MNCH COMMODITY SECURITY

SCOPING STUDY

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Issues paper

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1. INTRODUCTION

1.1. Background and objectives

This report has been prepared by Cambridge Economic Policy Associates (CEPA) for the Partnership for Maternal, Newborn and Child Health ('PMNCH' or the 'Partnership'). The role of PMNCH, as a partner-centric organisation, is to facilitate and support its Partners in achieving their joint objectives as set out in six Priority Action Areas (PA-1 to PA-6) in the Partnership's Strategy and Workplan document.

The report is the result of a short scoping study to:

- map the main players in the MNCH commodity management landscape and their focus areas;
- seek to identify the key issues impeding commodity security at both the global and country levels; and
- recommend potential areas for Partner collaboration, taking into account the focus and extent of existing initiatives in MNCH commodity management.

A first draft of the report was produced to inform Partner discussions in New York (1st and 2nd October, 2009), on how they might take forward PA-3 on achieving MNCH commodity security (Annex 1 provides more details on PA-3, its outputs, timelines and budgets).[1] The objectives of this meeting are set out below.

Partners' meeting objectives:

- **Review the MNCH commodity management landscape**
- **Highlight gaps and challenges in making supplies available to women and children**
- **Identify and agree on the possible role of partners in filling these gaps**
- **Review the 2009-2011 Partnership Strategy and Workplan activities related to commodity management and develop an implementation plan for the revised strategy**

This final version of the report takes into account comments and factual corrections made by Partners at the meeting. The main conclusions have not significantly changed from the draft version of the paper that was submitted as a basis for discussion before the meeting. However, in the key sections (4 – 11) we summarise our understanding of the main conclusions of the meeting. For the avoidance of doubt, we have not carried out any additional analysis or review in the areas where Partners have identified the need for further work.

[1] In summary, a successful outcome of the PA-3 work would see Partners reaching a consensus on the essential commodities required for MNCH, with Partners' commodity management being harmonised and implemented in the 25 high-burden countries.

1.2. Methodology and report structure

This report has been prepared over a three-week period, based on telephone consultations with a wide range of stakeholders including: multilateral and bilateral partners; foundations; private sector logistics providers and procurement agencies; social marketing agencies; health care professionals; and other global health partnerships. It has been updated in the light of Partner comments and discussion at the 1st – 2nd October meeting.

A full list of consultees is presented in Annex 2. The consultations have been supplemented by desk-based research. Details of relevant reference material (publications, websites) are provided in Annex 3.

The rest of the report is structured as follows.

- Section 2 maps the MNCH commodity supply chain and the main agencies involved.
- Section 3 introduces the subsequent sections of the report (Section 4-11) on our key findings for a series of commodity related issues in MNCH. In each of these subsequent sections, we: (i) set out our understanding of the issues; (ii) present existing initiatives and related case studies in the area; (iii) discuss potential areas for partner collaboration and possible PMNCH roles (if any); and (iv) summarise key conclusions of the New York partners meeting.
- Finally, Section 12 provides a summary and key conclusions.

We recognise that the mapping study (i.e. Section 2) is unlikely to provide any information that the Partners are not already aware of, and hence we would like to focus the attention of the reader to Sections 3-11, on the key issues in the commodity supply chain and a discussion of the potential role of the Partners.

The report is supported by the following annexes:

- Annex 1 reproduces the details on PA-3 from the PMNCH Strategy and Workplan 2009-11.
- Annex 2 provides a list of stakeholders we have consulted with.
- Annex 3 lists the main references, including publications and relevant websites.
- Annex 4 presents data on the volumes/ value of MNCH commodities handled by some of the main donor agencies.
- Annex 5 provides information on two institutions that are working in the area of commodity management – the RHSC and the H4 initiative.
- Annex 6 summarises a few country-level studies on MNCH commodities supply.

2. MNCH COMMODITY MANAGEMENT LANDSCAPE

This section first sets out the key definitions in relation to commodity management, as applicable to this study. It then maps the MNCH commodity management landscape in terms of the key activities/ functions and the main agencies involved.

2.1. Key definitions

Some of the key terms and their definitions as used in this paper are as follows:

- **MNCH commodities:** Products or supplies for maternal, newborn and child health; including medicines, drugs and vaccines. For the purposes of this study, and particularly in the interest of time, we do not explicitly cover medical equipment and devices, and laboratory diagnostic supplies within the scope of MNCH commodities.[2]
- **Commodity security:** The state of availability of essential health products at the right quantity, quality/ condition, price, and time as required by the customer, i.e. commodity security implies that the customer has the ability to choose, obtain and use correctly the product that provides them with maximum benefit.[3] This requires a range of enabling factors such as strong commodity supply chains, national leadership and health systems capacity, sufficient financing, supportive policies and regulations, active coordination among partners, and adequate service delivery.
- **Commodity supply chain:** The chain of activities involved in transferring products from the suppliers to the ultimate beneficiaries, and the supporting flows of finance and information. We also refer to this as the 'commodity management cycle'. The nature of the MNCH commodity supply chain is that some activities are undertaken at the country level, while others are mostly at the global/ regional level.

2.2. MNCH commodity value chain

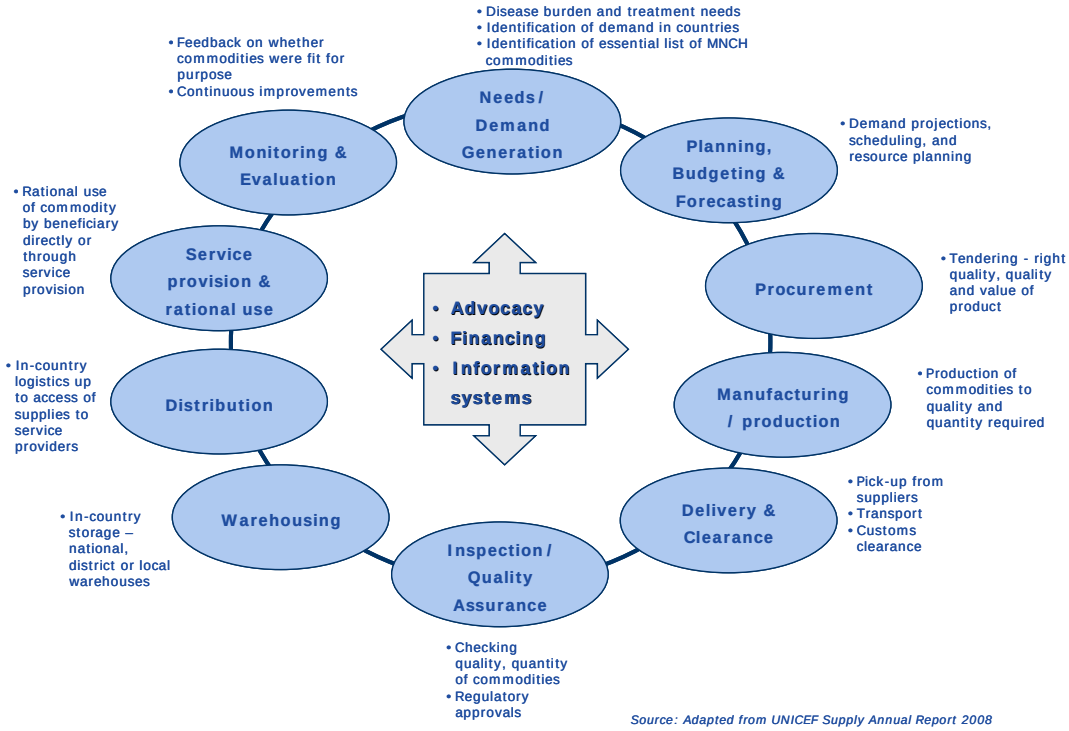
Figure 2.1 below presents the main elements of the commodity management cycle or supply chain in terms of procuring and delivering the products required by the customer. Our primary focus in this study has been on the procurement and distribution functions presented here and mapping the actors involved. We have included 'service provision and rational use' as essential part of the value chain, but we do not focus on the actors involved in service provision. We also only touch on factors or constraints that are related to commodity R&D and manufacturing.

[2] We recognise that some of the commodity security issues with respect to medical equipment and laboratory supplies are common to medical supplies. However, since the value chain and key actors differ across these commodities, we exclude equipment and devices from our study, as agreed with the PMNCH.

[3] Definition adapted from the USAID Deliver project.

The commodity management activities set out below are necessary to ensure that the 'right quantity and quality of commodities reach the right customer at the right place and time'. The activities in the circular value chain involve the flow of supplies/ commodities and may be regarded as **core functions**. Other activities presented in the centre of the figure, including advocacy, financing and information management, deal with the flow of information and resources and can be regarded as **support functions** that facilitate the smooth flow of commodities. We describe these in more detail below.

Figure 2.1: Commodity management cycle or supply chain



Source: Adapted from UNICEF Supply Annual Report 2008

Core functions: The core functions start with the definition of beneficiary needs in-country and the generation of demand and culminate with the supply of commodities to them.

- Most of the core functions such as planning and demand forecasting, customs clearance of commodities, inspection, warehousing, local transportation, distribution and service provision are undertaken at country level and therefore, depend on country health systems, infrastructure and capacities.
- However, the procurement and production of commodities typically have a global or regional reach. The procurement function seeks to secure the required supplies at the best value for money, through for example, international tendering or framework contracts (long-term agreements) with qualified suppliers, who are licensed to manufacture these commodities.
- The monitoring and evaluation function assesses the appropriate performance of all activities to ensure that commodities are delivered to the satisfaction of the consumer.

Support functions: The support functions include activities such as advocacy for MNCH commodities, financing, and information management. 'Advocacy' seeks to promote awareness and use of essential MNCH products at global, regional and country levels; and 'financing' provides the funds and resources to procure supplies and distribute them to the beneficiaries. 'Information management' refers to logistics management systems that provide up-to-date information on the supply chain and the quantity and prices of commodities being delivered.

2.3. Key agencies involved

Tables 2.1(a) and (b) map the key agencies involved in the various functions of the commodity value chain, based on feedback received during our consultations. The mapping is not exhaustive, and is intended only to illustrate the main agencies undertaking the various functions and to point out areas of limited focus.

The tables below do not discuss the key issues/ challenges associated with each stage of the commodity supply chain – which is the focus of the subsequent sections 3-11. We do however make some general observations on the areas that have received relatively greater attention from donor organisations and other stakeholders.

Table 2.1(a): Key actors by commodity management function (Core Functions)

Functions	Key actors	Some observations
1. Needs/ Demand Generation	Essential activity which is closely related to the development of national health strategies and the list of essential interventions. Primary role of local public sector healthcare agencies, but also forms a part of some donor programs.	The 'upfront' core functions of needs identification, demand generation, planning and forecasting have received limited attention in most countries. This has often hampered the ability of commodity suppliers, procurement and financing agencies to plan the timely provision and funding of the required commodities
2. Planning, Budgeting & Forecasting	Primarily the role of governments, but also carried out in conjunction with funding donor agencies.	
3. Procurement	Multiple agencies and approaches engaged in procurement: • MoH-led – either national or international tendering • Donor-led (UNFPA, UNICEF) – typically international competitive bidding/ framework contracts/ long term supplier agreements/ pooled procurement. UNFPA focuses mostly on RH commodities, and UNICEF on child vaccines, drugs, and other essential medicines. • Outsourced to third party private procurement agencies and logistics providers such as Crown Agents or JSI. • NGO-led such as MSI or PSI procuring commodities (social marketing) – although these agencies mostly deal with RH commodities. In addition to the above, if one of the above programs (say, MoH executed or donor-led) is financed by the World Bank or other bilateral funding agencies, their procurement guidelines may also apply.	There are multiple players involved in the procurement function. Procurement approaches tend to vary by agency – sometimes increasing the lead times, complexity and costs of commodity delivery. In addition, sometimes, the procurement guidelines of financing agencies such as the World Bank or USAID apply. However, these procurement agencies mostly specialise in RH or CH drugs and supplies – there is not a single agency focussing on 'MNCH commodities'.
4. Production	Generally private sector providers located in OECD, emerging and developing countries	Production is an essential part of the commodity value chain. Key issues relate to the existence of timely production at the right scale and in the right packages.
5. Delivery & clearance	Generally the role of the donor/ procurement agency and ends with customs clearance of commodities in country, from where the local health systems are expected to take over.	After customs clearance of the commodities at the entry point in country, the 'downstream' core functions such as inspection, warehousing,

Functions	Key actors	Some observations
	However, some programs may be vertically integrated, and the donor/ procurement agency may be responsible until delivery of commodities to the last mile.	transportation, distribution and service provision are dependent on the national infrastructure, capacity, and health systems
6. Inspection & QA	Generally the national regulatory/ inspection agencies. Sometimes, donor programs include quality assurance of products.	
7. Warehousing	National or local warehouses in country.	
8. Distribution	National or local infrastructure, depending on country capacity.	
9. Service provision / rational use	National and non-state health care providers in both primary and secondary care sectors. Ultimately leading to rational use by the beneficiaries.	
10. M&E	Sometimes undertaken as part of a donor or government funded program.	

