This report has been prepared for the independent Expert Review Group and documents the January 2014 to April 2015 progress against the recommendations outlined in the UN Commission on Life Saving Commodities report (Sept 2012).
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List of abbreviations

API – Active Pharmaceutical Ingredient
AMTSL - Active Management of Third Stage of Labor
ANCS – Antenatal Corticosteroids
AWG – Advocacy Working Group
cGMP – Current Good Manufacturing Practice
CHAI – Clinton Health Action Initiative
CHX – Chlorhexidine
COIA – Commission on Information and Accountability
CSO – Civil Society Organization
DGWG – Demand Generation Working Group
DT – Dispersible Tablet
DHIS – District Health Information System
EAC – East African Community
EC – Emergency Contraception
ECOWAS – Economic Community of West African States
EML – Essential Medicines List
EmONC – Emergency Obstetric and Newborn Care
ERP – Expert Review Panel
EWEC – Every Woman Every Child
FMoH – Federal Ministry of Health
GFF – Global Financing Facility
HMIS – Health Management Information System
HRITF – Health Results Innovation Trust Fund
ICT – Information and Communication Technology
iERG – Independent Expert Review Group
IV – Intravenous
LACI – Long Acting Contraceptive Implant
LMIS – Logistics Management Information System
LSC - Life-saving commodity
MDG – Millennium Development Goal
MDSR – Maternal Death Surveillance Review
MgSO4 – Magnesium Sulfate
MSH - Management Sciences for Health
NAFDAC - National Agency for Food and Drug Control
NASG – Non-pneumatic Anti-shock Garment
NEMCM - National Essential Medicines Coordination Mechanism
NGO – Non-governmental Organization
NPHCDA – National Primary Health Care Development Agency
NMRA – National Medicines Regulatory Authority
NGO – Non-governmental Organization
ORS – Oral Rehydration Solution
OTC – Over the counter
PMRN – Pediatric Medicines Regulatory Network
PPMV – Proprietary Patent Medicine Vendors
QoC – Quality of Care
RMNCH – Reproductive Maternal Newborn & Child Health
RBF – Results Based Financing
RFP – Request for Proposals
SADC – Southern African Development Community
SBCC – Social and Behavior Change Communication
SCT – Strategy and Coordination Team
SCTRT – Supply Chain Technical Resource Team
SDG – Sustainable Development Goal
TA – Technical Assistance
TRT - Technical Resource Team
SC – Supply Chain
SCT – Strategy & Coordination Team
SDG – Sustainable Development Goal
UNCoLSC - United Nations Commission on Life Saving Commodities
UNGA – United Nations General Assembly
I. Executive Summary

After 15 years of the MDGs, lives have been saved on an unprecedented scale largely through increasing access to proven interventions to end preventable maternal and child deaths. In September 2012, the UN Commission on Life Saving Commodities (UNCoLSC) launched its Report and Implementation Plan outlining a series of time-bound activities with corresponding milestones to improve availability and access to life-saving commodities. The report identified 13 underutilized, low-cost and high-impact commodities across the Reproductive, Maternal, Newborn and Child Health (RMNCH) spectrum that if implemented at scale could make the greatest impact in achieving Millennium Development Goals (MDGs) 4 and 5.

The Report also highlighted ten recommendations for addressing key systems-related bottlenecks such as the need to improve global and local markets, streamline regulatory systems, enhance the quality and safety of medicines, strengthen supply chains, improve health worker training and stimulate demand. The commodities provide a concrete and actionable focus for efforts across this continuum, effectively acting as ‘tracers’ to help identify and address persistent barriers to the delivery of essential interventions.

This report profiles progress made since the inception of the UNCoLSC report, with an emphasis on activities taking place between January 2014 and April 2015. It highlights the results of a multi-country assessment profiling the latest status of the commodities and UNCoLSC recommendations; highlights activities supported at the global-level by the network of Technical Resource Teams (TRTs) to push forward the UNCoLSC agenda; and underscores efforts at the country-level to expand availability and access to life saving commodities and services. Finally, the report reflects on the UNCoLSC’s unfinished agenda, making recommendations for positioning catalytic efforts and ‘global public goods’ within the updated Global Strategy for Women’s Children’s and Adolescent’s Health and post-2015 Sustainable Development Goal (SDG) framework.

Status of UNCoLSC commodities and recommendations – a multi-country assessment

To further our understanding of the current situation regarding country-specific bottlenecks related to implementing the UNCoLSC recommendations, a multi-country assessment was conducted from 2013 onwards. An RMNCH Landscape Synthesis was administered across 10 sub-Saharan African countries (Cameroon, Ethiopia, Kenya, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, Mali and Malawi) which generates a standardized set of indicators that capture progress across the commodity-continuum. More countries are being added over time.

While there has been substantial progress over the past three years in improving availability and access to LSCs at the country-level, major bottlenecks remain. Overall, maternal and child health commodities are the most widely available and accessible, with newborn and reproductive health commodities performing more poorly. The key challenge observed at the country-level was the limited downstream transfer of updated standards, guidelines and training, as well as commodities themselves, from the national-level warehouses to service delivery points where they are needed most. Specific gaps include:
UN Commission on Life Saving Commodities: 2014 Progress Report

- **Misaligned EMLs, commodity registration and treatment guidelines:** Relatively easy to address upstream bottlenecks are still present in nearly all countries – including out-of-date EMLs, commodities not being registered in-country, and prescription authorities either not being clearly defined or being overly restrictive. Ensuring these are well-harmonized and appropriately aligned is an important pre-requisite for the delivery of essential interventions.

- **Challenges assuring the quantity and quality of medicines:** Commodity security strategies, where they exist, are often poorly developed and implemented, with little in-country monitoring of the quality and safety of medicines.

- **Supply chain issues:** Logistics management information systems (LMIS) remain fragmented and fail to track supplies down to the district-level. Crucially, while national warehouses are generally well supplied, just over half of the 13 life-saving commodities were in stock at the point-of-service at the time of assessment.

- **Health worker performance:** Finally, while national protocols and training materials are now generally up-to-date, only 25% of facilities have staff that have been recently trained, and just one third have relevant job-aids and checklists.

In four countries where two rounds of data collection have taken place, consistent improvements have been observed for nearly all commodities and recommendations over an 18-24 month observation period.

**Global Technical Resource Teams (TRT)**

To carry forward the UNCoLSC recommendations, a network of Technical Resource Teams (TRTs) was established in 2012. There are currently nine TRTs that focus on the four RMNC commodity groupings; Global Regulation, Markets and Policy; Supply Chain; Demand, Access and Performance, and two cross-cutting areas including Digital Health and Advocacy.

Each TRT works as a consortium of experts to facilitate catalytic global-level actions in support of the UNCoLSC mandate while simultaneously assisting with country-level implementation.

The TRTs are also responsible for reporting on milestones outlined in the original UNCoLSC 2012 report. Updated progress towards these targets is profiled in the Table below.

During the past year, the work of the TRTs has been instrumental in furthering the UNCoLSC recommendations around a number of critical areas:

- **Inclusion of commodities on the WHO Essential Medicines List:** All LSCs are now listed on the WHO EML, including chlorhexidine and antenatal corticosteroids. The one-rod etonorgestrel hormonal contraceptive implant was approved for inclusion in the 2015 EML.

- **Fast track registration:** An accelerated registration process has been established for pre-qualified products, which now includes 23 countries.

- **Expanded list of prequalified and ERP products:** Since 2013, 17 RMNCH products have been submitted or re-certified successfully to the WHO Prequalification program, including contraceptive implants, oxytocin, zinc, and several hormonal contraceptives. Prequalification has been received for oxytocin for the first time ever, and two manufacturers of Amoxicillin Dispersible Tablet (DT) have completed the Expert Review Panel (ERP) process.
• **Enhanced manufacturing of life-saving commodities:** The scale-up of Chlorhexidine has been supported through the establishment of local and regional manufacture of high-quality Good Manufacturing Practice (GMP)-compliant chlorhexidine for umbilical cord care in Sub-Saharan Africa and South Asia.

• **Negotiated price reductions:** While not officially one of the 13 commodities, a 75% reduction in the cost per use of Non-pneumatic Anti-Shock Garment (NASG) was secured in 2014 to support the management of post-partum hemorrhage in remote settings.

• **Increased procurement of essential commodities:** Amoxicillin DT for pneumonia has been registered in 9 new countries and 30 countries have started procuring Amoxicillin DT from UNICEF Supply Division in 2014. 15 million treatments for childhood pneumonia were procured in 2014 which represents nearly five times the volume procured in 2012.

• **Regional Market Shaping:** Regional market shaping efforts were conducted with the East African Community (EAC) designed to strengthen the EAC pharmaceutical industry’s competitive position and market share of the health pharmaceutical market, while increasing access to high quality, affordable maternal and child health commodities and essential medicines.

• **Innovative financing for commodity purchase:** A multi-country study is underway to assess the feasibility of providing governments with access to working capital and international procurement agencies to secure better price, quality and timing of delivery of RMNCH commodities.

• **Enhanced quality assurance:** The WHO Collaborating Center in Ghana has developed model pharmacovigilance plans for selected commodities. This provides support to countries in following up on the quality of products and their safe use, especially in environments where prescription change has taken or will take place.

• **Supply chain strengthening:** A series of best-practice tools for harmonizing and strengthening supply chain management have been finalized, and dissemination at the country-level is underway.

• **Demand generation:** A demand generation tool-kit which been finalized during 2013 has been refined, translated and deployed to support at the country-level to enhance commodity utilization by providers, private-sector pharmacists and communities. In addition, countries including Uganda, DRC, Nepal and Bangladesh are now re-designing their demand generation programs.

• **High-quality adaptable job-aids and check-lists:** A compendium of up-to-date materials to improve health worker training and performance have been developed to include the 13 life-saving commodities. Work is underway to enhance country level uptake and dissemination.

• **Product innovation and production:** A number of innovations have been developed over the past year to improve effective commodity utilization including an agreement between UNICEF and WHO to allow oxytocin to be included in the cold-chain, and; new upright newborn resuscitators which are now available on the market world-wide.

**Country Engagement Process**

A central strategy to accelerate implementation of the UNCoLSC mandate has been the expansion of the RMNCH Country Engagement process. The goal of this initiative is to provide direct technical and financial support to sharpened RMNCH-focused national plans and to better align related funding streams to improve coverage with essential interventions.
In 2013, $39 million was provided through the RMNCH Trust Fund to support 9 countries. Funds were used in a variety of ways including updating policies and clinical guidelines, the training health-care workers and the development of demand-driven activities as critical prerequisites to expand access to life-saving commodities and scaling up RMNCH services. In 2014, a second wave of countries received technical and financial support. Overall commitments-to-date total $146 million for 14 countries, with most of the initial round of countries receiving follow-up disbursements. Support to another 5 countries is being finalized. All countries are sub-Saharan African with the exception of Afghanistan, Bangladesh and Pakistan.

Nearly half the resources underwrite cross-cutting systems strengthening interventions such as supply chains, integrated health worker training, or revisions to policies and guidelines. The remaining balance is fairly evenly split between family planning, maternal-newborn and discrete child health interventions.

When disbursements were assessed thematically, by UNCoLSC recommendation, over 90% of funds support downstream efforts to improve health worker performance and accountability, supply chain strengthening and demand generation. Several grants also include addressing upstream gaps in the regulatory environment and quality assurance, alongside local market shaping efforts.

Moving forward, it is envisioned that additional direct support to country plans will be identified and channeled through national, prioritized RMNCAH investment cases, under the umbrella of the new Global Financing Facility. Learning and experience from the RMNCH Country Engagement Process and Fund have critically informed the direction of this work.

Lessons learned and implications for the post-2015 agenda

The Secretary General's Progress Report on the Global Strategy for Women's and Children's Health (2010-2015) highlights that the world will fall short of achieving MDGs 4 and 5 – with just 2.4 million of the anticipated 6 million lives of women and children saved since 2010. While key milestones laid out in the original UNCoLSC Report and Implementation Plan have largely been achieved or are nearing completion (Table below), many of these targets were modest and emblematic of the ambitious global effort still required.

This report suggest that coordinated efforts to implement the UNCoLSC recommendations have served a critical ‘global public good’ in facilitating the relationships between global systems, countries and markets to propel more timely and effective pricing, procurement, distribution and delivery of essential commodities and related services. Furthermore, given persistent bottlenecks at the country-level, mechanisms to better translate global learning into country-level action are essential.

These findings carry implications for the emerging Sustainable Development Goal (SDG) agenda and the updated Global Strategy for Women’s, Children’s and Adolescents’ Health. Better defining which components of UNCoLSC agenda should be taken forward and folded into the ‘global public good’ framework is essential.

A meeting of the UNCoLSC TRT Conveners was recently held to document lessons learned and reflect on these broader questions. There was agreement that a post-2015 ‘unfinished agenda’ is remaining for the UNCoLSC, with the following thematic areas prioritized:
Global Market Shaping: This includes negotiation of further price reductions as appropriate (and extending beyond the 13 commodities); establishing product standards to rationalize manufacturing and country procurement; harmonization of regulatory guidelines between countries; further work on joint dossier and manufacturer inspections, and; global efforts to better understand the relative contribution of the private sector in the procurement and distribution of life saving commodities.

Ongoing support to quality assurance for commodities: This includes procurement from GMP accredited manufacturers, conducting bio-equivalence and bio-availability studies, establishing and supporting pharmaco-vigilance programs, and national and regional support for post market surveillance.

Procurement and Supply Chain Management: This includes assistance with national commodity security strategies; quantification support; the establishment of a fund for flexible financing for commodity purchasing; the coordination of IT innovations such as LMIS systems, LMIS/HMIS integration and facility-level stock assessments, and; national efforts to better understand the role of wholesalers and the private sector.

Standardized Monitoring Platform: The ‘commodity lens’ has been a useful and complementary approach for identifying and addressing systems-related and commodity-specific gaps. Beyond conventional activity-based monitoring, a standardized tracking platform mirroring the UNCoLSC recommendations should be maintained to inform both global priority setting and country RMNCH plans moving forward.

Knowledge Transfer: A mechanism to more effectively translate global learning to country-level action remains a critical priority. Such a mechanism should provide robust and sustained technical support to countries on a demand-driven basis, and should have at least two key components. Firstly, it should provide a hub for continually updated best practice materials that have become available from the UNCoLSC and related initiatives including a synthesis of the latest evidence, tool-kits, training materials, and treatment guidelines. Second, it should facilitate country-level access to established networks of global experts who can support key priorities including refining EMLs, treatment guidelines, training materials and job-aids based on the latest evidence, and coordinated guidance and technical support with IT innovations.
## Progress against UNCoLSC milestones

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Year of completion</th>
<th>Specified Milestone</th>
<th>Complete</th>
<th>Partial</th>
<th>Not started</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shaping Global Markets</td>
<td>2014</td>
<td>Sign volume guarantee with at least one manufacturer of contraceptive implants, if appropriate pricing and volume terms can be agreed upon</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Aligning the market data collection efforts being undertaken by various groups and consolidating this data in a web-based portal</td>
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<td></td>
<td>2014</td>
<td>Evaluate the increase in availability and affordability of contraceptive implants</td>
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<td></td>
<td>2013</td>
<td>Working with the commodity TRTs and other groups engaged in generating demand forecasts to consolidate this information at the global-level</td>
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<td>x</td>
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<tr>
<td>2. Shaping Local Delivery Markets</td>
<td>2014</td>
<td>Develop toolkits for a portfolio of interventions to engage private sector suppliers (manufacturers and distributors) to produce, distribute, and promote</td>
<td>x</td>
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<tr>
<td></td>
<td>2013</td>
<td>Identify appropriate supply interventions and begin implementing select supply side interventions for relevant life-saving commodities in targeted</td>
<td>x</td>
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<td></td>
<td>2014</td>
<td>Expand implementation of supply interventions and supply side communication to regional initiatives (such as pooled procurement and local</td>
<td>x</td>
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<tr>
<td>3. Innovative Financing</td>
<td>2012</td>
<td>Agree on the host of a result-based funding mechanism for life-saving commodities</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>At least 10 EWEC countries enter into an agreement with the funding mechanism to increase access to the life-saving commodities</td>
<td>x</td>
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<td></td>
<td>2014</td>
<td>Guidance developed for countries to implement in-country RBF-approaches to strengthen access to life-saving commodities at all levels</td>
<td>x</td>
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<tr>
<td>4. Quality Strengthening</td>
<td>2012</td>
<td>ERP for dispersible amoxicillin</td>
<td>x</td>
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<td></td>
<td>2012</td>
<td>Development of optimal quality assurance for zinc (e.g., market surveillance approach, ERP)</td>
<td>x</td>
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<tr>
<td></td>
<td>2013</td>
<td>ERP for chlorhexidine</td>
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<tr>
<td>5. Regulatory Efficiency</td>
<td>2013</td>
<td>WHO-EM includes all 13 life-saving commodities</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Joint inspections or dossier reviews are implemented for at least 3 LSC</td>
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<td></td>
<td>2013</td>
<td>Regulators in pathfinder countries agree on a common pathway for at least 5 life-saving commodities</td>
<td>x</td>
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<td>6. Supply &amp; Awareness</td>
<td>2013</td>
<td>Briefs/guidance and/or reference documents published on a range of supply chain topics</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Quantification and forecasting guidance for all LSC available to countries (including harmonized definitions of forecasting and quantification and</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Toolkit for private sector engagement in supply chain functions available</td>
<td>x</td>
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<td>7. Demand &amp; Utilization</td>
<td>2014</td>
<td>Global demand generation implementation Kit developed with adaptable communication strategies for at least 9 priority commodities</td>
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<td></td>
<td>2013</td>
<td>Commodity-related functionality for an open source LMIS system (LMIS 1.0) developed, and pilot integration with HMIS in at least one country</td>
<td>x</td>
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<td>2014</td>
<td>Country-specific communication strategies developed in at least two pathfinder countries that incorporate life-saving commodities from at least one health area</td>
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<tr>
<td></td>
<td>2014</td>
<td>Demand generation programs implemented in at least 4 pathfinder countries that incorporate life-saving commodities from at least one health area (e.g.,</td>
<td>x</td>
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<td>8. Reaching Women &amp; Children</td>
<td>2013</td>
<td>Eight EWEC countries have financial protection programmes with a commodity focus</td>
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<td></td>
<td>2014</td>
<td>Evaluate the increase in use of (a sub-set of) life-saving commodities in concerned countries</td>
<td>x</td>
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<tr>
<td>9. Performance &amp; Accountability</td>
<td>2014</td>
<td>The status of national availability and use of the 13 commodities and available guidelines (including m-applications) in 8 pathfinder countries for</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Development of generic checklists for implants and safe birth, including use of MgSO4, has begun</td>
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<tr>
<td></td>
<td>2014</td>
<td>Training and scalable strategies for checklist use including e- and m-learning have been developed and deployed</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Feasibility assessments on the use of social audits to improve accountability have been carried out in 10 countries</td>
<td>n/a</td>
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<tr>
<td>10. New Product Innovation</td>
<td>2014</td>
<td>Form a coordinating group to lead reviews, prioritization and monitoring of product improvements/innovations</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Prioritize four product improvement/innovation areas</td>
<td>x</td>
<td></td>
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<tr>
<td></td>
<td>2014</td>
<td>Secure commitments including donor and private industry earmarks for innovation and research and development</td>
<td>x</td>
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</table>
II. Background

In September 2010, with five years remaining to achieve the Millennium Development Goals (MDGs), the UN Secretary General launched the Every Woman Every Child movement to mobilize and intensify action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children around the world. The movement puts into action the Global Strategy for Women’s and Children’s Health, which presents a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children.

