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REPRODUCTIVE HEALTH COMMODITY SECURITY STRATEGY

FOR THE WEST AFRICA SUBREGION

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REPRODUCTIVE HEALTH COMMODITY SECURITY STRATEGY

FOR THE WEST AFRICA SUBREGION

DELIVER
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Abstract
The vision of this strategy is to achieve reproductive health commodity security (RHCS) in West Africa, which will exist when every West African can reliably choose, obtain, and use quality, affordable, essential reproductive health supplies when he or she needs them. This document demonstrates that the increased use of reproductive health (RH) products can reduce maternal and perinatal mortality and morbidity, which supports the West African Health Organization's (WAHO) maternal health objectives.

The scale, reach, and capacity to advocate for RHCS across the subregion complement and reinforce the implementation of existing efforts at the country level. The approach will serve as a catalyst for policymakers and program managers to share experiences and develop common methods to address the challenges common to countries in the subregion. These include, but are not limited to (1) access to RH commodities, (2) inadequate logistics systems, (3) insufficient commodity financing, (4) a multiplicity of poorly coordinated activities in countries, and (5) substantial national and operational policy barriers to RHCS. Key areas of work are identified where this subregional approach can add value to existing efforts. They include developing systems to enhance the sharing of RH commodity procurement information across countries, building human and institutional capacity, and advocating for harmonized RH commodity policy and regulatory frameworks across ECOWAS member states.

DELIVER
John Snow, Inc.
1616 North Fort Myer Drive
11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: deliver_project@jsi.com
Internet: deliver.jsi.com

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ACRONYMS

ACAME	*Association Africaine des Centrales d'Achats de Médicaments Essentiels*
ADB	Asian Development Bank
AIDS	acquired immune deficiency syndrome
ATP	ability to pay
AWARE-RH	Action for West Africa Region-Reproductive Health (project)
BCC	behavior change communication
BCEAO	*Banque Centrale des États de l'Afrique de l'Ouest*
CAMES	*Conseil Africain et Malgache Enseignement Supérieur*
CDC	Centers for Disease Control and Prevention
CERPOD	*Centre d'Etudes et de Recherche sur la Population pour le Developpement*
CESAG	*Centre Africain d'Etudes Supérieures en Gestion*
CHU	*Centre Hospitalier Universitaire*
CIB	coordinated informed buying
CIDA	Canadian International Development Agency
CPR	contraceptive prevalence rate
DANIDA	Danish International Development Agency
DFID	Department for International Development (United Kingdom)
DPAT	Direction Planification
DRP	drug registration procedure
DSSP-CM	*Division Soins de Santé Primaires-Controle de la Maladie*
ECOWAS	Economic Community of West African States
EML	essential medicines list
EOC	emergency obstetric care
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit*
HIV	human immunodeficiency virus
HMIS	health management information system
HQ	headquarters
IEC	information, education, and communication
IPC	International Planning Committee
IPPF	International Planned Parenthood Federation
IPS	international partners
IRSP	*Institut Régional de Santé Publique*
JICA	Japan International Cooperation Agency
KfW	*Kreditanstalt für Wiederaufbau*
LMIS	logistics management information system
M&E	monitoring and evaluation

MDG	Millennium Development Goal
MMR	maternal mortality ratio
MOEd	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MSA	market segmentation analysis
MSP/LCE	*Ministère de la Santé Publique/Lutte contre les endémies*
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organization
OOAS	*Organisation Ouest Africaine de la Santé*
OAU	Organisation of African Unity
PMLO	program managers and liaison officers
PPP	public- and private-sector partnership
PRB	Population Reference Bureau
RH	reproductive health
RHCS	reproductive health commodity security
SDP	service delivery point
SIDA	Swedish International Development Cooperation Agency
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STG	standard treatment guideline
STI	sexually transmitted infection
TA	technical assistance
TOR	terms of reference
TOT	training of trainers
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WAHO	West African Health Organization
WHO	World Health Organization
WHO-AFRO	World Health Organization-Regional Office for Africa
WTP	willingness to pay

ACKNOWLEDGMENTS

The West African Health Organization (WAHO) provided the technical direction and organization necessary to complete the reproductive health commodity security strategy. WAHO, led by Dr. Kabba Joiner, Director General, hosted three strategy development workshops between November 2005 and March 2006. Participants in the workshops included experts from the Economic Community of West African States governments, donors, nongovernmental organizations, and technical partners—grouped together as the reproductive health (RH) task force—and WAHO program managers and liaison officers. Annex 1 lists these individuals.

John Snow Inc./DELIVER was the facilitator for the workshops and the editor of this document. The Action for West Africa Region-RH project provided key technical and organizational support. Organizations that provided substantial staff time and financial support for the development of this document include United States Agency for International Development (USAID)/West Africa, USAID/Washington, the United Nations Population Fund, the *Kreditanstalt für Wiederaufbau*, and the World Bank.

The authors especially thank USAID for supporting WAHO and the writing of this document.

1.0 SUMMARY

In November 2005, a concept paper on RHCS in the subregion was presented to the West African Health Organization (WAHO) Ministers of Health at the 6th Ordinary Meeting of Health Experts and Ministers in Dakar, Senegal. At that meeting, Economic Community of West African States (ECOWAS) health ministers approved the development of a subregional reproductive health commodity security (RHCS) strategy and directed WAHO to lead this project. Later in November, the West Africa Reproductive Health Commodity Security Task Force (Task Force), led by WAHO, held an initial workshop to begin developing a subregional strategy for RHCS.

After the November workshop, in January 2006, the WAHO program managers and liaison officers (PMLO) met to review and further develop the strategy. In March, the Task Force met again to review the strategy and complete further revisions. These meetings resulted in this final draft. The combined efforts of the Task Force and the PMLO were instrumental in creating this document. The PMLO represented 14 of the 15 countries in ECOWAS; they drew on experiences from country programs to devise feasible RHCS interventions.

The RHCS concept paper underscored the importance of framing commodity security within the context of the "7 Cs" of the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS)[1] framework (Hare et al. 2004). The Task Force and the PMLO acknowledged that the 7 Cs—client, capacity, capital, commitment, coordination, commodities, and context—are the elements required to achieve RHCS, which exists when *every person can reliably choose, obtain, and use quality, affordable, essential reproductive health supplies whenever he or she needs them*. Nonetheless, the Task Force agreed that a regional strategy is not feasible if it tries to address the range of all the SPARHCS components. Instead, the focus should be on addressing cross-cutting subregional challenges where, because of scale, reach, and cost-effectiveness, subregional actors can add value by advocating, brokering, and catalyzing efforts that reinforce current and future country-based interventions.

National commodity security strategies, both existing and in development in Ghana, Mali, Nigeria, Burkina Faso, Togo, The Gambia, Cameroon, and Sierra Leone already address many of the SPARHCS components, and the regional strategy should not duplicate these efforts. The subregional approach will reflect and complement country efforts and reinforce national-level activities. The framework was modified to reflect subregional strengths—and the thematic areas identified in the concept paper (JSI/DELIVER 2005)—with scope for supporting ongoing country work. (See section 4.0.) The new framework includes four strategic objectives related to context, coordination, capacity building, and country support activities.

1.1 CONTEXT

Improve, increase, and streamline common and specific RHCS policies at the country and regional levels to create a policy environment that will support RHCS in the subregion.

To enhance policy support for RHCS and improve the environment for public- and private-sector partnerships, these efforts will focus on advocacy for common and specific RHCS policies at the country and subregional levels, including the establishment of government budget line items for reproductive health (RH) commodities (country level) and the dissemination of materials for information, education, and communication (IEC) (from the subregional level). As ECOWAS countries continue to converge around common economic policies, advocating for a

1 The SPARHCS tool, jointly published by USAID and UNFPA, is available under Publications at www.deliver.jsi.com.

common external tariff, comparable drug registration procedures (DRPs), and standard treatment guidelines (STGs) for RH supplies can help increase efficiencies and reduce costs.

1.2 COORDINATION

The goal of coordination is to—

Strengthen planning, management, and implementation of RHCS activities through coordinating mechanisms involving the engagement of a broad range of stakeholders, including donors, governments, the private sector, and civil society organizations.

WAHO's coordination efforts will focus mainly, but not exclusively, on the implementation of the coordinated informed buying (CIB) mechanism, which, as it is designed and implemented, will serve as a practical and ongoing coordinating mechanism that allows the routine accessing and sharing of procurement data. Other activities listed in the strategy enhance the coordination within countries and between countries and the subregion. Country support initiatives and capacity building measures will be undertaken throughout the subregion. Further, the development of common DRPs and STGs (noted under *Context*) will enhance coordination between countries and subregional bodies.

1.3 CAPACITY BUILDING

The goal of capacity building is to—

Improve human, technical, and organizational capacity for the achievement of RHCS in the West African subregion.

The capacity to deliver RH commodities to clients through effective supply chains, monitor and test the quality of commodities, and train personnel in the multitude of functions that include RHCS, varies by country. Yet, it is evident that these and other capacity weaknesses are common to countries in the subregion. A subregional RHCS strategy will address these issues through support for quality control testing laboratories and subregional training programs in supply chain management and procurement. Many countries do not have the resources for such facilities and activities. Subregional and country actors should also document and disseminate best practices and be regularly informed about each other's activities to avoid duplication of effort and to identify where complementary roles can be played and where south-to-south technical exchanges can be beneficial.

1.4 COUNTRY SUPPORT ACTIVITIES

The goal of the country support activities is to—

Increase targeted RHCS country-level technical assistance that produces results that can be replicated and disseminated throughout the subregion.

The rationale for this objective is based on the observation that deliberate and strategic technical assistance at the country level can substantially strengthen RHCS. Moreover, because resources are limited, there is a critical need to provide direct RHCS technical assistance to countries where experiences can be translated into best practices for other countries in the subregion. Weak program management systems, notably monitoring and evaluation (M&E) and financial management, characterize many country programs. Subregional country support activities will aim to support the development of a network of technical assistance providers and funding sources to focus on these gaps.

The final strategic plan, which follows, is divided into two components:

Component A is broadly structured to capture and address many of the issues discussed in the concept paper (JSI/DELIVER 2005). It includes a description of the objectives, strategies, actions, expected outcomes, assumptions,

and risks. Also included is a section on advocacy and financing for the subregional strategy that describes how technical and financial support for implementation of the strategy will be carried out.

Component B includes the operational plan, estimated budget, and M&E plan, including output indicators for the expected outcomes. This section includes the specific actions and subactions, timeframe, budget and costs, and detailed indicators.

The success of the strategy will depend on the participation and contributions of the many West African institutions working in reproductive health, as well as support from international and bilateral partners. WAHO, as the primary subregional health authority for ECOWAS, is positioned to take a leadership role in coordinating a subregional RHCS strategy and to advocate for material support directly with donors and member countries. In addition, with WAHO, other subregional actors, notably the World Health Organization's Regional Office for Africa (WHO-AFRO), the *Association Africaine des Centrales d'Achats de Médicaments Essentiels* (ACAME), the *Centre d'Etudes et de Recherche sur la Population pour le Developpement* (CERPOD), and others, will have a substantial role as advocates, brokers, and catalysts for the adoption and implementation of a subregional strategy. The challenge in implementing this plan is determining how to manage efforts at the subregional level while simultaneously supporting country-level interventions.

2.0 BACKGROUND

Maternal and infant health indicators in the countries of the West African subregion remain weak, although they are comparable to other developing countries. WAHO and its partners recognize the seriousness of the gaps in access and the quality of maternal and perinatal health services in the subregion. To address these challenges, they developed a *Strategic Plan for the Reduction of Maternal and Perinatal Mortality in West Africa*. This subregional strategy also supports the WHO-AFRO/African Union *Road Map* and the *New Partnership for Africa's Development* (NEPAD)/*United Nations Millennium Development Goals* (MDGs). Both the road map and the MDGs focus on the reduction of maternal and infant mortality and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) as key factors in poverty reduction. These reductions are dependent upon consistent availability and use of reproductive health (RH) commodities (UNFPA 2004).

To address these reproductive health challenges and to advance its Strategic Plan for the Reduction of Maternal and Perinatal Mortality, WAHO has identified and is systematically addressing the interdependence between RHCS and maternal and infant health outcomes. At the Fifth Annual Assembly in Accra in 2004, ECOWAS health ministers recommended that WAHO and its partners develop a subregional strategy for RHCS to support the maternal and perinatal strategic plan. The health ministers subsequently endorsed a road map for that strategy and presented it as the *RHCS Concept Paper* (JSI/DELIVER 2005) at their 2005 annual meeting in Dakar, Senegal. By promoting increased access to and use of RH commodities, the RHCS strategy will also support the attainment of the MDGs and the Road Map goals, which will result in a significant reduction of maternal and infant deaths by 2015 (UNFPA 2004).

Many of the challenges to RHCS are common across countries in the ECOWAS region. To take advantage of scale and to promote subregional cooperation, the challenges can be addressed at both the subregional and the country level. This approach has a number of benefits.

A subregional approach to RHCS can—

- function as an excellent vehicle for advocacy and for working across countries to compare, inform, and influence public health policies
- bring together key decision makers from different stakeholders around a common conceptual framework, terminology, tools, and methods for assessing and addressing challenges
- facilitate the sharing of experiences between countries
- attract the attention and support of governments, multilateral organizations, bilateral donors, and other partners for RHCS.

The partners—WAHO, United Nations Population Fund (UNFPA), USAID, *Kreditanstalt für Wiederaufbau* (KfW), the World Bank, and other agencies—recognized that there were many common challenges to RHCS that face countries in the subregion; and that a subregional RHCS strategy could be an effective mechanism to address them. The challenges that cut across countries in the subregion include (1) limited access to quality RH commodities and services; (2) weak national logistics systems for managing RH commodities; (3) insufficient financing for RH commodities and services from all sources (household, community, national governments, multilateral and bilateral donors, and lenders); (4) insufficient coordination mechanisms between partners in the subregion; (5) a multiplicity of poorly coordinated activities in countries, leading to unnecessary redundancies and an ineffi-

cient use of the limited resources available for RH; and (6) substantial national and operational policy barriers to RHCS.

Three key areas have been identified in which a subregional strategy can add maximum value for supporting and advancing RHCS:

1. A *CIB* system among ECOWAS countries would allow national procurement and supply managers to share supplier price information with their counterparts in the subregion, and in the future, to share quality data and other relevant data. This information could enable informed procurement decisions and, by comparing prices obtained by other countries in the network, help to ensure the procurement of RH commodities that provide the best value.

2. *The capacity to deliver RH commodities to clients through effective supply chains, monitor and test the quality of commodities, and train personnel* in the multitude of functions involving RHCS, varies by country. Weaknesses in human resource development, institutional capacity building, and technical assistance are common to countries in the subregion. The capacity to deliver commodities needs special attention.

3. The subregional strategy will advocate for a *harmonized regulatory and policy framework*. Subregional organizations can play a catalytic role in helping to establish a common external tariff, comparable drug registration procedures, and common standard treatment guidelines to support a strengthened policy and regulatory environment to support RHCS.

The proposed subregional strategy will seek to achieve RHCS by focusing on strengthening systems to increase access to RH commodities for current users and those expressing an unmet need for these commodities (that is, they have a desire or a need to use but are not currently using). The SPARHCS tool has been adapted for use as the conceptual framework. SPARHCS takes a strategic, long-term, multidisciplinary, and multi-stakeholder perspective on RHCS by identifying how different elements; including contextual environment, capacity, coordination, and financing, are both interdependent and a prerequisite to achieving RHCS. To assist in designing and implementing RHCS strategies, variations in the SPARHCS assessment tool and framework have already been used in Burkina Faso, Cameroon, The Gambia, Ghana, Nigeria, and Togo.