Table 2.1(b): Key actors by commodity management function (Support Functions)

Functions	Key actors	Some observations
1. Financing	Multiple financing sources, including (i) country government budgets; (ii) Donor funding – multilaterals such as the World Bank; bilaterals such as USAID, DFID, and the other European donors – through program financing or SWAps or general budget support; (iii) Foundations such as the Gates and Clinton foundations; (iv) Global health partnerships such as GAVI, GFATM, etc; (v) own funding (to a limited extent) by private/ NGO entities involved in commodity management.	Similar to procurement, there are multiple financing agencies for commodity management across the continuum of care
2. Information management	Generally the role of the Ministry of Health and its agencies. The Reproductive Health Supplies Coalition (RHSC), through its working group, supports information management initiatives such as the Country at Risk Group (CAR).	Information management and advocacy are vital support functions that do not see too many actors in the MNCH space, although there may be lessons to learn from the activities and initiatives of the RHSC and its members.
3. Advocacy	Undertaken by donors, global partnerships, and NGOs/ CSOs working in this space.	

2.3.1. Mapping of financing and procurement agencies

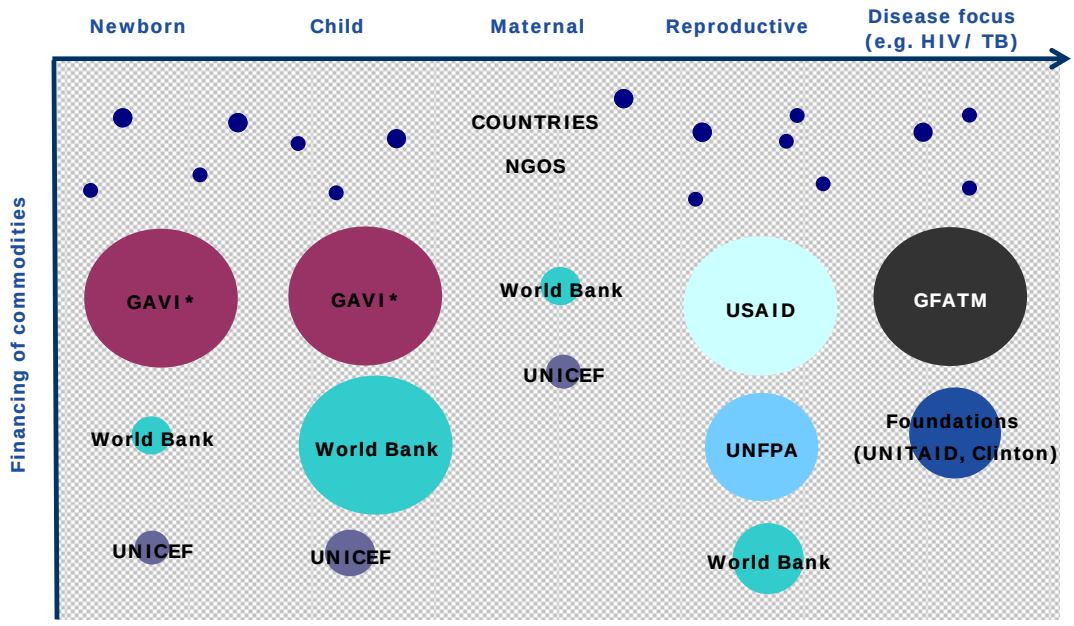
Given the multiple actors involved in financing and procurement of MNCH commodities, the figures below attempt to characterise the focus of different agencies.

In the absence of complete market data on the global volumes of MNCH commodities procured and the percentage share of different organisations, *these figures are illustrative*, based on annual funding figures for the key organisations as well as feedback on the focus and relative prominence of each player through stakeholder consultations (Annex 4 provides some statistics on the value and volume of MNCH commodities that key donor agencies deal with). Also, these figures attempt to map only the key global players, and are hence not exhaustive.

Figure 2.2 below presents an illustrative mapping of the key agencies involved in the financing of MNCH commodities. Main points to note are as follows:

- There are a few donor agencies providing a majority of global funding for MNCH commodities, supplemented by smaller levels of funding by governments (often in the form of co-financing to donor programs, or own budget expenditure) and NGOs/ community based organisations at the country level.
- The main donor organisations have tended to focus on specific components of the MNCH commodities space. In addition, some donor and health partnerships finance disease-based commodities (e.g. GFATM).
- While there are a number of donors financing commodities for reproductive health and child vaccines, maternal and newborn health commodities do not appear to have received particular focus. The gap is particularly stark for maternal health commodities in Figure 2.2.

Figure 2.2: Mapping of the key agencies for MNCH commodity financing[4]



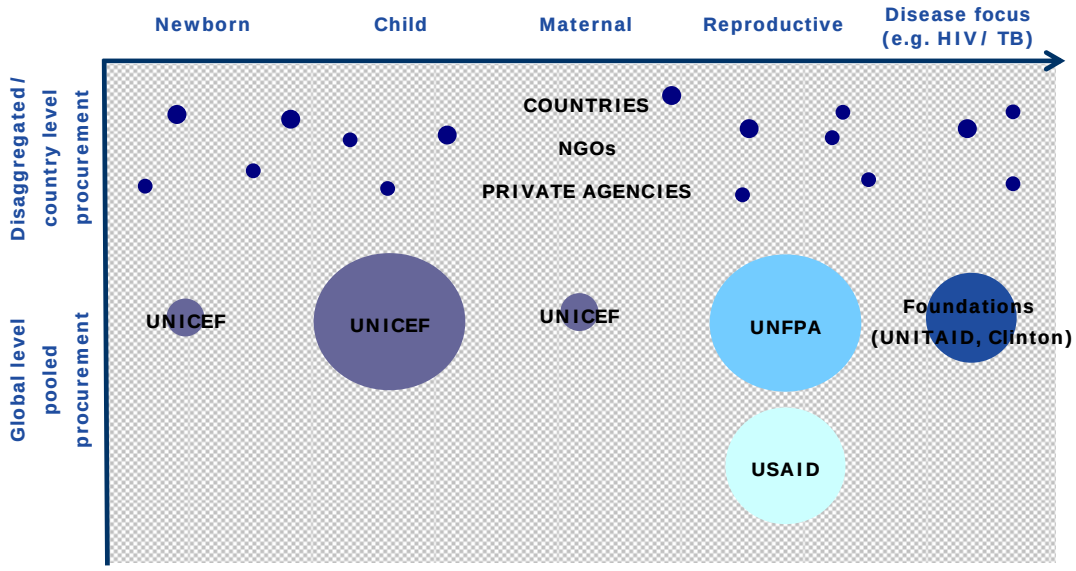
* Includes funding by international foundations such as Gates

Figure 2.3 maps the main procurement agencies in the MNCH space. Key points to note are the following:

- There are multiple agents involved in procuring MNCH commodities – while there are 2-3 large global donor agencies, there are a number of small country level players as well.
- At the global level, the main players (UNICEF, UNFPA and USAID) have focused on child and reproductive health commodities, with no single player focusing on MNCH commodities as a continuum.
- There are a number of private and non-state/ NGO agencies engaged in procurement of commodities – either managing procurements for large donor programs, or as outsourced to them by national governments, or as a part of their own organisational focus.

[4] The size of the circles is illustrative of the relative size of funding by the players. Please note that the circle size has not been estimated in any scientific manner, but is only to be interpreted as an indication of relative size. The information provided in this figure is primarily based on feedback on the focus and relative prominence of each player through stakeholder consultations, but also supported by annual funding figures for the key organisations (obtained from their websites/ annual reports).

Figure 2.3: Mapping of the key agencies for MNCH commodity procurement [5]



[5] The size of the circles is illustrative of the relative involvement of the organisation in MNCH commodity procurement. Please note that the circle size has not been estimated in any scientific manner, but is only to be interpreted as an indication of relative size. The information provided in this figure is primarily based on feedback on the focus and relative prominence of each player through stakeholder consultations, but also supported by procurement data obtained from the organisations' websites/ annual reports. The figure also draws on:
http://www.rhsupplies.org/fileadmin/user_upload/May_2008_meeting_Brussels/Update_to_RHSC_Brussels_FINAL__23_May_08_.pdf

3. KEY ISSUES AND POTENTIAL ROLES OF PARTNERS

Based on the mapping of commodity management functions and key actors, the following sections:

a) Present the main issues/ gaps in the MNCH commodity supply chain for discussion by the Partners.

b) Provide details of case studies from other areas of healthcare, especially RH commodity management, that may be relevant to the issues.

c) Offer initial views on (i) whether there might be potential for further Partner action and collaboration around some of the issues and, if so, what these might be; and (ii) the secondary question that relates to the potential role of PMNCH (if any) in each area.

d) Summarise the key conclusions from the Partners meeting in New York on 1st - 2nd October.

For each of the issues, we have drawn largely on the feedback from our consultations with various stakeholders. Before getting into the issues, we first draw readers' attention to two more general observations that inform the discussion of the issues.

3.1. General observations

3.1.1. Case for focus on MNCH commodities

We note that the timely availability and access of MNCH commodities at affordable prices is an essential component of delivering improved maternal and child care.

Although we have not identified specific studies that relate to the specific contribution of MNCH commodities to the MDGs4 and 5, there is anecdotal evidence on the significance of commodity security in maximising the likelihood of the impact of other health investments (such as systems strengthening and capacity building) in achieving the MDGs. For example:

- the impact assessment of the WHO and UNICEF spearheaded IMCI program (Integrated Management of Childhood Illnesses) highlighted the gaps in commodity management.
- the Matlabs project in Bangladesh raises issues of lower program impact on account of ignoring commodity supply issues.

Further, the establishment of organisations like GAVI focused on delivering vaccines to children in developing countries underlines the importance of essential commodities. In the case of vaccines in particular, there have been shortages in supply of certain new and underused vaccines such as the pentavalent DTP/ Hep B/ Hib vaccine, where the demand in countries far exceeded supply prior to GAVI's financing support. In addition, consultees have mentioned incidents of shortages of MNCH drugs (e.g. magnesium sulphate) in rural/ remote areas, often on account of poor transport/ storage

infrastructure in country obstructing the supply of commodities from the port to the door.

It has been interesting in particular to contrast MNCH with RH - where a consensus in the global health community was formed about the importance of commodity supply. This has reflected: (i) the existence of shortages and stock outs in many countries earlier in the decade; (ii) the nature of Reproductive Health which is more product-focused in terms of delivery (e.g. contraceptives, injectibles etc.), as compared to MNCH which requires high quality and accessible points of care that can provide both health services and medical supplies to mothers and children. However, our overall impression is that MNH is the poorer relation in terms of available evidence and studies on commodity related issues.

3.1.2. Commodity management and 'continuum of care'

We examine the implications of the 'continuum of care' approach on the commodity management cycle, in terms of (a) downstream supply to beneficiaries in countries, (b) upstream procurement from suppliers, and (c) support functions.

The 'continuum of care' approach to health service provision in countries reflects that there is often a single health service provider that treats mothers, newborn and children in a given geographical area. Therefore, managing MNCH commodities as a continuum at the national level could improve health outcomes significantly. Most of the stakeholders we have spoken to on this study emphasised the potential to streamline (and where possible, integrate)[6] deliveries of MNCH medical supplies in countries, in order to save costs, cut down lead times, and reduce the burden on the local health systems. It is also important to align the provision of medical supplies with the medical interventions and treatments, to ensure effectiveness of care.

However, this does not necessarily lead to a conclusion that procurement (as opposed to some of the downstream logistics components) should be integrated across the MNCH continuum. Indeed, this would depend on the range of qualified suppliers, their portfolio of products, location, as well as the mandates of the procurement agencies involved.[7] For example, as a consultee noted, often procurement is disaggregated by manufacturing location – for example, some products may be procured/ dispatched from Europe, others from India, and some others from Latin America. That said, as we discuss below, this does not preclude improving effectiveness and efficiency through collaboration and streamlining processes (e.g. cost-effective order placement and management; harmonised procurement approaches across donor agencies etc.).

Finally, the support functions of advocacy, information management, and financing are easily amenable to a 'continuum of care' approach - and indeed beneficial to do so -

[6] Whilst it may not be practical to integrate the supply of all MNCH commodities, effective commodity segmentation based on product or customer demand characteristics can help integrate the supplies of similar commodities to derive economies of scale and greater efficiencies in delivery.