Under this banner, The UN Commission on Life Saving Commodities (UNCoLSC) was established in 2012 with the aim of increasing access to life-saving commodities in the world’s poorest countries. The UNCoLSC Report identified 13 underutilized, low-cost and high-impact commodities that if implemented at scale, could make the greatest impact in reducing preventable maternal and child deaths (Figure 1).

The Commission also identified a series of interrelated barriers that prevent access and utilization of these 13 commodities. These include severely under-resourced regulatory agencies leading to delayed registration of commodities; lack of oversight of product quality; market failures, where return on investment is too low to encourage manufacturers to enter the market or produce sufficient quantities; and user supply and demand challenges such as limited demand for the product by end-users, local delivery problems and incorrect prescription and use.

Figure 1: UNCoLSC Recommendations to improve access to 13 Life-Saving Commodities

<table>
<thead>
<tr>
<th>Reproductive health</th>
<th>Oxytocin</th>
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<tbody>
<tr>
<td></td>
<td>Misoprostol</td>
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<td>Magnesium sulfate</td>
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<tr>
<th>Maternal Health</th>
<th>Injectable antibiotics</th>
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<tr>
<td></td>
<td>Antenatal</td>
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<td></td>
<td>Corticosteroids</td>
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<td></td>
<td>Chlorhexidine</td>
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<td></td>
<td>Resuscitation Equip.</td>
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<thead>
<tr>
<th>Newborn Health</th>
<th>Amoxicillin</th>
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<tbody>
<tr>
<td></td>
<td>Oral Rehydration Salts</td>
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<td></td>
<td>Zinc</td>
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<table>
<thead>
<tr>
<th>Child Health</th>
<th>Female Condoms</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Implants</td>
</tr>
<tr>
<td></td>
<td>Emergency Contraception</td>
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</tbody>
</table>

To take forward the UNCoLSC’s recommendations, an Interim Secretariat was rapidly established, with the RMNCH Strategy and Coordination Team (SCT) formalized in May 2013, hosted by UNICEF. The SCT is an interagency body comprising representatives of WHO, UNFPA and UNICEF. It acts as a coordinating mechanism to facilitate action on
three levels. First, it supports efforts to work with and through the H4+ and partners to track the status of commodities from manufacturing through to coverage in high burden countries. Second, it works to fund and facilitate a network of Technical Resource Teams (TRTs) who identify and address the interrelated barriers outlined above. Finally, alongside other financing streams, the SCT administers a Trust Fund which provides catalytic investments to support national RMNCH plans to address critical gaps.

Efforts have been ongoing at the global and country-levels for over two years to advance the UNCoLSC agenda within the wider EWEC framework. The 2015 deadline for the MDGs represents an important juncture for taking stock of global progress towards improving access to live saving commodities, while simultaneously highlighting remaining implementation gaps. Decisions should be made regarding where efforts have been sufficient and key milestones achieved, and where activities should be carried over into the post-2015 agenda.

This critical reflection is particularly timely given the emerging Sustainable Development Goal (SDG) agenda being launched at the UN General Assembly in September 2015 – which defines a new set of global commitments to create a healthy, prosperous, sustainable future for all people from 2016 to 2030. This is supported by an updated Global Strategy for Women’s, Children’s and Adolescent’s Health (Global Strategy 2.0) and a new Global Financing Facility which is being hosted by the World Bank and aims to be a major vehicle for the sustainable financing of this strategy.

The aim of this report is to review progress to date against the recommendations of the UNCoLSC, building on last year’s report – with an emphasis on activities taking place during 2014 and early 2015.

- The first section will profile the latest status of the UNCoLSC recommendations and the results of a recent multi-country assessment
- The second section expands upon the global work of the TRTs and documents progress against milestones outlined in the UNCoLSC report and Implementation Plan
- The third section will profile the RMNCH Country Engagement Process, which furthers the UNCoLSC agenda at the country-level through the provision of catalytic technical and financial support to RMNCH country plans
- The final section will discuss challenges, lessons learned and next steps for the post-2015 SDG agenda, with particular reference to the updated Global Strategy for Women’s Children’s and Adolescent’s Health and Global Financing Facility
III. Status of UNCoLSC commodities and recommendations: a multi-country assessment

When the UNCoLSC report was launched, its recommendations were largely based on the global and country-level perspectives of its Commissioners and partner organizations, drawing from a collective field experience and limited range of existing data. The overall approach was underpinned by the notion that commodities can be effective tracers, providing practical and operational focus for identifying and addressing challenges in delivering essential RMNCH interventions – from manufacturing and supply chain management to health worker performance and demand generation. This approach mirrors recent successful efforts to expand access to antiretrovirals for the prevention and management of HIV/AIDS, and malaria control efforts through improving access to bednets, rapid diagnostics and combination therapy.

While barriers to availability and access to commodities are broadly understood, there has been no robust platform to allow systematic tracking of systems-related and commodity-specific bottlenecks. Since its inception, the RMNCH SCT has been working with the UN agencies, partners and the global network of Technical Resource Teams (TRT) to develop a commodity tracking platform that fills this gap. This has required drawing together a wide range of existing data from in-country sources (ie. policies, guidelines, essential medicines lists, training materials), and refining existing assessment tools and surveys to include a focus on the 13 commodities. Every effort was made to harmonize indicators with other related initiatives, such as the Commission on Information and Accountability (COIA) and Countdown to 2015. The SCT has also worked with WHO, UNDP, the World Bank, and USAID in an effort to harmonize the content and scheduling of health facility assessments to maximize the availability of ground-level information on the 13 life-saving commodities.

To further our understanding of the current situation of the UNCoLSC commodities and recommendations, and to identify key global and country-specific bottlenecks, a multi-country assessment was conducted from 2013 onwards. The specific methods and findings from this assessment are described below.

Methods

To generate a standardized set of metrics against which to assess UNCoLSC progress, an RMNCH Landscape Synthesis tool was developed and implemented in countries receiving support from the RMNCH Fund, as well as a sub-set of additional Every Woman Every Child (EWEC) countries. The tool focuses on identifying systems-related and commodity-specific barriers, with a focus on the 13 lifesaving commodities. A harmonized and limited set of actionable indicators that capture progress around each UNCoLSC recommendation were developed, drawing from the expertise of the TRTs. The full indicator list is presented in Appendix 1. These indicators and a results framework was reviewed and approved by an interagency Monitoring and Advisory Committee.

The data synthesis process involves the compilation of existing information from a range of sources – including national strategic plans, essential medicine/medical device lists, training materials, and other related documents. To understand downstream facility and population-level issues, aggregated indicators from health facility assessments or health/logistics management information systems are reviewed where available, alongside the most recent population-
based survey data. This is complemented by semi-structured interviews with key stakeholders in the Ministries, procurement and regulatory agencies, and with local experts.

Categorical variables are generated based on the results of structured question sets and given a performance rating (weakest “1” to “5” strongest). The performance rating cut-offs were developed in consultation with the global TRTs and the Monitoring Advisory Committee to illustrate incremental improvements in systemic or programmatic conditions. These performance ratings generate an easy to interpret score, which is comparable over time and across countries.

Results are entered into a relational database and processed for upload to a web-based platform, for dissemination and visualization as a Dashboard (Figure 1). This Dashboard provides a visual representation of bottlenecks along the RMNCH continuum for a single country as well as multi-country maps and aggregations. Indicators are framed in line with the 13 life-saving commodities and UNCoLSC recommendations.

**Figure 1: UNCoLSC Dashboard Screenshot**

![Dashboard Screenshot](image-url)
Findings

Between January 2013 and May 2015, the RMNCH Landscape Synthesis was carried out in 10 countries in sub-Saharan Africa (Cameroon, Ethiopia, Kenya, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, Mali and Malawi). Data from an additional nine countries will be available in mid-2015. Follow-up assessments conducted on an annual basis will document change over time.

Figure 2 aggregates the overall performance across 10 countries for each commodity – summarizing the average index score for each UNCoLSC recommendation (maximum score: 100). For example, a commodity with a high score would (across the 10 countries) be on the EML and registered; have the prescription authority established at the most appropriate level of care; is tracked in the LMIS system; is in-stock at the national and facility level; has both training curricula and facility staff that have been recently trained; have available job-aids/checklists that include the commodity, and is exempt from user-fees. The small bars depict the range or minimum and maximum country scores, which helps illustrate variation across countries.

Performance by commodity was relatively consistent, which suggests a high-likelihood of common cross-commodity bottlenecks. Child and maternal health commodities performed the strongest, with newborn and reproductive health commodities performing slightly more poorly. National and facility-level supply was relatively poor for female condoms and misoprostol, respectively. For Chlorhexidine, weaknesses were evident at multiple points along the continuum including regulatory performance (e.g. on treatment guidelines and fully registered) and supply indicators (e.g. tracked in eLMIS and stock available at facilities).

Figure 2: Performance Index by Commodity across Recommendation indicators (10 countries)

<table>
<thead>
<tr>
<th>Commodity</th>
<th>Male</th>
<th>Female Condom</th>
<th>Implant</th>
<th>Emergency contraceptive</th>
<th>Oxytocin</th>
<th>Misoprostol</th>
<th>Magnesium Sulfate</th>
<th>Chlorhexidine</th>
<th>Neonatal Resuscitation</th>
<th>Amoxicillin</th>
<th>ORS</th>
<th>Zinc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index:</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>80</td>
<td>90</td>
<td>100</td>
<td></td>
<td></td>
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<tr>
<td>Reproductive</td>
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<td>Maternal</td>
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<tr>
<td>Newborn</td>
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<td>Child</td>
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</tbody>
</table>

Note: Indicator scoring based on a 100 point scale
Figure 3 summarizes data for the relevant UNCoLSC recommendation area from the 10 countries across all commodities. Regarding systems-related bottlenecks, most countries had strong RMNCH coordination mechanisms and costed-plans, used appropriate forecasting tools and procured commodities from Good Manufacturing Practice certified manufacturers. Fewer countries had commodity security strategies in place or systems for monitoring the quality and safety of medicines. Comprehensive logistics management information systems to track supplies to the district level were less developed, and performance-based financing mechanisms, if they existed, were generally still in pilot phase.

Several broad commodity-specific bottlenecks were identified – typically at the facility-level. Relatively easy to address upstream bottlenecks were still present in all countries – including out-of-date EMLs, commodities not being registered, and prescription authorities not sanctioning administration at the appropriate level of care. Weakness persists in LMIS tracking of commodities between central warehouse and health facilities, which limits informational reach and accountability. Health worker training and availability of job-aids or checklists at facilities is consistently underachieving, potentially limiting health provider performance. Crucially, just over half of the 13 life-saving commodities were in stock at the point-of-service at the time of assessment.

Figure 3: System-related and commodity-specific bottlenecks for 13 commodities (10 countries)
Across the 10 countries, stock-levels were examined for each commodity (Figure 4). Child health commodities were most commonly in stock, while misoprostol and antenatal corticosteroids were available just 21% and 45%, respectively. Lastly, the timeliness and availability of data is a limiting factor from several facility- and population-level data points. Accurate information on appropriate utilization or coverage with maternal and newborn commodities at the facility or population-level is currently non-existent – which is a major gap. This is being prioritized within the Quality of Care initiative for the post-2015 agenda (Case Study 1). Case Study 2 below highlights the application of the RMNCH Dashboard to understanding potential barriers to the uptake and utilization of implantable contraceptives since the 2012 price reductions and procurement agreements were signed.

**Figure 4: Percent of health facilities with stock available for 13 commodities (10 countries)**

[Diagram showing the percentage of health facilities with stock available for 13 commodities across categories: Reproductive, Maternal, Newborn, Child.]
How do UNCoLSC bottlenecks change over time? Results from 4 countries

In four of the ten countries assessed (Ethiopia, Malawi, Senegal, and Uganda) the RMNCH Landscape Synthesis was conducted in both 2013 and 2015. Over the 2-year span, performance improved across all commodities with the exception of ORS, which displayed a small decline due to a national-level stock-out in Senegal. Chlorhexidine, magnesium sulfate and implants posted the largest gains. Progress within the regulatory environment (e.g. treatment guidelines and registration) and health worker performance (e.g. national training curricula and job-aids / checklists) contributed most to these performance gains. System-related indicators showed relatively mixed results. Countries reported improvements in procurement from GMP-accredited manufacturers and comprehensive eLMIS capabilities, which were relatively poor performers at baseline. Weaknesses developed around RMNCH plans as new funding sources have yet to be identified for Ethiopia’s new 5-year strategic plan, which begins in 2015. Additional longitudinal data will be available in mid-2015.

Performance Index by Commodity over time

<table>
<thead>
<tr>
<th>Commodity</th>
<th>Index 2013</th>
<th>Index 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Condom</td>
<td>67.7</td>
<td>70.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Implant</td>
<td>77.9</td>
<td>86.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Emergency contraceptive</td>
<td>74.8</td>
<td>80.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Oxytocin</td>
<td>80.0</td>
<td>86.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Misoprostol</td>
<td>77.3</td>
<td>82.8</td>
<td>5.4</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>77.3</td>
<td>86.7</td>
<td>9.3</td>
</tr>
<tr>
<td>Injectable antibiotic</td>
<td>75.9</td>
<td>82.9</td>
<td>7.1</td>
</tr>
<tr>
<td>Antenatal Steriod</td>
<td>74.1</td>
<td>78.8</td>
<td>4.7</td>
</tr>
<tr>
<td>Chlorhexidine</td>
<td>55.6</td>
<td>73.9</td>
<td>18.4</td>
</tr>
<tr>
<td>Neonatal Resuscitation</td>
<td>75.7</td>
<td>80.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>81.5</td>
<td>82.9</td>
<td>1.5</td>
</tr>
<tr>
<td>ORS</td>
<td>91.7</td>
<td>90.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Zinc</td>
<td>86.4</td>
<td>86.5</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>76.8</strong></td>
<td><strong>82.3</strong></td>
<td><strong>5.5</strong></td>
</tr>
</tbody>
</table>

System-related bottlenecks over time

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Index 2013</th>
<th>Index 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination mechanism</td>
<td>70.0</td>
<td>85.0</td>
<td>15.0</td>
</tr>
<tr>
<td>RMNCH plan costed and budgeted</td>
<td>90.0</td>
<td>80.0</td>
<td>-10.0</td>
</tr>
<tr>
<td>Results-based financing mechanism</td>
<td>60.0</td>
<td>66.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Procure from GMP-accredited manuf.</td>
<td>60.0</td>
<td>95.0</td>
<td>35.0</td>
</tr>
<tr>
<td>National medicines control lab</td>
<td>65.0</td>
<td>75.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Monitor quality &amp; safety of medicines</td>
<td>70.0</td>
<td>75.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Forecasting tools</td>
<td>80.0</td>
<td>75.0</td>
<td>-5.0</td>
</tr>
<tr>
<td>Comprehensive national eLMIS</td>
<td>40.0</td>
<td>60.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Supply chain training to districts</td>
<td>90.0</td>
<td>85.0</td>
<td>-5.0</td>
</tr>
<tr>
<td>Demand generation</td>
<td>73.3</td>
<td>90.0</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>69.8</strong></td>
<td><strong>78.7</strong></td>
<td><strong>8.8</strong></td>
</tr>
</tbody>
</table>
Case Study 1: Improving quality of care for women, children and adolescents

While coverage indicators for maternal, newborn and child health are well-established, globally agreed upon indicators that capture the quality of health care have to be further developed. This is particularly relevant for maternal and newborn interventions where there are few existing data sources to document whether these interventions (and related commodities) have been delivered appropriately. A global consultation called by WHO in 2013 sought to achieve consensus on core indicators for global measurement and reporting on the quality of care (QoC) provided for mothers, newborns and children in health facilities. The meeting agreed on the establishment of a set of 19 indicators to be collected and reported. It is anticipated that the need for reporting on these indicators:

- encourages health facilities to improve the quality of record-keeping and in-facility data collection
- encourages national health information systems to integrate sentinel measures of quality of care
- increases the accountability of national health systems, thus adding to broader improvement of quality of health care
- at the global level, highlights the need for a shift from just “increasing coverage” of health services and commodities for maternal, newborn and child care to a more balanced focus on “coverage and quality”

These core indicators may be extended to a complementary set of measures to support intensive quality improvement efforts at community, primary care and referral levels. A reliable, sustainable process is required to collect data to measure these indicators routinely and use them to initiate actions at all levels of the health system to improve the quality of health care for mothers, newborns and children.

Since the meeting, a network for quality improvement composed of researchers and partner agencies has been established. This collaborative network devises mechanisms for collecting data, reviewing reports, recommending changes and improving indicators. Under WHO leadership, the group is pilot-testing these indicators for feasibility of collection and measurement, mainly through the routine information systems, supplemented by health facility surveys.

Currently, the set of the proposed QoC indicators is being tested in 35 hospitals spread around sub-Saharan Africa and India. Furthermore, maternal and newborn datasets from over 1000 hospitals from 11 countries in Africa and Asia being assessed for QoC data. These two studies together with the assessment of the information collected by the WHOs facility assessment tool and other facility-based surveys will inform the consolidation and rolling out of these indicators in countries to improve the effectiveness and efficiency of care delivery at all levels. Final results are due by the end of 2015.
Case Study 2: Using the RMNCH Dashboard to understand barriers to uptake and utilization of contraceptive implants across ten sub-Saharan African countries

Substantial price reduction agreements were secured from manufacturers for contraceptive implants in late 2012 which helped dramatically increase their availability and affordability. In 2013 alone, approximately 50% more implants were delivered to the world’s poorest countries. However, an increase in supply does not equate to effective utilization. Improving coverage with implants will require a range of complementary inputs from commodity registration and clear technical guidelines through to supply chain strengthening, health worker training and demand generation efforts.

Among the 10 countries included in the RMNCH Landscape Synthesis (all since the price reduction), the household survey data suggest coverage with implants remains low - the prevalence of modern contraceptive use was 23%, with implants making up 8.5% of the methods mix, and contributing to just 1.6% to overall coverage.

In these same countries, RMNCH Landscape Synthesis identified a range of persistent bottlenecks (below):

- **Gaps in EML and product registration:** The influx of implantables by donor organizations has sometimes by-passed national systems, and efforts to ensure national EMLs are up-to-date and products are registered in-country should be prioritized. While implants were included on the EML in 8/10 countries, these often excluded newer formulations. In addition, despite being widely available, implants were often not registered in-country.
- **Insufficient health worker training and availability of support tools:** While treatment guidelines and prescription authority were generally in-place along with national training curricula for insertion and removal, facility assessments documented persistent gaps in health worker training and in the availability of tools such as job-aids and checklists.
- **Supply chain shortfalls:** Supply chain-related issues were a pressing challenge - while stock at the national warehouses were sufficient over the preceding year, implantables are often not tracked in LMIS systems and point-of-service stock-outs at time of assessment were common - averaging 36% across countries with a wide range between 4% and 92%.
- **User fees:** Finally, user-fees remain an access barrier in some settings.

![System-related and commodity-specific bottlenecks for contraceptive implants(10 countries)](image)
IV. Global Technical Resource Teams (TRTs)

To carry forward the UNCoLSC recommendations at the global-level and provide support to country implementation, a network of Technical Reference Teams (TRTs) was established in time for the launch of the Commission’s report. One group was formed for each of the 13 commodities and 10 recommendations, with an Advocacy Working Group and Digital Health TRT dedicated to advancing cross-cutting themes. The aim of establishing the TRTs was to consolidate global expertise in a particular subject area to support a more coordinated and catalytic response to improving availability and access to life saving commodities.