The goal of the subregional approach detailed in this strategy is to build on, not displace, these efforts. Linkages between country and regional RHCS efforts are already under way. USAID's approach, for example—implemented in part by the Action for West Africa Region-Reproductive Health (AWARE-RH) project—has combined support for these country efforts while, at the same time, supported regional systems and institutions, including the *Centre Africain d'Etudes Supérieures en Gestion* (CESAG) and the *Institut Régional de Santé Publique* (IRSP)—an acknowledgment that the focus cannot be limited exclusively to one level. The adoption of the RHCS strategy by subregional-level organizations in West Africa should further strengthen these existing approaches and increase the compatibility with country-level RHCS efforts.

3.0 SUBREGIONAL CHALLENGES

Subregional challenges include linking the outcomes between maternal and infant health and RHCS; and issues that must be overcome to achieve RHCS.

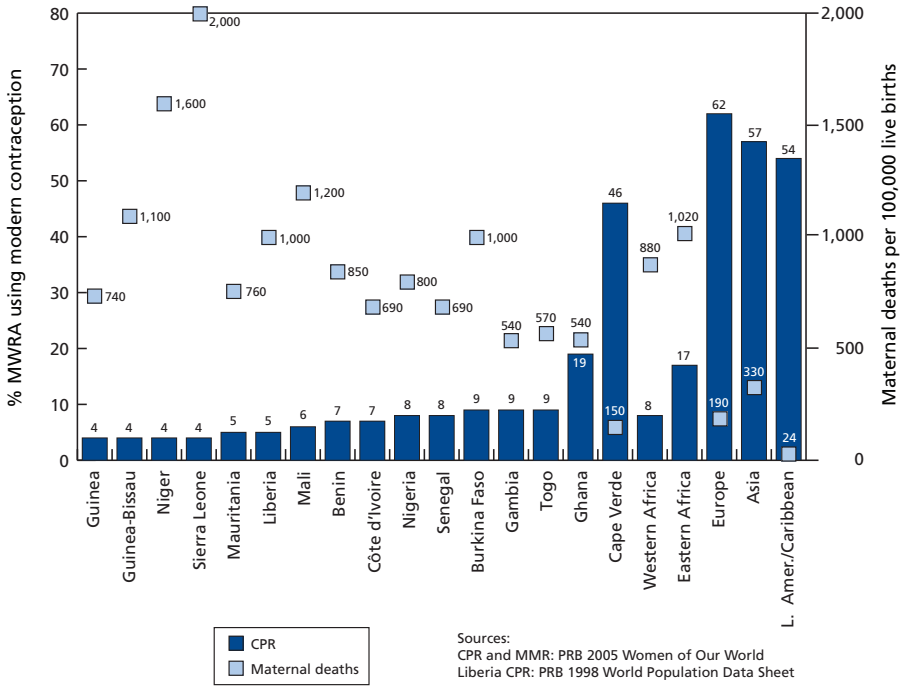
3.1 LINK BETWEEN MATERNAL AND INFANT HEALTH OUTCOMES AND RHCS

For every 100,000 live births in West Africa, there are 880 maternal deaths and more than 100 infant deaths (PRB 2005). The percentage of married women using modern methods of contraception in the subregion stands at 8 percent—making West Africa near the bottom worldwide for contraceptive use. In addition, 4.3 percent of adults in West Africa ages 15–49 have HIV/AIDS, and nearly 60 percent of those with AIDS are women (PRB 2005). These maternal, infant, and reproductive health statistics are unacceptable.

The United Nations MDGs include among their indicators the improvement of maternal and infant health outcomes and the reduction of the spread of HIV/AIDS, all of which depend on the consistent availability and use of RH commodities (UNFPA 2004). RHCS, which exists when *every person can reliably choose, obtain, and use quality, affordable, essential reproductive health supplies when he or she needs them*, is critical for achieving these international goals.

Figure 3.1 shows the relationship between high maternal mortality ratios (MMRs) and low contraceptive prevalence rates (CPRs). By helping women plan and space their children, and eliminate undesired pregnancies, RHCS can play an important role in reducing maternal mortality and improving maternal health.

Figure 3.1: Contraceptive Prevalence and Maternal Mortality



RHCS also has an impact on infant health. For example, when mothers space their births at least two years apart, infant mortality rates are reduced by as much as 50 percent (see figure 3.2).

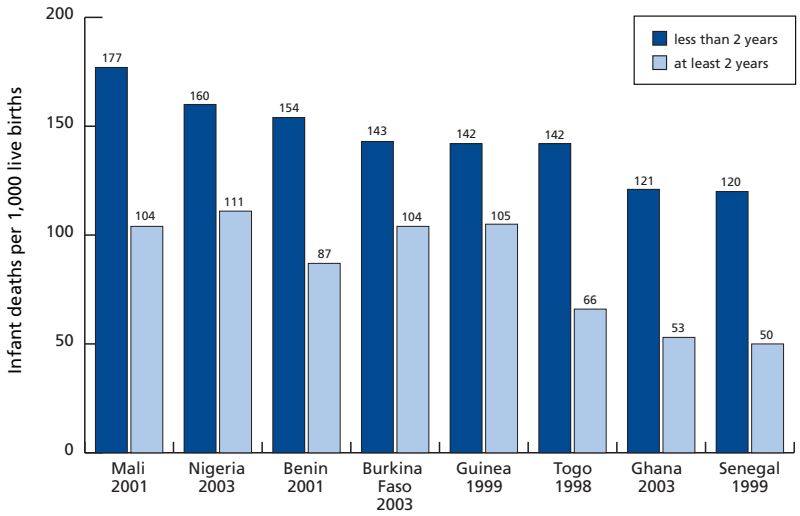
Although the subregion has made progress in increasing the use of family planning services during the past decade—CPR (for modern methods), for example, has doubled in a number of countries[2]—the use of family planning is still low and the unmet need is high (approximately 30 percent on average for the subregion).[3] If the 30 percent of women who are experiencing unmet need were using contraception, maternal and infant health outcomes would improve. According to the Human Development Report 2003, "If the unmet need for contraception were filled and women had only the number of pregnancies at the intervals they wanted, maternal mortality would drop by 20–35%." Unsafe abortions resulting from unwanted pregnancies cause about 13 percent of all maternal deaths every year (UNDP 2003). To cover this expressed need and to improve maternal and infant health outcomes, access to reproductive health services and commodities in West Africa must increase substantially.

Figures 3.1 and 3.2 indicate a strong relationship between RHCS, specifically for family planning and maternal and child health outcomes. In addition, the effect of the HIV/AIDS pandemic—which has already strained health delivery systems—will exacerbate the situation as the demand for condoms to prevent HIV and other HIV/AIDS products continues to rise. Studies have demonstrated that it is reasonable to expect that a secure supply of condoms for the prevention of sexually transmitted infections (STIs) and HIV/AIDS can help decrease the trend in the HIV/AIDS infection rate (CDC 1993).

There are numerous other demonstrated links between RHCS and improved maternal and infant health outcomes. For example, a document published by the POLICY project entitled, *What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions* (Gay et al. 2003), cites many examples of this relationship among the proven safe motherhood interventions, including—

- "Geographic access to and appropriate use of (emergency obstetric care [EOC]), trained responsive personnel, essential equipment, supplies, and drugs are correlated with improved maternal and infant health outcomes…" (page 18)

Figure 3.2: Infant Mortality by Birth Interval



2 CPR increased over the last decade in every ECOWAS country where data was available. However, CPR remains lower than in other regions of the world, at 8% compared to 14% overall in sub-Saharan Africa (Demographic and Health Surveys 1990–2003).

3 Unmet need is defined as the percentage of all women of reproductive age who wish to delay or prevent their next birth but are not currently using family planning.

A prospective study of 19,545 women in West Africa through pregnancy and for 60 days postpartum found that [in] 69.1 percent of all maternal deaths…[the women] gave birth without access to EOC…

- Eclampsia is most effectively treated by magnesium sulphate…. (page 29)
- "Use of prophylactic antibiotics at the time of cesarean sections decreases the incidence of post-operative infectious morbidity." (page 33)

  For example, the use of antibiotics reduces the incidence of endometriosis by two-thirds to three-quarters and "substantially reduces episodes of fever, wound infection, urinary tract infections, and serious infections."
- Immunizing pregnant women against tetanus is one of the simplest and most cost-effective means of reducing the neonatal mortality rate as well as reducing the incidence of maternal tetanus, which is responsible for at least 5 percent of maternal deaths in developing countries. (page 54)
- Administering drugs locally effective for malaria to pregnant women may reduce the incidence of low birth weight and anemia among low parity women. (page 55)
- Preventing, detecting, diagnosing, and treating TB can reduce the numbers of maternal deaths among pregnant women, including those with HIV. (page 58)
- Treating iron-deficiency anemia with iron during pregnancy has been shown to reduce … anemia and maternal morbidity …. (page 79) Treating severe iron-deficiency during pregnancy may reduce the risk of maternal mortality. (page 78)

These examples underscore the importance of RHCS in improving maternal and infant health outcomes; all of these important interventions require uninterrupted supplies of quality RH commodities.

3.2 COMMON CHALLENGES

As part of WAHO's RHCS initiative, in-depth RHCS assessments have been completed in Ghana and Burkina Faso. A similar assessment supported by USAID and UNFPA was conducted in Nigeria. Additional assessments designed to measure the feasibility of coordinated informed buying have also been carried out in Burkina Faso, Ghana, Mali, Nigeria, and Senegal. These assessments, combined with the program experience within the RHCS Task Force and PMLO Working Group, have provided critical country-level data that have informed the content of this strategy. Field and desk work completed in previous WAHO RHCS efforts have also identified some of the major obstacles facing the subregion. (See References for additional readings.)

On the basis of the desk research, country assessments, and deliberations of the strategy working groups, a number of key issues have been identified; including some of the major, cross-regional RHCS challenges that reinforce the benefits of a subregional RHCS strategy. The issues constitute a set of common challenges that must be overcome to achieve RHCS while, simultaneously, address maternal health outcomes and meet the challenges posed by the MDGs.

3.2.1 ACCESS TO QUALITY PRODUCTS AND SERVICES

Access to RH commodities is limited in many areas of West Africa. Long physical distances to health facilities, frequent stockouts that result in chronic unavailability, lack of reliable transportation, and poor infrastructure characterize the situation in many parts of the subregion. Affordability and inadequate or incorrect information on the use and benefits of RH products are also significant barriers to meeting client demand. In many cases, clients do not have access to a full range of commodities to meet their needs (e.g., there is a limited contraceptive method mix and limited access to new contraceptive technologies), and service providers often do not have the skills or motivation to offer quality services. Furthermore, social, cultural, and religious barriers exacerbate the limits to access in the subregion.

3.2.2 LOGISTICS MANAGEMENT

Although most countries in the subregion have public-sector logistics systems in place, the effectiveness of these systems varies. Assessments have revealed weaknesses in human resources, procurement capacity, data management, warehousing, and transportation (John Snow, Inc./DELIVER n.d.). Moreover, integration of product lines and decentralization are creating new complexities that sometimes hinder effective supply chain management. Systems will be further strained as they respond to the HIV/AIDS pandemic. These weaknesses in the logistics systems lead to expired products, supply imbalances (overstock), and stockouts at service delivery points.

To demonstrate the importance of logistics systems interventions in product availability, figure 3.3 shows the availability of contraceptives before and after logistics interventions in Mali. A recent DELIVER project logistics system assessment revealed that product availability at service delivery points (SDPs) and warehouses has increased sharply in Mali and Ghana.

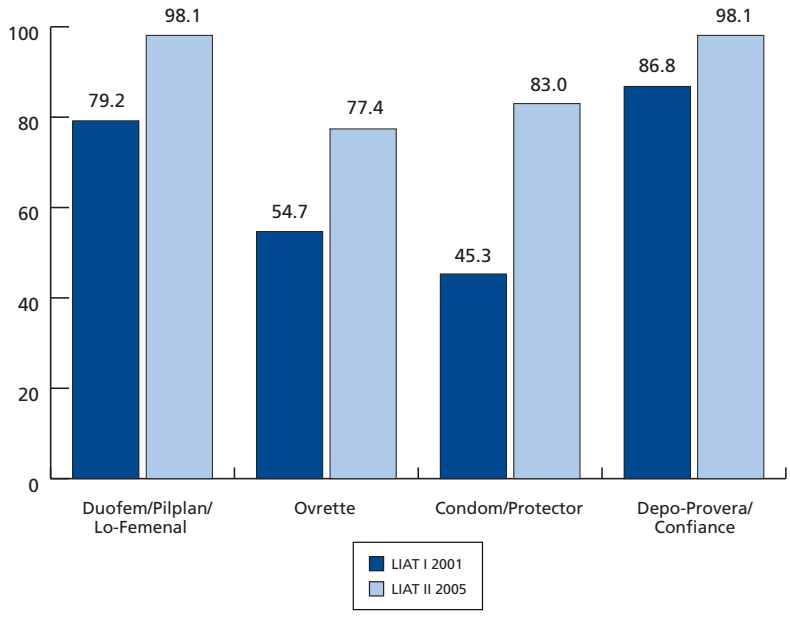
Although substantial resources directed at logistics system strengthening (i.e., forecasting, financing, procuring, and distributing) can increase availability and strengthen RHCS, stockouts of essential RH commodities remain a common occurrence, depriving clients of needed supplies.

The availability of *Protector* condoms in Mali increased by more than 40 percent in the four-year period. In Ghana, availability on the day of visits to SDPs has been sustained at nearly 80 percent over several years for a range of contraceptives (see figure 3.4).

3.2.3 FINANCING

The Abuja Declaration of 2001 stated that at least 15 percent of national budgets should be committed to improvements in the health sector (OAU 2001). No country in the subregion has met this goal. Resulting allocations for the RH sector remain grossly inadequate. The increasing number of women and men of reproductive age and the growing demand of this population for RH products indicates that the existing financing gap for RH commodities will grow unless a sustainable investment from all levels is made to finance commodity costs—from the household, communities, third parties, governments, and international donors and partners.

Figure 3.3: Public Sector SDP Stock Status: Mali (2001 and 2005) on Day of Visit



At the household and community level, there is a limit to what the people of West Africa can afford to contribute to financing for RH commodities. "Currently, the true commercial sector, defined as non- subsidized products and services provided for profit through private sector sources, has a limited role in West African reproductive health markets. A benchmark income level of around US$1000 per capita is taken as the level at which low-end commercial contraceptives become affordable. In West Africa, a very small percentage of the population (around 10 percent or less in most countries) has this income level" (Dowling 2004). Most cannot afford to contribute even nominally to financing RH commodities.

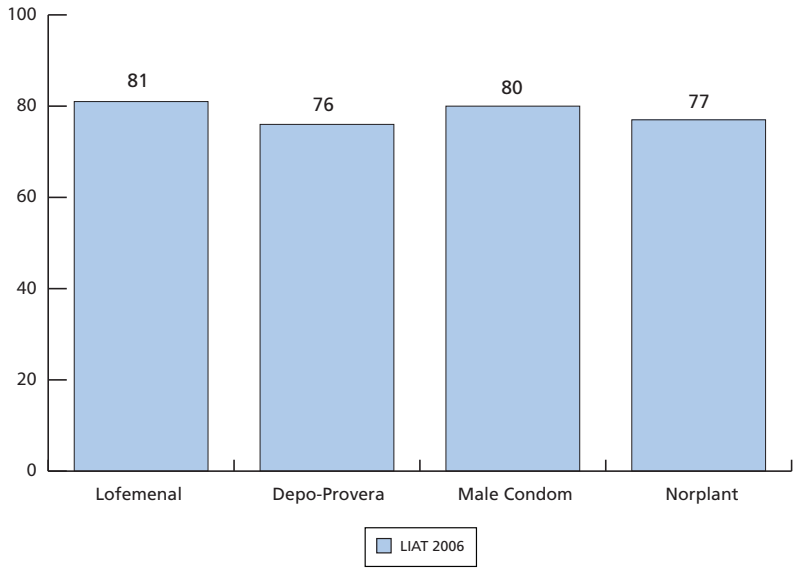
Also, most governments in West Africa do not contribute adequately to financing the procurement of RH commodities to meet the needs of their populations. Many do not have a budget line item for RH commodities. Whatever funding that does exist is often combined with other health commodities, which often leads to insufficient procurement quantities. This means that RH commodities are competing for scarce resources. As a result, governments are largely dependent on donor contributions, which often fluctuate from year to year.