[7] As noted in Section 2/ Figure 2.3, there are a wide range of actors involved in procurement activity; with mandates for different components of the MNCH continuum.

given the linkages between the global and national actors in this space and potential synergies to achieve MDGs 4 and 5.

4. ESSENTIAL MNCH COMMODITIES LIST

4.1. Do we need an essential list of MNCH commodities?

Given the number of different MNCH agencies, most consultees noted the need to develop a 'minimum package' of approved essential MNCH commodities. The main objective of agreeing such a commodity list are to:

- ensure international consensus and consistency between the essential medicines list of various donor agencies operating across the continuum of care;
- help the Partners focus on planning, financing, quality assurance, supplying and monitoring these essential products to the high burden countries;
- help facilitate negotiations with suppliers, determination of international prices, etc; and
- inform decisions about the allocation of scarce resources at global and country level to ensure that these minimum required commodities do not face any stock-outs.

It is important that any such packages are integrated with the countries' essential medicines list and supply chains, rather than create an additional burden on national health systems.[8]

4.2. Existing initiatives / Case studies

RH essential medicines list

A list of essential RH medicines has been approved by the UNFPA and WHO, which also helps guide the efforts of the RH Supplies Coalition.[9] In 2002, a study was initiated to compare the existing essential medicines lists of the various UN agencies, including (1) the 2002 draft UNFPA/ WHO list; (2) the Interagency UNFPA/ UNAIDS/ WHO Reproductive Health Medicines and Commodities List; and (3) the 13th WHO Model List of Essential Medicines of 2003. This study found a certain lack of consistency between various United Nations agencies on essential RH medicines, and identified 36 'discrepancy medicines' which figured on one list but not on another. This led to discussions among partners to re-align the various RH medicines list to develop the Interagency List of Essential Medicines for Reproductive Health (which is a sub-set of the WHO Model List of Essential Medicines).

[8] Countries would prefer to have an approved and common 'essential medicines list' across medical supplies and commodities, rather than 'vertically' focussed lists for MNCH, RH, Malaria, TB, HIV/ AIDS etc.

[9] The Interagency List of Essential Medicines for Reproductive Health 2006.

H4 MNH list (under development)

Since the creation of the H4 initiative in 2008,[10] we understand that its first focus activity has been to agree a master list of essential MNH commodities, which is currently being circulated amongst the agencies for approval and endorsement. Once approved, this list will be available publicly.

We note that the H4 list does not include child health medicines. In order to avoid duplication, it would be useful to draw on the consensus achieved among the H4 agencies on an integrated MNH list and to develop or add a similar essential medicines list for child care. This could then be shared among the wider MNCH partners/ stakeholders (e.g. health care professionals) for endorsement and use.

Core Packages of Interventions (PMNCH PA-2)

WHO and representatives of the health care professional organisations are currently working on an amended list of essential interventions – which takes account of delivery and health system constraints in high-burden countries.

MNCH commodity security and tools for advocacy

Our consultations highlighted the need for advocacy on essential products, depending on needs of countries/ beneficiaries. In order to tackle a similar problem in the RH arena, RHSC created a free, web-based tool targeted at RH workers in developing countries, and designed to raise awareness and foster policy change for increased commitment to RH supplies.

The toolkit provides a guide to advocacy communications and messages, five global supply shortage scenarios that can be customized to country needs, and a set of tools including power point presentations, policy briefs and fact sheets.[11]

4.3. Potential Partner and Partnership roles

There is a general consensus around the need to develop an essential list of MNCH medicines to avoid discrepancies across organisations that operate in this space. We understand that work is already underway by the H4 to develop an MNH list of essential medicines. Partners may therefore take a view on whether there is a case for:

- Including child health essential medicines to the MNH list developed by the H4 or agreeing a separate child health medicines list.
- Wider stakeholder engagement in the process to develop the 'minimum package' list, i.e. a short list of essential medicines that need to be prioritised and are an 'absolute must' in terms of delivery to countries and preventing stock-outs, or even a wider list from which countries can choose their essential MNCH medicines.

[10] Refer Annex 4 for details on H4.

[11] The Advocacy Guide and Toolkit is available at http://www.rhsupplies.org/guide-new.html

- Partner coordination and advocacy to ensure that the essential MNCH medicines list is aligned with the core package of MNCH interventions.
- Wide partner/ stakeholder support in advocacy for the integration of the essential list for MNCH commodities at the global and regional level, and in country planning and programming.

It is possible that PMNCH could play a role in making linkages with the work being undertaken by Partners under PA-2 on essential interventions.

There is also the possibility that PMNCH might support the partners in the wider advocacy piece in relation to a essential medicines list, although its global focus would tend to preclude activity that relates directly to country planning and programming. However, we see considerable value in PMNCH Partners engagement in the advocacy at national level e.g. through Health Professional Networks.

Partners' meeting conclusions:

- **It was agreed that it is not necessary or appropriate for Partners to duplicate existing work being carried out by H4 on commodities and by WHO on essential interventions.**
- **However, there is a potential role for PMNCH to support Partners in bringing together a wider group of stakeholders to agree both the intervention and commodity lists. There is also a clear role for PMNCH in supporting H4 and WHO in the advocacy needed to get the lists endorsed globally and nationally.**
- **More generally, Partners agreed that it would be appropriate for them to agree a short list of high-impact commodities that they could study to improve the evidence base on MNCH commodity supply (across the entire value chain, but with an emphasis on the global component). Identification of supply issues for these commodities would support future judgements about additional possible interventions discussed in the rest of this paper.**
- **It was agreed that the Partnership's focus commodities should be across the MNCH spectrum, although there was a recognition that there was perhaps more to be done in on MNH. Partners also noted that it should be possible to build on three planned Population Action International (PAI) country case studies to achieve this as well as to use existing sources.**

5. DEMAND FORECASTS

5.1. Is there a case for structuring interventions to improve commodity planning and forecasting in countries?

Reliable and timely demand forecasts for commodities is at the heart of planning their production, procurement and supply in the right quantities and at affordable prices. Demand estimation and forecasting is typically the responsibility of national or local governments (depending on the extent of decentralised health services).

However, often inadequate capacity in terms of untrained staff, limited financial resources, and poor planning/ systems (for example, lack of appropriate tools to facilitate estimation) in countries hinder the aggregation of medical requirements across the country and the development of these forecasts. The absence of complete and systemised baseline information is also a constraining factor in preparing forecasts. Sometimes, donor programs assist national governments in forecasting and planning supplies of essential commodities (e.g. GAVI encourages/ helps countries develop long-term forecasts of vaccine requirements).

Poor demand forecasts could lead to overall supply shortages, and inefficient deployment of limited resources. In addition, without reliable demand estimates, private pharmaceutical companies are not assured of a viable market, and therefore tend to under-invest in production capacity for essential commodities, and are reluctant to commit to costly clinical trials and other R&D activities to develop new products.

5.2. Existing initiatives/ Case studies

There are a wide range of activities being undertaken by Partners. We have not captured all of these here, but provide a flavour of some of the initiatives or pieces of work that we have come across as part of our consultations.

AMDS (Aids Medicines and Diagnostic Service)

AMDS (hosted in WHO) acts as clearing house collecting and disseminating strategic information through Global price reporting mechanism, Drug regulatory data database, and ARV forecasting.

It also has a dedicated website for procurement and supply management (PSM) tools.[12] This website is a repository of tools with a search engine intended to support the selection of the appropriate tool by procurement and supply management area, disease/ reproductive health, commodity and level of use.

[12] http://www.psmtoolbox.org/en/

The Global Health Forecasting Working Group

In early 2006, the Center for Global Development convened the Global Health Forecasting Working Group to study the challenges surrounding demand forecasting.[13] After a year of research and consultations, the group recommended the following three actions:

- *Improving the capacity to develop credible forecasts*: Logistics management software and assistance from technical agencies to help countries to improve their forecasting. [14]
- *Mobilising and sharing information in a coordinated way through the establishment of an 'infomediary'* – the GHFG note the vast amount of data collected by different stakeholders such as global health partnerships, governments, private companies, etc and the need of an 'infomediary' to serve as a central data repository.
- S*haring risks and aligning incentives through a broader range of contractual arrangements* – mechanisms such as minimum purchase commitments, quantity flexibility contracts, buyback contracts, revenue sharing, etc., that can help to better align incentives for information collection and sharing of risks.

We are not aware that this working group has continued.

Others

There has been some work in the area of technical support for demand forecasting/ pipeline tools – particularly for RH commodities – including:

- UNFPA's 'Country Commodity Manager'[15] – a computer based program to assist country offices in their efforts to assess their reproductive health commodity requirements, stock positions, and possible shortfalls.
- USAID/ UNFPA's Strategic Pathway to Reproductive Health Commodity Security (SPARCHS)[16] – a tool to help countries develop and implement strategies to secure essential supplies for family planning and reproductive health programs and is meant to bring together a wide range of stakeholders. SPARCHS can be customized to a country's specific needs and resources.

In addition we note the following:

- the World Bank is looking to develop a more universal tool for all health commodities in general.
- UNFPA is also working as part of its thematic funds to develop a toolkit for national strategic planning.

[13] More information can be obtained from http://www.cgdev.org/section/initiatives/_active/demandforecasting/

[14] The Global Health Forecasting Group identifies 10 basic principles for demand forecasting, including customer-focused, process and context focused, and methodology and data focused principles.

[15] Available at http://www.unfpa.org/upload/lib_pub_file/301_filename_ccm.pdf

[16] Available at http://www.maqweb.org/sparhcs/

- More generally, IHP – Working Group on Costing for Health Systems has carried out harmonisation work on health system costing tools. See particularly the PMNCH link.[17] We understand there may also be a Working Group related specifically to demand forecasting for commodities.

5.3. Potential Partner and Partnership roles

Further work is necessary to understand the range of work being undertaken by Partners in the area of improved MNCH commodity forecasts. However, subject to discussion, potential areas where Partners may wish to work together are as follows:

- Developing a harmonised tool-kit/ models that supports national health programs in forecasting demand for MNCH commodities (e.g. building on the PSM toolbox produced by AMDS). For example, there may be a tools that can help collate and estimate demand and stocking information on various products from different parts of a country. Another example might be the provision of up to date baseline data by country (and where possible by region), together with a pro-forma spreadsheet model for forecasting.
- Alternatively, to the extent that such demand forecasting tools exist there is a case for global, regional and national advocacy relating to their use and the importance of timely and reasonable forecasts to support MNCH commodity security.
- Product specific advocacy and training to help generate and forecast demand (as consumer usage and requirements vary by product).

The existence of a role here for PMNCH depends on Partners' discussion of the above points. We also note that there may be important lessons to be derived from PMNCH's previous support to the IHP Working Group on the process of harmonising the range of costing tools that currently exist.

Partners' meeting conclusions:

- **It was agreed that there was a considerable amount of existing work in the area, including by AMDS. However, it was agreed that there is value in carrying out a more detailed review of the existing tools to ensure coverage as well as to identify possible areas for improvement (harmonisation). Partners noted the importance of assessing whether and how the tools are being used at the national level.**
- **Partners noted (i) that there is a clear link with PA-1; and (ii) the output of any work here might feed into a possible IHP working group in due course, if appropriate.**

[17] http://www.who.int/pmnch/topics/economics/costing_tools/en/

6. SUPPLY CHAIN INFORMATION MANAGEMENT

6.1. Is there a need for greater visibility of information on MNCH commodity procurement and financing?

Effective commodity management is inhibited by the lack of relevant and timely information on suppliers, prices, quantity available, delivery status of ordered commodities, etc. For example, if there is timely information provided on possible stock-outs of commodities in a country, donors/ governments could try and secure alternate supplies through emergency procurement, re-scheduling shipments, fast-tracking new orders, etc.

Similarly, easy-to-access information on pre-qualified suppliers and commodity prices can help national governments manage their own procurement better. Multilateral procurement agencies such as UNICEF and UNFPA have the benefit of approved suppliers, as well as the technical expertise and volumes to negotiate good prices. National governments have lesser capacity and often, there are considerable delays in procurement as governments spend time and resources to seek out suitable suppliers and negotiate affordable prices.

There is therefore a need for greater transparency and visibility in the flow of commodities and finances through the supply chain at global and country levels.

6.2. Existing initiatives/ Case studies

RHInterchange

Consultees have cited the fragmented nature of donor efforts and inadequate information sharing as significant impediments to having an effective commodity supply chain management system. In order to achieve easier tracking of supplies, the RHSC and its members have created a free, web-based tool called RHInterchange.[18]

Containing information on past, present and future contraceptive supply orders for 144 countries, RHInterchange collects contraceptive procurement and shipment information from UNFPA, the International Planned Parenthood Federation (IPPF), and USAID. These three organizations make up about 60% of the world's donated contraceptive supplies.