Each TRT is a consortium of global experts, comprising UN agencies, NGOs, government partners and academic institutions. An inception meeting was held in Oslo in August 2012 where the TRTs were formed and focus areas refined – in particular to understand how the cross-cutting recommendations were relevant to the specific commodities and vice versa. The TRTs met again in late 2012 to finalize their workplans for the first year of implementation. A second phase of work plans were submitted in mid-2014 and approved after assessment by an Interagency Review Panel. The implementation of these workplans was financially supported by the RMNCH Fund.

A simplified TRT structure was adopted after a review process in November 2013 to improve inter-TRT communication, facilitate TRT administration/coordination by the RMNCH SCT, and better package global expertise to Ministries. This reconfigured structure of 9 TRTs is organized as follows (Figure 5):

- **Four Commodity TRTs** are thematically grouped by Reproductive, Maternal, Newborn and Child domain - with new product innovation contributing to each. These groups maintain a technical focus on compiling research and evidence for relevant commodities; advising on product specification; exploring opportunities for new product innovation; refining treatment guidelines; mapping the manufacturing landscape, and; technical input into the design of job-aids, check-lists and training materials.

- **Three Recommendation TRTs**: act as the interface to translate and disseminate the work of the UNCoLSC to the country-level.
  - A **Global Regulation, Markets, and Policy** TRT was created to support upstream challenges with global manufacturing, commodity availability and price, import and regulatory hurdles, post-market surveillance and pharmacovigilance
  - A **Supply Chain** TRT was created to address national procurement and distribution bottlenecks in the public and private sectors.
  - A **Demand, Access and Performance** TRT addresses challenges at the interface between facilities, health workers and communities.

- **Two cross cutting TRTs**: Advocacy and Digital Health
During the initial 2013 phase of the work, the TRTs focused primarily on **global-level activities** to further the UNCoLSC recommendations. Examples of early priorities included mapping commodity manufacturers; assessing alignment between global standards and national systems; reviewing and updating tools and training materials; systematic assessments of best practice and; new product development.

During the second phase of work from 2014 onwards, the TRTs also provided support to **country-level** implementation. First, they have the opportunity to provide technical inputs into country RMNCH plans. Second, they work through established networks of in-country partners to implement specific components of their workplans, or to support pieces of national plans, at countries’ requests. Finally, they work collectively to disseminate systems, tools and work-products to countries through professional organizations, national meetings, and regional and global conferences and workshops.

A set of proposed activities and time-bound milestones against each of the 10 UNCoLSC recommendations were outlined in the 2012 report and accompanying Implementation Plan. These were further refined by the TRTs based on feasibility and relevance as insights from global and country-level experience was gained. A final revised list was submitted to the iERG in December 2013, which formed the basis of last year’s progress report, as well the current report.

The sources of data for these metrics are variable and correspond to the workplans outlined in the logical frameworks for each TRT. Work done by the TRTs supporting the 13 commodities has been integrated into the reporting of cross-cutting recommendations below. Illustrative case studies are also profiled. As most activities pertain to addressing global bottlenecks, most progress gains outlined below have wider application across the full range of EWEC countries.
**Recommendation 1: Shaping Global Markets**

By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
<th>Status</th>
</tr>
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<tbody>
<tr>
<td>Identify priority commodities amenable to immediate, global market-shaping efforts and analyse markets to identify the most effective global market-shaping mechanism for the prioritized commodities</td>
<td>Negotiate price reduction with at least one manufacturer of contraceptive implants, if appropriate pricing and volume terms can be agreed upon (2014-2015).</td>
<td>Completed in 2013: Volume guarantees were negotiated with both SRA-approved/WHO-prequalified implant manufacturers (Bayer and MSD) resulting in a 50% price reduction for all FP2020 priority countries</td>
</tr>
<tr>
<td>Apply proposed market-shaping mechanisms to selected commodities</td>
<td></td>
<td>Completed in 2014; Announced in 2015: Successfully negotiated a volume guarantee with Blue Fuzion Group to reduce the cost-per-use of the non-pneumatic shock garment (NASG) by 75% through a reduction in product pricing combined with improvements in the durability of the product.</td>
</tr>
<tr>
<td>Establish mechanism for consolidating market data &amp; forecasts at the global level across all 13 essential commodities</td>
<td>Signed MoUs with three manufacturers of the neonatal bag and mask resuscitator, each of which have met WHO draft product/quality specifications and could achieve product pricing that is 30-40% lower than the market-leading resuscitator in LMICs. Discussions are underway to confirm adherence to WHO’s final product specifications and negotiate a definitive pricing agreement for LMIC markets.</td>
<td></td>
</tr>
</tbody>
</table>

Aligning the market data collection efforts being undertaken by various groups (including CHAI, USAID, WHO, and the commodity TRTs) and consolidating this data in a web-based portal

Completed in 2013: Market data collection, supplier mapping, and barrier-to-access assessments have been aligned and have informed the prioritization of products for forthcoming global market shaping interventions.

Additional market data collection is being prioritized to determine if other global market shaping priorities exist within the RMNCH space and to refine demand forecasts to support potential interventions.

Evaluate the increase in availability and affordability of contraceptive implants (2014).

Completed in 2013: Public and private sector partners worked together to halve the price of contraceptive implants, including Bayer’s Jadelle and MSD’s Implanon and Implanon NXT, over the next six years.

Deals have dramatically expanded availability and affordability, generated substantial procurement savings, and contributed to reductions in infant and maternal deaths as well as unintended pregnancies. Monitoring efforts are ongoing and show an increase in implants distributed to eligible countries from 4.8M in 2012 to 7.3M in 2013, with further increases in 2014.

Working with the commodity TRTs and other groups engaged in generating demand forecasts to consolidate this information at the global-level

Partial: Needs-based forecast algorithms have been developed for all commodities. Demand forecasts have been initiated for prioritized commodities with further refinement to occur, once additional market data has been collected and analysed. In 2014 TRT members provided technical assistance to governments and manufacturers in the development of reliable demand forecasts for key products, such as chlorhexidine and uterotonic.
Overview: Market inefficiencies often create barriers to access for health commodities in developing countries. Some key marketplace issues – such as high price/low volume traps, limited demand visibility, demand fragmentation, limited supply base, and suboptimal product design – can be mitigated by global market shaping interventions, if certain parameters are met.

One aim of the Global Regulation, Markets and Policy TRT is to assess whether global market shaping interventions could reduce some of the key barriers to access for the life-saving commodities prioritized by the UN Commission. As certain market characteristics are required to facilitate global market shaping interventions and as these interventions are only able to address some barriers to access, not all products prioritized by the UN Commission are likely to benefit from global market shaping interventions in the near-term. Therefore, the TRT collected relevant market data and information to prioritize those commodities for which global market shaping interventions could be feasible and productive in the near-term, and to subsequently structure appropriate interventions for the prioritized commodities.

In 2013, the major accomplishment was the achievement of 50% price reduction agreements for contraceptive implants with two manufacturers.

Deliverables for 2014:

- Needs-based forecasting algorithms have been finalized for all 13 life-saving commodities, and demand forecasting technical assistance has been provided to ministries of health and manufacturers for key products.
- 75% reduction in the cost per use of Non-pneumatic Anti-Shock Garment (NASG) supplied by Blue Fuzion Group, from $1.30 to less than $0.30 per use (2014)
- Signed MoUs with three manufacturers of the neonatal bag and mask resuscitator, each of which have met WHO draft product/quality specifications and could achieve product pricing that is 30-40% lower than the market-leading resuscitator in LMICs. Discussions are underway to confirm adherence to WHO’s final product specifications and negotiate a definitive pricing agreement for LMIC markets.
**Case Study 3: **Price reduction and durability improvement to increase access to the Non-pneumatic Anti Shock Garment (NASG)

Postpartum hemorrhage (PPH) is the leading cause of maternal mortality in most low-income countries and is responsible for nearly one quarter of all maternal deaths globally, most of which occur within the first 24 hours of delivery as a result of complications in the third stage of labor and delays in receiving proper treatment. Preventing PPH’s onset or stabilizing it immediately on occurrence and referring for treatment could avert the majority of these deaths.

The Non-Pneumatic Anti-Shock Garment (NASG) is a lightweight (1.5 kg), washable and reusable first aid compression device made of neoprene that reverses hypovolemic shock resulting from PPH. The NASG plays a unique role in PPH and hypovolemic shock management. In conjunction with interventions including increasing the availability and usage of oxytocin and misoprostol, the introduction and widespread rollout of the NASG is a core intervention to avert maternal deaths in low-income countries.

The price of the NASG represented a significant barrier to access in nearly all countries surveyed in 2013 and consequently, scale-up has been limited. In 2011, the Clinton Health Action Initiative’s (CHAI) Ethiopian country team purchased 120 NASGs at $272/unit and despite price reductions resulting from a PATH project aimed at identifying and facilitating market entry of low-cost producers, the 2013 price (excluding shipping costs) was $68.50/unit. From a supplier perspective, the small order quantities, short lead times, uncertain demand, and small market size increased the cost of producing and shipping NASGs to African countries.

Following discussions with country teams, funders, and public health managers, CHAI set a goal to reduce the price of the NASG. A market shaping approach was adopted to rationalize production costs and reduce pricing by providing suppliers increased visibility into demand. This involved working closely with suppliers, CHAI country teams, and MoH & NGO partners on a number of parameters for to improve production planning and procurement practices. A volume guarantee was ultimately negotiated with one manufacturer for 25,000 NASGs over two years in the EWEC 49 Global Strategy countries as well as Cameroon and South Sudan. In exchange, the supplier reduced its price to $41.55 per garment and, with the support of CHAI and the UCSF Safe Motherhood Program, developed a more durable material for the NASG that can withstand up to 144 wash and stretch-and-recovery cycles versus the previous indication of 50 uses per garment. As a result of the reduced unit price and improved durability, the cost per use is now $0.29 before shipping, a 78% reduction in the lowest-available cost per use of the NASG.
Recommendation 2: Shaping Local Delivery Markets

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<tr>
<th>Activities</th>
<th>Milestones</th>
<th>Status</th>
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<tr>
<td>Create incentives for national and regional wholesalers and large distributors to actively promote commodities over sub-optimal alternative treatments and to accelerate distribution through private channels</td>
<td>Develop toolkits for a portfolio of interventions to engage private sector suppliers (manufacturers and distributors) to produce, distribute, and promotion appropriate products. (early 2014)</td>
<td>Completed in 2013: Detailed assessments conducted across 4 countries (Nigeria, Kenya, Tanzania, Malawi) to identify local market gaps and strategies to address them. Market Shaping Primer completed</td>
</tr>
<tr>
<td>Perform WHO-supported global or regional joint regulatory reviews of safety for national approval of low-level and OTC use</td>
<td>Identify appropriate supply interventions and begin implementing select supply side interventions for relevant life-saving commodities in targeted countries (2013)</td>
<td>Completed in 2013: Developed a summary of (or high-level) local market shaping strategies for roll out of Chlorhexidine and Amoxicillin DT in Nigeria (signed Apr 2014 by MoH); The strategy document will be shaped in collaboration with the chlorhexidine commodity group. Discussions with Governments continue, with Newborn Resuscitation commodities promising</td>
</tr>
<tr>
<td>Expand implementation of supply interventions and supply side communication to regional initiatives. (such as pooled procurement and local manufacturer engagement) (2014)</td>
<td>Expand implementation of supply interventions and supply side communication to regional initiatives. (such as pooled procurement and local manufacturer engagement) (2014)</td>
<td>Completed in 2013: Engagement commenced with East African Community to design market shaping initiatives to strengthen the East African pharmaceutical industry’s competitive position and market share. In 2014, this included landscape analysis of existing regional production of UNCoLSC products, assessment of local manufacturer capabilities and commercial interest in UNCoLSC priority products, and developing market sizing estimates. Ongoing support was provided to the EAC Secretariat’s Pooled Procurement team, which included assessing opportunities for the pooled procurement of final products, intermediate products and packaging, and product specific innovations. Demonstrating success in EAC has been prioritised, consequently, other regions (ECOWAS, SADC) at an earlier stage of development, with engagement planned for 2015.</td>
</tr>
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</table>

**Overview:** The lack of consistent supplies of quality assured, WHO recommended formulations of RMNCH commodities has represented a major bottleneck to accelerating access. In many instances, the commodities that are procured are not the WHO recommended formulations and/or are not of internationally recognized quality. Where high-quality optimal commodities are available, they are often priced at levels which are uncompetitive compared to sub-standard products and manufactured by producers who have not invested in ensuring minimum quality standards.

The Global Regulation, Markets and Policy TRT addresses these local market failures (or ‘market traps’) particularly in situations where the local private sector comes into play. It may only therefore be relevant for a subset of commodities.

In 2013, a number of deliverables were produced with further refinement during 2014, including a Market Shaping Primer of private sector interventions designed to help stakeholders design and monitor market shaping interventions in global health markets and increase access to life saving commodities; In-country commodity assessments in Nigeria, Malawi, Tanzania and Kenya in order to identify specific local market bottlenecks, thus providing an initial framework and approach towards assessments in further countries and directly feeding into strategic planning at a country level, and; a synopsis of opportunities for Financing Diarrhea and Pneumonia Treatment Gaps in 10 high burden countries.

**Deliverables for 2014:**

- *Increasing Commodity Access by Shaping Local Markets at Regional and National Levels:* Regional market shaping efforts conducted with the East African Community (EAC) designed to strengthen the EAC
pharmaceutical industry’s competitive position and market share of the health pharmaceutical market, while increasing access to high quality, affordable maternal and child health commodities and essential medicines. Assessment of cost components for local and international manufacturers in producing target products identified the sourcing of Active Pharmaceutical Ingredients (API), the major cost driver, as being a critical cost disadvantage for local manufacturers. Price reductions for Active Pharmaceutical Ingredients (API) were negotiated with API suppliers of four target products, further improving the competitive position of local manufacturers. Quality assessments of local manufacturers commenced, with eight expressing interest in participating. These assessments serve as the basis for quality improvement roadmap. Finally, on-site engagements with local manufacturers to identify and implement cost compression opportunities commenced.

• *Improved supply of Amoxicillin Dispersible Tablets*: Amoxicillin DT for pneumonia has been registered in 9 new countries and 37 countries have started procuring Amoxicillin DT from UNICEF Supply Division in 2014. 15 million treatments for childhood pneumonia were procured in 2014, which represents more nearly five times the volume procured in 2012.
Case Study 4: Creating a Local Market Shaping Strategy for chlorhexidine gel and amoxicillin dispersible tablets in Nigeria

To ensure that significant contributions are made to MDGs 4 and 5, the Government of Nigeria has committed to increasing availability and access to RMNCH life-saving commodities. In alignment with this commitment, CHAI and other partners have been working closely with government agencies and implementing partners to develop market shaping strategies, design demand and supply approaches and implement activities to introduce, scale-up and increase coverage of chlorhexidine gel and amoxicillin dispersible tablets in selected states.

Working closely with the Federal Ministry of Health of Nigeria, CHAI is supporting the development of market shaping strategies of chlorhexidine gel and amoxicillin dispersible tablets. These strategies aim to achieve the following key objectives:

- Strengthen policies for product availability
- Improve demand generation for these products
- Ensure a sustainable and vibrant market of high-quality and affordable products

To date partners are supporting the incorporation of CHX and amoxicillin dispersible tablets into the EML and Standard Treatment Guidelines in Nigeria. Specifically, the Chlorhexidine working Group (CWG) of the newborn TRT has been driving its local/regional supply strategy for CHX at the country level in Nigeria. As part of this effort, PATH and Promoting Quality of Medicines Program at United States Pharmacopeia (PQM/USP) collaborated to identify and select qualified and interested pharmaceutical manufacturers in 2013 for CHX gel. The response from local suppliers to these efforts has been enthusiastic. Of the six companies that responded to the invitation to expression of interest, three companies were found to be qualified through GMP assessment. Of the six suppliers that expressed interest in the manufacture of CHX gel, two have submitted registration applications to NADFAC and another With continued technical assistance by PQM/USP, two companies have attained full registration from the national regulatory authority, National Agency for Food and Drug Control (NAFDAC), registration by the end of 2014. For amoxicillin dispersible tablets, seven suppliers have shown interest--two of which have attained a full NAFDAC registration and another two have submitted applications.

CHAI has continued to work closely with U.S Pharmacopeia PQM/USP and the national regulatory agency, National Agency for Food and Drug Control (NAFDAC) to engage and provide support in formulation development, cost of goods analyses, and mapping effective distribution strategies to local manufacturers who have expressed interest in the manufacture of high-quality but yet affordable chlorhexidine (CHX) gel and amoxicillin dispersible tablets. Combined with the demand generation and product quality assurance effort that the Chlorhexidine Working Group has been carrying out at the global level, these approaches will promote the launch of quality product at cost competitive prices; thus ensuring that these products are accessible at affordable prices in areas where they are most needed. This CHAI’s effort in Nigeria has also built on the great work that the USAID-funded TSHIP has undertaken to generate the much needed awareness for CHX gel in several states and to set up of an informal supplier forum for CHX gel in the country. CHAI and TSHIP are now working to identify ways of scaling up CHX gel availability in the private sector to make it less dependent on public-sector provision, incorporating learnings from PATH’s market research in Nigeria.
Case Study 5: Shaping local markets for ORS and Zinc in Nigeria

In Nigeria, significant progress has been made to improve the local market for high-quality and affordable zinc and ORS for the treatment of child diarrhea, which kills nearly 100,000 children each year in the country. Under the strategic guidance of the National Essential Childhood Medicines Scale-up Up Plan, which aligns with the recommendations of the UNCoLSC, and with the support of the Child Health TRT initiated in 2013, the government and partners have made substantial progress during 2014 in reducing local market barriers to improving access to and use of the life-saving commodities:

Enabling environment for implementation: Under the leadership of the FMOH and NPHCDA, the National Essential Medicines Coordination Mechanism (NEMCM) continued to serve as the primary mechanism for driving improved coordination and alignment of efforts, as needed, across nearly 20 implementing partners. To date, these partners have mobilized $45 million to support implementation activities in 24 states. Additionally, State Essential Medicines Coordinating Mechanisms were established in 12 high burden states to ensure local activities follow the national strategy and leverage lessons from the NEMCM.

Improving affordability and availability of supply: Important gains have been made to build a more reliable, affordable, and sustainable supply of zinc/ORS in the Nigeria market—today, there are now 4 LO-ORS and 5 zinc suppliers available (compared to only 1 ORS and 0 zinc suppliers prior to the launch of the UN Commission). This increased competition has enabled a 77% reduction in wholesale price per treatment course—which enabled the achievement of a target median co-pack price of USD0.50 in some states by the end of 2014. To ensure widespread distribution of zinc/ORS in rural areas, CHAI and Abt Associates partnered with several suppliers on a co-investment model—whereby partners provided capital and time-limited funding to suppliers who agreed to expand their rural sales force. In addition, CHAI also engaged suppliers to accelerate their zinc/ORS distribution, leveraging their wholesaler and distributor networks. Since 2013, annual volumes sold in the private sector have increased by 260% for zinc and 350% for ORS.