From 1996 to 2002, financing support in the subregion for contraceptives has been erratic at the donor level (see figure 3.5). Donor support for contraceptives in West Africa decreased sharply from $17 million in 2001 to less than $11 million in 2002. The projected costs for contraceptives are expected to reach nearly $25 million annually by 2010. Further, as shown in figure 3.5, if donor financing from 2002 levels remains constant, there will be, at a minimum, a $14 million funding gap for contraceptives every year starting in 2010, *excluding* condoms.

The levels of current and past donor support for contraceptives were obtained from UNFPA. The projected financing needs for contraceptives were obtained from the West African Reproductive Health Commodity Security Study and estimated by factoring projected needs with unit cost. The *Spectrum* software developed by the Futures Group was used to estimate the projected quantity needed, by applying demographic data from the most recent surveys (i.e., Demographic and Health Surveys conducted by ORC Macro International, the Multi-Indicator Cluster Surveys conducted by UNICEF, or the Reproductive Health Surveys conducted by Centers for Disease Control and Prevention [CDC]) to the United Nations estimated fertility goals for the region. The global average was used for the unit cost of contraceptives.

When additional RH commodities for STI prevention, antenatal care, and other conditions are considered, the requirement for the subregion doubles to nearly $60 million. In addition to commodity costs, substantial financ-

Figure 3.4: Public Sector SDP Stock Status: Ghana (2006) on Day of Visit



ing is required for routine operations, service delivery, capacity building, and infrastructure.

It is unreasonable to expect a substantial increase in household contributions and significant government expenditure for RH commodities in the near- and medium-term. The low purchasing power of clients, low prevalence, and uneven and slow economic growth means a continued reliance on donor assistance over the next several years.

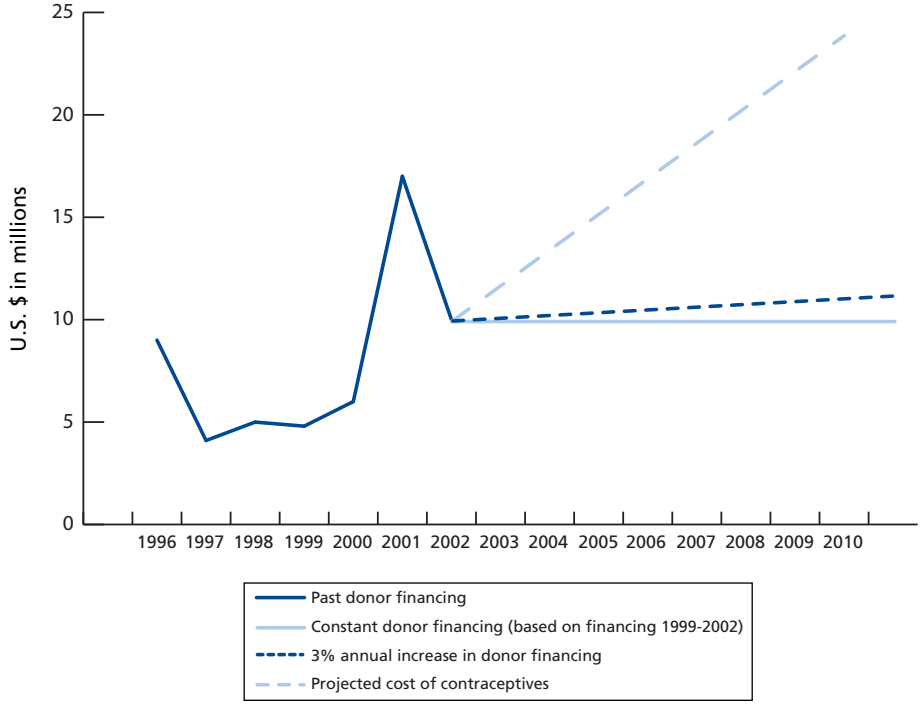
3.2.4 COORDINATION: DONOR, GOVERNMENT, AND PRIVATE SECTOR

The lack of coordination mechanisms among partners in the subregion and the multiplicity of uncoordinated activities at the country level often lead to unnecessary redundancies and an inefficient use of the limited resources available for RH. Because resources are limited, a premium is placed on effective coordination among governments, donors, lenders, and implementing agencies to minimize duplication and mobilize additional resources. WAHO is in a strong position to enable this effective coordination. There are good examples of stakeholder coordination at the country level within the ECOWAS community. Nevertheless, subregional and national efforts could be strengthened by engaging a broader range of stakeholders, including ministries other than health (finance, planning, education, and others), private-sector retailers and manufacturers, physician and nursing associations, and civil society organizations (religious institutions, nongovernmental organizations, and community-based agricultural and microfinance institutions).

3.2.5 POLICY SUPPORT

Many national and operational policy barriers to RHCS remain in place. Increased subregional and national policy support is needed to respond to these challenges, which include the lack of national financing for RH commodities (e.g., budget line item) and uneven, inconsistent, and excessive taxes, tariffs, and duties. Additional cross-cutting challenges include advertising restrictions, restrictive operational policies for service provision, and a lack of quality information, education, and awareness raising.

Figure 3.5: Donor Financing for Contraceptives (except condoms) Compared with Projected Need in West Africa



4.0 THEMATIC AREAS OF THE SUBREGIONAL STRATEGY

Three thematic areas have been identified where, because of scale, reach, and cost-effectiveness, subregional actors and activities can add value by advocating, brokering and catalyzing RHCS activities across the subregion. These areas address many of the challenges noted in section 3.0. They include the following:

4.1 COORDINATED INFORMED BUYING SYSTEM FOR RH COMMODITIES

In 2004 and 2005, the WAHO health ministers mandated that work begin on designing and implementing a CIB system that can be shared among ECOWAS countries. The CIB system would enable national procurement and supply managers to share information on supplier price, quality, and other procurement data with their counterparts in the subregion. This information will help countries make informed procurement decisions. It will also help to ensure that the procurement systems provide better value by, in part, comparing prices obtained by other countries in the network. Other potential benefits could include improved commodity quality and harmonization of standards, improved supply chain management, and reduced wastage and loss.

4.2 INSTITUTIONAL CAPACITY BUILDING

The capacity to deliver RH commodities to clients through effective supply chains, to monitor and test the quality of commodities, and to train personnel in the multitude of functions involving RHCS varies by country. Yet, it is evident that these and other capacity weaknesses are common to countries in the subregion. A subregional RHCS strategy can, therefore, address these issues by supporting, for example, quality control testing laboratories and subregional training programs in supply chain management and procurement. Resources for such facilities and activities are not available in many countries. Subregional and country actors should also document and disseminate best practices; and be regularly informed about each other's activities to avoid duplication of effort, to identify where complementary roles can be played, and to determine where south-to-south technical exchanges can be beneficial. A subregional reference center could be useful in supporting this type of information sharing.

4.3 ADVOCACY FOR A HARMONIZED REGULATORY AND POLICY FRAMEWORK

Subregional organizations can play a role as catalysts in advocating for a strengthened policy and regulatory environment for RHCS. These groups could, for example, be an informational focal point and advocate for common and specific RHCS policies at the country level. The policies could include government budget line items for RH commodities, support for RHCS coordinating groups, and the dissemination of IEC materials designed to enhance policy support for RHCS.

As ECOWAS countries continue to join together around common economic policies, advocating for a common goal could help reduce costs for RH commodities—for example, an external tariff for RH supplies or duty-free status for commodities considered to be of strategic importance for public health and/or an internal free trade zone.

Further, to achieve greater efficiency in access to RH commodities, subregional bodies such as WAHO could help advocate for standard DRPs across the subregion. Currently, registration is specific to a particular manufacturer and country. Harmonizing registration may help efforts to expand the private sector's ability to contribute to better access to RH commodities. Respondents to assessment questionnaires in Burkina Faso and Ghana (JSI/DELIVER 2005) indicated that the lack of coordinated and standardized product selection (e.g., for essential medicines lists [EMLs], STGs, and the like), harmonization of product registration, and standards in product labeling within the subregion were a constraint in promoting access to commodities. Subregional institutions could help coordinate and catalyze efforts between country stakeholders to adopt common DRPs, EMLs, and STGs within the ECOWAS community.

5.0 COMPONENT A: STRATEGIC PLAN

5.1 VISION, MISSION, AND GOAL

The RHCS strategy is a mechanism for improving maternal and child health in West Africa. The commodities it seeks to make regularly available to clients will include but be broader than those for family planning. The list will include health commodities for maternal health and HIV/AIDS as well as other essential RH products. The full list, in annex 2, provides all the stakeholders who are part of this strategy with a sense of the large number of products involved in securing RH supplies (WHO/UNFPA 2006). Country stakeholders will be encouraged to develop specific RH product lists from the therapeutic categories described in the essential list of RH commodities.[4]

The health partners involved in the development of this strategy—including WAHO, USAID, UNFPA, the World Bank, KfW, WHO-AFRO, and other technical agencies—spent a great deal of time talking about the goal. These discussions resulted in the agreement that RHCS will exist when *every West African can reliably choose, obtain, and use quality, affordable, essential reproductive health supplies when he or she needs them*. The goal is inexorably linked to the broader maternal and perinatal health mission in the subregion.

They are as follows:

Vision:	To achieve reproductive health commodity security in the West Africa subregion
Mission:	To ultimately reduce maternal and perinatal mortality in conjunction with the WAHO Strategic Plan for the Reduction of Maternal and Perinatal Mortality in the West Africa subregion
Goal:	To meet the demand of existing users and those expressing unmet need in the subregion.

5.2 OBJECTIVES

Each of the four objectives described below support country efforts, whether through capacity building or coordination at the subregional level or through direct country technical assistance. The objectives are linked to broad areas of work in advocacy, coordination, and the identification of resources and technical assistance. Regional and country actors should also regularly inform each other about their respective activities to avoid duplication of effort and to identify where complementary roles can be played.

CONTEXT

Improve, increase, and streamline common and specific RHCS policies at the country level to create a policy environment that will support RHCS in the subregion.

These efforts will focus on advocacy for common and specific RHCS policies at the country level, including the establishment of government budget line items for RH commodities, dissemination of IEC materials designed to enhance policy support for RHCS, and improvement of the environment for public- and private-sector partnerships. As ECOWAS countries continue to converge around common economic policies, advocating for a

4 The UNFPA/WHO list of essential RH medicines is a detailed list of these categories; it is the reference in this document. It provides the current consensus among WHO, UNFPA, and other partners on the "rational selection of essential RH medicines" (WHO/UNFPA 2006). See annex 2.

common external tariff, comparable DRPs, and common STGs for RH supplies can help increase efficiencies and reduce costs.

COORDINATION

Strengthen planning, management, and implementation of RHCS activities through coordinating mechanisms, involving a broad range of stakeholders, including donors, governments, the private sector, and civil society organizations.

WAHO's coordination efforts will focus mainly, but not exclusively, on the implementation of the CIB system, which, as the system is designed and implemented, will serve as a practical and ongoing coordinating mechanism that allows the routine accessing and sharing of procurement data. Many of the activities listed in the strategic plan will enhance coordination within countries and between countries and the subregion. Country support initiatives and capacity building measures will be undertaken throughout the subregion. Further, the development of common drug registration procedures, for example (noted above under *Context*), will enhance coordination between countries and subregional bodies.

CAPACITY BUILDING

Improve human, technical, and institutional capacity for the achievement of RHCS in the West African subregion.

The capacity to deliver RH commodities to clients through effective supply chains, to monitor and test the quality of commodities, and to train personnel in the multitude of functions involving RHCS, varies by country. Yet, it is evident that these and other capacity weaknesses are common to countries in the subregion. A subregional RHCS strategy can, therefore, address these issues through support, for example, for quality control testing laboratories and subregional training programs in supply chain management and procurement. Resources for such facilities and activities are not available in many countries. Subregional and country actors should also document and disseminate best practices and be regularly informed about the each other's activities to avoid duplication of effort and to identify where complementary roles can be played and where south-to-south technical exchanges can be beneficial.

COUNTRY SUPPORT ACTIVITIES

Increase targeted RHCS country-level technical assistance where results can be replicated and disseminated throughout the subregion.

The broad focus of this strategy is primarily on what can be done to strengthen RHCS from the subregional level. At the same time, the need is critical to provide direct RHCS technical assistance to countries where it can have the greatest impact and where experiences can be translated to best practices that can be shared within and among countries. Weak program management systems—notably, M&E and financial management—characterize many country programs. Subregional country support activities will aim to support the development of a network of technical assistance providers and funding sources to focus on these gaps.

5.3 CONTEXT

OBJECTIVE

Improve, increase, and streamline common and specific RHCS policies at the country level to create a policy environment that will support RHCS in the subregion.

SUBREGIONAL RHCS ISSUES

These issues include—

- inadequate integration of RHCS into national health and reproductive health policies in some countries
- inadequate financing for RH commodity and commodity logistics management at the national level
- excessive regulatory barriers (e.g., excessive taxes, tariffs, and advertising restrictions)
- uneven political commitment or prioritization of RHCS on governmental agenda
- lack of enforcement of regulatory guidelines at national service delivery levels
- absence of advocacy materials to enhance policy support for financing and promoting RHCS
- lack of information on unmet need and other data for RH commodity programming
- poor access and low utilization of RH commodities.

STRATEGIES

1. *Advocacy:* Advocate for a strengthened and harmonized policy and regulatory framework for RHCS, including DRPs, STGs, and EMLs.
2. *Public-Private Sector Partnerships:* Create an enabling environment for public-private partnerships.
3. *Finance:* Encourage countries to establish sustainable financing for RHCS.
4. *Unmet Need:* Address the issues of unmet need for RH commodities in the subregion.

KEY OUTCOMES

Key outcomes may include—

- increased client access to and use of affordable, quality RH services and commodities through public and private services
- improved political commitment to RHCS
- increased funding to purchase RH commodities in the subregion
- a supportive policy environment to improve RHCS in the subregion.

ASSUMPTIONS

- There will be political stability in the subregion.
- Policymakers are willing to support a coordinated approach to RHCS.
- Some countries are already engaged in the process of improving the national context for RHCS.
- Appropriate capacity exists in the subregion and member countries to create the necessary policy environment to support RHCS.
- The policy environment is adaptable to new RHCS strategies.

RISKS

- The subregion will have political instability, resulting in the inability to implement RHCS activities.
- Some countries do not perceive RHCS as a priority issue.

- Ongoing efforts to improve RHCS context have stalled or are not effective.
- Policymakers prefer not to engage in a subregional effort.
- It is difficult to identify the appropriate leadership ("national champions") at the country level to move the RHCS agenda forward.