The intended users of RHInterchange are a variety of decision makers including Ministry of Health officials in donor recipient countries, service delivery organizations, procurement planners and donor agencies. By providing real-time supply information to its users, RHInterchange aims at better coordination and planning of RH commodities.

Countries-at-Risk Group

Along with RHInterchange, RHSC also created the Countries-at-Risk (CAR) group in order to facilitate commodity supply information flow between stakeholders. This group

[18] RHInterchange is available at http://rhi.rhsupplies.org/rhi/index.do?locale=en_US

brings together the representatives from the world's leading RH commodity suppliers. Coordinated by the RHSC Secretariat, the group members include UNFPA, USAID, the World Bank, RHInterchange, and KfW. At its monthly meetings, the organizations share information on central contraceptive stock levels in priority countries, identify any impending stock imbalances/shortages, develop solutions (such as organizing emergency shipment or bringing forward planned shipments), and implement these solutions where possible.

Depending on the countries under review, other organizations such as DFID, IPPF and Crown Agents also take part in the discussions.

6.3. Potential Partner and Partnership roles

In our view, the activity of the RHSC in improving information available on RH commodities provides a good example of what might be done across the MNCH space. There is therefore a case for Partners to consider what if anything might be done to replicate what is currently undertaken by the RHInterchange (to develop an online easy-to-access database on MNCH supplies, quantities and prices in terms of orders, shipments etc.) and CAR (which tracks commodity stocks and issues red flags before stock-outs in high burden countries). A similar information portal could be helpful on financing flows for MNCH commodities to identify any financing gaps, and undertake advocacy to mobilise additional resources.

We do not have a view about whether or not this is feasible or indeed whether it makes sense to set up new initiatives or work with RHSC to expand these initiatives to include MNCH commodities. However, our view is that this global information provision role would be consistent with the operating model of a partnership type organisation such as PMNCH (it also has some fit with PA-1 on knowledge management).

It was also suggested that supply chain information may be facilitated through country-level case studies commissioned by the Partners – especially in the context of the dearth of these types of studies at present (see Annex 6 which summarises a few of the available studies).

Partners' meeting conclusions:

- **It was agreed that the case studies on high-impact commodities would consider whether information management is a material issue that requires additional interventions (e.g of the kind existing for RH).**

7. PROCUREMENT EFFICIENCY

7.1. Are there ways in which improved coordination of procurement among agencies could improve efficiency?

There are no integrated agencies or programs addressing the commodity requirements of the continuum of care as a whole. As discussed in Section 3.1 above, we do not see this as a problem per se. However, the fact that there are multiple agencies involved in the financing and procurement of MNCH commodities suggests that there may be potential to improve collaboration, information exchange and efficiency. Possible areas for consideration include:

- *More centralised/ aggregated procurement.* For example, GAVI's procurement of vaccines is centralised through UNICEF – as an approved procurement agency - with the products being delivered directly to the countries, as against giving them funding. This contrast with the approach used by the Global Fund which provides funding to the recipient countries for procuring commodities through their own processes (or through contracting third party procurement agents). Our presumption is that procurement is an activity that does exhibit economies of scale and that there is potential for improved prices and processes through centralisation where appropriate. However, we note that there are different views on this.

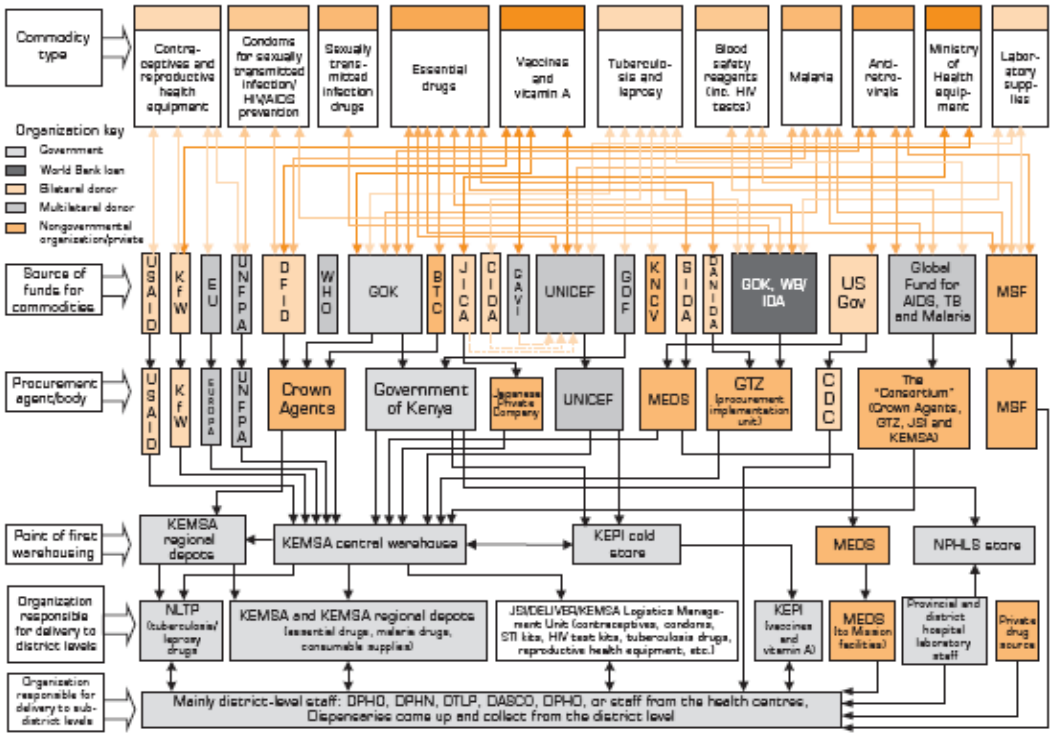
- *More co-ordination at the Global level:*. For example, both UNFPA and UNICEF engage in the procurement of medical equipment and some essential MCH drugs. Greater specialisation may improve efficiency and bargaining power with the suppliers, and also prevent additional costs of multiple procurement channels for the same commodity.

- *Harmonised procurement methods.* There are a range of procurement approaches followed by different donor agencies, including national/ international competitive bidding for each order, pooled procurement, framework contracts, supplier long term agreement etc. Further, some countries have additional procurement rules and procedures, which need to be synchronised with donor processes when the latter are involved in financing and/ or procuring health commodities. Consultees have quoted instances of procurement delays due to differences among donor agencies on a suitable procurement approach to adopt. At times, it may be necessary to speed-track procurement for essential and urgent supplies, rather than follow a circuitous two-stage bidding process.

- *Better coordination of donor agency procurement requirements.* Dealing with the specific requirements of different agencies results in higher transactions costs for countries, and imposes a burden on their limited health systems infrastructure/ human resources. The complexity of multiple players and supply chains is illustrated by the example of Kenya in Figure 7.1 below. We note that some agencies are engaged in joint programming in a few countries, in order to achieve

synergies through harmonised operations on common areas of interest/ expertise.

Figure 7.1: Commodity logistics systems in Kenya



Source: Steve Kinzett, reproduced from Global Health Forecasting Group Report, 2007

7.2. Existing initiatives/ Case studies

Supply Chain Management System

Established in 2005 and funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Supply Chain Management System (SCMS) brings together 13 private sector, non-governmental and faith-based organisations that operate in the areas of supply chain management and international public health and development. SCMS has field offices in 16 countries, 13 of which are in Sub-Saharan Africa.

The aim of SCMS is to strengthen supply chain systems to deliver an uninterrupted supply of high-quality, low-cost HIV/AIDS commodities[19]. In order to achieve its mission, SCMS employs a range of strategies, which include:

- Aggregating procurement across many countries through longer-term supplier contracts, in order to leverage economies of scale
- Using regional distribution centres (RDCs) in Ghana, Kenya and South Africa for efficiency and cost savings

[19] The commodities include ARV drugs, medicines for opportunistic infections such as TB, rapid HIV test kits, laboratory equipment and medical supplies.

- Improving availability and use of logistics information
- Monitoring global quantification of needs and coordination of efforts
- Providing technical assistance to improve local supply chains

Through a combination of pooled procurement, generics purchases and the establishment of long-term, indefinite quantity contracts with manufacturers, PEPFAR and SCMS have secured low prices for ARVs. For example, in Rwanda, they achieved cost savings of 23 percent compared with previous orders, which was enough to potentially treat 3,000 more adults for one year.

The RDCs ensure a rapid supply of frequently-requested commodities and have helped avert a number of stock-outs. For example, in May 2007, the Kenya RDC supplied two months' worth of ARVs to Mozambique which was experiencing a severe ARV shortfall due to delays from its supplier.

SCMS also provides an e-catalogue on its website which provides a list of products available and price estimates for many items.[20]

AccessRH

Various studies commissioned by the RHSC determined that many of the issues associated with suboptimal pricing/ delivery terms and the variability of product quality of RH commodities were due to the fragmented way in which procurement was undertaken.

To address these inefficiencies, RHSC spearheaded efforts to design a new procurement mechanism called AccessRH. As presented in Figure 7.2, this mechanism was initially envisaged to work in three steps.

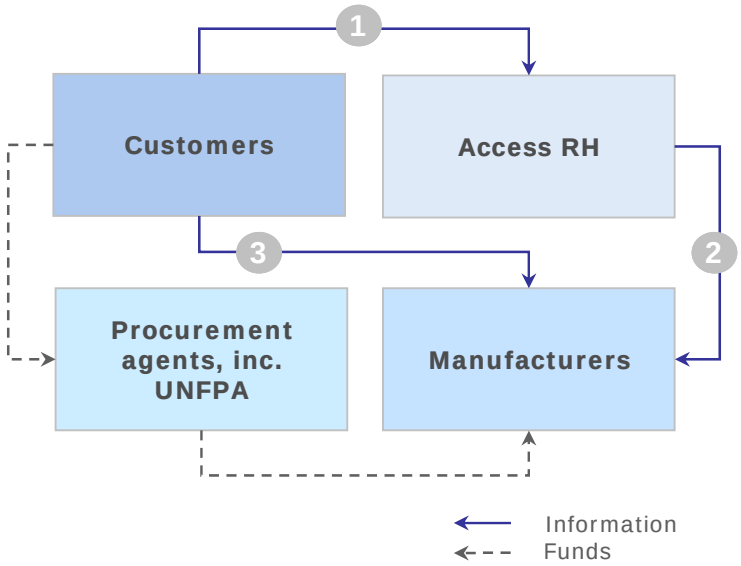
- In step 1, recipients of donor funding provide demand forecasts outlining the minimum quantity of supplies they are committed to buying and the maximum amount they anticipate to buy.
- In step 2, the AccessRH administration establishes framework contracts with manufacturers where it guarantees minimum volumes.
- In step 3, funding recipients access these framework contracts using any procurement channel they see fit.

By increasing the number of potential buyers, aggregating demand, and providing upfront commitments to the manufacturers, AccessRH is expected to yield lower unit prices, which was expected to be particularly beneficial for smaller-scale buyers.

We understand, that the final structure for the initiative **now focuses on UNFPA alone and does not allow countries to access the framework contract through third-party procurement agents.**

[20] The e-catalogue can be accessed at http://scms.pfscm.org/scms/ecatalog

Figure 7.2: Initial AccessRHStructure



Source: RHSC and Dalberg Global Development Advisors 2008

7.3. Potential Partner and Partnership roles

In our view, there is a strong case for pursuing initiatives that seek to improve efficiency of procurement for MNCH commodities. As noted above, there are a range of ways in which this might be achieved. We think that increased collaboration and information exchange between partners, say through joint programming, is one option to achieve this.

We note the role played by the RHSC in facilitating the Partners work to develop the AccessRH project. In our view, this provides one potential model for taking forward an assessment of areas to improve procurement efficiency.

Partners' meeting conclusions:

- **It was agreed that the case studies on high-impact commodities would consider whether there is a case for additional interventions to improve procurement efficiency.**

8. FINANCING AND AFFORDABILITY

8.1. Is there a need for additional financing mechanisms for MNCH commodities?

Recipients of donor funding often need to wait for such funding to materialize before undertaking any commodity procurement. This may lead to a situation where a country is aware that it is running low on supplies but cannot purchase them due to a lack of funds.

Similarly, the prices of several commodities delivered to countries are not affordable to the beneficiaries. Countries often seek donor financing support through grants or negotiations/ agreements with commodity suppliers to be able to 'subsidise' the cost of essential commodities.