Improved public sector distribution: For the first time in the public sector, state governments are now procuring appropriate quantities of zinc and ORS in selected states, with support from NPHCDA and CHAI. This included support on forecasting, quantification and tendering processes, advocacy for budget allocation toward essential commodities, and facilitating direct links with suppliers. NPHCDA also issued its first ever procurement guidance during maternal, neonatal, and child health weeks. This has led to an increase in procurement of 433% for zinc and 267% for ORS in selected states since 2013.
Recommendaion 3: Innovative Financing

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<th>Activities</th>
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<tr>
<td>Review the use of the results-based financing mechanism to improve access to the 13 commodities; solicit country interest and applications for results-based financing and enter into agreements with relevant countries</td>
<td>Agree on the host of a result-based funding mechanism for life-saving commodities (2012).</td>
<td>Completed: In late 2012, it was agreed that UNFPA would host the RMNCH Trust Fund.</td>
</tr>
<tr>
<td>Ensure linkages between the results-based financing mechanism and funding mechanisms identified for the procurement of commodities and work with the private sector</td>
<td>At least 10 EWEC countries enter into an agreement with the funding mechanism to increase access to the life-saving commodities (2013).</td>
<td>Completed: In September 2013, 8 countries submitted national plans to increase access to life-saving commodities and services. A total of US$38m was approved across these 8 countries for catalytic, one-year investments. In 2014, support was provided to an additional 11 new countries (19 total), with current disbursement at $146 million.</td>
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<tr>
<td>Include commodities in various monitoring systems; develop and use simple scorecard on access; link to other accountability recommendations</td>
<td>Guidance developed for countries to implement in-country RBF-approaches to strengthen access to life-saving commodities at all levels (2014)</td>
<td>Partial: An extensive amount of guidance has been developed by the World Bank as well as other partners (RBF Community of Practice) on implementing RBF approaches. These are most often aimed at primary and secondary health care services and RMNCH in particular and target increasing the coverage and quality of critical services, including commodities. Based on lessons learnt, work is on-going to develop more specific guidance on the commodity aspect within RBF approaches.</td>
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Overview: *(Progress on providing direct financing to EWEC countries through the RMNCH Country Engagement Process – second milestone above - will be profiled in Section V below)*

Health services in the public sector often struggle with poor supervision, the lack of use of data for decision making, and the absence of performance-based incentives. Results-Based Financing (RBF) is an approach that provides additional financing to frontline health workers and facilities on the basis of verifiable results. The approach has evolved over the past decade and several robust impact evaluations and a large amount of independently verified operational data show that RBF has strengthened accountability, empowered frontline providers, achieved remarkable results working in countries of greatest need, such as Rwanda, Nigeria, Zimbabwe, and Afghanistan.

Specific RBF efforts have been introduced during 2014 in some settings to specifically target the delivery of high quality commodities to the end-user. This is achieved by increasing facility-level accountability, developing demand-driven systems, strengthening pharmaceutical management and providing the opportunity to use part of the subsidies received by facilities to purchase medicines. In most if not all World Bank-funded PBF-based health projects, a dramatic increase in availability of tracer drugs has been noticed, as illustrated below for the projects in Cameroon and in Nigeria (Ondo state) (Figures 6 and 7).

As fragmented and poorly functioning supply chains remain one of the major bottlenecks hindering effective service delivery, efforts are underway to better understand how to maximize the contribution of RBF mechanisms to supply chain strengthening. A tool has been developed to identify which level (central, intermediate, peripheral) is responsible for the bottleneck in a particular context, and what types of incentives might be introduced to overcome them.

For example, in DRC the World Bank (PDSS II) is developing a performance-based contract with the Central Medical Store, while USAID and the World Bank are working on a similar approach in Tanzania. The World Bank is also planning GAVI-supported efforts to explore the feasibility a PBF approach for vaccine systems in Cameroon and DRC.
Last, RBF-based approaches are generating verified data regarding availability of tracer drugs and pharmaceutical management on a frequent basis (monthly to quarterly) which could be used to strengthen supply systems and complement HMIS and LMIS. Exploratory discussions are underway between the World Bank, Gavi and BlueSquare in this regards.

**Figure 6: Increase in utilization of tracer medicines after the introduction of RBF in Cameroon**

![Graph showing increase in utilization of tracer medicines](image)

**Figure 7: RBF facility score-card that includes monitoring of stock levels of tracer medicines**

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In partnership with USAID, the RMNCH Fund has financed Financing for Development (F4D) to undertake a study to determine whether a working capital facility would be useful to countries that purchase RMNCH commodities with their own funds in order to bridge short term gaps in funding availability and to assure quality in their procurements.

The background situation

Unlike other global health commodities such as ARVs, vaccines and contraceptives, the bulk of maternal, neonatal and child health commodities domestically financed and procured by national governments and the in-country private sector.

The challenge

Countries that finance procurements from national budgets often cannot access the capital they need in time to appropriately plan for procurements. As a result, countries either have to buy on credit or delay procurement until full funding becomes available. Furthermore, most procurement agents and suppliers are not willing to extend credit; and as a result, delays are common, leading to decreased access to essential health supplies, stock outs, and ultimately, resulting in significant negative health impact. Indeed, the UNCoLSC’s report identified financial barriers as a key obstacle in the RMNCH commodity related market, affecting the supply chain, overall access to healthcare, and performance.

In addition, evidence suggests that even when national funding is available, the prices countries are charged vary widely, with only some countries being able to negotiate competitive prices. Perhaps more critically, what remains unknown is the quality of the commodities being procured. In some cases, governments are procuring MNCH commodities via reputable procurement agents and the quality, to some extent, can be assured. But for a number of countries negotiating directly with suppliers and manufacturers, or procuring via smaller, less well-regulated procurement agents, the lower prices often come at the expense of quality, even when quality specifications have been included in the tenders.

The potential solution

With the goal of driving more efficient procurement of RMNCH commodities, the objective of the study is to identify the challenges and find solutions that will help national governments avoid delays in procurements and ensure funds are available when needed. Based on the needs identified in the study, Financing for Development and its partners are considering supporting the creation of a working capital facility that will provide Governments with access to working capital and international procurement agencies to secure better price, quality and timing of delivery of RMNCH commodities, as an immediate solution, while simultaneously developing longer term solutions. Interim results indicate that many countries do face financing obstacles related to mismatches in their budgetary and procurement cycles, and that they would be open to procuring through IPAs, if financing issues can be overcome. Final results of the study will be available in June 2015.
Recommendation 4: Quality Strengthening

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<th>Activities</th>
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<tr>
<td>The risk and nature of quality gaps of 5 lifesaving commodities are quantified</td>
<td>ERP for dispersible amoxicillin (2012).</td>
<td>Completed in 2013: The finalized ERP facilitated procurement through UNICEF, which makes the product available for EWEC countries</td>
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<tr>
<td>Quality testing includes updates to useable monographs where missing</td>
<td>Development of optimal quality assurance for zinc (e.g., market surveillance approach, ERP) (2012).</td>
<td>Completed in 2013: Substantial assistance was provided to manufacturers as a means of strengthening quality production of zinc, along with a number of other LSCs</td>
</tr>
<tr>
<td>Technical assistance is provided to at least 3 manufacturers of life-saving commodities</td>
<td>ERP for chlorhexidine (2013).</td>
<td>Achieved through alternate means: To avoid precedent for an unrealistic regulatory pathway, CHX was procured and distributed using a quality assurance approach more suitable for antiseptics.</td>
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Overview: The markets for many of the LSCs remain fragmented and unstable, often with entry costs that reduce incentives to invest in production. Lack of, degraded, or non-performant active pharmaceutical ingredients (API) are among the more serious risks as patients incur costs for these medicines but are undertreated or not treated at all with those products. While many of the key UNCoLSC milestones for quality assurance were achieved in 2013, substantial additional work has been undertaken during 2014 to accelerate progress in this neglected area.

WHO prequalification is a mechanism to ensure quality by evaluating the quality, safety and efficacy of products, based on information submitted by the manufacturers and inspection of the corresponding manufacturing and clinical sites. When medicines prequalified by WHO are not available, either because they are too new to the market (such as Dispersible Amoxicillin (Amoxicillin DT) or because there is no available prequalified source, procurers will still need to find a way to provide needed medicines. The Expert Review Panel (ERP process) was developed as a rapid assessment for products pending prequalification to provide a means to evaluate quality of certain medicines in their procurement transactions on a case by case basis.

To support quality of products procured through these and other mechanisms, ERP processes have continued for Amoxicillin DT, Family Planning and Maternal Health commodities. Procurers have continued to invite manufacturers to submit product dossiers for consideration and to date more than 50 dossiers for LSC have been reviewed. This has facilitated procurement of Amoxicillin DT and the Family Planning products through UNICEF and UNFPA, increasing availability to all EWEC countries. WHO provided technical assistance to manufacturers in Nigeria, Tanzania, Indonesia, Zambia, Zimbabwe, and Kenya, which all supply product to Phase I pathfinder countries. A similar process is underway for magnesium sulfate to ensure quality product. For misoprostol and oxytocin, technical assistance was provided and two manufacturers of misoprostol and one manufacturer of oxytocin have received prequalification and one misoprostol manufacturer has received ERP approval with another submitted. Applications to the Prequalification program have been received. Technical assistance to all manufacturers typically represents a continuum of activities and not a one-time event, with the implication that assistance that began in 2013 continued in 2014 and 4 new initiatives were started in 2014.

A quality survey as well as a survey of the regulatory and procurement status of the LSCs were undertaken during 2013. The information and results from those surveys has been used to analyze additional market risks, assess other potential interventions and to promote information sharing across countries within regions. While information indicates that the
quality of many LSCs circulating on markets was acceptable at the time of testing, it also showed controls were weak and with higher risks to products such as oxytocin that require special handling and products that move in high volumes, such as antibiotics.

A survey of procurement agencies was conducted during 2013 and 2014 to document the regulatory and procurement status of the LSCs in EWEC countries, to better understand the country and principal manufacturers of LSCs. The survey showed encouraging numbers of manufacturers of Amoxicillin DT, but relatively few for chlorhexidine 7.1% and pediatric formulations of IV antibiotics. Further analysis also revealed high number of registrations for certain antibiotics—almost 300 in responding countries versus 15-30 for other LSC—suggesting that demand and marketing of antibiotics may be contributing to overuse. The disproportionate investment in production of antibiotics over other LSCs may indicate a lack of market incentives for certain LSCs. The data for both of these surveys were gatherer from country regulatory and procurement agencies, who have a responsibility to maintain certain levels of confidentiality of sensitive data. Most data were collected in 2013, while the review, analysis and agreement to release the data were achieved in 2014.

Finally, for Amoxicillin and Emergency Contraception, advocacy TRTs are developing materials to support shifts in the prescription authority. Reaching high-level policy makers creates a supportive environment for this type of change; however, the actual decision and its implementation should engage the national regulatory authorities. In a decision making process that supports strong regulatory systems and processes, the national regulatory authorities should review evidence and also be available to follow up on safe and effective use in environments with lesser degrees of medical supervision and training. Addressing issues and making corrective actions as needed is key in the sustainability of a prescription authority change. To this end, model pharmaco-vigilance tools were developed for these products and training will be made available throughout 2015. It should be noted that certain activities were conducted by the WHO Collaborating Center in Ghana, where travel was highly restricted. Nonetheless the desk portions of the work were completed, opening possibilities to train and share information with other EWEC countries throughout the year.

Deliverables for 2014:

- A [dossier of Essential Medicines Lists from 65 countries](#) has been finalized.
- 1st ERP completed for Amoxicillin DT, 2nd ERP round to start in Q2 2015. Since 2013, one oxytocin and one misoprostol manufacturer have received PQ, one misoprostol manufacturer is ERP approved and one dossier for misoprostol has been submitted
- [A detailed mapping survey from national procurement agencies and regulatory agencies](#) was expanded from 8 to 19 countries to assess the status of the products in EWEC countries.
- ERP completed for Amoxicillin DT and levonorgestrel Emergency Contraception; Dossier submitted for ERP and pre-qualification for Magnesium sulfate and misoprostol.
- Four local manufacturers have now achieved cGMP certification in Nigeria. A fifth manufacturer of LSCs in Indonesia is expected to reach GMP certification by the end of 2015. These include producers of misoprostol supplements such as zinc as well as anti-infective products.
- Technical support for quality improvement has been provided to manufacturers in 5 countries (Zimbabwe, Tanzania, Zambia, Nigeria, Kenya, Pakistan, Indonesia) who are major manufacturers of 4 LSCs including Oxytocin, ORS, Magnesium Sulfate and Amoxicillin DT.
• The scale-up of Chlorhexidine has been supported through the establishment of local and regional manufacture of high-quality, cGMP-compliant chlorhexidine for umbilical cord care in Sub-Saharan Africa and South Asia. To facilitate this process, a case study has been developed to inform policy makers and program implementers of how a Market Sizing Tool can be adapted to support country’s program procurement and implementation plans.
• The WHO Collaborating Center in Ghana has developed model pharmacovigilance plans for selected commodities. This provides support to countries in following up on the quality of products and their safe use, especially in environments where prescription change has taken or will take place, such as Amoxicillin and EC.
• By the end of 2014, 17 RNMCH products have been submitted or re-certified successfully to the WHO Prequalification program, including contraceptive implants, misoprostol, oxytocin, zinc, and several hormonal contraceptives. For the complete list, see: [http://apps.who.int/prequal/query/ProductRegistry.aspx](http://apps.who.int/prequal/query/ProductRegistry.aspx)

Recommendation 5: Regulatory Efficiency

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<tr>
<td>Evidence is developed, submitted, and reviewed for the EML Expert Committee for missing lifesaving commodities</td>
<td>WHO-EML includes all 13 life-saving commodities (2013).</td>
<td>Completed in 2013: The WHO EML and revised lists were completed for 2015 and will be disseminated to all country offices. While all LSC have been listed since 2013, a submission was made to simplify the listing for misoprostol. This reinforces further facilitates the work of other actors in the RMNCH space to support countries</td>
</tr>
<tr>
<td>Joint inspections or dossier reviews are implemented for at least 3 lifesaving commodities</td>
<td>Joint inspections or dossier reviews are implemented for at least 3 LSC (2013).</td>
<td>Completed in 2014: Three joint dossier review have been held in the East African Community for misoprostol and levonorgestrel EC submissions. In addition, 2 joint inspections have been conducted. WHO conducted 4 joint inspections in collaboration with countries and manufacturers.</td>
</tr>
<tr>
<td>Regulators in pathfinder countries agree on a common pathway for at least 5 lifesaving commodities</td>
<td>Regulators in pathfinder countries agree on a common pathway for at least 5 lifesaving commodities.</td>
<td>Completed in 2013: The Collaborative review process has attracted over 25 participants, including the 8 pathfinder countries. Several products have now been approved through this mechanism on local markets.</td>
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</table>

Overview: Regulatory systems are designed to ensure that products on national markets are safe, effective and of appropriate quality. In addition to regulation, the recommendation also notes a number of important policy activities that must work in concert with regulatory affairs to move a LSC onto a local market.

Manufacturers and their representatives must submit to a regulatory agency for market authorization to make, sell, import or distribute medicines. Noting the high cost of submitting a unique dossier with different data requirements and in some cases different requirements for clinical studies, market actors in low- and middle income countries often wait for procurement agencies to indicate willingness to purchase prior to investing in the regulatory process. The TRT works with regulatory harmonization initiatives to promote streamlining of regulatory processes to allow for the same dossiers and data to be used by multiple countries. There are numerous mechanisms to achieve this and the effect is to reduce the cost and time to register the LSCs in countries.
In addition, policy activities include inclusion on the WHO Model List of Essential Medicines (EML) as well as in treatment guidelines. These policy recommendations have to be translated to the National EMLs and treatment guidelines on the appropriate use of products. Commodities on the National EML are prioritized for public procurement; however, EMLs and treatment guidelines are policy level documents and there are risks that when the information is used to develop procurement specifications they may not align across groups of countries. When countries specify products differently e.g., different dosages, packaging or formats (tablets versus gelcaps etc), regulatory harmonization efforts cannot be used because the products are not the same.

As reported last year, to support efficiency and reduce these problems, WHO initiated a fast track approach that NMRAs can use to accelerate registration for products that have already been prequalified by the WHO. The increase to date now includes 25 countries that have signed agreements to participate in the collaborative registration program, including the following countries: Burkina Faso, Democratic Republic of Congo, Ethiopia, Malawi, Mozambique, Nigeria, Sierra Leone, Tanzania and Uganda. For a complete listing, please see http://apps.who.int/prequal/info_applicants/collaborative_registration_main.htm.

In addressing the procurement environment, the TRT has also developed procurement workshops that are scheduled throughout 2015. The purpose is to collaborate across countries to improve quantification and specification of the LSCs.

Finally, WHO finalized specifications of newborn resuscitation devices, including upright resuscitators, to promote alignment in procurement across multiple countries and to support related market shaping efforts.

**Deliverables for 2014:**

- By the end of 2013, all LSCs were listed on the WHO EML, including chlorhexidine 7.1% and antenatal corticosteroids. The one-rod etonorgestrel hormonal contraceptive implant was also approved in the 2015 EML. [www.who.int/selection_medicines/committees/expert/19/en/](http://www.who.int/selection_medicines/committees/expert/19/en/)
- Fast track registration process for pre-qualified products ([http://apps.who.int/prequal](http://apps.who.int/prequal)) now includes an additional 8 countries for 2014 (now 25 countries in total), including multiple pathfinder and EWEC countries. The dossier for Sino-Implant, another hormonal contraceptive implant was submitted to the PQ at WHO in early May 2015.
- Procurement specifications developed for targeted commodities
- Workshops for procurement alignment are in process
- A [WHO Advocacy Package on Amoxicillin DT](http://apps.who.int/prequal) on the new treatment recommendations for childhood pneumonia has been developed and is being disseminated.
- **Guidelines for Maternal Health Commodities:** A protocol and study tools have been developed and ethical clearances obtained for a multi-country activity on optimizing implementation of WHO guidelines that utilize oxytocin, misoprostol and magnesium sulfate.
  - Country workshops were completed in [Uganda](http://apps.who.int/prequal), [Tanzania](http://apps.who.int/prequal) and Ethiopia with multiple stakeholders on priorities, barriers and facilitators to implementing WHO maternal health guidelines
  - Contextualized implementation strategies were identified in workshops, and the piloting phase in countries is currently being planned and documented. These activities will provide necessary evidence to these and other countries on how clinical guideline use can be implemented and sustained
- **Guideline on the registration and use of newborn commodities:** The Newborn TRT is closely linked with the results of the SATT and AFRINEST trials and the WHO Guideline Development Review process which is expected
to result in a new WHO recommendation for treatment of severe newborn infection where hospital referral is not possible. The TRT is also working in parallel to the global WHO guideline process to undertake a review of the Pharmacokinetic data from SATT and AFRINEST for Gentamicin and Amoxicillin to simplify the weight and treatment bands that would be included as part of implementation guidance in programmatic settings. As part of this effort, the TRT is developing, testing and evaluating new implementation tools and job aids as well as product presentations.

Recommendation 6: Supply and Awareness

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<tr>
<th>Conduct country assessments and landscaping activities to identify key barriers and challenges to effective supply chains</th>
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<tr>
<td><strong>Activities</strong></td>
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<tr>
<td>Gather and share Supply Chain Challenges, best practices and lessons learned across countries and partners</td>
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<tr>
<td>Develop common tools, guidance and approaches that can be leveraged by countries in addressing their supply chain challenges including SC Design, ICT solutions and engagement of private sector</td>
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Overview: Despite substantial efforts and resources over the past decades, supply chain management remains an intractable challenge in many low income countries, creating major barriers to accelerating access to life-saving commodities. During 2013, the Supply Chain TRT (SCCRT) brought together a wide consortium of experts to synthesize existing tools and lessons where relevant, provide clear needs-based forecasting algorithms for 13 life-saving commodities, develop and deploy novel innovations ICT applications to generate real-time metrics on facility stock levels.