ACTIONS

TABLE 1: ACTIONS TO IMPROVE, INCREASE, AND STREAMLINE COMMON AND SPECIFIC RHCS POLICIES AT THE COUNTRY LEVEL

Strategies	Actions	Subactions
1. Advocacy: Advocate for a strengthened and harmonized policy and regulatory framework for RHCS, including DRPs, STGs, and EMLs.	1. Advocate to ensure that RHCS is integrated into RH policy in all countries of the subregion.	1.1 Identify a pool of consultants to provide technical assistance (TA) to countries, as needed. 1.2 Collate and provide technical reference materials to countries for the integration of RHCS into the national RH policies. 1.3 Carry out advocacy for the integration of RHCS into RH policies (include issues of non-supportive sociocultural norms). 1.4 Monitor the integration of RHCS into national RH policies.
	2. Harmonize country DRPs, STGs, and EMLs (with a focus on RH commodities).	2 1. Collect and review the drug registration procedures of DRPs, STGs, and EMLs. 2.2 Convene a meeting of stakeholders to review and establish consensus on the benefits of common approaches. 2.3 Implement advocacy efforts to revise and standardize DRPs, STGs, and national EMLs to conform to subregional consensus. 2.4 Monitor the implementation of changes in DRPs, STGs, and EMLs.
2. Public- and Private-Sector Partnerships: Create an enabling environment for public-private partnerships.	1. Encourage national-level stakeholders to encourage the private sector to participate more actively in the provision of RH commodities.	1.1 Mobilize national stakeholders to conduct studies on willingness to pay (WTP), ability to pay (ATP), and market segmentation analyses (MSAs). 1.2 Collate and disseminate existing data on WTP, ATP, and MSAs. 1.3 Support national stakeholders to demonstrate the potential benefits of the whole market approach to product availability to the public and private sectors and civil society. 1.4 Motivate member states to share this information at the subregional level to disseminate best and promising practices in public-private partnerships.
3. Finance: Encourage countries to establish sustainable financing mechanisms for RHCS.	1. Facilitate the creation of sustainable financing mechanisms for RH commodities.	1.1 Encourage the creation of dedicated budget line items for RH commodities in national health budgets. 1.2 Mobilize partners (donors, lenders, private sector, and NGOs) to increase funding for RH commodities.
4. Unmet Need: Address unmet need for RH commodities in the subregion.	1. Undertake an advocacy campaign to address the unmet need of RH commodities in the subregion.	1.1 Conduct a desk review on factors contributing to unmet need (e.g., sociocultural, service delivery). 1.2 Prepare and disseminate evidence-based materials for advocacy campaign. 1.3 Monitor actions that have been taken by countries as a result of the advocacy campaign.

5.4 COORDINATION

OBJECTIVE

Strengthen planning, management, and implementation of RHCS activities through coordinating mechanisms that involve the engagement of a broad range of stakeholders, including donors, governments, the private sector, and civil society organization.

SUBREGIONAL RHCS ISSUES

Issues include—

- poor information management
- insufficient coordination mechanisms and inadequate use of existing ones
- limited or inefficient use of resources
- multiplicity or duplication of procedures and activities by stakeholders
- inadequate inclusion of all stakeholders (public, private, and others) in the coordination process
- failure on the part of governments to honor political commitments
- failure by donors to honor pledges of support.

STRATEGIES

Strategies include—

1. *Coordinated Informed Buying:* Establish a coordinating mechanism to facilitate access to and the sharing of procurement information about RH commodities.
2. *Interagency Coordination:* Improve coordination among partners in the area of RHCS.

KEY OUTCOMES

- More effective coordination among partners is seen in the subregion.
- All ECOWAS countries have access to and share information on RH commodity procurement.

ASSUMPTIONS

- Stakeholders are willing to participate in coordination activities (with particular reference to CIB).
- National RHCS plans, strategies, and committees exist.
- Capacity for coordination exists at the subregional level.
- Implementation of RHCS activities are documented at the national level.
- Number of stakeholders to be coordinated is manageable.
- Stakeholders to be coordinated will be appropriately represented.

RISKS

- Stakeholders prefer to engage in independent planning, management, and implementation of RHCS activities.

- National RHCS plans, strategies, and committees do not exist. There are barriers to their formation.
- Stakeholders are unable to be flexible and do not adapt to common coordination mechanisms.
- Implementation of RHCS activities are not documented at the national level, resulting in the need for unplanned intensive data collection efforts.
- Stakeholders to be coordinated may be inappropriately represented or not represented in appropriate numbers.

ACTIONS

TABLE 2: ACTIONS TO STRENGTHEN PLANNING, MANAGEMENT, AND IMPLEMENTATION OF RHCS ACTIVITIES

Strategies	Actions	Subactions
1. Coordinated Informed Buying: Establish a coordinating mechanism to facilitate access to and the sharing of procurement information on RH commodities.	1. Make the CIB network operational.	1.1 Plan and manage implementation (develop indicators, develop workplan, etc.). 1.2. Hire a CIB system manager. 1.3 Hold technical design workshop. 1.4 Develop terms of reference (TORs) for the network participants. 1.5 Validate TORs by countries. 1.6 Designate one contact person from every country, based on the content of the TORs. 1.7 Identify the other actors in the countries. 1.8 Purchase necessary hardware; install initial software. 1.9 Design and manage a pilot phase with five countries for one year. 1.10 Design prototype. 1.11 Develop training materials; identify and train users, operators, and technical staff. 1.12 Install production-ready software. 1.13 Begin network operation. 1.14 Conduct pilot data collection, analyze results, and resolve issues. 1.15 Evaluate pilot phase mid-term review. 1.16 Disseminate evaluation report on the pilot phase. 1.17 Extend network to all 15 countries. 1.18 Conduct annual meetings to analyze CIB information and discuss improvements. 1.19 Update workplan and provide periodic updates to stakeholders.
2. Interagency Coordination: Improve coordination among partners in the area of RHCS.	1. Create a subregional RHCS partners' network.	1.1 Identify all the RHCS partners working at the subregional level. 1.2 Convene regular meetings of subregional agencies/partners to facilitate coordination and collaboration (e.g., share workplans; identify action items and data gaps). 1.3 Establish electronic network (email) to keep partners informed on RHCS activities and issues. 1.4 Monitor national-level RHCS interagency coordination and collaboration and share findings in partners' forum.

5.5 CAPACITY BUILDING

OBJECTIVE

Improve human, technical, and institutional capacity for the achievement of RHCS in the West African subregion.

SUBREGIONAL RHCS ISSUES

Issues include—

- insufficient number of qualified personnel
- inadequate training of health workers in RH
- low staff retention rates
- absence of effective motivation programs for personnel
- inefficient logistics management systems
- inadequate financing mechanisms for RHCS
- uneven, ineffective follow-through on commitments made by governments
- low-level use of RH services by the population
- absence of a mechanism to ensure continuity.

STRATEGIES

1. *Human Resource Development:* Advocate strengthening of human resources and management of RHCS.
2. *Logistics Management Capacity Building:* Promote logistics management capacity building, including integration of health management information systems (HMISs), logistics management information systems (LMISs), and vertical programs.
3. *Integration of RHCS into the public health curriculum:* Advocate for the integration of RHCS into the public health curriculum.
4. *Promoting IEC and behavior change communication* (BCC): Promote the use of IEC and BCC to increase awareness of RHCS issues in the community.
5. *Program sustainability:* Advocate for the importance of maintaining trained staff for program sustainability.

KEY OUTCOMES

Outcomes include—

- number of policies implemented to address program sustainability
- retention rate in RHCS programs
- effective and efficient logistic RH management system in place
- commodity security components of RH teaching introduced into schools and faculties
- number of countries using IEC and BCC to promote RHCS issues in the community
- number of skilled personnel providing quality services.

ASSUMPTIONS

Assumptions include—

- high priority accorded to health sector in national development programs
- continued limited absorption and retention of health care personnel
- priority given to reproductive health financing by partners.

RISKS

- New priorities (e.g., HIV/AIDS) emerge.
- Despite retention efforts, brain drain continues.
- Partners do not provide financial support.

ACTIONS

TABLE 3: ACTIONS TO IMPROVE HUMAN, TECHNICAL, AND INSTITUTIONAL CAPACITY FOR THE ACHIEVEMENT OF RHCS IN THE WEST AFRICAN SUBREGION.

Strategies	Actions	Subactions
1. *Human Resource Development:* Advocate strengthening of human resources and management of RHCS.	1. Strengthen regional training centers for human resource management of RHCS.	1.1 Identify regional training centers. 1.2 Conduct training of trainers (TOTs) for RHCS.
	2. Promote retention of trained staff involved in RHCS.	2.1 Identify and share motivational best practices.
2. *Logistics Management Capacity Building:* Promote logistics management capacity building, including integration of HMIS/ LMIS and vertical programs.	1. Promote training of trainers in— • logistics management system • integration of HMIS/LMIS into RH • service delivery • policy formulation • quality control • implementation of RHCS.	1.1 Adapt curriculum. 1.2 Identify training institutions and trainers. 1.3 Organize the training. 1.4 Monitor trainees to determine training efficacy. 1.5 Collect and disseminate data on countries training in RHCS.
3. *Integration of RHCS into Public Health Curriculum:* Advocate for the integration of RHCS into public health curriculum.	1. Introduce RHCS curriculum into public health programs in universities and public health institutions.	1.1 Identify universities and public health institutions. 1.2 Adapt curriculum. 1.3 Identify trainers. 1.4 Train staff in RHCS curriculum. 1.5 Organize the training. 1.6 Monitor trainees to determine training efficacy. 1.7 Collect and disseminate data on countries training in RHCS.
4. *Promoting IEC/BCC:* Promote the use of IEC/BCC to increase awareness of RHCS issues in the community.	1. Develop subregional capacity for the promotion of training community agents in IEC/BCC.	1.1 Assess current community-based IEC/ BCC systems. 1.2 Prepare training documents. 1.3 Organize training sessions.
5. *Program Sustainability:* Advocate for the importance of maintaining trained staff for program sustainability.	1. Promote program sustainability.	1.1 Emphasize the importance of staff retention at policymaking fora. 1.2 Encourage partners to develop exit strategies. 1.3 Develop and disseminate advocacy materials including guidelines for staff retention.

5.6 COUNTRY SUPPORT

OBJECTIVE

Strengthen subregional institutions and networks to deliver targeted RHCS technical assistance to the country level where results can be replicated and disseminated throughout the subregion.

SUBREGIONAL RHCS ISSUES

Issues include—

- ineffective program management practices in—
  - program development
  - financial management
  - monitoring and evaluation
- low absorptive capacity of allocated funds
- underutilization and lack of development of coordinating mechanisms.

STRATEGIES

1. *Provision of Technical Assistance:* Establish mechanism for provision of technical assistance (TA) for RHCS.

2. *Advocacy:* Advocate for the harmonization of country management tools across the subregion.

KEY OUTCOMES

Outcomes include—

- increased partners' support for the implementation of harmonized RHCS management tools
- number of countries that have benefited from TA
- number of countries applying common management tools
- number of countries that have applied for and received TA.

ASSUMPTIONS

Assumptions include—

- political commitment exists
- regional experts exist
- national RH programs and RHCS plans in WAHO member countries exist
- funding identified for technical assistance.

RISKS

Risks include—

- absence of commitment by countries to receive technical assistance

- unwillingness to take the necessary steps to harmonize standards
- insufficient funding to carry out TA.

ACTIONS

TABLE 4: ACTIONS TO STRENGTHEN SUBREGIONAL INSTITUTIONS AND NETWORKS TO DELIVER TARGETED RHCS TECHNICAL ASSISTANCE

Strategies	Actions	Subactions
Provision of Technical Assistance: Establish mechanism for provision of TA for RHCS.	1. Identify and provide country support for TA activities.	1.1 Identify TA needs and process. 1.2 Prepare and implement a workplan to provide TA to the countries. 1.3 Identify partners to support the implementation of the workplan.
	2. Establish regional experts network in RHCS.	2.1 Identify regional experts in RHCS. 2.2 Prepare the TORs of network of experts. 2.3 Promote networking of subregional experts.
Advocacy: Advocate for the harmonization of country management tools across the subregion.	1. Develop common management tools for RHCS components (e.g., procurement planning, LMIS/ pipeline monitoring, strategic planning [SPARHCS], drug registration database).	1.1 Define the key areas for harmonization. 1.2 Formulate the common management tools. 1.3 Disseminate the harmonized tools in the subregion. 1.4 Present the harmonized tools to partners/stakeholders fora. 1.5 Follow up on implementation.
	2. Organize advocacy meetings with partners and stakeholders (round table, fora, conference).	2.1 Define audience for evidence-based data presentations. 2.2 Identify the best approaches for each group of partners and stakeholders. 2.3 Conduct regular meetings with stakeholders.

6.0 ADVOCACY PLAN FOR FINANCING THE IMPLEMENTATION

During the January 2006 PMLO strategy development workshop it was agreed that advocacy efforts aimed at securing commitments for the strategy would be crucial to success. The subregional strategy will require the concerted action and commitment of donors, governments, technical agencies, NGOs, and others. Financial commitments will be required from multiple sources.

A road map or plan to help ensure that the strategy is disseminated to these groups and their support to implement actions are identified as necessary prerequisites.

During the development phase, it is important to engage donors, lending institutions, ECOWAS member governments, community-based organizations, the private sector, international and national nongovernmental organizations (NGOs), and others with a stake in RHCS outcomes in the West Africa subregion.

The overall goal of the advocacy plan is to secure adequate and sustainable financing for the implementation of the strategy. The following advocacy plan consists of three objectives. These objectives were included in the *Context* section. The following section further defines and details how these objectives will be achieved. It proposes a decision-making process, suggested message channels to include in that process, and specific activities.

The objectives are as follows:

1. Obtain sufficient funding to support the development and implementation of the RHCS strategy.

2. Establish public- and private-sector partnerships (PPPs) for RHCS in all 15 ECOWAS countries by 2010.

3. Help all 15 ECOWAS countries to include government budget lines for RH commodities by 2010.

TABLE 5: OBJECTIVES AND HOW THEY WILL BE ACCOMPLISHED

Objective #1: Obtain sufficient funding to support the development and implementation of the RHCS strategy.

Audiences		Decision-making Process	Coalition	Message/Channels	Key Activities/ Responsibilities	Timeline
Primary*	***Secondary***					
Donors: *Bilateral:* • USAID • DFID • JICA • CIDA • KFW *Multilateral:* • UNFPA • WHO • Global Fund • World Bank • BCEAO • ADB *Private Sector:* • GATES Foundation • MTN Foundation for RH • Manufacturers of commodities and their distributors • Hewlett Packard Foundation • NGOs: • IPPF	• Ministers of Health • Other donors • Country governments • WAHO • NGOs • Other implementing partners	***Step 1:*** WAHO and partners determine costs needed for each component of the RHCS strategy. ***Step 2:*** WAHO approaches donors asking them to fund specific components of the plan. ***Step 3:*** WAHO and partners invite key donors to the IPC launch of the RHCS strategy. ***Step 4:*** Donors review aspects of the plan and commit to funding. ***Step 5:*** Donors award funding.	Task Force, PLMO, other donors, ECOWAS health ministers	For every 100,000 live births in West Africa, 880 mothers die from complications of pregnancy and childbirth. For every 1,000 live births, more than 100 infants do not live to see their first birthday (PRB 2005). The high rates of maternal and infant deaths in West Africa are unacceptable. One effective way to reduce maternal and infant deaths is to ensure family planning methods are available to all who want to plan and space their births. For example, when mothers space their births at least two years apart, infant mortality rates are reduced by as much as 50 percent. Additionally, studies show that if women had the number of pregnancies at the intervals they wanted, maternal mortality would drop by 20–35 percent. Despite the proven links between the use of family planning and reductions in maternal and infant mortality, improving access to family planning methods has not been a high priority for policymakers. Women in the subregion who express a desire to plan and space their births still lack access to family planning methods. We need to act now to make family planning methods available to all women who want to plan and space births. The regional RHCS strategy will help increase access to RCHS products and ensure the best value for the products.	1. Finish RHCS plan. 2. Develop materials (a one-page fact sheet/presentation) to advocate for the RHCS/CIB plan. 3. Identify key donors and identify specific areas for funding. Target IPC members. 4. Use the IPC meeting in September to *launch the RHCS strategy*, which will be a donor's meeting where potential donors are invited to hear the presentation of the strategy and the specific areas of funding. The goal of this meeting would be to obtain commitments from donors. Before the launch, specific donors will need to be contacted. WAHO and the task force need to identify donors to fund each aspect of the plan. 5. After the launch, individual meetings need to be held with specific donors to discuss RHCS plan with donors. 6. Establish contact person at WAHO to coordinate finances. 7. Discuss with partners the possibility of managing specific components of the RHCS financing plan.	***Activity 1:*** June 2006 ***Activity 2:*** September 2006 ***Activity 3:*** June–September 2006 ***Activity 4:*** September 2006 ***Activity 5:*** September–December 2006 ***Activity 6:*** January 2007 ***Activity 7:*** June–December 2006

* Each donor here represents a separate decision maker. Each should be targeted separately for funding.

