The fertility analysis was presented to women members of Parliament (MPs) and women's groups. Afterward, when they heard about a new project being developed, they stated that if it did not have an RH component, they wouldn't approve it. Additional money has been made available, and includes procurement of LAPMs, safe delivery, and neonatal care; completely earmarked, separate monitoring. The WB supports innovative approaches to improve the performance of both state and non-state providers. It is important to consult with partners and know what they want in countries. The big paradigm change the WB would like to see is more consulting with partners.

Discussion:

- Pleased to see logistics included, in the earlier country presentations a common problem mentioned was procurement. The WB has a competitive edge in procurement since they oversee much of it. However, the current model does not work because it takes too long to get product in and build capacity, we need more flexible models. We understand the need for transparency, but plead for the bank to engage at the country level.
    - The WB is agreeing to proactively look at procurement rules and make things simpler; other agencies have offered to help
    - Memorandums of Understanding have been signed with WHO and UNFPA. This has been and will continue to be a difficult process, balancing control and corruption with transparency and speed. Have to develop both procurement and logistics capacity, which is not for the WB. Guarding against corruption is difficult; we all must work together.

18. Coalition activities and continuing Innovation Fund projects

Speaker:

- John Skibiak, Director, Reproductive Health Supplies Coalition

Over the last year, US$61,000 was provided in grants to Coalition members through the Innovation Fund. Round 4 of the Fund concluded in February. Awardees included JSI for PRODOPS II, which calls for the development of a user-friendly online database where supply chain managers can identify professional training opportunities. June 1 is the closing date for Round 5. Priority over the coming year will be to replenish the fund to carry it beyond 2012. The Coalition is looking to work with representatives from low- and middle-income countries to assist their work with the Working Groups and support workplans through their proposals.

Next year's membership meeting will mark exactly 10 years since the 2001 "Meeting the Challenge" meeting. In the coming weeks and months, the Secretariat will work closely with the RMA WG to identify a location that will be in the spirit and content of what we are calling "Istanbul +10."

19. Closing remarks
Speaker:

- Julia Bunting, Team Leader, AIDS and Reproductive Health Team, Department for International Development (DFID), and Chair, Reproductive Health Supplies Coalition Executive Committee

Everything that needs to be said has been said over the last two days. The Coalition brings so many people together with different views and focus areas; this meeting is an excellent forum to discuss these different views and focus areas. Thank you to the Secretariat for your organizational efforts. This is your opportunity to get involved with the many groups organized through the Coalition and become an active member. Please bring the power of the partnership to the work we're all doing on reproductive health. Thank you all for attending and we look forward to the year ahead.

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