A series of outputs were produced including: Challenges and Barriers along the In-Country Supply Chain based on the experience of eight pathfinder countries; Promising Practices in Supply Chain Management Series which is a systematic review of existing promising supply chain interventions; Recommended Indicators to Address In-Country Supply Chain Barriers in an effort to develop a standardized set of metrics for assessing supply chains; Inventory of Information and Communication Technology Solutions for Supply Chains to assist countries in selecting appropriate supply chain ICT solutions; Guidance and Resources for Inclusion of Reproductive, Maternal, Newborn, and Child Health Commodities in National Commodity Supply Coordination Committees as a toolkit has been developed that provides clear guidance on how to establish, effectively operationalize, or expand existing commodity coordination mechanisms for RMNCH; Three Case Studies. Integration: Guidance for Reproductive, Maternal, Newborn, and Child Health Context as a guidance
document on successful supply chain integration; *Quantification of Health Commodities: RMNCH Supplement Forecasting Consumption of Select Reproductive, Maternal, Newborn and Child Health Commodity* which is a tool to support forecasting capacity of national level program managers for the 13 UNCOLSC products; *Private Sector Engagement: A Guidance Document for Supply Chains in the Modern Context* which assessed the feasibility of using private sector warehousing for MNCH commodities to address the challenges around ensuring adequate quality storage for the increased volumes of commodities.

In this second phase of work, the SCTRT has focused on validating and disseminating the guidance produced to date, and work with countries to address key supply chain challenges. Specific activities will be highlighted below.

**Deliverables for 2014:**

- **Information Communications Technology (ICT) systems**
  - **Pilot LMIS integration with HMIS**: A “basic LMIS package” has been developed for DHIS2 (a widely used electronic Health Management Information System (HMIS)) to support stock management at the facility level. The focus of this package is to make the data available, visible and easily accessible, to improve the data quality, and to inform decision-making on logistics management, especially commodity distribution. The LMIS extension in DHIS2 is being developed and piloted in Benue State, Nigeria, where nearly all facilities have been reporting monthly stock out data.
  - **Develop an integrated RMNCH dashboard**: Stakeholders in Tanzania and members of the SCTRT are currently finalizing a list of indicators that capitalize on the benefits of integrating LMIS and HMIS datasets to inform decision-making. The dashboard will visualize indicators that capture information including: demand for and availability of commodities, data validation and reporting rates (*Case Study 8*).

- **Commodity Security Strategies for Maternal Health**: The Maternal Health Commodity Security (MHCS) sub-group of the Maternal Health TRT developed an MHCS Framework and White Paper that will help countries to identify weaknesses or gaps at various levels and functions of their health systems. Countries can use the framework to identify specific components of their health system to improve and to develop strategies to address the gaps. Once the framework is applied, countries can use it to monitor their progress toward attaining MHCS and to adapt or adopt the necessary changes for improvement. Ultimately, the framework will help countries take action to improve key components of health systems to improve the availability of oxytocin, misoprostol, and magnesium sulfate to monitor their commodity security for maternal health.

- **Dissemination Activities**: The SCTRT has been disseminating the guidance documents developed in the initial phase through active and passive strategies.
  - The documents have been uploaded to [WHO’s Procurement and Supply Chain Management (PSM) toolbox](https://www.who.int/medicines/publications/procurement-and-supply-chain-management-toolbox/en/), and are included in [the Supplies Information Database of the Reproductive Health Supplies Coalition](https://www.reproductivehealthsupplies.org/). Several members of the SCTRT also include links to the documents on their websites.
The SCTRT shared the guidance documents with the Systems Strengthening Working Group of the Reproductive Health Supplies Coalition at its annual membership meeting in October 2014. The Global Health Supply Chain Summit held in Copenhagen, in November 2014 provided another excellent opportunity to share the guidance documents developed in the initial phase with supply chain practitioners from around the world. The SCTRT presented on the systematic review of promising practices in supply chain, as well as on the work of the SCTRT in general. Following the summit, the SCTRT held a one-day hands-on workshop. Participants were able to choose among three tracks: quantification, data management or private sector engagement (Case Study 7).

**Direct Country Support:** Besides validating some of the guidance documents at the country level, and the continuing LMIS–HMIS work in Tanzania the SCTRT decided on three targeted activities that began in May 2014:

- **Malawi:** Support planned eLMIS Upgrade
- **Mozambique:** Improve the planning and prioritization of in-service training and define strategy to increase motivation and retention of logisticians
- **Myanmar:** Design and introduction of supply chain quality improvement teams

**Interagency Supply Chain Group (ISG):** In order to further strengthen the coordination of supply chain efforts at the global and country levels, the composition and activity of an existing ISG was expanded substantially. The purpose of this group is to identify areas of convergence and ways to harmonize supply-chains and supply activities where appropriate, optimize synergies across supply-chains and focus efforts towards building sustainable country-led national systems (Case study 9).

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### Case Study 7: Promoting South-to-South Learning

In conjunction with the Global Health Supply Chain Summit, the SCTRT held a South-to-South Learning Workshop to provide hands-on training and technical assistance in the use of a select set of Supply Chain strengthening tools and systems. The objectives of the workshop included promoting information sharing and learning among health supply chain implementers and giving implementers hands-on exposure to deliverables, specifically the RMNCH Quantification Supplement, the Private Sector Engagement Toolkit, and data management tools (DHIS2, CommTrack, and OpenLMIS).

The workshop opened with a plenary session with 100 participants from donor agencies, international agencies, academia, implementing partners and national supply chain managers from more than 10 countries. The following day workshops were attended by 48 participants, with an additional 20 people acting as facilitators, co-facilitators, and/or panelists. Participants chose one of three tracks: data management, private sector engagement, or quantification.

Overall, feedback from participants was very positive. Many attendees talked about how much they liked the interactive element of the workshops, appreciating the ability to engage in discussions and dialogue with facilitators and participants. On feedback surveys, nearly everyone ranked each individual session as either “excellent” or “good.” The SCTRT plans to replicate the experience in a venue for Francophone participants this year.
Case Study 8: Integrated RMNCH Dashboard: Linking HMIS and LMIS data to improve supply chain performance

The Supply Chain Technical Resource Team (TRT) is working to demonstrate the benefits and challenges of linking HMIS and LMIS data to improve supply chain performance. Presently, routine logistics and health service data are rarely linked, making it difficult to use the two data sets for ongoing decision-making to improve access to and utilization of life-saving commodities. The purpose of this activity is to improve supply chain data management and visibility by developing a standard RMNCH dashboard to gather and publish routine data across LMIS and HMIS systems that tracks key supply chain management performance indicators. Tanzania was chosen as the pilot location for the implementation of this dashboard. However, the overall intent of the project is to create a model that can be deployed in other countries, and funding is available for adapting and deploying integrated dashboards in two other pathfinder countries.

Stakeholders in Tanzania and members of the Supply Chain TRT are currently finalizing a list of indicators that capitalize on the benefits of integrating LMIS and HMIS datasets to inform decision-making. The dashboard will visualize indicators that allow decision-makers to quickly and easily assess demand for commodities, availability of commodities, data quality based on cross-validation, and reporting rates. The dashboard also provides an opportunity to link to additional data sets and data sources. For example, the dashboard could also pull in data regarding the locations of healthcare workers trained in RMNCH to map service delivery, human resource, and logistics data together.

The process of developing an integrated dashboard in Tanzania has provided the team with an opportunity to work through a number of issues and challenges, and find solutions that can inform the development of dashboards in other countries, such as:

- Lack of a common facility list or common facility standards that can be used to easily link facility data between the two systems
- Differences in product lists and labeling standards in the two systems
- Incongruent reporting periods for the two systems (for example, monthly vs. quarterly)
- Incomplete understanding of the most useful ways to visualize and interpret the data on the dashboard, so that it is actionable for decision-makers

The TRT and stakeholders in Tanzania plan to launch the dashboard in August, 2015.

Sample data visualization: months of stock of MgSO4.
Case Study 9: The Interagency Supply Chain Group

Since late 2013 there has been renewed interest by various donors, agencies and implementing partners in convening an Inter-agency Supply Chain Group focused specifically on supply chain issues. In 2014, the RMNCH SCT joined the group and was asked to play a facilitating role. The Inter-agency Supply Chain Group now meets on a quarterly basis, alongside other key supply chain related events and is hosted by one of the participating agency of the ISG. The Inter-agency Supply Chain Group, comprising of the World Bank Group, UNICEF, UNFPA, USAID, The Global Fund, GAVI, The Bill and Melinda Gates Foundation, DFID, Government of Canada, Government of Norway and WHO has come to an agreement on several fronts. This includes the development of a joint vision statement that was adopted 2014. This vision is supported by a set of key thematic areas identified as priorities for greater convergence and collaboration.

The main opportunities for greater collaboration lie at the country level. Already, many such efforts are underway. In the Democratic Republic of the Congo, for example, the RMNCH Fund and the Bill & Melinda Gates Foundation are co-financing the development of a strategic national plan to help the convergence and alignment of supply chain efforts across the health sector. Building on experience in this country and in Nigeria, where inter-agency collaboration is extensive, it was agreed to pursue similar efforts in additional countries in 2015. The ISG will expand and assess gains and benefits from joint efforts and joint investments in at least a dozen focus countries in 2015, including those where alignment is already underway (e.g., Tanzania, Kenya, Uganda, Myanmar, Senegal, Mozambique, Zambia, DRC, Nigeria and Ethiopia).

At the global level, the RMNCH SCT has facilitated a technical and policy dialogue that resulted in donor agreement, in March 2015, to promote and recommend the use of a common set of 15 supply chain key performance indicators by international donors and countries to measure impact of their investments on the performance of in-country supply-chains.
Recommendation 7: Demand and Utilization

By 2014, all EWEC countries in conjunction with the private sector and civil society have developed plans to implement at scale appropriate interventions to increase demand for and utilization of health services and products, particularly among under-served populations.

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<tr>
<th>Activities</th>
<th>Milestones</th>
<th>Status</th>
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<tbody>
<tr>
<td>Review and collate evidence of supply- and commodity-related communications including those that combine social and behavioral change communication (SBCC) and commercialization, social networking, franchising and marketing</td>
<td>Global demand generation implementation Kit developed with adaptable communication strategies for at least 9 priority commodities (2013)</td>
<td>Completed in 2013: Web-based Demand Generation tool-kit developed in English and French</td>
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<td>Establish innovative PPPs to address SBCC needs and develop materials and messages for the 13 commodities to enhance consumer and provider demand through high-impact marketing and promotion, including private sector providers</td>
<td>Country-specific communication strategies developed in at least two pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning) (2014)</td>
<td>Completed in 2014: Cameroon is still finalizing their RMNCAH national strategic communication plan; Uganda is updating their family planning BCC strategy, based on the demand generation tools developed by the global TRT; and DRC is developing an updated communication strategy for demand generation with inputs from a global TRT-led demand generation landscape assessment.</td>
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<tr>
<td>Support government agencies in EWEC countries to establish a sustainability roadmap and build capacity to develop, monitor and sustain SBCC and mass-media activities</td>
<td>Demand generation programs implemented in at least 4 pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning) (2014)</td>
<td>Completed in 2014: Several countries have incorporated demand generation programs in the roll-out of the activities in their country plans. The global TRT is also supporting up to 5 countries, including Nepal, Bangladesh, and Madagascar, to design communication strategies and implement demand generation programs for a sub-set of priority commodities</td>
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Overview: Demand generation, or the process of creating a need, or belief in the need for a health product or service among a particular target audience, is a persistent weakness across all priority commodities. Demand generation programs, when well-designed and implemented, can help countries reach the goal of increased utilization of life saving commodities by: creating informed and voluntary demand for health commodities and services; helping health care providers and clients interact with each other in an effective manner; shifting social and cultural norms that can influence individual and collective behavior related to commodity uptake; and/or encouraging correct and appropriate use of commodities by individuals and service providers alike.

Low demand among both providers and end-users is a significant factor in low utilization of the 13 commodities; however, few tools exist to guide demand generation efforts for these specific commodities. To address that gap, in 2013 the Demand Generation Working Group (DGWG) of the Demand, Access and Performance TRT created a comprehensive online Demand Generation Implementation Kit for Underutilized, Life-Saving Commodities (I-Kit). The I-Kit includes an evidence review, communication strategies for 9 commodities, and cross-cutting tools in gender, ICTs and new media and public-private partnerships, all packaged with clear guidance and links to additional tools, resources and project examples. A series of related supplementary materials include:

- Illustrative adaptable communication strategies for 9 priority commodities
- Demand Generation for 13 Life-Saving Commodities: A Synthesis of Evidence
- 10 "Spotlight" briefs summarizing the evidence review covering all 13 commodities
- Evidence Frameworks for 13 Commodities
- Conducting a national assessment on demand generation for under-utilized, life-saving commodities: Guidance and Tools
Demand assessments & stakeholder workshop in 2-3 pathfinder countries (2 complete)
Addressing the Role of Gender in the Demand for RMNCH Commodities: A Programming Guide
A Theory-Based Framework for Media Selection in Demand Generation Program
Utilizing ICT in Demand Generation for RMNCH: Three Case Studies and Recommendations
The “P” for Partnership: A Guide to Public-Private Partnerships to Increase the Demand for RMNCH Commodities

Specific efforts were also undertaken to enhance demand for ORS and Zinc by healthcare workers, community leaders, and caregivers. Materials are available at www.zinc-ORS.org. Similar resources for pneumonia are being developed to promote improved care-seeking and diagnosis of pneumonia among providers and caregivers.

In 2014, the DGWG focused its efforts on pretesting and finalizing the I-Kit and its global, regional and national dissemination for accelerated implementation of demand generation activities at the country level. By using the I-Kit, country teams can fast-track implementation of demand generation interventions in order to accelerate progress towards MDGs 4 and 5.

Deliverables for 2014:

- **Country testing of the Demand Generation I-Kit**: The web-based I-Kit was pre-tested in Uganda in July 2014 and has been finalized, with supplementary materials completed, undergoing final editing and translation into French.

- **Country-level dissemination of the I-Kit**: A dissemination plan was developed to leverage opportunities to promote the I-Kit at the global and regional level. In 2014, the DGWG promoted the I-Kit with a diverse group of stakeholders, including presentations at:
  - Core Group Meeting
  - Chlorhexidine Working Group Meeting
  - Pneumonia and Diarrhea Working Group Quarterly Meeting
  - World Bank Community of Practice for SBCC
  - USAID Washington and Missions brown bag
  - International AIDS Conference 2014
  - Knowledge for Health East Africa Share Fair, Arusha, Tanzania
  - Reproductive Health Supplies Coalition Annual Meeting, Mexico City, Mexico
  - American Public Health Association Annual Conference, New Orleans, USA
  - Global Consultation on Female Condoms, Lusaka, Zambia (1.5-day SBCC skills building session)
  - Dissemination workshops in Nepal and Bangladesh in January 2015

- **Demand generation for Family Planning**: Additional demand generation work was conducted with the Family Planning TRT to support access to the 3 family planning commodities. Activities include:
  - Pilot demand generation programs were implemented for Emergency Contraception (EC), Female Condoms and Implants in Nigeria, Senegal and for EC in DRC and Malawi. The aim was to increase awareness among target population for the 3 Family Planning commodities.
- Operations research on improving access to EC in Malawi led by MOH was completed. An investigators was meeting held in April 2015 and a report on the results is forthcoming.
- A systematic review of the evidence on workforce interventions to improve access to EC through strengthening service delivery and demand was completed and published.
- A multi-country study was conducted and published on the knowledge and use of Emergency Contraception in 45 countries using population-based survey data.

**Recommendation 8: Reaching Women and Children (Financial Access)**

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<tr>
<th>Activities</th>
<th>Milestones</th>
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<td>Apply a commodity-lens to existing work on financial barriers and the WHO’s work on universal access, and ensure that commodities are appropriately included in global and national financial protection mechanisms (e.g., conditional cash transfers)</td>
<td>Eight EWEC countries have financial protection programmes with a commodity focus (2013)</td>
<td>Partial: Of the 10 EWEC countries for which there are data, 6 have relatively solid user-fee exemption programs, 3 have partial exemption programs, and Cameroon has serious remaining challenges</td>
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<td>Assist EWEC countries in establishing financial mechanisms to ensure equitable access to commodities by the poorest segments of society</td>
<td>Evaluate the increase in use of (a sub-set of) life-saving commodities in concerned countries (2014)</td>
<td>Partial: Global expert review group has convened to discuss; RFP for EWEC country mapping has been tendered and bids are under review. The mapping will inform country policy dialogue towards the first milestone regarding point-of-service fee exemptions.</td>
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**Overview:** In many settings, despite RMNCH commodities and related services being available at the point-of-service, formal and informal financial barriers remain an obstacle that limits access to life-saving commodities when in need.

In the first year of the UNCoLSC, the financial access TRT was slow to take shape and no progress was made. In 2014, at the advice of the Interagency Review Panel, an Expert Review Group was established with the aim of assessing the appropriateness and feasibility of moving this component of the UNCoLSC mandate forward. A meeting was held in November 2014, which resulted in a recommendation to solicit a request for proposals (RFP) to conduct a systematic mapping of the existing policies and mechanisms that allow for financial access to thirteen life-saving commodities recommended for all EWEC countries. This mapping, which is on-going is supported by an analysis of success stories, challenges and bottlenecks in implementation of these policies, and identification of opportunities for policy dialogue to improve financial access to life saving commodities in priority countries.

The *RMNCH Landscape Synthesis* currently tracks user-fee exemption status for the 13 LSCs. Of the 10 EWEC countries for which there are data, 6 have relatively solid user-fee exemption programs, 3 have partial exemption programs, and Cameroon has serious remaining user fee barriers.

- **Cameroon:** User fees still exist for many RMNCH commodities and services with the exceptions of malaria treatment for children under five, bed nets for children and pregnant women, HIV testing, PMTCT as well as vaccinations and vitamin A for newborns. FP commodities are heavily subsidized, but not officially free. Free-of-
charge commodities and services for child health exist in highly affected regions (between the north and far north regions of Cameroon).

- **Ethiopia**: Family planning services and commodities are **fee-exempted at all levels of care**. All maternal and newborn health services, including caesarean sections, are intended to be provided for free at all levels of care as per national policy. In practice though, some health facilities charged women for normal deliveries or required them to buy supplies. Child health services are not exempt from user fees in some areas. ORS, Zinc, and Amoxicillin can be provided for free in public sector facilities, but only at the health post level.

- **Kenya**: The Ministry of Health provides family planning services and commodities, ANC and deliveries as well as treatment for children under 5 years for **fee-exempt at all public health facilities at all levels of care**.

- **Malawi**: The MoH provides Essential Health Package services **free of charge at primary care facilities** but will charge user fees in paying wings of central and district hospitals. Patients have to follow strict referral procedures and where this is not followed a by-pass fee will be charged to patients. Private religious sector health centres charge user fees for consultations when the government provides them with Essential Medicines.

- **Mali**: There is a **partial user-fee exemption** with state subsidy for the purchase of contraceptives, ARVs, as well as malaria treatment, zinc and micronutrients for children under five. Maternal health commodities and services such as prevention and management of malaria, caesarean sections and ARVs are provided free of charge.

- **Nigeria**: There is a **partial user-fee exemption only**. Since 2011, Nigeria has made the provision of FP services free across all public health facilities; however, many women are still charged for the consumables used for insertion and removal. Maternal health commodities are provided by either national programs, state governments or development partners which are used to support the fee exemption schemes; however, it is unclear if there are service charges. Free neonatal care exists in some states but not on a national level. There is no national policy against user fees for child health; however CHAI signed a price-reduction agreement with manufacturers of essential child health commodities in 2013.

- **Senegal**: There is a **partial user-fee exemption only**. Female condoms are provided free but emergency contraception products and implants, and related family planning services are not free. The National Health Development Plan indicates that maternal health services such as deliveries and caesarean sections are free, except in Dakar. Some essential drugs for maternal health are not free. Charges also apply to newborn health products and professional services. For children, the treatment of diarrhoea is free at the basic level of the health system, but ORS and zinc require payment. No clear information is provided concerning fees for Amoxicillin.