Objective #2: Establish private-sector investment for RHCS in all 15 ECOWAS countries by 2010.

Audiences		Decision-making Process	Coalition	Message/Channels	Key Activities/ Responsibilities	Timeline
Primary*	***Secondary***					
• MTN Foundation for RH • Manufacturers of commodities and their distributors • Other private-sector companies involved in country-level activities	• Ministries of Health • Other donors • Country governments • WAHO • NGOs • Other program implementers	*Step 1:* WAHO and partners identify examples of public-private partnerships in the region that are working to establish RHCS. If RHCS examples are not available, examples from other sectors such as nutrition, HIV/AIDS, and family planning, should be given. Contact with existing partners working in the field is necessary. *Step 2:* WAHO identifies at least five private-sector companies to target. *Step 3:* WAHO and other partners organize a private- sector dialogue to solicit additional public- and private-sector partners. *Step 4:* WAHO establishes partnerships with regional management of individual companies. *Step 5:* WAHO targets regional private-sector companies to encourage country-level offices to collaborate with ministries on RHCS.	Task Force, PLMO, other donors, ECOWAS health ministries	For every 100,000 live births in West Africa, 880 mothers die from complications of pregnancy and childbirth. For every 1,000 live births, more than 100 infants do not live to see their first birthday (PRB 2005). The high rates of maternal and infant deaths in West Africa are unacceptable. One effective way to reduce maternal and infant deaths is to ensure that family planning methods are available to all who want to plan and space their births. For example, when mothers space their births at least two years apart, infant mortality rates are reduced by as much as 50 percent. Additionally, studies show that if women had the number of pregnancies at the intervals they wanted, maternal mortality would drop by 20–35 percent. Despite the proven links between the use of family planning and reductions in maternal and infant mortality, contraceptive security has not been a high priority for policymakers. Women in the subregion who express a desire to plan and space their births still lack access to family planning methods. We need to act now to make family planning methods available to all women who want to plan and space births. Public- and private-sector partnerships have been instrumantal to improving the health of individuals in the subregion. Establishing country-level public-private partnerships will help ensure women in the subregion will have access to family planing products. The regional RHCS strategy will help increase access to RCHS products and ensure the best value for the products.	1. Finish RHCS plan. 2. Hire a consultant to conduct a situational analysis on successful public-private partnerships in RHCS. Use other health sectors (nutrition, HIV/AIDS, and family planning) as models or case studies. 3. Meet with the task force to review findings of the consultants' report. 4. Develop advocacy materials to promote public- and private-sector partnership. 5. Organize a "Private Sector Investment in RHCS Dialogue." Invite key private- sector organizations to a forum where case studies are represented and opportunities for PPP are identified. Address specific concerns and challenges regarding T&T and other issues. 6. Identify concrete areas for collaboration. 7. Hold country-level meetings to develop country-specific action plans.	**Activity 1:** June 2006 **Activity 2:** September–December 2006 **Activity 3:** January–February 2007 **Activity 4:** January–April 2007 **Activity 5:** April 2007 **Activity 6:** April 2007–April 2010 **Activity 7:** April 2007–ongoing

* Each company listed here represents a separate decision maker. Each should be targeted separately for funding.

Objective #3: Help all 15 ECOWAS countries to include government budget lines for RH commodities by 2010.

Audiences		Decision-making Process	Coalition	Message/Channels	Key Activities/ Responsibilities	Timeline
Primary	***Secondary***					
• Ministry of Health • Parliaments of all 15 ECOWAS countries • Ministry of Finance	• ECOWAS Health Ministers • ECOWAS Parliament's Health Committee • ECOWAS Parliament • Ministries of Finance • Other Donors • Country Governments • WAHO	1. Reenergize counsel of ministers to promote policy at country level. 2. Present strategy to the ECOWAS parliament. 3. Members of ECOWAS parliament follow the process at the country level.	Task Force, PLMO, other donors, ECOWAS health ministries	For every 100,000 live births in West Africa, 880 mothers die from complications of pregnancy and childbirth. Moreover, for every 1,000 live births, more than 100 infants do not live to see their first birthday (PRB 2005). The high rates of maternal and infant deaths in West Africa are unacceptable. One effective way of reducing maternal and infant deaths is ensuring family planning methods are available to all who want to plan and space their births. For example, when mothers space their births at least two years apart, infant mortality rates are reduced by as much as 50 percent. Additionally, studies show that if women had the number of pregnancies at the intervals they wanted, maternal mortality would drop by 20–35 percent. The regional RHCS strategy will help increase access to RH products and ensure the best value for the products. Despite the proven links between the use of family planning and improved maternal and infant health outcomes, most governments in West Africa do not have a budget line for RH commodities. The purchase of RH commodities is often combined with other health commodities. As a result, RH commodities are often bought in insufficient quantities and countries are forced to rely on donors to increase their supply. However, relying on donor support is not sustainable. For example, if donor financing remains at constant levels, there will be at least a $14 million gap for contraceptives in 2010. The time is now for ECOWAS countries to demonstrate leadership and commit themselves to saving the lives of women and children. Establish a budget line for RH commodities now.	1. Finish RHCS plan. 2. Review data to determine which ECOWAS countries have adopted RH commodities budget lines (Niger/Gambia). 3. Hire a consultant to develop a case study on a country that has successfully advocated for a budget line item for RH commodities (Niger/Gambia). Include concrete steps as to how this was done. 4. Develop one-page fact sheet outlining importance of budget line items (for the ECOWAS parliament). 5. Hold a subregional meeting with the health committee of the ECOWAS parliament to discuss the importance of adopting budget line items for RH commodities. 6. Ensure that ECOWAS Health Committee develops a plan of action to gain political commitment from ECOWAS parliament.. 7. Hold a subregional meeting with the MOF, the MOH, and parliament members from all 15 countries to develop national-level action plans for the adoption of budget lines.	***Activity 1:*** June 2006 ***Activity 2:*** June–July 2006 ***Activity 3:*** August–December 2006 ***Activity 4:*** January 2007–May 2007 ***Activity 5:*** May 2007 ***Activity 6:*** May 2007 ***Activity 7:*** June–July 2007 ***Activity 8:*** June/July 2007–June/July 2010

7.0 COMPONENT B: OPERATIONAL PLAN

7.1 BUDGET SUMMARY

TABLE 6: SUMMARY OF BUDGET FOR YEARS 1–5

	Total Estimated Requirements in U.S.$[1]					
	Year 1 ***2007***	***Year 2*** ***2008***	***Year 3*** ***2009***	***Year 4*** ***2010***	***Year 5*** ***2011***	***Total***
1. Context	$195,364	$195,364	$195,365	$195,364	$195,364	**$976,821**
2. Coordination	$270,045	$270,045	$270,045	$270,045	$270,045	**$1,350,226**
3. Capacity	$235,850	$235,849	$235,849	$235,849	$235,850	**$1,179,247**
4. Country Support	$98,494	$98,495	$98,495	$98,495	$98,494	**$492,473**
5. Coordination, Monitoring, & Evaluation[2]	$230,645	$230,645	$230,645	$230,645	$230,645	**$1,153,225**
Total						**$6,128,813**

1 Total costs over the five-year period were divided equally for the years between 2007 and 2011. Annual workplans will show greater activity detail and will provide more accurate year-to-year expenditure projections.

2 This includes substantial staff time to manage and implement RHCS activities. See section 8.0 for more details.

7.2 CONTEXT

TABLE 7: CONTEXT FOR THE ORGANIZATIONAL PLAN

Strategies	Actions	Subactions	Proposed Implementing Agencies	Coordinating Agencies	Timeframe	Cost
1. Advocacy: Advocate for a strengthened and harmonized policy and regulatory framework for RHCS, including drug registration, standard treatment guidelines, and essential medicines lists.	1. Advocate to ensure the integration of RHCS into RH policy in all countries of the subregion.	1.1 Identify a pool of consultants to provide TA to countries as needed. 1.2 Collate and provide technical reference materials to countries for the integration of RHCS into the national RH policies. 1.3 Carry out advocacy for the integration of RHCS into RH policies (include issues of non-supportive sociocultural norms). 1.4 Monitor the integration of RHCS into national RH policies.	WAHO MOHs USAID Cooperating Agencies UNFPA IPS	WAHO MOHs	April 2007–October 2011	$19,317 $9,659 $379,928 $69,542
	2. Harmonize country drug registration protocols, STGs, and EMLs (with a focus on RH commodities).	2 1. Collect and review member countries drug registration procedures (DRPs), STGs, and EMLs. 2.2 Convene a meeting of stakeholders to review, and establish consensus on, benefits of common approaches. 2.3 Implement advocacy efforts to revise and standardize (DRPs), STGs, and national EMLs to conform to subregional consensus. 2.4 Monitor implementation of changes in (DRPs), STGs, and EMLs.	WAHO ACAME UNFPA MOHs WHO USAID cooperating agencies IPS Suppliers and manufacturers	WAHO ACAME MOHs (Drug Control Authority)	April–Sept. 2007	$19,317 $48,941 $34,771 $34,771
2. Public Sector and Private Sector Partnerships: Create an enabling environment for public-private partnerships.	1. Encourage national-level stakeholders to engage the private sector to participate more actively in the provision of RH commodities.	1.1 Mobilize national stakeholders to conduct studies on willingness to pay (WTP), ability to pay (ATP), and market segmentation analyses (MSAs). 1.2 Collate and disseminate existing data on WTP, ATP, and MSAs. 1.3 Support national stakeholders to demonstrate the potential benefits of the whole market approach to product availability for the public-private sector and civil society. 1.4 Motivate member states to share this information at the subregional level to disseminate best and promising practices in public-private partnerships.	MOHs USAID cooperating agencies UNFPA Private sector (Chambers of Commerce) IPPF Marie Stopes NGOs Civil society organizations	WAHO ECOWAS Business Men's Forum MOHs Line government agencies (e.g. Ministries of Finance, Trade, Development, Economic Planning)	January 2008–December 2010	$19,317 $9,659 $57,952 $57,952

3. Finance: Encourage countries to establish a sustainable financing mechanism for RHCS.	1. Facilitate the creation of sustainable financing mechanisms for RH commodities.	1.1 Encourage the creation of dedicated budget line items for RH commodities in national health budgets. 1.2 Mobilize partners (donors, lenders, private sector, NGOs) to increase funding for RH commodities.	WAHO USAID cooperating agencies MOH MOF ECOWAS parliament Country parliaments UNFPA USAID World Bank DFID JICA CIDA KfW IPS	WAHO MOHs	January 2007–December 2011	$57,952 $70,101
4. Unmet Need: Address unmet need of RH commodities in the subregion.	1. Undertake an advocacy campaign to address unmet need of RH commodities in the subregion.	1.1 Conduct desk review on factors contributing to unmet need (e.g., socio-cultural, service delivery). 1.2 Prepare and disseminate evidence-based materials for advocacy campaign. 1.3 Monitor actions that have been taken by countries as a result of the advocacy campaign.	WAHO UNFPA IPS	WAHO MOH	Feb. 2007–Dec. 2007	$38,635 $2,645 $46,362
					Total	**$976,821**

7.3 COORDINATION

TABLE 8: COORDINATED ACTIONS FOR THE OPERATIONAL PLAN

Strategies	Actions	Subactions	Proposed Implementing Agencies	Coordinating Agencies	Timeframe	Cost
1. Coordinated Informed Buying: Establish a coordinating mechanism to facilitate access to and the sharing of procurement information on RH commodities.	1. Make the CIB network operational.	1.1 Plan and manage implementation (develop indicators, develop workplan, etc.).	WAHO ACAME UNFPA USAID cooperating agencies World Bank MOH Procurement Units	WAHO ACAME MOH	January 2007–December 2011	$0
		1.2. Hire a CIB system manager.				$1,062,452
		1.3 Hold technical design workshop.				$93,138
		1.4 Develop terms of reference (TORs) for the network participants.				$4,829
		1.5 Validation of TORs by countries.				$0
		1.6 Designate one contact person from every country, based on the content of the TORs.				$0
		1.7 Identify the other actors in the countries.				$0
		1.8 Purchase necessary hardware; install initial software.				$67,787
		1.9 Design and manage a pilot phase with five countries for one year.				$13,225
		1.10 Design prototype.				$0
		1.11 Develop training materials; identify and train users, operators, and technical staff.				$0
		1.12 Install production-ready software.				$0
		1.13 Begin network operation.				$2,645
		1.14 Conduct pilot data collection, analyze results, and resolve issues.				$0
		1.15 Evaluate pilot phase mid-term review.				$2,645
		1.16 Disseminate evaluation report on the pilot phase.				$0
		1.17 Extend network to all 15 countries.				$343,299
		1.18 Conduct annual meetings to analyze CIB information and discuss improvements.				$0
		1.19 Update workplan and provide periodic updates to stakeholders.				

2. Inter-Agency Coordination: Improve coordination among partners in the area of RHCS.	1. Create a subregional RHCS partners' network.	1.1 Identify all the RHCS partners working at the subregional level. 1.2 Convene regular meetings of subregional agencies/ partners to facilitate coordination and collaboration (e.g., share workplans; identify action items, data gaps). 1.3 Establish electronic network (email) to keep partners informed about RHCS activities and issues. 1.4 Monitor national- level RHCS interagency coordination and collaboration and share findings in partners' forum.	WAHO European Union UNFPA SIDA CIDA DANIDA DFID UNICEF WHO USAID cooperating agencies JICA KFW GTZ DSW IPPF MTN Foundation World Bank Gates Foundation	WAHO	September 2007–December 2011	$4,829 $292,978 $24,147
					Total	**$1,911,975**

7.4 CAPACITY BUILDING

TABLE 9: CAPACITY BUILDING FOR THE ORGANIZATIONAL PLAN

Strategies	Actions	Subactions	Proposed Implementing Agencies	Coordinating Agencies	Timeframe	Cost
1. Human Resource Development: Advocate strengthening of human resources and management of RHCS.	1. Strengthen regional training centers for human resource management of RHCS.	1.1 Identify regional training centers. 1.2 Conduct training of trainers (TOTs) for RHCS.	MOH CAMES UNFPA USAID cooperating agencies WHO Professional bodies and associations WAHO	WAHO	June 2007–June 2010	$19,143 $117,187
	2. Promote retention of trained staff involved in RHCS.	2.1 Identify and share motivational best practices.	Countries WHO WAHO	WAHO WHO	February 2008–June 2010	$20,640
2. Logistics Management Capacity Building: Promote logistics management capacity building, including integration of HMIS/LMIS and vertical programs.	1. Promote training of trainers in— • logistics management system • integration of HMIS/LMIS into RH • service delivery • policy formulation • quality control • implementation of RHCS.	1.1 Adapt curriculum. 1.2 Identify training institutions and trainers. 1.3 Organize the training. 1.4 Monitor trainees to determine training efficacy. 1.5 Collect and disseminate data on countries training in RHCS.	MOH Professional bodies and associations UNFPA USAID cooperating agencies CAMES WAHO	WAHO WHO UNFPA	June 2008–October 2011	$141,333 (for 1.1–1.3) $19,317 $15,810
3. Integration of RHCS into Public Health Curriculum: Advocate for the integration of RHCS into the public health curriculum.	1. Introduce RHCS curriculum into public health programs in universities and public health institutions.	1.1 Identify universities and public health institutions. 1.2 Adapt curriculum. 1.3 Identify trainers. 1.4 Train staff in RHCS curriculum. 1.5 Organize the training. 1.6 Monitor trainees to determine training efficacy. 1.7 Collect and disseminate data on countries training in RHCS.	MOH MOEd WAHO UNFPA CAMES Subregional training institutions USAID cooperating agencies	WAHO USAID	January 2008–December 2011	$14,488 $141,333 (for 1.2–1.5) $19,317 $15,810