8.2. Existing initiatives / Case studies

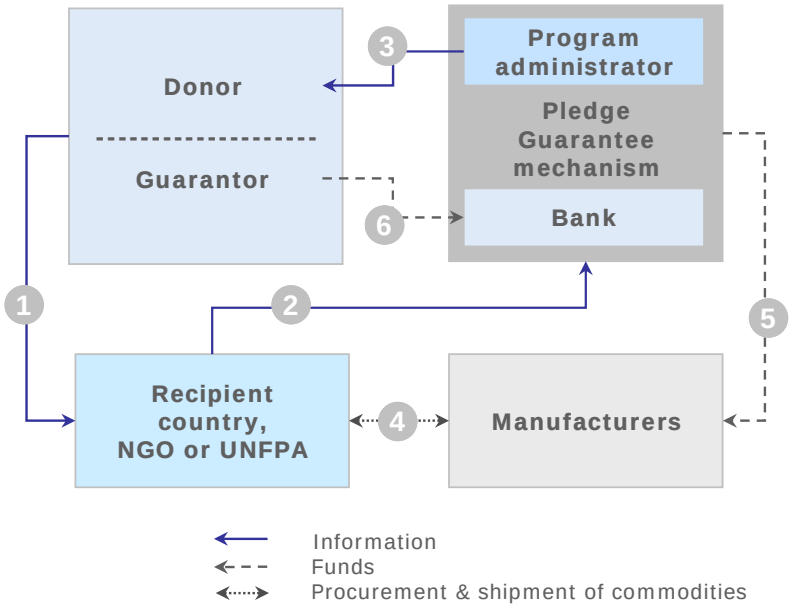
Pledge Guarantee for Health

RHSC members have developed a financing mechanism called the Pledge Guarantee for Health (PG) which allows donor recipients to obtain commercial credit by using their pending donor pledges as collateral. Hence, PG is expected to smooth out the lumpy nature of donor funding and to introduce more predictability into funds available for commodity purchase, leading to fewer emergency shipments, fewer stock-outs, and reduced cost of capital for the recipients.

As presented in Figure 8.1, the PG mechanism works through six steps.

- First, the donor makes a pledge to a specific recipient.
- The recipient then notifies the PG mechanism that it would like to obtain a loan against the donor's pledge.
- In the third step, the PG mechanism confirms the pledge with the donor and makes an agreement with the donor on the interest it needs to pay for the period between the credit extension and the realisation of the donor funding.
- Assuming such an agreement is reached with the donor, the PG mechanism notifies the recipient country that the credit has been granted.
- The country then undertakes product procurement and the PG mechanism pays the manufacturer.
- When the donor is ready to pay its pledge, it deposits the funds directly into the PG mechanism.

Figure 8.1: Pledge Guarantee Structure



Source: RHSC and Dalberg Global Development Advisors 2008

The design stage of this initiative has been completed and the UN Foundation has been assigned responsibility for implementation. The PG is expected to be launched in the first quarter of 2010.

Affordable Medicines Facility - malaria (AMFm)

Affordable Medicines Facility – malaria (AMFm) is a financing mechanism designed to expand access to affordable artemisinin-based combination therapies (ACTs) for malaria[21]. The AMFm is hosted by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), with key financial support provided by UNITAID, the United Kingdom, and potentially others, with technical support provided by members of the Roll Back Malaria Partnership (RBM).

AMFm's goals are to save more lives by making ACTs more available and affordable, and to slow down resistance by reducing the use of artemisinin-based monotherapies and increasing the use of ACTs. AMFm aims to achieve these goals by reducing consumer prices of ACTs through price negotiations and a buyer co-payment, and by introducing in-country supporting interventions.

The Global Fund, as the host and manager of the AMFm, is negotiating with the drug manufacturers to lower the price of ACTs, with the condition that the price must be the same for public and private sector first-line buyers[22]. The Global Fund will then pay a proportion of this reduced price (called a 'buyer co-payment') directly to the

[21] More information is available at http://www.theglobalfund.org/en/amfm/

[22] These first-line buyers include international, regional or national buyers from the public, private or non-profit sectors. They may either procure the ACTs directly from the manufacturer or employ a procurement agent to purchase drugs on their behalf.

manufacturer, which allows the first-line buyers to pay only the remainder of the sales price. These first-line buyers are expected to pass on a proportion of this price reduction to patients, which is expected to lower the price of ACTs from about US$ 6-10 per treatment to US$0.20-0.50 for patients.

The AMFm is to be introduced in a phased manner in up to 11 countries between 2009 and 2011.

The Clinton HIV/AIDS Initiative (CHAI)[23]

In an effort to stabilise and reduce the prices of the leading treatments for malaria and HIV/AIDS, CHAI has reached agreements with suppliers of ACTs and ARVs, which establish price ceilings for these commodities. To access the terms of these agreements, a country must be one of the 70 members of CHAI's Procurement Consortium. Countries should reference their status as consortium members when issuing tenders for the commodities and are expected to notify CHAI if they are offered a price above the agreed ceiling by one of the partner suppliers.

CHAI's negotiations with HIV/AIDS drug suppliers have taken place in collaboration with UNITAID. Under this partnership, CHAI procures the drugs at agreed prices using UNITAID funds. The drugs are then supplied to 42 beneficiary countries through two projects funded by UNITAID and implemented by CHAI. Cumulatively, since the start of their partnership in 2006, CHAI and UNITAID have reduced prices by an average of 64 percent for leading paediatric regimens and 43 percent for leading adult ARV regimens in low-income countries.

8.3. Potential Partner and Partnership roles

On the basis of this short study, we are not in a position to make a judgement as to whether there is further work by Partners that needs to be done to support financing of MNCH commodity procurement. However, we note that both the Pledge Guarantee and Affordable Medicines Facility are good examples of the types of collaborative mechanisms that might be worth considering.

The role of PMNCH (if any) might be in supporting Partners to carry out relevant studies (similar to those carried out by RHSC for the Pledge Guarantee), and if necessary and feasible, to support (through for example, commissioning independent experts) the Partners in the structuring and design of any implementation. Similar to the Pledge Guarantee, we believe that any such intervention is best implemented through a Partner organisation.

Partners' meeting conclusions:

- **It was agreed that the proposed case studies on high-impact commodities would consider whether there is a case for additional interventions to improve financing and affordability.**

[23] "Overview of New ACT Pricing for CHAI Procurement Consortium", The Clinton Foundation, 2008.

9. SUPPLY CONSTRAINTS

9.1. Are there supply issues relating to existing and new/ under-used MNCH commodities?

9.1.1. Existing commodities

It often takes up to five years or more to obtain WHO pre-qualification for health products and then further time for pre-qualification of suppliers. Most donors would not look beyond qualified suppliers to source essential commodities. This can result in supply-side bottlenecks, especially where the need and demand for the product is high.

For example, we were informed that there is only one German supplier that has passed WHO's pre-qualification procedure for hormonal contraceptives. Such a monopoly situation is likely to lead to undesirable prices and supply shortages across countries in need. Some of the consultees emphasised the need for flexibility to procure from approved 'generics' manufacturers, at least for stable, low-value and routine commodities where demand outstrips supply.

9.1.2. New and underused commodities

In the area of vaccines, there has been a particular concern that the absence of markets has meant that the private sector do not have the incentive to invest in research and product development/ or manufacturing infrastructure for particular products. One of the responses of the global health community (through the GAVI Alliance) has been to look at the potential of Advance Market Commitment mechanisms (see below). A question for the Partners is whether there are new or underused commodities in MNCH that may require similar impetus mechanisms to mobilise private financing in R&D/ manufacturing capacity.

9.2. Existing initiatives/ Case studies

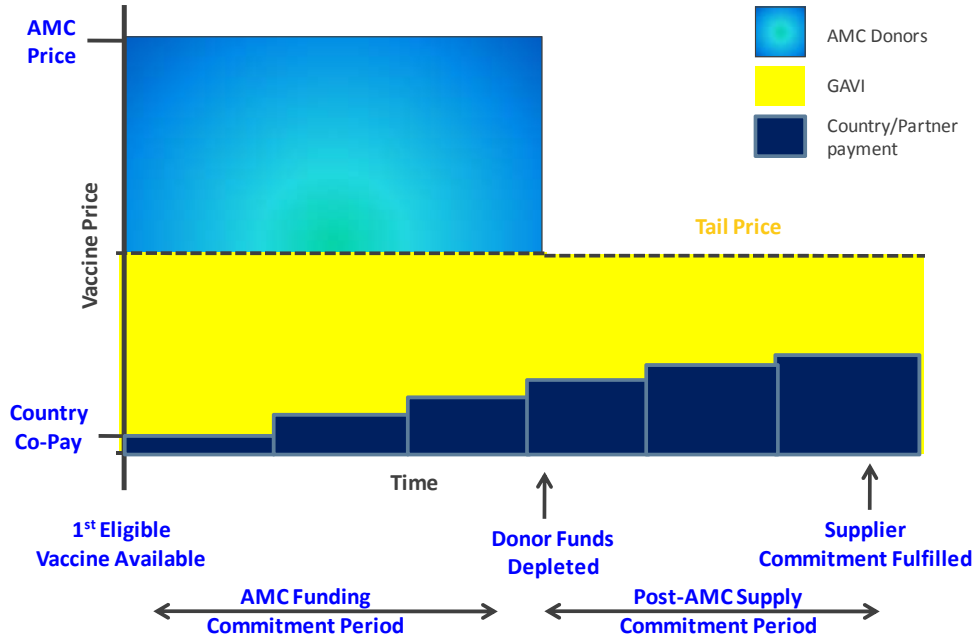
Advance Market Commitments (AMCs)

Spearheaded by the GAVI Alliance, AMCs is a funding mechanism designed to address market failures of low and uncertain demand from developing countries that inhibit investments in the development and supply of new vaccines. Through AMCs, donors commit money to guarantee the price of vaccines once the market is developed, and hence create the potential for a viable future market. These donor commitments are intended to provide the incentive for vaccine manufacturers to invest the considerable sums required to undertake research and development, hire and train staff, and build manufacturing facilities. The vaccine manufacturers willing to take advantage of AMCs make a legally-binding commitment to provide the vaccines at low prices after the donor funding made available for the initial fixed price is used up.

In June 2009, the GAVI Alliance partners (World Bank, UNICEF and WHO), along with the Gates Foundation and the Finance Ministers of Italy, UK, Canada, Russia and

Norway, activated the AMC pilot project against pneumococcal disease. The AMC agreement is currently being bid out to interested suppliers. The structure of this AMC pneumococcal vaccine pilot is presented in Figure 9.1 below.

Figure 9.1: Pneumococcal vaccine pilot



Source: AMC Factsheet, GAVI Alliance, 2009

The AMC price has been set at US$7 per dose during the 10-year AMC period. US$3.50 of this will come from AMC donor commitment and US$3.50 will be provided by GAVI and country co-payments. Some of the US$1.5bn AMC donor commitment will also be used to underwrite a portion of the volume demand: 20%, 15% and 10% of the annual production in the first, second and third years respectively. No volume demand is provided in the remaining seven years of the AMC contract.

Once the AMC funding commitment period is over, the manufacturer will be obliged to sell the vaccine at the US$3.50 tail price for an agreed time period.

9.3. Potential Partner and Partnership roles

Based on the study to date, we do not have a view as to whether there is more for Partners to do on existing and new/ or underused commodities in the MNCH. One issue to discuss is how Partners may be able to facilitate speedier pre-qualification of products/ suppliers, where this is feasible; and if more information etc. is required to be shared among the H4 and other agencies to facilitate this. This is an issue for Partners to discuss in New York.

However, when the area of commodities was initially discussed by the PMNCH Board members, our understanding was the UNICEF's interest related to whether there was a

case for the Partners to work together to study / and then advocate for the use of AMC-type mechanisms for MNCH commodities.

Partners' meeting conclusions:

- **It was agreed that the proposed case studies on high-impact commodities would consider whether there is a case for additional interventions to improve any identified supply side constraints.**

10. HEALTH SYSTEM CAPACITY

10.1. Is there additional support that the Partners can offer to improve capacities of national health systems as they relate to MNCH commodities?

Many consultees felt that the real issues to address in the MNCH commodity supply chain begin after customs clearance in countries. Unless the procured commodities are delivered to the ultimate beneficiaries on time, improvements in upstream procurement systems will not achieve their purpose.

Annex 6 provides a limited number of case studies that we have reviewed in this area. However, key capacity issues in countries include:

- Limited resources for capital and recurring expenditure to improve healthcare services and provision of medical commodities.
- Poor health systems, such as an absence of health logistics and related information systems, weak health planning/ budgeting process by national governments, etc.
- Lack of supporting infrastructure, including warehouses, cold storage, port facilities, roads for transportation, etc. to ensure that the commodities reach the beneficiaries, especially in far flung and rural areas.
- Poor human resource capacity and lack of training of public health workers on the appropriate handling and use of many MNCH commodities.
- Lack of effective leadership and governance, and issues of corruption, disrupting timely supply of commodities.