- **Sierra Leone**: There is a **user-fee exemption** with the launch of a "Free Health Care Initiative" introduced in 2010 which entails free services and commodities for children under 5 years of age, pregnant women, and lactating mothers in any government facility. Reproductive health commodities are provided free of charge, but the patient pays a registration fee for services provided.

- **Tanzania**: The 2003 National Health Policy states that postnatal care for newborns and mothers, reproductive health services, child health services and the associated commodities should be provided **free of charge in public health facilities**. The policy encourages communities to contribute through user fees to complement government financing; however, it notes that exemptions are still provided for poor and vulnerable groups.

- **Uganda**: There is **user fee exemption in all public health facilities** since 2001. However, user fees remain in some wards of tertiary institutions and in private wings of public hospitals. There are some reports of cases where clients had to buy commodities during stock outs.
Recommendation 9: Performance and Accountability

**By end 2013, all EWEC countries have proven mechanisms such as checklists in place to ensure that health-care providers are knowledgeable about the latest national guidelines**

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<td>Support EWEC countries to develop and adapt national clinical guidelines to reflect international guidance on the use of the 13 commodities</td>
<td>The status of national availability and use of the 13 commodities and available guidelines (including m-applications) in 8 pathfinder countries for their use have been analyzed (by March 2014).</td>
<td>Completed in 2014: Report on the availability, content, appropriateness, usability and gaps in the existing tools, guidelines and job aids for Health workers for 13 LSCs finalized based on work in Malawi, Tanzania, Uganda, Ethiopia, Sierra Leone and Senegal.</td>
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<td>Develop and use national checklists, job aids, training programs and supervision structures to promote and monitor the use of clinical guidelines by public and private providers</td>
<td>Development of generic checklists for implants and safe birth, including use of MgSO4, has begun (by December 2013).</td>
<td>Completed in 2014: English and French versions completed. Portuguese adaptation underway.</td>
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<tr>
<td>Strengthen EWEC country accountability mechanisms to monitor scale-up and use of the 13 commodities, including improved regulation and oversight of the private sector and mechanisms for community-level monitoring and feedback around service provision, availability and affordability</td>
<td>Training and scalable strategies for checklist use including e- and m-learning have been developed and deployed (by March 2014).</td>
<td>Partial: M health global assessment and Tanzania case study completed. Dissemination of job-aids and checklist for EAC, ECOWAS and SADC underway in 2015.</td>
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<td>Feasibility assessments on the use of social audits to improve accountability have been carried out in 10 countries (by December 2014).</td>
<td>Not applicable: No longer included in work plan on the recommendation of Interagency Review Committee</td>
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**Overview:** Effective utilization of the 13 life-saving commodities is hampered by several factors related to the health worker performance including not being up-to-date with the latest guidelines and protocols, the lack of training materials that reflect recent policy shifts, and absent job aids and check-lists to facilitate best-practice at the health facility level. In some cases health care workers are also faced with policies and guidelines restricting them from prescribing and administering life-saving commodities at the appropriate level of care.

During the initial year (2013), the Performance and Accountability TRT has carried out a review and synthesis of available guidelines and health worker support tools in 6 pathfinder countries (Uganda, Senegal, Tanzania, Ethiopia, Sierra Leone, Malawi) as well as generic tools developed by WHO.

To support eHealth and m-health based health worker learning, a global inventory of e and m-Health applications and the ICT policy landscape that could be used to support health worker performance were conducted in 2013. Specific work was conducted to support emerging needs for training in neonatal resuscitation, with country-level work conducted in Tanzania. This work included the development of an infographic of the inventory of 100+ e- and mHealth support tools for health workers.

Based on these findings, in 2014, work to develop generic high-quality, adaptable guidelines, checklists and job aids for all 13 commodities has been drafted. These have been reviewed by the relevant TRTs as well as professional associations in pediatrics, obstetrics and gynecology, midwifery and public health across a range of countries including Malawi, Zambia, Mozambique, Botswana, Lesotho and Zimbabwe. Dissemination activities have taken place as part of this engagement in Kenya, Uganda, Tanzania, Ethiopia, Ghana, Nigeria, Gambia and South Sudan. Adaptation to francophone countries has also taken place. Portuguese adaptation is ongoing, and formal dissemination workshops are planned for mid-2015.
Additional work has taken place to support health worker training in Emergency Contraception, designing a quality framework for neonatal resuscitation training, and a review of promising e-and m-Health practices.

**Deliverables for 2014**

- Finalization of *generic high-quality, adaptable guidelines, checklists and job aids* for all 13 commodities, with translation into French and Portuguese
- Training modules on Emergency Contraception for health providers and for pharmacists have been developed as part of the Family Planning Training Resource Package, an online resource for training materials on Contraception. Modules on the Female Condom and Contraceptive Implants have been earlier completed. ([www.Fptraining.org](http://www.Fptraining.org))
- A mechanism has been established for provision of country-level technical assistance in Digital Health (through the m and eHealth Expert Learning Program – mHELP). Support for 2014 work includes a systematic approach and process for adapting content for delivery via mobile devices.
- Review of promising practices for the use of e- and mHealth support tools for health workers
- A Quality Framework has been developed for the implementation of neonatal resuscitation to assure the quality improvement process for training and education programs
- The Newborn TRT is disseminating the 2014 Cochrane review on the use of antenatal corticosteroids, targeting country representatives, health facilities, and more to ensure that health care providers are aware of the findings; furthermore, a dissemination plan is being developed for launch once the new WHO recommendations are finalized and released

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**Case Study 10: Integrated Community Case Management**

Scaling up Integrated Community Case Management (iCCM) of childhood illness has the potential to deliver life-saving commodities—including zinc and ORS for diarrhea and amoxicillin DT for pneumonia—at the community level for children who need them most. Field studies show that iCCM programs—which rely on community health workers (CHWs) to diagnose and treat malaria, pneumonia, and diarrhea—can yield mortality reductions of up to 40 percent.

The global iCCM Financing Task Team, with support from the Child Health TRT, continues to provide technical support to countries to secure funding to expand iCCM leveraging the Global Fund New Funding Model (NFM). To date, over $160 million in funding has been mobilized to support iCCM scale-up in 8 countries, of which $70M is directly supported by Global Fund and a further $10.7 million from the RMNCH Fund. The progress made on iCCM serves as an important example of how alignment of RMNCH funding streams—including from the RMNCH Fund, World Bank, WHO, USAID, bilateral donors and others—can be achieved to advance health outcomes for children.
Case Study 11: Reaching out for health providers to prescribe zinc/ORS against diarrhea
Each year, diarrhea is responsible for nearly 600,000 child deaths. A key problem is that most health providers are not aware of the WHO-recommended treatment for diarrhea—zinc and ORS—and their life-saving benefits and hence do not prescribe them.

To help address these challenges, the Child Health Technical Resource Team launched an online global communications platform, http://www.zinc-ORS.org which includes a suite of tools such as job aids, posters, brochures, and videos to educate providers about the importance of using zinc and ORS to treat child diarrhea. This represents the first effort of its kind to provide adaptable, downloadable, market-researched tools that can be customized, printed, and shared locally. In particular, the materials are designed for country stakeholders—NGOs, governments, and local manufacturers—who need materials to support provider outreach efforts around diarrhea treatment, but have limited time and resources to create new materials from scratch.

Since its launch, partners in Nigeria and Uganda have already adapted and implemented these materials. In Nigeria, the zinc/ORS video, The Strength to Fight, was translated into several local languages and is being used by SHOPS, CHAI and ICARE projects during trainings for proprietary patent medicine vendors (‘PPMVs’ or drug shop operators). Posters were also customized, printed, and distributed to nearly all PPMVs in three high burden states. In Uganda, the Ministry of Health adapted the tools to train more than 10,000 frontline healthcare workers, 12,000 rural and urban retail drug shop owners, and 6,000 clinicians from faith-based clinics.

The Child Health TRT is currently developing similar tools to help improve timely care-seeking and diagnosis of pneumonia and treatment with amoxicillin dispersible tablets. The tools will be available by Fall 2015.

Recommendation 10: Product Innovation

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<tr>
<th>Activities</th>
<th>Milestones</th>
<th>Status</th>
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<tr>
<td>Establish incentives for further commodity research and product innovation</td>
<td>Form a coordinating group to lead reviews, prioritization and monitoring of product improvements/innovations (2014)</td>
<td>Completed in 2013: Coordinated by PATH, USAID and the Child health TRT</td>
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<tr>
<td>Invest in product innovation, including translational research, formulation development, new technological product development, stability studies and bioequivalence</td>
<td>Prioritize four product improvement/innovation areas (2014)</td>
<td>Completed in 2014: Innovations in packaging and education materials for misoprostol and dispersible amoxicillin; Oxytocin time-temperature sensor; thermostable inhaled preparations of oxytocin; MgSO4 bundling with injection equipment; an upright resuscitator for newborn resuscitation is developed and undergoing testing</td>
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<tr>
<td>Use the public health need for new formulations, packaging or technological update of the 13 commodities as a practical example and justification in the global discussion on financing research and development</td>
<td>Secure commitments including donor and private industry earmarks for innovation and research and development (2014).</td>
<td>Completed in 2014: Co-financing for development of inhaled oxytocin has been identified. Protocol has been completed and research and development is ongoing</td>
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<tr>
<td>Facilitate technology and knowledge transfer, together with financial incentives, to reinforce national and regional efforts in research, development, regulation and manufacturing of life-saving commodities</td>
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Overview: Product innovation involves modifications to the formulations of the existing group of life-saving commodities, or alternatively changes in the packaging, delivery mechanism, or other product-specific dimension that
will increase effective utilization. In 2013, efforts were made to support improved packaging for misoprostol, preliminary work to develop heat stable inhaled oxytocin, efforts to include oxytocin in the cold chain and the bundling MgSO₄ with ancillary devices/products to improve the quality of treatment for pre-eclampsia/eclampsia.

For 2014, the misoprostol packaging of 3 tablets, including development of IEC materials was completed and the remainder of this work has largely continued and intensified with in-country activities underway or completed in Ghana, and Mali.

**Deliverables for 2014:**

A range of product innovations are completed or underway to address critical bottlenecks:

- **Dispersible Amoxicillin (2014):** A new patient-friendly product presentation concept for Amoxicillin DT for childhood pneumonia has been developed and is currently being pretested in 8 high-burden countries. The final output will be used to inform direct engagements with suppliers to adopt the optimal packaging and presentation. In addition, to address the need for improve pneumonia diagnostics to drive uptake of Amoxicillin DT, a Target Product Profile for automated respiratory diagnostic aids was released.

- **Oxytocin:** As a ‘biological product’, the quality of oxytocin is compromised by heat/time exposure. Women can thus receive oxytocin that has less than the recommended 10 IU – which leads to post-partum haemorrhage despite appropriate use by providers. A finalized Joint Statement developed to get oxytocin in the cold chain and titled, “WHO/UNICEF Joint Statement: Temperature-sensitive health products in the EPI cold chain” has been sent to WHO and UNICEF for their signoff and release. Ghana and Mali have conducted operational case studies of oxytocin in the cold chain and these reports are being finalized.

  - A time-temperature sensor has been developed for oxytocin, to be included in the packaging for each batch to assess whether products are likely to be viable and effective at the point of administration. A pilot test of the feasibility and acceptability of this device on oxytocin is planned in the Greater Accra region in Ghana in the next six months.

  - To make oxytocin available for community use (self-administration) efforts to advance the manufacture of ‘inhaled oxytocin’ have been initiated, which obviates the need for syringes/injections and cold storage - both bottlenecks to increasing the use of this drug. A protocol with MONASH University and PATH has been developed and approved for this work during 2014.

- **Magnesium Sulphate (MgSO₄):** MgSO₄ is still underutilized, incorrectly administered, or unavailable at health care facilities in many low-resource settings, primarily due to the complex regimen and lack of availability of the right concentration of MgSO₄ and other essential items. The ready-to-use packs consist of a loading dose pack and a maintenance dose pack, each of which would contain the appropriate strength of MgSO₄. Other critical items, such as lidocaine and a 20mL syringe, could be added to these packs. The ready-to-use packs would obviate the need for dilution at time of use and could contribute to increased use of MgSO₄ for treatment of PE/E.

  - In mid-2014, PATH conducted a rapid survey with stakeholders such as policymakers and health care professionals in four countries—the Democratic Republic of Congo, Ethiopia, Senegal, and Uganda—to understand current practices regarding the use of MgSO₄ for treatment of PE/E and stakeholders’ perceptions about the concept of the ready-to-use packs. Findings from this survey indicated that there were challenges with the current administration regimen since it requires diluting 50% MgSO₄ to make a 20% solution. Also, stockouts of MgSO₄ and other items such as lidocaine and large syringes were found to be a significant issue. These findings supported the need for the ready-to-use packs. In fact, most
respondents in the rapid survey were enthusiastic about the concept of the ready-to-use pack and perceived that having the ready-to-use packs (both loading and maintenance dose packs) would be an advantage.

- In Q1, 2015, PATH conducted in-depth interviews with policy makers and procurement personnel and focus group discussions with healthcare professionals in Ethiopia and Uganda in order to: 1) ascertain what the optimal components of the ready-to-use packs should be and 2) elicit users’ willingness to use the packs as well as understand what potential impact the ready-to-use packs might have on country health systems. The mock-up packs that were created with the 3D printer at PATH were used for this qualitative study. The report from this study will be available in June 2015.

- **Upright neonatal resuscitator**: user-evaluations of this technology are ongoing to foster continuous product improvement.

### Advocacy Working Group

**To improve global advocacy and awareness of the UNCoLSC mandate and activities, and better align the range of advocacy initiatives across the RMNCH space**

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<tr>
<th>Activities</th>
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<tr>
<td>Develop Advocacy Working Group steering committee that includes representatives of the EWECC-related initiatives (e.g. APR, GNAP, GAPP-D, FP2020)</td>
<td>Formation of advocacy steering committee (2013)</td>
<td>Completed in 2013, ongoing 2014: Steering committee has been formed and continues to meet on a monthly basis to coordinate and align advocacy related activities across the UNCoLSC. Committee includes country grantees representatives and members from partner TRTs.</td>
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<td>Develop integrated advocacy messaging framework that spans the 13 commodities, promotes linkages with related initiatives (e.g. APR, GNAP, FP2020, GAPP-D) and highlights the importance of commodities within broader RMNCH initiatives/strategies.</td>
<td>Development of messaging framework in the lead up to UNGA (2013-2014)</td>
<td>Completed in 2013, ongoing 2014: Two frameworks were developed a Backgrounder document on the Commission and a Messaging Framework. Integration of commodities messaging/objectives into related platforms like EWECC Messaging Framework. Message development continues for global events, including WHA 2014 and UNGA 2014, to highlight importance of commodity access and availability.</td>
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<td>Develop advocacy toolkit for primary use in EWEC countries.</td>
<td>Development and launch of an Advocacy Toolkit (2013)</td>
<td>Completed in 2013: The revised <strong>Scaling up Life-Saving Commodities for Women, Children and Newborns – An Advocacy Toolkit</strong> features a revised overview of gaps &amp; barriers related to each commodity and advocacy related asks and activities that can be undertaken to advance agenda at a country level. The revised version also features progress and advances made by TRTs and countries during the first year of the UNCoLSC.</td>
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<tr>
<td>Increase visibility of the Commission at global, regional and national levels and coordinate activities across EWEC related initiatives.</td>
<td>Revised Advocacy Toolkit (2015)</td>
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<td>Increased visibility of the UNCoLSC at key global events(2013)</td>
<td>Completed in 2013: The Messaging Framework developed were used in the lead up to UNGA 2013 to ensure that messages on the UNCoLSC were incorporated into events focused on maternal and child health. A side event on the Commission was hosted at the International Family Planning Conference. The side event was co-hosted by the AWG and Rec 7 WG. In 2014, the Advocacy Working Group (AWG) provided collective feedback during the Every Newborn Action Plan consultative process, helping to ensure commodities were prioritized in the ENAP revisions adopted at WHA 2014. Similarly, feedback was submitted for the Ending Preventable Maternal Mortality plan, and the Global Financing Facility. The AWG contributed to joint messaging to support the ENAP launch and highlight the importance of maternal and newborn commodities, programs, and services to save more lives. Common and consistent messaging proved key for moving this agenda forward. Alongside the Strategy &amp; Coordination Team, the AWG provided commodities messaging for Every Woman Every Child partners during UNGA 2014 to ensure joint and coordinated messaging. As part of UNGA 2014, the AWG provided talking points for a high-level Financial Times panel that focused on innovations and the importance of maternal and newborn commodities.</td>
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Overview: A new TRT on global Advocacy was formed in 2013 to increase the awareness of the UNCoLSC mandate and activities and better align the range of advocacy initiatives across the RMNCH space.

The Advocacy Working Group (AWG) is convened by PATH as a board alternate and representative of the Partnership for Maternal, Newborn, and Child Health. The AWG—a diverse group of approximately 100 partners from more than ten countries—works across the RMNCH spectrum to promote joint planning and advocacy to amplify a unified voice among the Commodities Commission’s stakeholders. The AWG seeks to ensure that stakeholders from different sectors and various EWEC initiatives are involved in the Commodities Commission’s advocacy activities to improve access to and availability of lifesaving maternal, newborn, and child health commodities, programs, and services.

To engage and support country partners in leading commodity-related advocacy, the AWG held advocacy strategy development workshops in four target countries in April and May 2014: Malawi, Senegal, Sierra Leone, and Uganda. During these four-day workshops, participants from local organizations used the toolkit to develop advocacy strategies that ameliorated gaps in their country’s RMNCH policies and develop policy change solutions. The workshops provided a platform for advocates to create linkages among colleagues to ensure a coordinated advocacy approach to advance RMNCH issues, the UNCoLSC, and other EWEC initiatives. After the four workshops, the AWG sub-granted to nine organizations across the four countries to carry-out specific advocacy strategies. In Malawi, successful advocacy efforts led to the January 2015 update of the Malawi Essential Medicines List, to reflect all 13 lifesaving commodities, and ensuring increased access to family planning and newborn health commodities.

Targeted advocacy efforts are now underway in additional countries: Ghana, Kenya, Uganda, and Zambia.

The AWG is also engaged in current efforts for the revised Global Strategy for Women’s Children’s and Adolescent’s Health (Global Strategy 2.0) to advocate for the prominent and prioritized inclusion of commodities in the strategies. The working group seeks to ensure that new funding mechanisms and global initiatives continue to prioritize access and availability to RMNCAH commodities, services, and programs. Comments and responses have been submitted on behalf of the working group for the Global Financing Facility and the Global Strategy 2.0.

Deliverables for 2014:

- **Advocacy Tool Kit:** This toolkit provides information about the UNCoLSC, its 13 priority commodities, and examples of how its ten recommendations to improve access and availability are being applied globally and within countries. It also provides advocacy resources for utilizing the Commodities Commission platform to raise awareness and engage stakeholders in addressing commodity-related gaps in global and national plans, policies and initiatives, as well as providing strategic input to advance implementation of the recommendations. The [2015 revisions](#) reflect progress made by the technical resource teams, as well as revised data, recommendations, and messages. The resource pages also feature newly available resources for the various commodities.

- **NGO partners meeting:** The Advocacy Working Group, in conjunction with the SCT, hosted an international nongovernmental organization partners’ meeting to inform and update on the RMNCH process and engagement structure and ensure CSOs were involved in the consultative engagement activities. The AWG-led
meeting served as an opportunity for the SCT to solicit feedback on existing partners, mechanisms, and groups working in the RMNCH space at the country level. The AWG continues to be a dissemination mechanism for these process updates and to solicit feedback on country proposals.