4. Promoting IEC/BCC: Promote the use of IEC/BCC to increase awareness of RHCS issues in the community.	1. Develop subregional capacity for the promotion of training community agents in IEC/BCC.	1.1 Assess current community-based IEC/BCC systems. 1.2 Prepare training documents. 1.3 Organize training sessions.	PSI UNFPA MOH USAID cooperating agencies IPPF	WAHO	January 2007–December 2011	$14,488 $14,488 $585,934
5. Program Sustainability: Advocate for the importance of maintaining trained staff for program sustainability.	1. Promote program sustainability.	1.1 Emphasize the importance of staff retention at policymaking fora. 1.2 Encourage partners to develop exit strategies. 1.3 Develop and disseminate advocacy materials including guidelines for staff retention.	WAHO WHO MOH UNFPA USAID cooperating agencies	WAHO	January 2007–December 2011	$12,878 $12,878 $14,201
					Total	**$1,179,247**

7.5 COUNTRY SUPPORT ACTIVITIES

TABLE 10: COUNTRY SUPPORT ACTIVITIES FOR THE ORGANIZATIONAL PLAN

Strategies	Actions	Subactions	Proposed Implementing Agencies	Coordinating Agencies	Timeframe	Cost
1. Provision of Technical Assistance: Establish mechanism for provision of TA for RHCS.	1. Identify and provide country support technical assistance activities.	1.1 Identify TA needs and process. 1.2 Prepare and implement a workplan for the providing TA to the countries. 1.3 Identify partners to support the implementation of the workplan.	WAHO UNFPA USAID cooperating agencies MOHs IPS	WAHO	October 2007–December 2010	$19,317 $19,317 $19,317
	2. Establish regional experts network in RHCS.	2.1 Identify regional experts in RHCS. 2.2 Prepare the TORs of network of experts. 2.3 Promote networking of subregional experts.	WAHO WHO USAID cooperating agencies UNFPA	WAHO	January 2007–December 2007	$16,098 $16,098 $16,098
2. *Advocacy:* Advocate for the harmonization of country management tools across the subregion.	1. Develop common management tools for RHCS.	1.1 Define the keys areas for harmonization. 1.2 Formulate the common management tools. 1.3 Disseminate the harmonized tools in the subregion. 1.4 Present the harmonized tools to partners/stakeholders fora. 1.5 Follow up on implementation.	WAHO UNFPA USAID cooperating agencies WHO MOH	WAHO	March 2007–November 2009	$13,522 $13,522 $13,522 $61,796 $13,522
	2. Organize advocacy meetings with partners and stakeholders (roundtable, fora, conference).	2.1 Define audience for evidence-based data presentations. 2.2 Identify the best approaches for each group of partners and stakeholders. 2.3 Conduct regular meetings with stakeholders.	WAHO IPS	WAHO	May 2007–December 2011	$16,098 $16,098 $238,148
					Total	**$492,473**

8.0 COORDINATION AND MONITORING AND EVALUATION

The success of the subregional RHCS strategy depends in part on the human and institutional capacity to effectively manage and coordinate the activities of numerous partners within and across the technical objectives (context, coordination, capacity, and country support). Furthermore, WAHO, as the main subregional coordinating body, with other partners, is tasked with implementing several of the activities, including the identification of TA needs (country support) and the collection and analysis of data on factors affecting unmet need (context). As a result, an RHCS implementation manager will need to be in place as the technical and operational lead to ensure that the range of country, subregional, and technical assistance partners complete these tasks.

Additional proposed staff requirements include a full-time monitoring and evaluation manager. Section 8.1 identifies the output indicators that correspond to each action and the expected outcomes. Using these indicators as the basis, a detailed M&E plan will need to be developed that includes the routine progress evaluations implementation of the strategy. After the plan is in place, the M&E manager will conduct regular evaluations and compare the findings with the expected outcomes and disseminate the results to all stakeholders.

TABLE 11: OBJECTIVES, ACTIONS, SUBACTIONS, ESTIMATED COST, AND TIMING FOR M&E PLAN

Objective	Actions	Subactions	Estimated Cost	Timing
WAHO coordinates with country partners, donors, and TA providers to effectively implement the activities in the strategy.	1. Develop the human and institutional capacity to coordinate with partners and implement action and subactions across the range of objectives.	1.1 Hire an RHCS implementation manager.	$544,505	2007–2011
A mechanism for monitoring and evaluating results from actions and subactions is developed and implemented.	2. Establish an M&E system.	2.1 Develop, plan, and manage a monitoring and evaluation system (develop indicators, develop workplan, etc.).	(included above)	2007–2011
		2.2 Hire an M&E manager.	$500,703	2007–2011
		2.3 Conduct monitoring and evaluation activities.	$108,017	2007–2011
		2.4 Analyze and compare data to outputs and outcomes.	(included above)	2007–2011
		2.5 Disseminate results to stakeholders.	(included in above)	
		Total	**$1,153,225**	

8.1 RESULTS INDICATORS

TABLE 12: RESULTS INDICATORS—ACTION, OUTPUT INDICATORS, AND EXPECTED OUTCOMES

Action	Output Indicators	Expected Outcomes
Context		
1. Advocate to ensure the integration of RHCS into RH policy in all countries of the subregion.	Number of member countries incorporating RHCS into the national RH policy	A supportive policy environment to improve RHCS in the subregion. Improved political commitment to RHCS.
2. Harmonize subregional DPRs, STGs, and EMLs (with a focus on RH commodities).	Harmonized (DRPs), STGs, and EMLs developed for the subregion.	A policy environment to improve the quality of RH services in the subregion. Increased access to RH services.
3. Encourage national-level stakeholders to engage the private sector in participating more actively in the provision of RH commodities.	Increased number of private-sector providers involved in RHCS coordinating bodies at the national level.	Increased access for clients to RH commodities in the public, private, and NGO sectors.
4. Facilitate the creation of sustainable financing mechanisms for RH commodities.	Number of member countries that have a dedicated budget line item for the procurement of RH commodities.	Increased funding to purchase RH commodities in the subregion.
5. Undertake an advocacy campaign to address unmet need of RH commodities in the subregion.	Number of member countries that have developed action plans to address unmet need.	Improved access and utilization of RH services. Unmet need decreased.
Coordination		
1. Make the CIB network operational.	Number of member countries reporting procurement data into an operational CIB system. Number of member countries receiving procurement data reports back from the CIB system.	Access to and sharing of information on RH commodities for all ECOWAS countries.
2. Create a subregional RHCS partners' forum.	A functioning partners' forum at the subregional level meeting at least annually.	More effective coordination among partners in the subregion.
Capacity Building		
1. Strengthen regional training centers for human resource management of RHCS.	Number of TOTs carried out on RHCS from subregional training centers.	Quality of RH services improved in the subregion provided by skilled personnel.
2. Promote retention of trained staff involved in RHCS.	Number of member countries that have developed a motivational strategy for retention of trained staff.	Improved staff retention in RH programs (i.e., decreased staff turnover) due to implementation of national strategies.
3. Promote TOTs in— • logistics management system • integration of HMIS/LMIS into RH • service delivery • policy formulation • quality control • implementation of RHCS.	Number of people trained through TOTs in each subject area listed.	Effective and efficient logistic RH management system in place. Improved service delivery and quality control systems leading to increased access to and use of RH services in the subregion.

Action	Output Indicators	Expected Outcomes
Capacity Building (continued)		
4. Introduce RHCS curriculum into public health programs in universities and public health institutions.	Number of schools and faculties implementing the RHCS training curriculum.	CS components of RH teaching introduced into schools and faculties, leading to better-trained staff committed to RHCS in the subregion.
5. Develop subregional capacity for the promotion of training community agents in IEC/BCC.	Number of trained trainers for community agents in IEC/BCC.	Countries use of IEC/BCC to promote RHCS issues in local communities.
6. Promote program sustainability.	Number of member countries with national RHCS policies in place for program sustainability.	Policies implemented to address program sustainability.
Country Support		
1. Identify and provide country support technical assistance activities.	Number of TA visits provided to countries by WAHO/partners.	Improved access to and utilization of RH services.
2. Establish regional experts network in RHCS.	Regional network of RH experts established.	Improved access to and utilization of RH services due to inputs from a regional network of RH experts.
3. Develop common management tools for RHCS.	Common management tools developed (as defined by subregional stakeholders)	Member countries applying common management tools to improve political commitment to RHCS.
4. Organize advocacy meetings with partners and stakeholders (roundtable, fora, conference).	Number of advocacy meetings held per year.	Increased partners' support for the implementation of harmonized RHCS management tools.

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10.0 ANNEXES

ANNEX 1 – LIST OF WORKSHOP PARTICIPANTS

Following are the names and information of the individuals who participated in the series of WAHO-sponsored subregional strategy development workshops. Between November 2005 and March, 2006, WAHO technical staff, country program managers, and liaison officers, donors (USAID and UNFPA), and RHCS technical assistance projects (DELIVER and AWARE-RH) participated in and provided substantial technical input to the process.

TABLE 13: LIST OF PARTICIPANTS: DEVELOPMENT OF A STRATEGIC PLAN FOR REPRODUCTIVE HEALTH SECURITY COMMODITY JANUARY 24–26, 2006, BOBO-DIOULASSO, BURKINA FASO

No.	Name	Function	Country/ Organization	Address
1	Alh. Omar TAAL	DPS/Liaison Officer WAHO	The Gambia	Department of State for Health and Social Welfare, Banjul, The Gambia Tel. : (+220) 42 28 709 Fax : (+220) 42 25 873 Email: alhomartaal@yahoo.com
2	Mrs. Ramou Cole CEESAY	Head of RCH Programme DOSH, The Gambia	The Gambia	RCH Programme Unit, DOSH, Medical HQs Banjul, The Gambia Tel. : (+220) 42 28 742 Fax : (+220) 42 28 742 Email: onim11@yahoo.com
3	Dr. Laurent A. ASSOGBA	Focal Point Directeur National de la Protection Sanitaire	Benin	Ministère de la Santé Publique 01 BP 882 Cotonou, Benin Tel. : (+229) 21 33 66 79 / 90 04 55 31 Fax: (+229) 21 33 04 64 E-mail: laurassog@yahoo.fr
4	Marguerite DAVID	Chief of Division Logistique Contraceptive	Benin	Direction Santé Familiale Cotonou- Benin Tél.: (+229) 33 20 21 Fax: (+229) 33 00 63 Email: mazolikpo@yahoo.fr
5	Dr. Boubacar Samba DANKOKO	Point Focal Conseiller Technique n°1	Senegal	Ministère de la Santé et de la Prévention Médicale – Rue Aimée Césaire - B.P. 4024 Fann Résidence Dakar, Senegal Tel.:(+221) 869 42 47/ 648 34 14 Fax:(+221) 869 42 49 E-mail : drdankoko@yahoo.fr

No.	Name	Function	Country/ Organization	Address
6	Dr. Amath MBAYE	Chief de la Division de la Santé de la Reproduction (SR)	Senegal	Ministère de la Santé et de la Prévention Médicale – Rue Aimée Césaire – B.P. 4024 Fann Résidence Dakar, Senegal Tel.:(+221) 821 71 55 E-mail : mbayepf@yahoo.fr
7	Dr. Benie Bi Joseph VROH	Directeur Coordonnateur du Programme National de la Santé de Reproduction	Ivory Coast	Ministère de la Santé et de l'Hygiène Publique de la République de Côte d'Ivoire – BP V4 Abidjan Tél. : (+225) 20 32 24 15 Fax : (+225) 20 32 24 63 Email : benie4@hotmail.com dcpnsrpf@aviso.ci
8	Dr. Jean-Marc DJOMAN	Sous Directeur chargé des Etudes et réflexions au Secrétariat Technique	Ivory Coast	Ministère de la Santé et de l'Hygiène Publique BP V4 Abidjan Tél. : (+225) 20 21 22 97 Fax : (+225) 20 22 22 20 Email: djoman_jeanmarc@yahoo.fr
9	Dr. Mamadou Souncalo TRAORE	Directeur National Santé, Point Focal OOAS Mali	Mali	Ministère de la Santé BP : 232 – Koulouba - Bamako République du MALI Tél : (+223) 222 64 97 Fax : (+223) 222 36 74 Email : mstraore@dnsmali.org
10	Dr. Binta KEITA	Chief Division Santé de la Reproduction	Mali	Ministère de la Santé /Direction Nationale de la Santé BP : 232 – Koulouba - Bamako République du Mali Cell : (+223) 673 14 14 / 222 64 97 Fax : (+223) 222 36 74 Email : bkeita@dnsmali.org
11	Dr. Paulo RABNA	Responsable du Programme National de Lutte contre le SIDA, Point Focal OOAS Guinée Bissau	Guinea Bissau	Ministerio da Saude Guinée Bissau – Bissau PO Box 55 Tel. : (+245) 721 56 25 / 665 73 96 Email : paulo6602@yahoo.co.uk paulorabna@eguitel.com
12	Dr. Paulo DJATA	Directeur des Soins de Santé Familiale et Coordinateur de Santé de la Reproduction	Guinea Bissau	MINSAP Av. Unidade Africana BP 50, Bissau, Guinée-Bissau Tél. : (+245) 21 12 00/ 72 00 635
13	Dr. Margarida CARDOSO	Directrice Générale des Etudes et de la Planification Point Focal OOAS Cap Vert	Cape Verde	Ministère de la Santé du Cap-Vert – CP 47 Praia Tél. : (+238) 26 10 111 Fax : (+238) 26 10 163 Email : margarida.cardoso@ms.gov.cv

No.	Name	Function	Country/ Organization	Address
14	Dr. Mohamed Sidatty KEITA	Chief de la Division Santé de la Reproduction/ Directeur du Programme National Santé de la Reproduction	Guinea	Ministère de la Santé Publique de Guinée – Conakry Tél. : Bur : (+224) 45 20 10 / Privé : 29 09 43 Email : sidattymk@yahoo.fr
15	Dr. Nangnouma SANO	Chief Section Etablissements Pharmaceutiques, Direction Nationale Pharmacie-Labo	Guinea	BP 585 Guinée Tél. : (+224) 27 16 11 Email : snagnouma@yahoo.fr
16	Dr. Aïssa Bouwayé ADO	Directrice de la Santé de la Reproduction au MSP/LCE	Niger	Ministère de la Santé du Niger – Niamey BP 626 Niamey -Niger Cell : (+227) : 26 31 31 Email : aissaado@yahoo.com Email Direction Santé de la Reproduction Niger : santereproduction@yahoo.fr
17	Mme Rakiatou DANIA	Point Focal OOAS Conseiller Technique du MSP/LCE	Niger	Ministère de la Santé Publique et de la Lutte contre les Epidémies BP 623 Niamey -Niger Tel : (+227)72 28 08 / 72 59 06/ Cell : (+227) 96 96 11 Fax: (+227) 73 35 70 / 72 59 06 Email : rakiadm@yahoo.fr ooasnig@intnet.ne
18	Dr. Ernest OUEDRAOGO	Responsable Logistique Contraceptive	Burkina Faso	Direction Santé de la Famille – Burkina Faso Tél. : (+226) 50 30 77 78 Fax : (+226) 50 30 77 68 Email : ernest_ouedraogo@hotmail.com
19	Dr. Kodjo Kitchoou ALEKI	Conseiller Technique, Point Focal OOAS	Togo	Ministère de la Santé du Togo BP 30542 Lomé Tél. : (+228) 222 61 08 Cell : (+228) 911 11 84 Email: draleki@yahoo.fr
20	Mr Aboudou DARE	Directeur du Programme Santé de la Reproduction Chief de Division de la Santé Familiale	Togo	Ministère de la Santé du Togo Division de la Santé Familiale 07 BP 14536 Lomé Togo Tel. : (+228) 223 33 70 Fax: (+228) 223 33 87 Cell. : (+228) 904 70 02 Email: darab93@yahoo.fr
21	Dr. Adetunji Labiran	Assistant Director (HRH)	Nigeria	Department of Health Planning & Research Federal Ministry of Health, Abuja Nigeria, Tel.: (+234) 803 439 6581 Email: alabiran@yahoo.com