10.2. Existing initiatives/ Case studies

Several donors and global partnerships now invest in health systems strengthening in parallel with other commodity or healthcare initiatives, to address some of the above constraints. We do not seek to summarise them here as they will be well known to the participants.

10.3. Potential Partner and Partnership roles

This is a potentially vast area of activity and the importance of improving human capacity in country cannot be overstated. However, although we see improved Partner coordination on their various Health Systems Strengthening initiatives as an important part of this, the national focus of these activities suggests that it is (i) only likely to be a focus for Global Partners to the extent that their commodity procurement activity impacts on national health systems; and (ii) unlikely to be a focus for Partners in the context of PMNCH.

Partners' meeting conclusions:

- **The importance of national action to improve integration and effectiveness of commodity supply as part of wider improvements in health systems was emphasised by Partners.**
- **It was also noted that Partners need to think separately about global action that could improve commodity issues at the national and global levels. (in contrast to the emphasis in Section 9.3 above).**

11. NON-STATE ACTORS

11.1. Is there more that should be done to recognise the role of non-state actors and engage them in delivering MNCH commodities?

Non-state actors including the formal and informal private sector, NGOs, social marketing companies, etc. play an important role in health care delivery and advocacy in general, and MNCH healthcare provision and commodity supply in particular.[24] However, their role is often not actively recognised by country governments and many of the donor agencies/ global health partnerships. Therefore, their contributions are generally 'outside' of the national health systems rather than being integrated within the country's overall health planning and budgeting process.

A major requirement of integrated and streamlined MNCH procurement systems is to recognise the role of these non-state actors, especially at community levels and in difficult-to-reach areas, so that demand forecasts for essential commodities and supply planning can take account of their needs and delivery systems. Also, any training or technical assistance related to essential medicines or effective interventions need to include these non-state actors who carry out advocacy and 'last mile' healthcare delivery in several countries.

11.2. Existing initiatives/ Case studies

We recognise that agencies such as the USAID explicitly include private and non-state actors in their MNCH programs. For example, the USAID Strengthening Pharmaceutical Systems (SPS) project aims to improve the availability of medicines/ health commodities (across maternal/child health, TB, HIV/AIDS, and malaria programs) of assured quality for priority interventions and promote their appropriate use. The project specifically includes 'support for enhanced use of the private sector for the provision of pharmaceutical services by designing innovative approaches and mechanisms for improved access to medicines and services, including the establishment and monitoring of standards for pharmaceutical care'.

Also, global health partnerships such as GAVI, GFATM, and PMNCH include NGOs/ CSOs as a constituency in their membership (and governance) and actively seek ways to involve and support them in their activities. GAVI also includes the private sector pharmaceutical industry (representatives from OECD and developing countries) in their membership, given its focus on vaccines. This constituency contributes to developing strategies and financing mechanisms to ensure vaccine security in countries (subject to conflict of interest policies). GAIN has also been noted for its engagement of the private sector in delivering improved nutrition outcomes.

[24] "Around 60 percent of health care financing in Africa comes from private sources, and about 50 percent of total health expenditure goes to private providers." IFC – The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives.

11.3. Potential Partner and Partnership roles

We have not identified particular activities for the Partners of the Partnership in this area. We understand that PMNCH is evaluating possible roles for and better engagement of non-state actors across its PAs.

Partners' did not discuss this issue specifically.

12. SUMMARY AND CONCLUSIONS

This short study has sought to map the activities of existing Partners in the MNCH commodity space; and then to identify areas or issues where there is a case for further work by Partners. As part of the work we have also offered some observations about the potential role of PMNCH in this context. Table 12.1 over page summarises the main issues and observations and links these to the relevant Priority Action Area outputs in PMNCH's 2009-11 Strategy and Workplan (also reproduced in Annex 1 for ease of reference). We have also updated this table to reflect Partner discussions at the New York meeting.

Table 12.1: Summary and conclusions

Issue / Area	Role of Partners	PMNCH	PA Output
Essential MNCH commodities list	General consensus around the need to develop an essential list of MNCH medicines. Work underway by H4. Key issues: • Inclusion of child health list • Wider stakeholder engagement and alignment with core package of MNCH interventions (PA-2) • Advocacy for integration into country planning and programming.	Possible roles: • Facilitation of wider stakeholder engagement and alignment with core-package work. • Support for the partners in Advocacy at global level • Partners engagement (with PMNCH support) in the advocacy at national level e.g. through Health Professional Networks.	Output 1 OVIs 1.1, 1.2 Output 3 OVIs 3.1, 3.2
	Partners' meeting conclusions: • Not necessary or appropriate for Partners to duplicate existing work being carried out by H4 on commodities and by WHO on essential interventions. However, potential role for PMNCH to support Partners in bringing together a wider group of stakeholders to agree both the intervention and commodity lists. Also, a clear role for PMNCH in supporting H4 and WHO in the advocacy needed to get the lists endorsed globally and nationally. • Partners to agree a short list of high-impact commodities that they could study to improve the evidence base on MNCH commodity supply (across the entire value chain, but with an emphasis on the global component). Identification of supply issues for these commodities would support future judgements about other additional possible interventions (see below). • Partnership's focus commodities should be across the MNCH spectrum, although there was a recognition that there was perhaps more to be done in on MNH.		

Issue / Area	Role of Partners	PMNCH	PA Output
Demand forecasting	Further work necessary to understand full range of work being undertaken. Possible areas of collaboration: • harmonised tool-kit / models that support national health programmes in forecasting demand • global and national advocacy relating to their use and the importance of forecasts • product specific advocacy and training to help generate and forecast demand	The existence of a role here for PMNCH depends on Partners' discussion of the possible areas of collaboration. We also note that there may be important lessons to be derived from PMNCH's previous support in the process of harmonising the range of costing tools that currently exist.	Output 2 OV1 2.1
	Partners' meeting conclusions: • It was agreed that there was a considerable amount of existing work in the area, including by AMDS. However, it was agreed that there is value in carrying out a more detailed review of the existing tools to ensure coverage as well as to identify possible areas for improvement (harmonisation). Partners noted the importance of assessing whether and how the tools are being used at the national level. • Partners noted (i) that there is a clear link with PA-1; and (ii) the output of any work here might feed into a possible IHP working group in due course, if appropriate.		
Supply chain information	RHSC activity provides a good example of what might be done across the MNCH space (e.g. RHInterchange, Countries at Risk project) Case for new initiative or for RHSC to expand its existing initiatives might be explored. Case for commissioning of country-level case studies by Partners.	Global information provision role would be consistent with the operating model of a partnership type organisation such as PMNCH (it also has some fit with PA-1 (on knowledge management)	
	Partners' meeting conclusions: It was agreed that the case studies on high-impact commodities would consider whether information management is a material issue that requires additional interventions (e.g of the kind existing for RH).		

Issue / Area	Role of Partners	PMNCH	PA Output
Procurement Efficiency	In our view there is a strong case for pursuing initiatives that seek to improve efficiency of procurement for MNCH commodities - increased collaboration and information exchange between partners, say through joint programming, is one option to achieve this. We note the role played by the RHSC in facilitating the Partners work to develop the AccessRH project. There is perhaps a case for a full review of areas to improve procurement efficiency across MNCH.	It is not obvious to us that PMNCH currently has particular expertise to offer this facilitation to Partners already engaged with PMNCH procurement.	Output 4 OV1 4.1
	Partners' meeting conclusions: It was agreed that the case studies on high-impact commodities would consider whether there is a case for additional interventions to improve procurement efficiency.		
Financing	On the basis of this short study we are not in a position to make a judgement as to whether there is further work by Partners that needs to be done to support financing of MNCH commodity procurement. Examples include the Pledge Guarantee and Affordable Medicines Facility.	The role of PMNCH (if any) might be in supporting Partners to carry out relevant studies (similar to those carried out by RHSC for the Pledge Guarantee), and if necessary and feasible, to support (through for example, commissioning independent experts) the Partners in the structuring and design of any implementation.	Output 4 OV1 4.1
	Partners' meeting conclusions: It was agreed that the proposed case studies on high-impact commodities would consider whether there is a case for additional interventions to improve financing and affordability.		

Issue / Area	Role of Partners	PMNCH	PA Output
Supply Constraints	Based on the study to date, we do not have a view as to whether there is more for Partners to do on existing and new / or underused commodities in the MNCH. One issue to discuss is how Partners may be able to facilitate speedier pre-qualification of products/ suppliers, where this is feasible; and if more information etc is required to be shared among the H4 and other agencies to facilitate this.	We note that when the area of commodities was initially discussed by PMNCH Board members, our understanding was the UNICEF's interest related to whether there was a case for the Partners to work together to study / and then advocate for the use of AMC-type mechanisms for MNCH commodities.	Output 4 OV1 4.1
	Partners' meeting conclusions: It was agreed that the proposed case studies on high-impact commodities would consider whether there is a case for additional interventions to improve any identified supply side constraints.		
Health System capacity	This is a potentially vast area of activity and the importance of improving human capacity in country cannot be overstated. However, although we see improved Partner coordination on their various Health Systems Strengthening initiatives as an important part of this, the national focus of these activities suggests that it is unlikely to be a focus for Partners in the context of PMNCH.		
	Partners' meeting conclusions: • The importance of national action to improve integration and effectiveness of commodity supply as part of wider improvements in health systems was emphasised by Partners. • It was also noted that Partners need to think separately about global action that could improve commodity issues at the national and global levels.		
Non-State actors	Nothing identified. We understand that PMNCH is evaluating possible roles for and better engagement of non-state actors across its PAs.		
	Partners' did not discuss this issue specifically.		

ANNEX 1: DETAILS ON PA-3 OUTPUTS, OVIS, TIMELINES AND BUDGETS

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action EC (3): Essential MNCH Commodities are secured globally and in countries **Outcome:** Consensus reached on the essential commodities for MNCH and partners commodity management harmonized and implemented in 25 countries. **Value added:** Partners are currently working separately on developing capacity and meeting supply/commodities needs. Close coordination will harmonize supply policies and strategies and maximize the use of collective resources, increasingly meeting countries' needs with reduced transaction costs.						
1. Consensus reached on the supply component of evidence-based MNCH interventions and define a basket of essential commodities identified	**1.1** List of essential MNCH commodities developed and made available; **1.2** Country-specific minimum commodity package determined in 25 countries.	MNCH minimum supply package identified (draw from existing disparate guidelines for MN and C); Expert meeting to develop a minimum core consensus MNCH package (including FP) at the global level in coordination with WHO essential medicine list; Country specific minimum package of commodities determined and adopted by national coordination committees in 25 countries.	2009 December 2009 2nd Qtr 2010	US$25,000 includes external experts travel. Participating agencies' support their own technical staff; US$ 10 000 (local expenses) per country x 3= US$ 30 000 in 2009; x15=US$150 000 in 2010; x 7=US$ 70000 in 2011.	WHO, UNICEF, UNFPA, USAID Members of the RH CS Coalition, including World Bank, Save The Children etc.	Facilitate convening of experts to identify the components of an essential MNCH supplies package + supporting documentation. Assist with the development of the list/document; Ensure smooth and coordinated interactions between PAs.
2. Set of tools and guidance material agreed and used by partners for country MNCH commodity supply management.	**2.1** A common guideline and tool for in-country supply management system developed and made widely available.	Agree on tools for supply management, forecasting, costing and information management system and their use by Partners.	Tools designed and tested in 2009, 2010. Final version ready in 2011.	Consultative meetings (up to 5): US$ 300 000; US$ 60 000 in 2009. Refer to PA1	WHO, UNICEF, World UNFPA, World Bank, USAID, John Hopkins , Costing Working Group	Facilitate interaction between working groups and impact assessment; Facilitate development of guideline and tool and disseminate when available.