- **Advocacy strategy workshops:** As mentioned above, the AWG hosted advocacy strategy development workshops in four countries in April and May 2014. After these workshops, sub-grants were awarded to local partners to carry out specific advocacy strategies targeted to increased commodity accessibility and availability.

Country grants were awarded as follows:

- **Malawi:** To update the Malawi Essential Medicines List with the four missing commodities (newborn resuscitation devices, antenatal corticosteroids, injectable antibiotics, and contraceptive implants) to ensure alignment with the WHO global recommendation and updated global EML.
  - This deliverable was achieved in January 2015 when the Ministry of Health signed a revised EML to include these four commodities. A case study on this effort will be published in June 2015.

- **Senegal (1):** Advocacy efforts were focused on the Ministry of Finance increasing allocations to the national health budget from 11 to 15% to meet the Abuja commitment.
  - Strong partnerships and alliances were formed among the RMNCH Technical Working Group to gain support for the advocacy issue. The budget advocacy component has been slow to move forward as national budgets are not publicly available and it has been difficult to identify the correct mechanism for accessing this information.

- **Senegal (2):** The advocacy goal was to improve access to select RMNCH commodities by ensuring socially marketed products are registered on the Senegal Essential Medicines List.
  - The Essential Medicines List has been successfully updated to include generic versions of female condoms, contraceptive implants, and ORS/zinc. At the request of the Director General for Health, there is a partnership agreement underway to provide socially marketed products through the public health system.

- **Sierra Leone:** To advocate for the Ministry of Finance to update the national health budget to include a 10 percent budget line for reproductive health commodities.
  - The Ebola crisis presented major challenges to this advocacy strategy. Many health resources, as well as personnel and bandwidth went to emergency response efforts. There was still progress made when the Ministry of Health and the Reproductive Health Commodity Security Committee both endorsed the 10 percent budget line increase. By the end of the year, the Ministry of Finance had tentatively agreed to the first ever allocation of 31 billion Leones for procurement and distribution of reproductive health commodities.

- **Uganda (1):** The advocacy goal was to institutionalize an essential medicines framework within the next National Health Sector Strategic Plan.
  - A mapping and analysis of essential medicines activities was conducted to identify key opportunities to strengthen the National Health Sector Strategic Plan. The mapping was shared with the Ministry of Health Medicines Procurement and Management TWG. Based on the progress to date, WHO has agreed to fund further activities in the lead up to the plan revisions (to be finalized in 2016).
• **Uganda (2):** The advocacy goal was to allow select RMNCH commodities to be available at lower level health facilities and at the community level as appropriate.
  o A series of policy briefs and fact sheets on key commodities were developed and helped garner the support of Uganda’s Director of Community Health Services. An Essential Medicines List addendum has been drafted as have updated clinical guidelines. Approval is expected in 2015.

• **Uganda (3):** The advocacy goal was to reverse the policy that governed the procurement of newborn resuscitation devices to move from a push system to a pull system.
  o This advocacy effort was successful: the Ministry of Health has directed the National Medical Stores to include newborn resuscitation devices on the procurement list. Now the National Medical Stores has the authority to pull the order when needed.
  o Given success on this policy change, efforts in Phase 2 (2015) will now focus on ensuring there is sufficient budget for newborn resuscitation devices to be procured and delivered. The budget advocacy efforts are ongoing.

• **Uganda (4):** This goal was to push forward a tripartite agreement between the Ministry of Health, the National Medical Stores, and the Uganda Health Marketing Group to institutionalize alternative distribution channels for family planning commodities.
  o Efforts successfully led to an agreement between the Ministry of Health and the Uganda Health Marketing Group to allow for an alternative distribution channel for contraceptives and other reproductive health supplies. Alternative distribution guidelines have been drafted but are not yet finalized.

Additionally, grantees in Uganda recognized the need for RMNCH partners to coordinate more deliberately on advocacy objectives and formed the RMNCH Advocacy Working Group. Meetings are held for partners to share updates and troubleshoot challenges. The Ministry of Health has attended meetings has appropriate and this mechanism has helped to align partners working on similar advocacy agendas or activities.

V. **RMNCH Country Engagement Strategy**

An additional strategy to accelerate implementation of the UNCoLSC mandate during 2014-2015 has been the expansion of the RMNCH Country Engagement process. Building on the principles of IHP+, this process responds to a country’s expressed interest to engage in support of national efforts to ‘bend the curve’ towards achieving MDGs 4 and 5. The goal is to provide direct technical and financial support to countries and better align related RMNCH funding streams to improve coverage of interventions that can reduce preventable deaths. Led by the Ministries of Health, this process includes:

• A joint, rapid multi-stakeholder synthesis of the RMNCH landscape that brings together the various plans, sub-plans and initiatives that are relevant to a particular country context
• A prioritization process, based on the landscape review, the burden of disease and specific programmatic and financial gaps across the RMNCH continuum-of-care
Commitment of development partners to support implementation of prioritized interventions, under the leadership of the relevant Ministry. The prioritized actions build off other major planning processes in-country such as Results Based Financing expansion through HRITF funds, the New Funding Model of the Global Fund, or other processes as decided by the country in consultation with key stakeholders, including civil society.

Working in conjunction with key partners such as the H4+ and the UN Special Envoy’s Office for Financing the Health MDGs, the RMNCH SCT actively facilitates the RMNCH Country Engagement process. Throughout this process, the ‘commodity-focus’ of the UNCoLSC remains a central planning tool to help identify, prioritize and track progress against key bottlenecks. This generally involves a range of ‘systems-strengthening’ interventions that act interdependently to improve access to commodities and related interventions, accelerate progress towards achieving the MDGs, reducing health inequalities, and contributing towards universal health coverage.

Phase I countries

Pathfinder countries: An initial group of ‘pathfinder countries’ were supported to scale up the UNCoLSC recommendations by the RMNCH Fund in 2013, and also improve RMNCH programmes at large. This initial grant of $39 million financed country plans in the Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Senegal, Sierra Leone, Uganda and the United Republic of Tanzania. Niger was also supported through this initial round with catalytic funding to improve reproductive health.

Grant implementation has relied upon the engagement of Ministries of Health, United Nations organizations, non-governmental organizations (e.g., Clinton Health Access Initiative (CHAI), Management Sciences for Health (MSH), John Snow, Inc. (JSI) and Save the Children, etc.) and other stakeholders.

Progress to date: The following section provides illustrative examples of progress being made in these countries to increase availability and access to life-saving commodities.

Democratic Republic of Congo:

The DRC received an initial US$3.7 million grant from the RMNCH Fund, to address some of the national level bottlenecks in order to expand access to the 13 UNCoLSC recommendations. Over the past year, it has increased regulatory efficiency by listing manufacturers of 12 products, in view of their New Drug Application, and including misoprostol, amoxicillin disposable tablets and chlorhexidine on the national Essential Medicines List. Quality assurance has been strengthened by training 30 auditors in quality assurance for pharmaceutical laboratories – and audited ten of those laboratories, for the preparation of chlorhexidine digluconate 7.1%, zinc and ORS. In order to increase health worker performance treatment guidelines for amoxicillin dispersible tablets, chlorhexidine digluconate 7.1%, misoprostol, emergency contraception and female condoms have been developed or updated. These guidelines are currently being distributed to 207 health zones. Other important enabling activities to allow for increased access to commodities have been carried out this year including: elaborating a needs-base supply plan for all 13 life-saving commodities; strengthening monitoring and evaluation of health interventions, with a training plan targeting the health zones’ management teams; a mapping of the community health centres, their stocks, needs and degree of functioning;
and feasibility studies on the integration of the 13 life-saving commodities into the complementary health insurance care packages.

Building on this work, a follow-up grant worth $15 million which focuses on scaling up family kits for the improvement of child health was approved in mid-2014 by the RMNCH Fund.

**Ethiopia**

An initial grant of US$3.5 million has been implemented in Ethiopia, cutting across the entire RMNCH continuum of care. The grant had a strong focus on making the three family planning commodities – female condom, contraceptive implant and emergency contraception – more available and used. Both female condoms and emergency contraception were procured, to be available in 60 per cent and 80 per cent of public health facilities respectively. Ethiopia worked to boost the demand for both these commodities by distributing over 10,000 leaflets and 8,000 posters, organizing female condom training for university students and peer educators, broadcasting 200 radio spots and several documentaries on emergency contraception, and training journalists to report on female condoms and emergency contraception. In support of an increased use of contraceptive implants, over 3,000 health extension workers were trained on Implanon insertion and removal. The grant has also financed increased availability of newborn essential commodities, in particular oral and injectable antibiotics. These were made available to 100 health posts in four regions. Over 400 health centers and 20 hospitals were provided with selected commodities including injectable antibiotics to improve quality referral and ensure continuum of care.

Ethiopia also started implementing a US$10 million follow-up grant focusing on maternal and newborn health in several under-served pastoralist regions. A baseline assessment is being conducted to help identify gaps for improved quality of basic emergency obstetric and neonatal care (BEmONC) services in health facilities, and hundred midwife mentors have been recruited are trained on BEmONC.

**Malawi**

The US$3.7m RMNCH grant helped strengthen the capacity to promote rational medicine use by creating an enabling environment for the appropriate use of the 13 essential RMNCH commodities. Policy documents such as the Malawi Standard Treatment Guidelines (MSTG) and Essential Medicines List (EML) were reviewed to include life-saving commodities, and the Logistics Management Information System tools were reviewed to incorporate the 13 essential commodities.

Efforts to strengthen the supply chain included building the capacity for evidence-based quantification, forecasting and procurement, and stock management, at national and district levels. The grant funded the training of over 1,700 health facility in-charges and health assistants on drug management, including LMIS reporting; it kick-started an LMIS Ambassadors program – a supportive supervision program by zonal pharmacy officers to district hospitals and health centers – in 121 health facilities. The grant also made it possible for two districts to develop multi-year investment plans for life-saving commodities.

In addition, the running cost of cStock, a mobile based community level supply chain system, was supported in order to provide real time data on the stock status of supplies at community level. To increase demand for RMNCH services in health facilities, training materials were developed for service providers on use of magnesium sulphate, misoprostol, chlorhexidine, zinc, as well as insertion and removal of contraceptive implants. In terms of supplies, neonatal
resuscitation equipment and training mannequins were procured and distributed to all districts, in 530 health facilities, while sufficient quantities of chlorhexidine and dexamethasone were procured for national use for one year.

**Niger**

The US$1.7m grant in Niger focused on reproductive health, and in particular on addressing high adolescent fertility rates. Increased access to family planning services was supported by the procurement of family planning commodities, including contraceptive implants and the establishment of mobile clinics in five districts. Raising awareness and understanding of reproductive health and family planning has also been prioritized through the training of 36 trainers of trainers (ToTs) and 1,366 teachers to educate youth about sexuality and contraception. Niger also broadcast films on family planning and illegal abortion, early marriage and teenage pregnancy. Building and expanding on this work, Niger has also prepared a follow-on catalytic and gap-filling programme to be financed and implemented in 2015.

**Nigeria**

Nigeria received a US$9.6 million grant from the RMNCH Fund for several catalytic interventions across RMNCH. Strengthening local markets to increase product availability has been an important focus of this grant, resulting in the regulatory approval for the local production of chlorhexidine; a local market shaping strategy for amoxicillin dispersible tablets and chlorhexidine gel, and a market analysis for pneumonia treatment and pediatric amoxicillin have also been carried out; and Nigeria has established a manufacturers’ forum on amoxicillin dispersible tablets, seeking to enhance local production. Nigeria has provided access to chlorhexidine for umbilical cord care in five priority states for 350,000 newborns.

Supply chain management has been strengthening by training over 200 providers on using maternal health logistics tools in nine states, which are being supported with magnesium sulphate, misoprostol, oxytocin, antibiotics, and other maternal health commodities. Nigeria also put in place a mentoring system for the Federal Ministry of Health staff on monitoring family planning programs, including commodity security, use of tracking tools for procurement and supply chain management.

The training of nearly 400 health care providers on active management of third stage of labor with focus on using misoprostol, magnesium sulphate and oxytocin as well as anti-shock garments has helped reduced maternal deaths due to complications in pregnancy including post-partum hemorrhage and pre-eclampsia/eclampsia. Nigeria provided access to misoprostol and magnesium sulphate for managing post-partum hemorrhage and eclampsia in 15 priority states to about 350,000 women in 2014. The Ministry of Health estimates that over 5,000 maternal deaths were averted.

Access to family planning has been significantly improved, especially for poor and marginalized women and girls by training 350 health care workers in six states on long acting reversible contraception, and providing technical and financial support to 31 states to distribute contraceptives to the last mile including in humanitarian situations. Alongside other support as well, Nigeria has provided access to modern family planning to 3.5 million women in 2013 and 2014. The Ministry of Health estimates that over 900,000 unwanted pregnancies and 70,000 unsafe abortions were prevented.

**Senegal**

The US$ 5 million initial grant to Senegal financed priority activities across the RMNCH continuum through strengthening the national supply chain system, transport and commodity distribution, assessing the capacity for local production of
child health products and community health worker training and support. The policy and regulatory environment has been strengthened by updating the national Essential Medicines List to include misoprostol and amoxicillin dispersible tablets at the community level. Senegal also updated training material on pharmacovigilance, and improved quality assurance by visiting manufacturing and packaging sites and conducting study on local production capacity for amoxicillin dispersible tablets, chlorhexidine, ORS and zinc. In addition to procuring key life-saving commodities, this investment has helped strengthen supply chain management by controlling the quality of the life-saving commodities and training the national medical store pharmacists on the distribution model. Demand and utilization have been increased by training providers of integrated management of childhood illness in each medical zone, implementing community activities such as child survival day, and supporting free care for children under five. Senegal is also expected to benefit from a follow on grant by the RMNCH Fund in 2015, to expand access to RMNCH services.

**Sierra Leone**

The US$4.7m RMNCH Fund grant to Sierra Leone was set up to expand access to family planning commodities and expand newborn care. The outbreak of Ebola, however, necessitated a significant reprogramming of funds in support of the emergency response towards, amongst other things, the procurement and distribution of equipment and supplies necessary to run Ebola treatment and holding centres, and for the training, remuneration, mentorship and monitoring of 570 contact tracers and contact tracing supervisors in several parts of the country.

Despite the Ebola virus outbreak and reprogramming of funds, the grant helped train as many as 1,700 health workers for long acting and permanent family planning (LAPFP) methods and now more than 130 community health clinics and 14 district hospitals are providing quality LAPFP services. The grant also supported demand for RMNCH commodities with a training and information package on emergency contraception and misoprostol for health workers. In preparation for the scale-up of integrated community health care, a strategic plan was developed and will soon be launched, and standardized training manuals and job aids for community health workers were updated.

**Uganda**

The US$3.7 million RMNCH Fund grant to Uganda aimed to align and harmonize activities related to RMNCH, expand essential newborn care, scale up integrated case community management, support innovations, develop local market shaping, and improve demand-based forecasting for family planning commodities. Of note, zinc and ORS for diarrhoea treatment were made more available and affordable with a 60% price reduction, and three new zinc and one new ORS products are entering the market, (versus one zinc and two ORS products a year ago). Working towards increasing performance and accountability in administrating the essential RMNCH commodities, a balance scorecard for performance based financing was developed and pre-tested. Increased availability has been ensured through supply chain management strengthening, including kit quantification for lower level public health facilities to meet district consumption trends, and the creation of an online data platform for key tracer medicines designed for national medical stores employees who are in charge of essential medicine kit revisions throughout the country. Furthermore, female condoms were integrated into the public sector supply chain and Health Management Information System. Efforts have been underway to improve the way essential commodities are being administrated with a first phase of non-institutional training on integrated management of childhood illness (IMCI) for district trainers in five districts, using training materials specifically adapted to local needs and recently endorsed as the official IMCI national training materials.
Building on this work, a follow-up grant worth $7 million which focuses on scaling up maternal, newborn and child health outcomes will be approved in 2015 by the RMNCH Fund.

**United Republic of Tanzania**
The RMNCH Fund financed the United Republic of Tanzania with a US$3.8 million grant. Regulatory efficiency has been increased by having most life-saving commodities registered, and two in progress (ORS and Zinc). All registered commodities can also be imported and utilized in Zanzibar. In Zanzibar, the Standard Treatment Guidelines and Essential Medicines List were reviewed to incorporate life-saving commodities. In terms of ensuring better supply, Tanzania has also improved data accessibility to improve availability of the life-saving commodities at facility level by expanding the Integrated Logistics System to the remaining 12 regions that were not covered yet and training providers and supervisors. A revised quantification report and supply plan has been made available for maternal, newborn and child health commodities, and a procurement process for neonatal equipment and antenatal corticosteroids.

Zanzibar conducted a quantification exercise highlighting the needs in essential commodities for 2015, which will guide procurement, and re-established the reproductive and child health commodity security committee to address bottlenecks of commodity availability.

Tanzania conducted a knowledge, attitude and practices study to guide demand creation and service utilization interventions and adapted ten demand creation tools. Tanzania also put together a user friendly package on life-saving commodities to better orient trainers, supervisors and service providers. Zanzibar supported demand for family planning commodities with televised youth debates. Tanzania will also benefit from a follow on grant by the RMNCH Fund in 2015, to expand access to RMNCH services.

**Case Study 12** below profiles the experience of Malawi in more detail.
Replenishment of the RMNCH Fund by Norway and DFID in 2014 allowed for additional support to be provided to the Phase I countries, alongside new financing for an additional 10 countries (See Figure 8). As of April 2015, a total of $146 million has been approved by the RMNCH Allocation Committee, 80% of which has already been disbursed to countries. An additional $57 million is still pending approval (Figure 9). Grants to the initial pathfinder countries will conclude in June 2016. New grants recently approved, have a time frame between 12-18 months, and will conclude by October 2016.

Nearly all the countries whose proposals are pending approval, are currently in the final stages of review. The country engagement process has been instrumental in securing complementary resources at country level and these plans will be critical in informing upcoming initiatives such as the Global Finance Facility (GFF), where they will be used as one basis upon which to build longer-term, more sustainable support.
Figure 8: RMNCH Fund Supported Countries (2013-2015)

RMNCH Funded Countries in Asia:
- Afghanistan
- Bangladesh
- Pakistan

Figure 9: Country grants approved by the RMNCH Fund (2013-2015) (millions USD)

- DRC: 3.5, 14.8, 7.5
- Nigeria: 10.3, 15.0
- Ethiopia: 3.6, 10.0, 10.0
- Tanzania: 4.0, 12.0
- Kenya: 7.5
- Malawi: 3.9, 7.5
- Uganda: 3.9, 7.0
- Senegal: 5.4, 4.9
- Mozambique: 8.0
- Cameroon: 8.0
- Pakistan: 7.9
- Afghanistan: 7.0
- Zambia: 7.0
- Niger: 1.8, 5.0
- Sierra Leone: 5.0
- Mali: 5.0
- Burkina Faso: 5.0
- Benin: 4.0
- Bangladesh: 0.7
**Phase II country priorities:** While the initial pathfinder countries focused on the scale up of the UNCoLSC recommendations, the country engagement grants are centered on wider systems-strengthening efforts across the RMNCH spectrum. **Figure 10** shows the distribution of approved funds by RMNCH area. To date, nearly half of resources disbursed have been directed towards systems strengthening interventions such as supply chain improvement or integrated RMNCH health worker training. Other system wide interventions include strengthening Maternal Death Surveillance Review (MDSR) which is critical to providing information to effectively guide decisions and actions to address maternal mortality at health facilities and in the community. MDSR interventions are being prioritized in Cameroon, Kenya, Burkina Faso, and Ethiopia. Approximately 20% of funds were used to procure commodities- largely driven by DRC, Ethiopia and Kenya.