No.	Name	Function	Country/ Organization	Address
22	Pauline ARIBISALA	Assistant Director (Programme/RHCS)	Nigeria	Federal Ministry of Health, Department of Community Development & Population Activities Abuja, Nigeria, Tel.: (+234) 803 3094675/805 9384505 Email: pabari2002@yahoo.com
23	Dr. Kisito. S. DAOH	RH Programme Manager	Sierra Leone	Ministry of Health and Sanitation 4th Floor Youyi Building, Brookfields Freetown Sierra Leone Tel: (+232) 76 658 976 / 33 315 375/ 22 238 831 Fax: c/o DPI (232) 22 235 063 Email : ksdaoh@yahoo.com
24	Mr. Tommy T. TENGBEH	WAHO Liaison Officer Deputy Secretary (International Div)	Sierra Leone	Ministry of Health and Sanitation 4th Floor Youyi Building, Brookfields Freetown Sierra Leone Tel: (+232) 33 327 474 / 76 634 721 Fax: c/o Dr. Clifford W. KAMARA (+232) 22 235 063 Email : tommytengbeh@yahoo.com
25	Dr. Gloria QUANSAH ASARE	Family Planning Programme Manager	Ghana	Ghana Heath Service Private Mail Bag Ministries Post Office, Accra Tel.: (+223) 21 68 42 17/244 281 732 Fax : (+233) 21 66 38 10/21 67 43 66 Email : gloasare1@yahoo.com
26	Mr. Ahmed MOHAMMED	Assistant Director	Ghana	Ministry of Health Ghana PO Box m44 Accra Tel.: (+223) 21 68 42 47/ 243 289 692 Fax : (+233) 21 67 00 76/21 66 01 76/ 21 66 38 10 Email : ahmedmoh2@yahoo.com
27	Blami DAO	Chief du Département de Gynécologie Obstétrique du CHU Souro SANOU	Burkina Faso	Bobo-Dioulasso Burkina Faso Tél. : (+226) 20 97 00 44 Ext 1133 Fax : (+226) 20 97 26 93 Email : bdao@fasonet.bf
28	Raja RAO	Policy Adviser DELIVER/JSI USA	United States	1616 N. Fort Myer Drive 11th floor, Arlington, VA 22209 USA TEL.: (+1) 703 528 7474 Fax: (+1) 703 528 7480 Email: raja_rao@jsi.com

No.	Name	Function	Country/ Organization	Address
29	Dr. Kabba JOINER	Director General/ WAHO	ECOWAS	OOAS BP 153 Bobo-Dioulasso Burkina Faso Tél: (+226) 20 97 57 75/ 20 97 00 97 Fax: (+226) 20 97 57 72 Email: wahooas@fasonet.bf
30	Dr. Johanna AUSTIN	DSSP-CM	ECOWAS	OOAS BP 153 Bobo-Dioulasso Burkina Faso Tél: (+226) 20 97 57 75/ 20 97 00 97 Fax: (+226) 20 97 57 72 Email: austinjohanna@yahoo.fr jaustin@wahooas.org
31	Mr. Salifou ZOUMA	DPAT	ECOWAS	OOAS BP 153 Bobo-Dioulasso Burkina Faso Tél: (+226) 20 97 57 75/ 20 97 00 97 Fax: (+226) 20 97 57 72 Email: yzsalifou@yahoo.fr szouma@wahooas.org
32	Dr. Angela OKOLO		ECOWAS	OOAS BP 153 Bobo-Dioulasso Burkina Faso Tél: (+226) 20 97 57 75/ 20 97 00 97 Fax: (+226) 20 97 57 72 Email: aokolo@wahooas.org Angelok4@yahoo.com

TABLE 14: LIST OF PARTICIPANTS: WEST AFRICA SUBREGION RHCS STRATEGIC PLANNING, MEETING OF THE REPRODUCTIVE HEALTH COMMODITY SECURITY TASK FORCE, MARCH 8–10, 2006, ACCRA, GHANA

N.	Name	Function	Country/ Organization	Address
1	Prof. Dao BLAMI	Chief du Département de Gynécologie Obstétrique CHU Souro Sanou, Bobo-Dioulasso	Burkina Faso	CHU Sourou Sanou Bobo-Dioulasso Tel : (226)78802444 Fax : (226) 20972693 bdao@fasonet.bf daoblami@hotmail.com
2	Gloria Q. ASARE	National Family Planning Programme Manager	Ghana	Ghana Health Service Private Mail Bag Ministries Post Office Accra Tel : (233)0244 281 732 Fax : (233) 021 663810 gloasare1@yahoo.com
3	Pauline B. ARIBISALA	Assistant Director (Programme / RHCS)	Nigeria	Federal Ministry of Health Department of Community Dvelopment & Population Activities Federal Ministry of Health, Central Medical Library Compound, Yaba, Lagos, Nigeria Tel : (234) 803 309 4675 pabari2002@yahoo.com
4	Raja RAO	Policy Adviser DELIVER/JSI	United States	1616 N. Fort Myer Drive 11th floor Arlington, VA USA 22209 Tel : (703) 528 7474 Fax : (703) 588 7480 rajarao@jsi.com
5	Danièle LANDRY – MUGENGANA	Technical Adviser RHCS UNFPA	UNFPA	220 East 42nd St New York, NY 10027 Tel : 212-297- 5143 Fax : 212- 297- 4917 landry@unfpa.org
6	Penda NDIAYE	RHCS.CST UNFPA – DAKAR	UNFPA	Immeuble FADH, Rue Djily Mbaye Dakar – Senegal Tel : 21-88 03 53 Pndiaye@unfpa.org
7	Carmen COLES	Technical Adviser for Advocacy AWARE–RH	GHANA	1 Crescent PMB 242 Demmco House Airport West Accra – Ghana Tel : 233-2425281 15 ccoles@aware-rh.org
8	Antoine NDIAYE	Commodity Security Advisor AWARE-RH	GHANA	PMB CT 242 Tel : 233 – 2178612 Cell : 233- 244 47 6 99 Fax : 233 – 2186197 andiaye@aware-rh.org antoinendiaye@hotmail.com

N.	Name	Function	Country/ Organization	Address
9	Kabba T. JOINER	Director General WAHO	ECOWAS	BP: 153 Bobo-Dioulasso Tel : (226)20975775 / 20971560 Fax: (226)20975772 wahooas@fasonet.bf kjoiner@wahooas.org kabajoiner@hotmail.com
10	Dr. Johanna L. AUSTIN	Directrice de la Division Soins de Santé Primaires et Contrôle des Maladies OOAS - WAHO	ECOWAS	OOAS /WAHO BP: 153 Bobo-Dioulasso Tel : (226)20975775 / 76456483 Fax: (226)20975772 austinjohanna@yahoo.fr wahooas@fasonet.bf jaustine@wahooas.org
11	Prof. Angela OKOLO	Professional Officer Maternal & Perinatal Health WAHO (HQ)	ECOWAS	WAHO : 01 BP 153 Bobo-Dioulasso Tel : (226) 20970100 Fax : (226) 20975772 angelok4@yahoo.com akolo@wahooas.org
12	Seynabou GAYE	Secrétaire de Direction OOAS	ECOWAS	BP : 153 Bobo-Dioulasso Fax : 226-20975772 Tel : 226-20975775 sgaye@wahooas.org seynabougaye@hotmail.com

ANNEX 2 – THE INTERAGENCY LIST OF ESSENTIAL MEDICINES FOR REPRODUCTIVE HEALTH

The Interagency List of Essential Medicines for Reproductive Health is first presented in the format used in previous RH lists—by clinical groups, with certain medicines repeated in different groups (WHO/UNFPA 2006). Relevant RH STGs developed by WHO's Department of Reproductive Health Research are included for each clinical group. Information regarding WHO's Model List therapeutic categories are included for each medicine.

The list presents the minimum medicine needs for a basic health care system, listing the most efficacious, safe, and cost-effective medicines for priority conditions. Priority conditions are selected on the basis of current and estimated future public health relevance and the potential for safe and cost-effective treatment. Complementary medicines (indicated with a "c" in the first column of the table) are also listed; these medicines need specialized diagnostic or monitoring facilities and/or specialist medical care and specialist training. If in doubt, medicines can also be listed as complementary on the basis of consistent higher costs or less attractive cost-effectiveness in a variety of settings.

When the strength of a medicine is specified in terms of a selected salt or ester, this is mentioned in brackets; when it refers to the active moiety, the name of the salt or ester in brackets is preceded by the word "as."

TABLE 15: MINIMUM MEDICINE NEEDS FOR A BASIC HEALTH CARE SYSTEM (WHO/UNFPA 2006)

	Medicine	Dosage	Therapeutic category (14th WHO Model List)
Maternal and Neonatal Health			
1. Managing complications in pregnancy and childbirth: a guide for midwives and doctors. Geneva: World Health Organization; 2000. http://www.who.int/reproductive-health/impac/index.html 2. Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice. Geneva: World Health Organization; 2003. http://www.who.int/reproductive-health/publications/pcpnc/index.html 3. Managing new born problems: A guide for doctors, nurses, and midwives. Geneva: World Health Organization; 2003. http://www.who.int/reproductive-health/publications/mnp/index.html 4. The WHO Reproductive Health Library; http://www.who.int/reproductive-health/rhl/index.html 5. Additional information: http://www.who.int/reproductive-health/			
Anaesthetics, general			
	halothane	inhalation	1.1
	ketamine	injection, 50 mg (as hydrochloride)/ml in 10-ml vial	1.1
	nitrous oxide	inhalation	1.1
	oxygen	inhalation (medicinal gas)	1.1
	thiopental	powder for injection, 0.5 g, 1.0 g (sodium salt) in ampoule	1.1
	atropine	injection, 1 mg (sulfate) in 1-ml ampoule	1.3
	suxamethonium chloride	injection, 50 mg (chloride)/ml in 2-ml ampoule; powder for injection (chloride), in vial	20
Anaesthetics, local			
	lidocaine	injection, 1%, 2% (hydrochloride) in vial, injection for spinal anaesthesia, 5% (hydrochloride) in 2-ml ampoule to be mixed with 7.5% glucose solution topical forms, 2-4% (hydrochloride)	1.2
	lidocaine + epinephrine (adrenaline)	injection, 1%, 2% (hydrochloride) + epinephrine 1:200 000 in vial; dental cartridge 2% (hydrochloride) + epinephrine 1:80 000	1.2
c	epinephrine	injection, 30 mg (hydrochloride)/ml in 1-ml ampoule (for use in spinal anaesthesia during delivery, to prevent hypotension)	1.2
Analgesics			
Opioid			
	morphine	injection, 10 mg in 1-ml ampoule (sulfate or hydrochloride); oral solution, 10 mg (hydrochloride or sulfate)/5-ml; tablet, 10 mg (sulfate)	2.2
Non-opioid			
	paracetamol*	tablet, 100-500 mg; suppository, 100 mg; syrup, 125 mg/5 ml *not recommended for anti-inflammatory use due to lack of proven benefit to that effect	2.1
	acetylsalicylic acid	tablet, 100-500 mg; suppository, 50-150 mg	2.1
Antianaemia			
	ferrous salt	tablet, equivalent to 60 mg iron; oral solution equivalent to 25 mg iron (as sulfate)/ml	10.1
	folic acid	tablet 1mg, 5 mg	10.1
	ferrous salt + folic acid	tablet equivalent to 60 mg iron + 400 micrograms folic acid (nutritional supplement for use during pregnancy	10.1

	Medicine	Dosage	Therapeutic category (14th EML)
Antibacterials			
	amoxicillin	capsule or tablet, 250 mg, 500 mg (anhydrous); powder for oral suspension, 125 mg (anhydrous)/5 ml	6.2.1
	ampicillin	powder for injection, 500 mg, 1 g (as sodium salt) in vial	6.2.1
	benzylpenicillin	powder for injection, 600 mg (= 1 million IU), 3 g (= 5 million IU) (sodium or potassium salt) in vial	6.2.1
	benzathine benzylpenicillin	powder for injection, 1.44 g benzylpenicillin (= 2.4 million IU) in 5-ml vial	6.2.1
c	ceftriaxone	powder for injection, 250 mg, 1 g (as sodium salt) in vial	6.2.1
	cloxacillin	capsule, 500 mg, 1 g (as sodium salt); powder for oral solution, 125 mg (as sodium salt)/5 ml; powder for injection, 500 mg (as sodium salt) in vial	6.2.1
	chloramphenicol	capsule, 250 mg; oral suspension, 150 mg (as palmitate)/ 5 ml; powder for injection, 1 g (sodium succinate) in vial; oily suspension for injection 0.5 g (as sodium succinate)/ml in 2-ml ampoule	6.2.2
	ciprofloxacin*	tablet 250 mg (as hydrochloride) * final selection depends on indication for use	6.2.2
	clotrimazole	vaginal tablet, 100 mg, 500 mg, vaginal cream 1%, 10%	6.3
	doxycycline*	capsule or tablet, 100 mg (hydrochloride) * final selection depends on indication for use	6.2.2
	erythromycin	capsule or tablet, 250 mg (as stearate or ethyl succinate); powder for oral suspension, 125 mg (as stearate or ethyl succinate); powder for injection, 500 mg (as lactobionate) in vial	6.2.2
	gentamicin*	injection, 10 mg, 40 mg (as sulfate)/ml in 2-ml vial * final selection depends on indication for use	6.2.2
	metronidazole	tablet, 200-500 mg; injection, 500 mg in 100-ml vial; suppository, 500 mg, 1 g; oral suspension, 200 mg (as benzoate)/5 ml	6.2.2
	miconazole	ointment or cream, 2% (nitrate)	13.1
	nitrofurantoin	tablet, 100 mg	6.2.2
	procaine benzylpenicillin	powder for injection, 1 g (=1 million IU), 3 g (= 3 million IU) in vial	6.2.1
	tetracycline	eye ointment, 1% (hydrochloride)	21.1
	sulfamethoxazole + trimethoprim	tablet, 100 mg + 20 mg, 400 mg + 80 mg; oral suspension, 200 mg + 40 mg/5 ml; injection, 80 mg + 16 mg/ml in 5-ml and 10-ml ampoules	6.2.2