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3. Partners' supply management system harmonized, agreed upon, and implemented in up to 25 countries.	**3.1** A common, harmonized partners supply management system emerging from country assessments leading to global action; **3.2** Identification of existing delivery gaps through research.	Strategic plan developed for 25 countries; A costed master commodity plan prepared based on priority setting for an integrated MNCH package; Commodity guidelines for in country distribution; Guidelines for forecasting and quality assurances; Resource mobilization plan for MNC (incl FP) logistics and supplies developed and 90% requirement met from domestic and development partners' resources.	Starts in 2010-completed by End 2014 2010-2014	US$ 100 000 per country (co-shared) consisting of: 3 pilots in 2009 (US$ 300 000); 2 pilots in 2010 (200,000); 10 second phase countries in 2010 (at US$ 20 000); US$ 200 000; 10 in 2011 at 20,000= US$ 200 000: Total US$ 900 000; In-country and 1-2 regional meetings of 10-20 experts = US$ 115 000 (US$ 57.5 in 2010 and 2011. DSA and Travel not included. Shared by agencies.	IHP+/HHA (and equivalent in Asia), include WHO, UNICEF, UNFPA, World Bank, and USAID, John Hopkins, DfID, CIDA, KFW, IPPF; International Task Force on Innovative Financing, Working Group 1.	Help monitor through central data base of progress in the selected countries. Facilitate meetings and partner discussions leading to the development of the supply management system;
4. Global availability and efficiency in procurement by innovative ways for sustained supply of quality commodities to developing countries.	**4.1** Innovative mechanism of procurement and supply identified at global level; **4.2** Supply/demand gaps are identified in 25 countries, and a strategy defined to address them is developed through global public/private dialogue.	PMNCH lead partners engage with public/private sector (economies of scale and leveraging costs). New solutions for cheaper medicines, new commodities, global manufacturing to increase supply of commodities; Reduction in price with quality commodities obtained. Patent and generic production related trade issues evaluated and agreed.	Mapping of potential public/private sector sources in 2010	Assessment study public-private + Global expert meeting/review of supply and financial gaps US$120 000 In 2010; US$ 50 000 in 2011; Evaluation/ Assessment of results achieved (data collection+ consultancy);	UNICEF, UNFPA, WHO, USAID. Work with RH commodity security Coalition, GAVI, UNITAID, KFW, GF etc.	Help identify new private sector partners/mapping; Manage consultants to contribute to the assessment of new solutions for cheaper medicines, global manufacturing and commodities; Contribute with technical inputs on drafts; Advocate dissemination of reports emerging from this work;

ANNEX 2: LIST OF CONSULTEES

The table below lists the interviewees consulted (organized alphabetically by last name) in preparing this report. In addition, our participation in the Partners meeting in New York on 1st - 2nd October has informed the finalization of the report.

Table A2.1: List of consultees

Name	Country	Organisation	Designation
Alan Bornbusch	USA	USAID	Public health adviser
Tracey Brett	UK	Marie Stopes International	Head of Procurement
Neil Datta	Belgium	Inter-European Parliamentary Forum on Population and Development & RHSC	Secretary (IEPFPD) Co-head of Resource Mobilization and Awareness Working Group (RHSC)
Chris Harris	UK	ICON	Chief Executive
Carolyn Hart	USA	John Snow Inc.	Director, Logistics Services
Joseph Johnson	USA	Save the Children	Maternal and newborn health advisor
Steve Kinzett	Belgium	RHSC	Technical Officer
André B. Lalonde, MD, FRCSC, MSc	Canada	The Society of Obstetricians and Gynaecologists of Canada (SOGC)	Executive Vice-President
Ben Light	Belgium	UNFPA & RHSC	Technical Adviser (UNFPA) Head of Market Development Approaches Working Group (RHSC)
Nahed Matta	USA	USAID	Senior maternal and newborn health advisor
Dr Elizabeth Mason	Switzerland	WHO	Director Department of Child and Adolescent Health and Development (CAH)
Indira Narayanan	USA	BASICS	Newborn specialist
Charity Ngaruro	USA	Population Services International	Deputy Director, Procurement and Logistics
Sharmila Raj	USA	USAID	Logistics advisor
Sangeeta Raja	USA	World Bank	Senior health logistics advisor
Susan Rich	USA	The Bill & Melinda Gates Foundation	Senior program officer for RH
Mark Rilling	USA	USAID	Chief of Commodities Security and Logistics Division
John Skibiak	Belgium	RHSC	Head of Secretariat

Name	Country	Organisation	Designation
David Smith	Denmark	UNFPA & RHSC	Chief of Procurement Services (UNFPA) Head of Systems Strengthening Working Group (RHSC)
Pamela Steele	Denmark	UNFPA	Humanitarian logistics specialist
Pat Taylor	USA	John Snow Inc.	Project director
John Townsend	USA	Population Council & RHSC	Director (Population Council) Head of New/Underused RH Technologies (RHSC)
Jagdish Upadhyay	USA	UNFPA	Senior Technical Officer
Juliana Yartey	USA	UNICEF	Senior advisor, health (maternal and neonatal)

Table A2.2: Participants at the New York meeting

Organisation	Attendees
UNFPA	Jagdish Upadhyay, Yves Bergevin, Kechi Ogbuagu
UNICEF	Kaisamaija Valimaki-Erk, Juliana Yartey, Ian Pett, Ahmet Afsar
World Bank	Sangeeta Raja
Reproductive Health Supplies Coalition	John Skibiak
USAID	Alan Bornbusch, Helena Walkowiak
PAI	Suzanne Ehlers
WVI	Cliff Lenton
JSI	John Durgavich
PMNCH	Andres de Francisco, Kadidiatou Toure
CEPA	Daniel Hulls

ANNEX 3: LIST OF SELECTED REFERENCES

Reports/ publications

1. Center for Global Development, Global Health Forecasting Working Group, "A Risky Business: Saving money and improving global health through better demand forecasts", 2007.
2. Dalberg Global Development Advisors, "The Pledge Guarantee (PG) and Minimum Volume Guarantee (MVG): A Path Forward for Action and Impact", Presentation to the Reproductive Health Supplies Coalition, 23 May 2008.
3. GAVI Alliance and World Bank, "Advance Market Commitments for Vaccines: An innovative way to make vaccines available for children", 2009.
4. The Global Fund, "Affordable Medicines Facility - malaria: Frequently Asked Questions", July 2009.
5. Pett, Ian, "UN H4: Joint Country Support for Accelerated Implementation of Reproductive, Maternal and Newborn Care", Presentation at the Coogee Beach Group Meeting of the MNCH Network for Asia and the Pacific, 10-11 August 2009.
6. Raja, Sangeeta and Carolyn Shelton, "Pharmaceutical Procurement Demystified: Managing supply chains through the public sector".
7. Reproductive Health Supplies Coalition and Dalberg Global Development Advisors, "Designing a Global Financing and Procurement Mechanism for Reproductive Health Supplies", Final Report, 2008.
8. UNFPA, "Procurement Statistics", 2008.
9. UNICEF Supply Division, "Supply Annual Report: Global Availability, Local Delivery", 2008.
10. UNICEF Supply Division, "Report of the Maternal and Newborn Health Supplies Workshop", 1-3 April 2009.
11. WHO, UNFPA, et al. "The Interagency List of Essential Medicines for Reproductive Health", 2006.
12. WHO, "WHO Model List of Essential Medicines for Children", October 2007.
13. WHO, "WHO Model List of Essential Medicines", March 2007.

Websites

1. Center for Global Development, Global Health Forecasting Working Group website, http://www.cgdev.org/section/initiatives/_active/demandforecasting/
2. The Global Fund, Affordable Medicines Facility – malaria website, http://www.theglobalfund.org/en/amfm/

3. Reproductive Health Supplies Coalition, RHInterchange website, http://www.rhsupplies.org/resources/rhinterchange.html
4. Reproductive Health Supplies Coalition, Countries at Risk Group, http://www.rhsupplies.org/working-groups/systems-strengthening/countries-at-risk.html
5. Reproductive Health Supplies Coalition, AccessRH and Pledge Guarantee website, http://www.rhsupplies.org/working-groups/systems-strengthening/global-financing-and-procurement.html
6. Reproductive Health Supplies Coalition, Advocacy Guide and Toolkit website, http://www.rhsupplies.org/guide-new.html
7. UNFPA: www.unfpa.org
8. UNICEF: www.unicef.org
9. USAID Deliver project: http://deliver.jsi.com/dhome
10. World Bank: www.worldbank.org

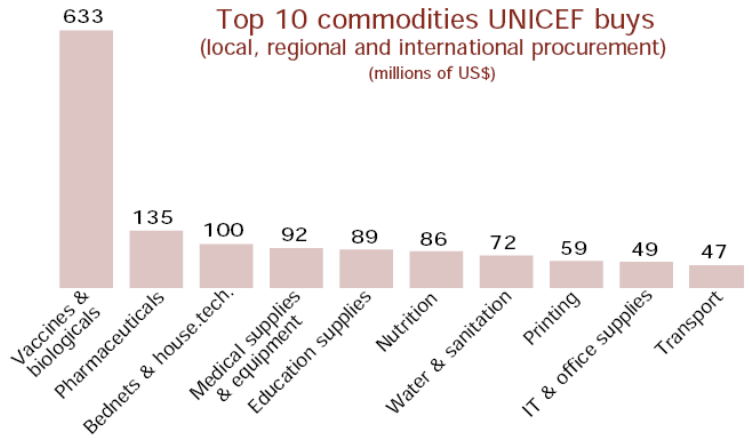
ANNEX 4: SOME INDICATORS OF FINANCING AND PROCUREMENT BY KEY AGENCIES

This annex collates relevant data on the MNCH commodity volumes/ values handled by some of the key donor procurement and financing agencies. The information is based on desk research of publicly available documents as well as specific data provided by some of our consultees.

UNICEF

As per the UNICEF Supply Annual Report for 2008, the total global value of goods procured was $1.46bn, with child health commodities such as vaccines and biologicals being the largest share, followed closely by pharmaceuticals and medical supplies and equipment (see Figure A4.1).

Figure A4.1: Top 10 commodities procured by UNICEF, 2008



Source: UNICEF Supply Annual Report 2008

UNICEF remained the largest procurer of vaccines globally, buying 2.6bn doses of vaccines in 2008. Figure A4.2 provides data on the volumes of the top 6 vaccines procured by UNICEF.

Figure A4.2: Number of doses of vaccines procured by UNICEF (Top 6)

Top six vaccines procured	millions of doses
Oral Polio Vaccine (OPV)	1,817
Tetanus Toxoid (TT)	179
Measles	173
Bacillus of Calmette and Guerin (BCG)	106
Hepatitis B (HepB)	81
Dipheria, Tetanus, Pertussis, HepB, Hib (DTP-HepB/Hib)	73

Of total UNICEF procured supplies in 2008, 56% were used in Sub Saharan Africa and 31% in Asia. The balance was used in the Middle East and North Africa, Central and South America and the Caribbean, and Central and Eastern European regions.

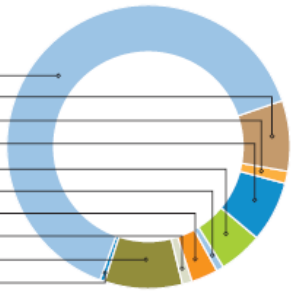
UNFPA

UNFPA Procurement Statistics, 2008, provides recent data on the procurement activities of the organisation.[25] Majority of the commodities procured by UNFPA are contraceptives (65%), with other pharmaceuticals forming less than 3% of its procurement (figure A4.3).[26]

Figure A4.3: Total value of UNFPA procurement in 2008, and shares by major categories of commodities

Products/Services Distribution

USD		
86,201,663.61	Contraceptives	64.49%
11,417,588.52	Freight Transportation	8.54%
2,057,199.91	IT/AV/Communications equipment	1.54%
9,693,974.48	Medical equipment/Supplies	7.25%
5,839,767.58	Miscellaneous	4.37%
350,259.32	Office furniture and supplies	0.26%
3,973,630.63	Pharmaceuticals	2.97%
1,376,306.37	Printing and Publication	1.03%
12,226,266.21	Services	9.15%
532,325.97	Vehicles	0.40%
133,668,982.59	Grand Total	100.00%



Source: UNFPA Procurement Statistics, 2008

World Bank

Workd Bank has provided us information on its financing for procurement of pharmaceuticals. However, this information is not yet in the public domain, so it is not possible to reproduce it here.

USAID

Majority of USAID's funding for commodities is focused on the RH space. Procurement of contraceptives is conducted through a 'Central Contraceptive Procurement' (CCP) mechanism, with latest information provided from USAID for 2008 being presented below.[27]

In 2008, CCP made 399 shipments to Mission programs in 52 countries with a total value of $73.2 million. These shipments included 5 emergency shipments of contraceptives (Ghana, Malawi, Dominican Republic, Kenya and Nepal) and 1 emergency condom shipment to Bangladesh. Volume data on quantities shipped in FY08 is provided in Table A4.1 below.

[25] http://www.unfpa.org/webdav/site/global/shared/procurement/procurement-statistics2008.pdf

[26] We have presented here the figures for UNFPA procurement by the PSB (Procurement Services Branch) and Third Party Procurement (outsourced to UNFPA), but excluded procurement figures by local UNFPA offices (which represents a small proportion in the total UNFPA procurement).