The balance of the approved budget is fairly equally distributed by RMNCH area. However, a particular emphasis was also placed on newborn outcomes in countries where this is lagging behind. As a result, the financing request from Kenya, for example, has prioritized maternal and newborn health through: strengthening EmONC services, identification and management of long-term pregnancy and labor related morbidity, Result-based Financing, setting up a functional referral system and establishing innovative maternity waiting homes. Similarly, proposals from Benin, Burkina Faso, Cameroon, Ethiopia, Mozambique, Pakistan and Uganda all prioritize newborn outcomes.

Child health interventions which include efforts around ICCM and IMCI, are also being supported in countries such as Afghanistan, Burkina Faso, Malawi and Uganda. The RMNCH Fund is also supporting the scale up of reproductive health interventions to prevent unwanted pregnancies in DRC, Mozambique Benin, Burkina Faso, Niger, Senegal, Uganda and Bangladesh. Ethiopia, Nigeria and DRC account for the largest share of the country grants funding (35%). Support to Bangladesh, which may appear disproportionally small relative to other countries, responds to a very specific request from the Ministry of Health towards bridging a temporary financing gap to scale up access to Misoprostol and Dispersible Amoxicillin tablets.

A further breakdown of the approved budget by UNCOLSC Recommendations, indicates emphasis is towards improving performance and accountability, strengthening supply chain systems and demand driven activities. Improving performance and accountability is driven by training, mentorship and support supervision of health workers. Nearly all plans included harmonization and alignment of national EML, treatment guidelines and training materials with latest recommendations. Resources are less focused around efforts towards shaping local and global markets, increasing financial accessibility, quality, innovation and regulations. This is in part because these are often areas harder to tackle through short-term financing and also in part because they are largely policy-driven and do not require substantial amounts of funding. **Appendix 2** provides further details of the focus areas for new and upcoming 2014-2015 grants.
VI. Lessons learned and implications for the post-2015 agenda

For more than two years, efforts have been ongoing at the global and country-levels to advance the UNCoLSC agenda within the wider Every Woman Every Child framework. The upcoming 2015 deadline for the MDGs represents an important juncture for taking stock of global progress towards improving access to live saving commodities, while simultaneously highlighting remaining implementation gaps.

This report suggests that key milestones highlighted in the UNCoLSC Report and Implementation Plan have largely been achieved or are nearing completion – with the exception of systematic work to address issues of user-fees and financial accessibility which requires additional focus. However, many of these targets were modest and emblematic of a more ambitious and well-coordinated global effort that is still required. This report suggests that coordinated efforts to implement the UNCoLSC mandate has provided a critical ‘global public good’ for strategically facilitating the relationships between countries and markets to propel more effective pricing, procurement, distribution and delivery of essential commodities and related services.

The report also documented substantial efforts at the country-level through the ongoing work of the Ministries, agencies and implementing partners to implement the UNCoLSC recommendations. The multi-country assessment profiled in this report emphasizes that we are still in early days and more needs to be done. Translating global learning into country action requires an on-going and systematic push. There is need for continuous re-alignment of EMLs, treatment guidelines, and commodity registration as new evidence becomes available. Supply chain architectures remain overly complex and fragmented with facility-level stock-outs still far too common. Health workers require continuous re-training in the latest treatment protocols, alongside the provision of basic learning and support materials such as job-aids and check-lists. Echoing this need for additional country progress, the Secretary General’s report on the status of women and children’s health suggests we will fall well short of achieving MDGs 4 and 5 – with just 2.4 million of the anticipate 6 million lives of women and children saved since 2010.

These findings have important implications for the emerging Sustainable Development Goal (SDG) agenda – which defines a new set of global commitments to create a healthy, prosperous, sustainable future for all people. The updated Global Strategy for Women’s, Children’s and Adolescents’ Health is the frontrunner platform for the implementation of the health-related SDGs, and ensuring universal coverage with proven interventions remains a top-tier priority. The importance of maintaining a focus on access to commodities must be strongly highlighted in the updated Global Strategy – indeed it needs to remain on top of the agenda through 2030.

To support these efforts, better defining which components of UNCoLSC agenda should be included within the ‘global public good’ framework is essential, alongside defining a global mechanism for supporting progress at the country-level. A meeting of the UNCoLSC TRTs was held in April 2015 to reflect on these broader questions. There was agreement that an ‘unfinished agenda’ remains for UNCoLSC and that the following thematic areas should be the subject of ongoing ‘global public good’ deliberations:

- Global Market Shaping: Market forces often run contrary to making comparatively inexpensive commodities widely accessible to poor countries. In addition, countries themselves have regulatory hurdles that create
disincentives for manufacturers to register their products. Concerted global efforts will be required for the foreseeable future to mitigate these barriers including the negotiation of further price reductions as appropriate (and extending beyond the 13 commodities); establishing product standards to rationalize manufacturing and country procurement; harmonization of regulatory guidelines between countries; further work on joint dossier and manufacturer inspections, and; global efforts to better understand the relative contribution of the private sector in the procurement and distribution of life saving commodities.

- **Ongoing support to quality assurance for commodities:** Few countries have comprehensive systems in place to ensure a sufficient and safe supply of essential commodities. This area includes procurement from GMP accredited manufacturers, conducting bio-equivalence and bio-availability studies, establishing and supporting pharmaco-vigilance programs, and national and regional support for post market surveillance.

- **Procurement and Supply Chain Management:** A consistent in the multi-country assessment was the fundamental challenges to procurement and supply chain management. Areas where countries require additional support include negotiation of further price reductions as appropriate (and extending beyond the 13 commodities); establishing product standards; assistance with commodity security strategies; quantification support; a fund for flexible financing for commodity purchasing; IT innovations such as comprehensive LMIS systems, LMIS/HMIS integration and facility-level stock assessments, and; better understanding the role of wholesalers and the private sector more generally. Much of this work could be taken forward and supported by the Interagency Supply Group (Case Study 9)

- **Standardized Monitoring Platform:** Experience with the UNCoLSC has demonstrated that the ‘commodity lens’ has been a useful and complementary approach for identifying and addressing systems-related and commodity-specific gaps. Above and beyond conventional ‘activity-based monitoring’, it was felt that a standardized tracking system mirroring the UNCoLSC recommendations should be maintained to inform both global priority setting for sharpened country RMNCH plans moving forward.

- **Knowledge Transfer:** A mechanism to more effectively translate global learning to country-level action remains a critical priority. Such a mechanism should provide robust and sustained technical support to countries, and should have a two key components. Firstly, it should provide a hub for continually updated best practice materials that have become available from the UNCoLSC and related initiatives including a synthesis of the latest evidence, tool-kits, training materials, and treatment guidelines. Second, it should facilitate country-level access to established networks of global experts who can support key priorities including refining EMLs, treatment guidelines, training materials and job-aids based on the latest evidence, and coordinated guidance and technical support with IT innovations.
## Appendices

### Appendix 1: Key Indicators and Performance Ratings (Cutoffs)

<table>
<thead>
<tr>
<th>Category / Item</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S1 Coordination</strong></td>
<td>Coordination Mechanism: A functional national coordination mechanism on RMNCH exists (or RMNCH is included in broader coordination mechanism)</td>
</tr>
<tr>
<td>Typical Data Source</td>
<td>SCT Landscape</td>
</tr>
<tr>
<td><strong>S2 Coordination</strong></td>
<td>RMNCH plan cost and budgeted: A national RMNCH plan/strategy exists that is costed with a budget allocated for interventions that deliver LSCs at the national and sub-national levels</td>
</tr>
<tr>
<td><strong>S3 Coordination</strong></td>
<td>Commodity Security Strategy (CSS) exists and addressing LSCs for RMNCH</td>
</tr>
<tr>
<td><strong>Innovating Financing</strong></td>
<td>Results-based financing mechanism: Country entered into an agreement with the results-based financing mechanism to increase access to the life-saving commodities and related services</td>
</tr>
<tr>
<td>Typical Data Source</td>
<td>SCT Landscape</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>GMP-accredited manufacturers: Procurement in the public sector is done only from manufacturers with a valid GMP accreditation certificate</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>National medicines control laboratory: At least one national medicines control laboratory exists in-country that is certified by any standards accreditation agency</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Monitoring and quality of medicines: Monitoring systems exist for monitoring quantity and patient safety of medicines in the country</td>
</tr>
<tr>
<td>Typical Data Source</td>
<td>SCT Landscape</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cutoff: Good</th>
<th>Cutoff: Moderate</th>
<th>Cutoff: Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets 4-6 of 8 criteria listed in &quot;Coordination Criteria&quot;</td>
<td>Meets 3 of 5 criteria listed in &quot;Coordination Criteria&quot;</td>
<td>Meets 2 of 5 criteria listed in &quot;Coordination Criteria&quot;</td>
</tr>
<tr>
<td>Light green - 4 criteria met</td>
<td>Yellow - 3 criteria met</td>
<td>Darkest red - 0-1 criteria met</td>
</tr>
<tr>
<td>Darkest green - 5 criteria met</td>
<td>Light yellow - 4 criteria met</td>
<td>Lighter red - 2 criteria met</td>
</tr>
<tr>
<td>Darker red: No RMNCH plan exists; needs to be developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RMNCH Commodity Security Strategy has been developed but not approved by MoH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country is NOT entered into RBF agreement to increase access to LSCs and related services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement of RMNCH commodities only from manufacturers with a GMP accreditation for both domestic and international purchases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darkest green: At least one national medicines control laboratory exists in-country and is certified by WHO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one national medicines control laboratory exists in-country, but is not certified by a standards accreditation agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No national medicines control laboratory in-country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functioning medicines quality monitoring system (1) AND patient safety monitoring system (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functioning medicines quality monitoring system (1) OR patient safety monitoring system (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No functioning system (1 or 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category / Rec</td>
<td>Indicator</td>
<td>Typical Data Source</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>58 Supply</td>
<td>Forecasting Tools: Existence of a forecasting tool or method used routinely for forecasting needs for RMNCH medicines and medical devices</td>
<td>SCT Landscape</td>
</tr>
<tr>
<td>59 Supply</td>
<td>Comprehensive national eMIS: At the national level, there is a single electronic eMIS or an interoperable platform for multiple eMIS’s that tracks commodity availability and distributions from first point of warehousing to service delivery point for each RMNCH service area AND automatically compiles and aggregates information on a continuous basis</td>
<td>SCT Landscape</td>
</tr>
<tr>
<td>510 Supply</td>
<td>Supply chain training to districts: Training in supply chain management for RMNCH commodities has been deployed to 55% at the district level</td>
<td>SCT Landscape</td>
</tr>
<tr>
<td>511 Demand &amp; access</td>
<td>National RMNCH plan includes demand generation/behaviour change initiatives that are costed with a budget allocated.</td>
<td>SCT Landscape</td>
</tr>
<tr>
<td>Category / Item</td>
<td>Indicator</td>
<td>Typical Data Source</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>COMMODITY LEVEL INPUTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td>Regulatory</td>
<td>National EML: Commodity is included in the national essential medicines list (EML) with a context-appropriate level of commodity specification and/or formulation</td>
</tr>
<tr>
<td>C2</td>
<td>Regulatory</td>
<td>National treatment guidelines exist for interventions to deliver the commodity</td>
</tr>
<tr>
<td>C3</td>
<td>Regulatory</td>
<td>Registered in-country: Commodity is fully registered in-country under approved &amp; relevant formulations</td>
</tr>
<tr>
<td>C4</td>
<td>Regulatory</td>
<td>Prescription authority: Commodity prescribed at lowest appropriate level of service delivery (as per national policy and essential intervention package)</td>
</tr>
<tr>
<td>C5</td>
<td>Supply</td>
<td>Tracked in eLMIS: Commodity availability is tracked from first point of warehousing to service delivery point by an electronic LMIS</td>
</tr>
<tr>
<td>C6</td>
<td>Supply</td>
<td>National stock-outs: No commodity stock-out at the national level in the past 12 months (for commodities on the EML)</td>
</tr>
<tr>
<td>C7</td>
<td>Supply</td>
<td>% POS with stock available: Percentage of health facilities with no commodity stock-out reported (by commodity) at the time of assessment for facilities authorized to provide the commodity</td>
</tr>
</tbody>
</table>

For each commodity: Light red = 60-69% | Dark red = <60%
<table>
<thead>
<tr>
<th>Category / Rec.</th>
<th>Indicator</th>
<th>Typical Data Source</th>
<th>Cutoff: Good</th>
<th>Cutoff: Moderate</th>
<th>Cutoff: Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>C8</td>
<td>Performance</td>
<td>Training curriculum (national). In-service training curriculum exist at all the relevant level(s) for interventions that deliver the commodity at the appropriate level of care.</td>
<td>SCT Landscape</td>
<td>In-service training curriculum for the commodity and associated service have been developed at the national level, are written in clear language, are up-to-date, and reference the latest WHO version available</td>
<td>In-service training curriculum for the commodity exist at the national level but need strengthening (i.e., they are not up to date, are unclear, and/or have significant deviations from WHO curricula) or are under development</td>
</tr>
<tr>
<td>C9</td>
<td>Performance</td>
<td>% facilities with recent training: Percentage of Health Facilities with at least one Health Worker Trained in Service Delivery (by RMNCH component) in the past two (2) years.</td>
<td>Health Facility Assessment (HFA)</td>
<td>For each RMNCH service area: Dark green ≥ 80% Light green 60-80% Yellow 50-60% Red ≤ 50%</td>
<td>For each RMNCH service area: Dark green ≥ 70% Light green 60-70% Yellow 50-60% Red ≤ 40%</td>
</tr>
<tr>
<td>C10</td>
<td>Performance</td>
<td>Job aids or check lists (national): At the national level, job aids/check lists have been developed or updated for interventions that include the specific commodity.</td>
<td>SCT Landscape</td>
<td>Jobs aids/check lists at national level have been developed, are written in clear language, are up-to-date, and reference the latest WHO version available</td>
<td>Job aids/check lists for the commodity exist at the national level but need strengthening (i.e., they are not up to date, are unclear, and/or have significant deviations from WHO versions) or are under development</td>
</tr>
<tr>
<td>C11</td>
<td>Performance</td>
<td>% facilities with job aids or check lists: Percentage of health facilities where relevant job aids/check lists exist at the facility at the time of assessment.</td>
<td>Health Facility Assessment (HFA)</td>
<td>For each RMNCH service area: Dark green ≥ 80% Light green 60-80% Yellow 50-60% Red ≤ 50%</td>
<td>For each RMNCH service area: Dark green ≥ 70% Light green 60-70% Yellow 50-60% Red ≤ 40%</td>
</tr>
<tr>
<td>C12</td>
<td>Demand &amp; access</td>
<td>Policy against user fees: National policy states that the life-saving commodities or related services are provided free of charge (e.g., no user fee) at the point of service delivery as part of the essential intervention package in the public sector.</td>
<td>SCT Landscape</td>
<td>National policy states that patients should not be assessed any fee or out of pocket expense for the LSCs and related services.</td>
<td>National policy states that patients should not be assessed any fee or out of pocket expense for the LSCs and related services.</td>
</tr>
<tr>
<td>C13</td>
<td>Demand &amp; access</td>
<td>Coverage Rate: % of affected population with specified medical condition receiving treatment with appropriate life-saving commodity.</td>
<td>MICS, DHS</td>
<td>For each commodity (except FP): Dark green ≥ 80% Light green 60-80% Yellow 40-60% Red ≤ 40%</td>
<td>For each commodity (except FP): Light green 30-50% Yellow 20-30% Red ≤ 20%</td>
</tr>
</tbody>
</table>
## Appendix 2: Summary of 2014-2015 grants

<table>
<thead>
<tr>
<th>Country</th>
<th>RMNCH Focus</th>
</tr>
</thead>
</table>
| Afghanistan   |  • Strengthening the quality of community and facility based RMNCH services  
                   • Improving availability of essential RMNCH supplies, equipment and drugs  
                   • Strengthening and expanding the referral system, and  
                   • Enhancing the M&E system                                                                                                                                 |
| Bangladesh    |  • Procurement of Misoprostol  
                   • Capacity development of service providers and managers for Misoprostol distribution to be coupled with Post-Partum Family Planning counselling as an integrated approach.  
                   • Study on the quality of Misoprostol and Oxytocin                                                                                                                                 |
| Benin         |  • BEMOC, improving supply, FP, sexual health and reproduction,  
                   • Prevention of Mother to Child Transmission of HIV,  
                   • Vaccine supply management.                                                                                                                                 |
| Burkina Faso  |  • EmONC, IMCI, essential newborn care, maternal care, reproductive health products, medical and technical equipment,  
                   • MDSR, Improving Strategic Information, RH / FP services,  
                   • Strengthening coordination and M&E                                                                                                                                 |
| Cameroon      |  • Family planning, Essential and emergency obstetric and newborn care.  
                   • Commodities and equipment purchase,  
                   • Health workforce capacity building  
                   • Improving community awareness and demand  
                   • Improving community health interventions to strengthen health service delivery  
                   • Health information systems including MDSR  
                   • Coordination, Monitoring and Supervision.                                                                                                                                 |
| DRC III       |  • Scale up of Reproductive health interventions, MDSR                                                                                                                                 |
| Ethiopia III  |  • Capacity building, Social mobilization and IEC/BCC  
                   • Essential MNCH drugs, supplies, equipment purchase,  
                   • Scale up Maternal Death Surveillance Response (MDSR) System.  
                   • Strengthen referral network through innovative transport, medical devices and communication system to improve access to SBA, EmONC services,  
                   • Improving quality, Quality Improvement                                                                                                                                 |
| Kenya         |  • Strengthening EmONC services, identification and management of long-term pregnancy and labor related morbidity, Result based Financing, setting up functional referral system and establishing innovative maternity waiting homes  
                   • Referral and transport Vouchers, working with religious leaders, TBAs, community volunteers, county governments and facilities  
                   • Institutional capacity building: Developing strategic plans for Maternal and Newborn Health, HRH strategies, Continuous quality improvement embedded into supportive supervision  
                   • M&E: Supporting HMIS/DHIS2, conducting annual EmONC & RMNCH surveys and improving data availability, vital registration, and the demand and use of data for decision making                                                                                                                                 |
| Mozambique    |  • Reducing the incidence of unwanted pregnancies,  
                   • postpartum hemorrhage and neonatal infections,  
                   • Capacity building                                                                                                                                 |
| Niger II      |  • Strengthening integrated management of childhood illnesses (IMCI),  
                   • improving the supply of Family Planning,  
                   • prenatal care, assisted delivery and emergency obstetric and neonatal and  
                   • strengthening prevention of transmission of HIV/AIDS from mother to child (PMTCT)                                                                                                                                 |
| Pakistan      |  • Strengthening policy, capacity building efforts, strengthening service delivery, provision of essential supplies and system strengthening, strengthening social mobilization for awareness and behavior change and demand creation for services.                                                                                                                                 |
| Senegal II    |  • Strengthening of community-based interventions,  

---
- Improving the private sector contribution,
- Improving accessibility to adolescent reproductive health services, strengthening and expansion of emergency obstetric and neonatal care,
- Providing nutrition support interventions and behavior change communication. Improve the political and regulatory environment for the vital products,
- Strengthen the supply chain and distribution of 17 key life-saving commodities and products and improve coordination and monitoring and evaluation of the plan.

| Uganda II | • Capacity building of health workforce, ICCM, FP, EmONC, PBF, MPDSR, Leadership and Governance |
| Tanzania  | • Leadership and governance, Essential medicines and medical products, Health workforce capacity strengthening, Health information systems, Health service delivery: strengthening health systems to provide Emergency obstetric and newborn care. |

** Upcoming grants from Mali and Zambia not listed above, as the countries are yet to submit financing request to the RMNCH Fund