	Medicine	Dosage	Therapeutic category (14th WHO Model List)
Antimalarials			
It should be noted that the standard treatment guidelines for the treatment and prevention of malaria are currently being updated and should be referred to when available			
c	artemether	injection, 80 mg/ml in 1-ml ampoule	6.5.3.1
c	artesunate	tablet, 50 mg	6.5.3.1
	chloroquine	tablet, 150 mg (as phosphate or sulfate); syrup, 50 mg (as phosphate or sulfate)/5 ml	6.5.3.1 6.5.3.2
c	mefloquine	tablet, 250 mg (as hydrochloride)	6.5.3.1 6.5.3.2
	quinine	tablet, 300 mg (as bisulfate or sulfate); injection, 300 mg (as dihydrochloride)/ml in 2-ml ampoule	6.5.3.1
c	doxycycline	capsule or tablet, 100 mg (hydrochloride) *(for use only in combination with quinine)*	6.5.3.1 6.5.3.2
c	sulfadoxine + pyrimethamine	tablet, 500 mg + 25 mg	6.5.3.1
	proguanil	tablet, 100 mg (hydrochloride) *(for use only in combination with chloroquine)*	6.5.3.2
Antituberculosis			
	ethambutol	tablet, 100 mg-400 mg (hydrochloride)	6.2.4
	isoniazid	tablet, 100 mg-300 mg	6.2.4
	isoniazid + ethambutol	tablet, 150 mg + 400 mg	6.2.4
	pyrazinamide	tablet, 400 mg	6.2.4
	rifampicin	capsule or tablet, 150 mg, 300 mg	6.2.4
	rifampicin + isoniazid	tablet, 60 mg + 30 mg; 150 mg + 75 mg; 300 mg + 150 mg; 60 mg + 60 mg *(for intermittent use three times weekly)*; 150 mg + 150 mg *(for intermittent use three times weekly)*	6.2.4
	rifampicin + isoniazid + pyrazinamide	tablet, 60 mg + 30 mg + 150 mg; 150 mg + 75 mg + 400 mg; 150 mg + 150 mg + 500 mg *(for intermittent use three times weekly)*	6.2.4
	rifampicin + isoniazid + pyrazinamide + ethambutol	tablet, 150 mg + 75 mg + 400 mg + 275 mg	6.2.4
Anthelmintics			
	pyrantel	chewable tablet 250 mg (as embonate); oral suspension, 50 mg (as embonate)/ml	6.1.1
	mebendazole	chewable tablet, 100 mg, 500 mg	6.1.1
Anticonvulsants			
	diazepam	injection, 5 mg/ml in 2-ml ampoule (intravenous or rectal)	5
	magnesium sulfate*	injection, 500 mg/ml in 2-ml ampoule; 500 mg/ml in 10-ml ampoule *for use in eclampsia and severe pre-eclampsia and not for other convulsant disorders	5
	phenobarbital	tablet, 15-100 mg; elixir, 15 mg/5 ml	5
	phenytoin	capsule or tablet, 25 mg, 50 mg, 100 mg (sodium salt); injection, 50 mg/ml in 5-ml vial (sodium salt)	5

	Medicine	Dosage	Therapeutic category (14th WHO Model List)
Antihypertensives			
	hydralazine*	tablet, 25 mg, 50 mg (hydrochloride); powder for injection, 20 mg (hydrochloride) in ampoule *hydralazine is listed for use in the acute management of severe pregnancy-induced hypertension only	12.3
	methyldopa*	tablet, 250 mg *methyldopa is listed for use in the management of pregnancy-induced hypertension only	12.3
Diuretics			
	furosemide	tablet, 40 mg; injection, 10 mg/ml in 2-ml ampoule	16
IV Fluids			
	glucose	injectable solution, 5%, 10% isotonic; 50% hypertonic	26.2
	sodium chloride	injectable solution, 0.9% isotonic (equivalent to Na+ 154 mmol/L, Cl^- 154 mmol/L	26.2
	Ringer's lactate	injectable solution	26.2
	glucose with sodium chloride	injectable solution, 4% glucose, 0.18% sodium chloride (equivalent to Na+ 30 mmol/L, Cl^- 30 mmol/L)	26.2
Plasma substitutes			
	dextran 70*	injectable solution, 6% *polygeline, injectable solution, 3.5% is considered as equivalent	11.1
Anticoagulants			
	heparin sodium	injection, 1000 IU/ml, 5000 IU/ml, 20 000 IU/ml in 1-ml ampoule	10.2
	protamine sulfate	injection, 10 mg/ml in 5-ml ampoule	10.2
	phytomenadione (vitamin K)	injection, 10 mg/ml in 5-ml ampoule; tablet, 10 mg	10.2
Antidiabetics			
	insulin	injection, 40 IU/ml in 10-ml vial, 100 IU/ml in 10-ml vial	18.5
	intermediate-acting insulin	injection, 40 IU/ml in 10-ml vial; 100 IU/ml in 10-ml vial (as compound insulin zinc suspension or isophane insulin)	18.5
Immunologicals and vaccines			
	anti-D immunoglobulin	injection, 250 micrograms in single-dose vial	19.2
	antitetanus immunoglobulin	injection, 500 IU in vial	19.2
	BCG vaccine		19.3.1
	diphtheria vaccine		19.3.1
	hepatitis B vaccine		19.3.1
	poliomyelitis vaccine		19.3.1
	tetanus vaccine		19.3.1
Dermatologicals			
	methylrosanilinium chloride (gentian violet)	aqueous solution, 0.5%; tincture, 0.5%	13.2

	Medicine	Dosage	Therapeutic category (14th WHO Model List)
Disinfectants and antiseptics			
	polyvidone iodine	solution, 10%	15.1
	chlorhexidine	solution, 5% (digluconate) for dilution	15.1
	calcium hypochlorite (chlorine base compound)	powder (0.1% available chlorine) for solution	15.2
	ethanol	solution, 70% (denatured)	15.1
Oxytocics			
c	mifepristone* + misoprostol*	tablet 200 mg - tablet 200 micrograms, * requires close medical supervision where permitted under national law and where culturally acceptable	22.1
c	misoprostol	vaginal tablet, 25 micrograms	22.1
	oxytocin	injection, 10 IU in 1-ml ampoule	22.1
	ergometrine	injection, 200 micrograms (hydrogen maleate) in 1-ml ampoule	22.1
Tocolytics			
	nifedipine	immediate release capsule, 10 mg	22.2
Sedatives			
	diazepam	injection, 5 mg/ml in 2-ml ampoule; tablet, 5 mg	1.3
Antiallergics and medicines used in anaphylaxis			
	epinephrine (adrenaline)	injection, 1 mg (as hydrochloride)/ml in ampoule	3
Medicines used in emergencies			
	atropine sulfate	injection, 1 mg (sulfate) in 1-ml ampoule	4.2
	digoxin	tablet, 62.5 micrograms, 250 micrograms; oral solution 50 micrograms/ml; injection 250 micrograms/ml in 2-ml ampoule	12.2 12.4
	epinephrine (adrenaline)	injection, 1 mg (hydrochloride)/ml in ampoule	12.2
	promethazine	elixir or syrup, 5 mg (hydrochloride)/5 ml	1.3
	glyceryl trinitrate	tablet (sublingual), 500 micrograms	12.1
	calcium gluconate	injection, 100 mg/ml in 10-ml ampoule	4.2
	naloxone	injection, 400 micrograms (hydrochloride) in 1-ml ampoule	4.2
	furosemide	tablet, 40 mg; injection, 10 mg/ml in 2-ml ampoule	12.4
	prednisolone*	tablet, 5 mg, 25 mg * there is no evidence for complete clinical similarity between prednisolone and dexamethasone at high doses	3
	chlorphenamine	tablet, 4 mg (hydrogen maleate); injection, 10 mg (hydrogen maleate) in 1-ml ampoule	3
Steroids			
	dexamethasone	injection, 4 mg dexamethasone phosphate (as disodium salt) in 1-ml ampoule	3
	hydrocortisone	powder for injection, 100 mg (as sodium succinate) in vial	3

Medicine	Dosage	Therapeutic category (14th WHO Model List)
Others		
oral rehydration salts* (for glucose-electrolyte solution)	glucose: 75 mEq; potassium: 20 mEq or mmol/l; sodium: 75 mEq or mmol/l; citrate: 10 mmol/l; chloride: 65 mEq or mmol/l; osmolarity: 245 mOsm/l	17.5.1
zinc sulfate*	tablet or syrup in 10 mg per unit dosage forms * in acute diarrhoea zinc sulfate should be used as an adjunct to oral rehydration salts	17.5.2
retinol	sugar-coated tablet, 10 000 IU (as palmitate) (5.5 mg); capsule, 200 000 IU (as palmitate) (110 mg); oral oily solution 100 000 IU (as palmitate)/ ml in multidose dispenser; water-miscible injection 100 000 IU (as palmitate) (55 mg) in 2-ml ampoule	27

	Medicine	Dosage	Therapeutic category (14th WHO Model List)
Family Planning			
1. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva: World Health Organization; 2004. http://www.who.int/reproductive-health/publications/mec/index.htm			
Oral hormonal contraceptives			
	ethinylestradiol + levonorgestrel	tablet, 30 micrograms + 150 micrograms	18.3.1
	levonorgestrel	tablet, 30 micrograms, 750 micrograms (pack of two), 1.5 mg	18.3.1
	ethinylestradiol + norethisterone	tablet, 35 micrograms + 1.0 mg	18.3.1
Injectable hormonal contraceptives			
	medroxyprogesterone acetate	depot injection, 150 mg/ml in 1-ml vial	18.3.2
	norethisterone enanthate	oily solution, 200 mg/ml in 1-ml ampoule	18.3.2
IUD			
	copper IUD		18.3.3
Barrier methods			
	condoms		18.3.4
	diaphragms		18.3.4
Reproductive Tract Infections/Sexually Transmitted Diseases			
1. Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice. Geneva: World Health Organization; 2003. http://www.who.int/reproductive-health/publications/pcpnc/index.html 2. Managing complications in pregnancy and childbirth: a guide for midwives and doctors. Geneva: World Health Organization; 2000. http://www.who.int/reproductive-health/impac/index.html 3. Managing new born problems: A guide for doctors, nurses, and midwives. Geneva: World Health Organization; 2003. http://www.who.int/reproductive-health/publications/mnp/index.html 4. Guidelines for the management of sexually transmitted infections. Geneva: World Health Organization; 2003. http://www.who.int/reproductive-health/publications/rhr_01_10_mngt_stis/index.html			
c	ceftriaxone	powder for injection, 250 mg, 1 g (as sodium salt) in vial	6.2.1
	cefixime*	capsule 400 mg * only listed for single-dose treatment of uncomplicated ano-genital gonorrhoea	6.2.1
	azithromycin*	capsule, 250 mg or 500 mg; suspension 200 mg/5 ml * only listed for single-dose treatment of genital C. trachomatis and of trachoma	6.2.2
	spectinomycin	powder for injection, 2 g (as hydrochloride) in vial	6.2.2
	amoxicillin	capsule or tablet, 250 mg, 500 mg (anhydrous); powder for oral suspension, 125 mg (anhydrous)/5 ml	6.2.1
	sulfamethoxazole + trimethoprim	tablet, 100 mg + 20 mg, 400 mg + 80 mg; oral suspension, 200 mg + 40 mg/5 ml; injection, 80 mg + 16 mg/ml in 5-ml and 10-ml ampoules	6.2.2
	doxycycline*	capsule or tablet, 100 mg (hydrochloride) * final selection depends on indication for use	6.2.2
	erythromycin	capsule or tablet, 250 mg (as stearate or ethyl succinate); powder for oral suspension, 125 mg (as stearate or ethyl succinate); powder for injection, 500 mg (as lactobionate) in vial	6.2.2
	tetracycline	eye ointment, 1% (hydrochloride)	21.1

	Medicine	Dosage	Therapeutic category (14th EML)
	benzathine benzylpenicillin	powder for injection, 1.44 g benzylpenicillin (= 2.4 million IU) in 5-ml vial	6.2.1
	metronidazole	tablet, 200-500 mg; injection, 500 mg in 100-ml vial; suppository, 500 mg, 1 g; oral suspension, 200 mg (as benzoate)/5 ml	6.2.2
c	clindamycin	capsule, 150 mg; injection, 150 mg (as phosphate)/ml	6.2.2
	miconazole	ointment or cream, 2% (nitrate)	13.1
	clotrimazole	vaginal tablet, 100 mg, 500 mg, vaginal cream 1%, 10%	6.3
	fluconazole	capsule 50 mg; injection 2 mg/ml in vial; oral suspension 50 mg/5 ml	6.3
	nystatin	tablet, 100 000, 500 000 IU; lozenge 100 000 IU; pessary, 100 000 IU	6.3
	gentamicin*	injection, 10 mg, 40 mg (as sulfate)/ml in 2-ml vial *final selection depends on indication for use	6.2.2
	chloramphenicol	capsule, 250 mg; oral suspension, 150 mg (as palmitate)/5 ml; powder for injection, 1 g (sodium succinate) in vial; oily suspension for injection 0.5 g (as sodium succinate)/ml in 2 ml ampoule	6.2.2
	procaine benzylpenicillin	powder for injection, 1 g (= 1 million IU), 3 g (= 3 million IU) in vial	6.2.1
HIV Medicines (ART, MTCT and Opportunistic Infections)			
1.	Scaling up antiretroviral therapy in resource-limited settings. Treatment guidelines for a public health approach. Geneva: World Health Organization; 2004. http://www.who.int/3by5/publications/documents/arv_guidelines/en/index.html		
	zidovudine	tablet, 300 mg; capsule 100 mg, 250 mg; oral solution or syrup, 50 mg/5 ml; solution for IV infusion injection, 10 mg/ml in 20-ml vial	6.4.2.1
	didanosine	buffered chewable, dispersible tablet, 25 mg, 50 mg, 100 mg, 150 mg, 200 mg; buffered powder for oral solution, 100 mg, 167 mg, 250 mg packets; unbuffered enteric coated capsule, 125 mg, 200 mg, 250 mg, 400 mg	6.4.2.1
	stavudine	capsule 15 mg, 20 mg, 30 mg, 40 mg, powder for oral solution, 5 mg/5 ml	6.4.2.1
	lamivudine	tablet, 150 mg, oral solution 50 mg/5 ml	6.4.2.1
	abacavir	tablet, 300 mg (as sulfate), oral solution, 100 mg (as sulfate)/5 ml	6.4.2.1
Non-nucleoside reverse transcriptase inhibitors			
	nevirapine	tablet 200 mg; oral suspension 50 mg/5 ml	6.4.2.2
	efavirenz	capsule, 50 mg, 100 mg, 200 mg; oral solution, 150 mg/5 ml	6.4.2.2
Protease inhibitors			
	saquinavir	capsule, 200 mg	6.4.2.3
	ritonavir	capsule, 100 mg, oral solution 400 mg/5 ml	6.4.2.3
	indinavir	capsule, 200 mg, 333 mg, 400 mg (as sulfate)	6.4.2.3
	nelfinavir	tablet, 250 mg (as mesilate), oral powder 50 mg/g	6.4.2.3
	lopinavir + ritonavir	capsule, 133.3 mg + 33.3 mg, oral solution 400 mg + 100 mg/5 ml	6.4.2.3

	Medicine	Dosage	Therapeutic category (14th EML)
Medicines used in opportunistic infections			
c	ceftriaxone	powder for injection, 250 mg, 1 g (as sodium salt) in vial	6.2.1
c	clindamycin	capsule, 150 mg; injection, 150 mg (as phosphate)/ml	6.2.2
	ciprofloxacin*	tablet 250 mg (as hydrochloride) *final selection depends on indication for use	6.2.2
c	sulfadiazine	tablet, 500 mg; injection, 250 mg (sodium salt) in 4-ml ampoule	6.2.2
	fluconazole	capsule 50 mg; injection 2 mg/ml in vial; oral suspension 50 mg/5 ml	6.3
	aciclovir	tablet, 200 mg; powder for injection 250 mg (as sodium salt) in vial	6.4.1
c	pentamidine	tablet, 200 mg, 300 mg	6.5.4
	pyrimethamine	tablet, 25 mg	6.5.4
	sulfamethoxazole + trimethoprim	injection 80 mg + 16 mg/ml in 5-ml ampoule 80 mg + 16 mg/ml in 10-ml ampoule	6.5.4

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DELIVER
John Snow, Inc.
1616 N. Fort Myer Drive
11th Floor
Arlington, VA 22209
USA tel: 703-528-7474 fax: 703-528-7480
deliver.jsi.com