[27] Information provided by Sharmila Raj, USAID.

Table A4.1: USAID CCP volumes data

RH commodity	Volume (million)
Condom Pieces	412.82
Oral Cycles	83.54
Injectables	13.65
Female Condom Pieces	7.25
Lubricant	4.81
Implants	0.24
IUD Units	0.06
Standard Days	0.05

ANNEX 5: OTHER INITIATIVES

This annex provides information on two institutions that are working in the area of commodity management – the RHSC and the H4 initiative.

Reproductive Health Supplies Coalition

Name	Reproductive Health Supplies Coalition (RHSC)
Year of establishment	2004
Members	97 members including multilateral and bilateral organizations, private foundations, low- and middle-income country governments, civil society, inter- and non-governmental organizations, and the private sector
Key objectives	To make sure that all people in low- and middle-income countries can access and use affordable, high-quality supplies to ensure their better reproductive health. Increasing resources, strengthening systems, and building effective partnerships are the three broad goals at the core of the strategic plan.
Structure	RHSC works along the following three working groups (WGs): • Market Development Approaches (MDA): It focuses on the "total market", i.e. including the private sector. It aims to facilitate overall market growth, greater equity through better targeting of subsidies, and wider private sector involvement. • Resource Mobilization and Awareness (RMA): It aims to create an environment conducive to political support for RH supplies at country, regional and global levels; and to increase financial resources for RH supplies. • Systems Strengthening: Its aim is the strengthening of the systems needed to ensure reliable and predictable RH supplies. It has worked on new funding mechanisms, and better systems for forecasting, warehousing, distribution, and information management.
Key initiatives on commodity management	• RHInterchange: It is a free, web-based tool that provides information on past, present and future contraceptive supply orders. Containing data from 144 countries, it includes order, shipment and pricing information from UNFPA, USAID and IPPF, who together account for about 60% of the world's donated contraceptive supplies. It is intended to be used by a variety of decision makers including Ministry of Health program managers, service delivery organizations, procurement planners and donors in order to have better coordination and planning of RH commodities. • AccessRH: This is an initiative that has been undertaken to address the need for framework agreements in RH. AccessRH is a procurement mechanism that aims to provide a quantity guarantee to manufacturers in exchange for improved pricing and delivery times. Increasing the number of potential buyers, aggregating demand and providing upfront commitments to the manufacturers are expected to yield lower unit prices, which is particularly beneficial for smaller-scale buyers. The design stage of the initiative has been completed and the implementation process, which will be undertaken by UNFPA, is expected to start soon. • Pledge Guarantee: This is a global financing mechanism that will allow

	recipients of international donor funding to obtain short-term commercial credit by using their pending donor pledges as collateral. The recipients can use these credit lines to purchase RH supplies when needed as opposed to having to wait for donor funding to come through. This initiative is undertaken as a way to cut waiting times and make funding for RH supplies less volatile and unreliable, and hence is expected to lead to fewer emergency shipments, fewer stock-outs, and reduced cost of capital for recipients. The design stage of the initiative has been completed and the implementation process, which will be undertaken by the UN Foundation, is expected to start soon. • Advocacy guide and toolkit: This is a free, web-based tool targeted to RH workers in developing countries, and designed to raise awareness and foster policy change for increased commitment to RH supplies. It provides a guide to advocacy communications and messages, five global supply shortage scenarios (customizable to country needs), and a set of tools including PowerPoint presentations, policy briefs and fact sheets. • Countries-at-Risk (CAR) group: This group brings together the representatives of the world's key commodity suppliers including UNFPA, USAID, World Bank, RHInterchange and KfW. At the monthly CAR group meetings, the organizations share information on central contraceptive stock levels in priority countries, identify any impending stock imbalances/shortages, develop solutions (such as organizing emergency shipment or bringing forward planned shipments), and implement these solutions. Depending on the countries under review, other organizations such as DFID, IPPF and Crown Agents also take part in the discussions.

Sources: RHSC website (http://www.rhsupplies.org) "Designing a Global Financing and Procurement Mechanism for Reproductive Health Supplies", Reproductive Health Supplies Coalition and Dalberg Global Development Advisors, June 2008.

The Health 4

Name	The Health 4 (H4)
Year of establishment	2008
Members	WHO, UNFPA, UNICEF, The World Bank
Key objectives	To accelerate coordinated support to countries to improve maternal and newborn health and to strengthen national capacity to: • Conduct needs assessments; • Cost national plans and mobilize resources; • Scale-up quality health services; • Address the urgent need for skilled health workers, particularly midwives; • Address financial barriers to access, especially for the poorest; • Tackle the root causes of maternal mortality and morbidity; • Strengthen monitoring and evaluation systems.
Potential contribution to commodity management	It was identified that the four agencies could contribute to the joint UN scope of work by: • Harmonizing their efforts in the procurement of essential MNH supplies and streamlining procurement; • Building national capacity in procurement and logistics distribution systems; • Contributing to ensure adequate flow of maternal health equipment, supplies and medicines, through national capacity building in procurement and logistics systems and through the provision of quality MNH commodities with agency funding and/or other resources.
Key initiatives on commodity management	At the MNH supplies workshop that took place in Copenhagen in April 2009, the participants worked on the following issues related to commodity management: • List of essential medicines for MNH: The workshop participants worked on a list of essential MNH medicines using the 2006 Interagency List of Essential Medicines for Reproductive Health and the 2007 WHO Model List of Essential Medicines. The list was expected to be completed once the 2009 WHO Essential Medicines List is finalized. • List of medical devices for MNH: The Interagency List of Essential Medical Devices for Reproductive Health was reviewed line by line with items being removed/added according to recommended interventions. Further consultations will be undertaken for some items such as sterilization, surgical sets and sutures. • Procurement: Each agency is to provide expertise, technical support, capacity building and procurement based on their current strengths. Areas of expertise are defined as follows: o UNFPA for family planning products and other RH supplies; o WHO for laboratory, diagnostics and blood banks; o UNICEF for essential medicines and medical devices.

	• Quality assurance: It was decided that the WHO Model Quality Assurance system for procurement agencies will apply for medicines. For medical devices, diagnostics and medicines for which WHO pre-qualification exists, such mechanism will be followed. Further work will be done on quality assurance for the procurement of medical devices. • National capacity building: In order to have countries drive their own programs, procure commodities, build logistics systems and financial capacity, the agencies aim to assist countries with issues such as: o Forming a national framework of guidelines, policies and regulation; o Training of health care providers on the use of commodities; o Supply chain management across all components (forecasting, procurement, etc); o Maintenance of medical equipment. H4 is in the process of establishing a working group to address capacity building in the context of supply management. Since the April workshop in Copenhagen, a preliminary list of essential medicines and medical devices for MNH has been circulated to the agencies for approval/endorsement. Once the list is approved, it will be shared with countries and will be made public. The health sector capacity building project is in very early stages. The agencies are in the process of deciding the scope of this work.

Sources: Report of the Maternal and Newborn Health Supplies Workshop, UNICEF Supply Division, Copenhagen, 1-3 April 2009.

"UN H4: Joint Country Support for Accelerated Implementation of Reproductive, Maternal and Newborn Care", Ian Pett (UNICEF), Coogee Beach Group Meeting of the MNCH Network for Asia and the Pacific, 10-11 August 2009.

ANNEX 6: SUMMARY OF KEY COUNTRY-LEVEL STUDIES/ REPORTS ON MNCH

This annex summarises some of the available country-level reports on MNCH commodities supply. At the outset it is important to note that we have not come across any country studies that describe the aggregate MNCH commodities supply chain and key issues thereof. This, to an extent, reflects the fact that the key partners operating in this space work on specific aspects of MNCH and not across the continuum of care (as illustrated in Section 2).

Table A6.1: Summary of country-level reports

Name of report	Summary
Planning documents	
Ethiopia Pharmaceutical Logistics Master Plan (PLMP)	• The PLMP aims to establish a new health commodities supply system (HCSS) for Ethiopia. The vision of the PLMP is: "A constant and uninterrupted supply of vital and essential health commodities for the end users of all public health facilities." The plan looks at several aspects of commodity management including policy and legislation, governance, financing, selection and quantification of commodities, procurement, storage and inventory control, human resource management, R&D, M&E, etc. • A number of organisations have contributed to its development including Ethiopian government department and international donor agencies. • The master-plan is an important document, given the relatively low and disaggregated attention that health commodity management and logistics have received at the country level.
Country public health commodities logistics systems review	
Brumburgh, Scott, and Sangeeta Raja. 2001. Ghana: Process Mapping: First Step to Reengineering the Health Supply Chains of the Public Sector System. Arlington, Va.: DELIVER/JSI for USAID.	• The report uses process mapping to assess supply chains and identify areas for improvement for 4 public sector health logistics systems: essential drugs, non-drug consumables, contraceptives and vaccines. • The major findings from the study include: (i) the system is highly complex, with hundreds of steps involved in moving a product across all tiers in the supply chains; (ii) there are many required, but non value added steps; (iii) those working with the supply chain, in general, understand their customer's needs, but the workflow is designed and operated to accommodate the administration of the MOH, not the customer requirements; and (iv) The system does not have measurable standards.

Name of report	Summary
Rao, Raja and John Durgavich. 2008. Malawi: ARV Supply Chain Integration: An Assessment of the ARV and Essential Medicines Logistics Systems. Arlington, Va. and Malawi: USAID | DELIVER PROJECT, Task Order 1.	• The purpose of the study was to determine whether the antiretroviral (ARV) supply chain — of which several components are managed vertically to the Central Medical Stores (CMS) system — can be integrated into the CMS system without a loss of service. The report suggests that the CMS and related public sector agencies do not currently possess adequate technical, organizational, and human resource capacity to integrate procurement, inventory control, distribution, and data collection and management of ARVs without compromising the current quality of service. As such, these functions should remain vertical to the CMS, until suggested reforms have been enacted and subsequent capacity developed.
RH commodities logistics systems review[28]	
Global Programme to Enhance Reproductive Health Commodity Security, Joint ACP/UNFPA/EC programme for assistance to ACP countries to achieve RHCS - Mozambique monitoring mission – August 2009	• The mission report notes the plan of the MOH to draw up a Pharmaceutical Logistics Master Plan (PLMP) for the country, which once approved, will have far-reaching consequences for all partners involved in the health logistics sphere in Mozambique. • Some of the practical issues and challenges highlighted with regards to Mozambique's logistical infrastructure include poorly designed warehouses; lack of trained and skilled staff; lack of material handling equipment including pallets and racking systems; outdated/ lack of logistics management information systems; insufficient transport facilities; poor distribution management systems; amongst others. • Other longer term strategic issues include the need for a move towards a unitary health supply chain incorporating both medical supplies and durable medical equipment (the planned PLMP will look at medical supplies only) as well as the observation that the current warehousing and delivery arrangements for contraceptives seem to be under-prioritised to life saving MNCH health medicines and supplies.
Dickens, Todd. 2008. Bangladesh: Govt. of Bangladesh Contraceptive Procurement Bottleneck Study, Full Report. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.	• The report is a review of the IDA-funded procurement of health care commodities under the Health, Nutrition, and Population Sector Program in Bangladesh. The study's overall objective was to identify bottlenecks and problems that have lead to recent stockouts of contraceptives, and recommend possible actions. • The problems include lack of technical capacity, staff turnover, lengthy government and World Bank review process, and government bureaucratic delays and lack of commitment to prompt decision making.

[28] There are a number of studies on RH commodities and in-country supply chains which can be accessed from: http://deliver.jsi.com/dhome/resources/publications. We summarise here only a few reports relevant to identifying country-level supply chain bottlenecks/ challenges for the 25 high-burden countries.

Name of report	Summary
Allers, Claudia and Peter Riwa. 2001. Preliminary Assessment of HIV/AIDS Commodity Needs And Logistics Capacity in Tanzania Ministry of Health Final Report. Arlington, Va.: John Snow Inc./DELIVER, for USAID.	• The study provides an assessment of the HIV/AIDS commodity needs and logistics capacity in Tanzania. Key findings include: (i) lack of availability and quality of data on consumption, stock status and other data necessary for logistics management; (ii) unavailable, outdated or underestimated forecasts of demand for HIV/AIDS commodities; (iii) procurement driven by budget rather than actual forecasts/ demand; (iv) complicated multi donor environment of short term financial commitments for HIV/AIDS commodities; (v) delays in procurement and parallel sources of procurement implying inefficient use of resources; (vi) absence of M&E for storage systems; (vii) parallel distribution systems exist which duplicate efforts and cause inefficient use of resources; (viii) poor human resource capacity; (ix) severe constraints related to infrastructure and availability of functioning equipment to support HIV testing exists in peripheral district health facilities.