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NEWSLETTER

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1. NEWS: In Unfunded Quality Demand register, some insight into program gaps for key populations

Gemma Oberth 11 March 2015

The $2 billion register so far includes $44 million in key population-specific programs

Under the new funding model (NFM), the Global Fund created a system to maintain an inventory of unmet needs identified by countries, the funding for which exceeds their allocation for the period 2014-2017. The register of Unfunded Quality Demand (UQD) was designed in response to deliberations within the Board that sought to encourage countries to develop their full expressions of demand: a comprehensive inventory of all of the interventions that would help countries in their fight against the three diseases, if there were no financial limitations on the size of the resource envelope available.

In a first look at the register, made available on 11 February on the Fund's website here, there are some $2 billion in provisional requests for technically sound interventions from across the countries eligible for Global Fund support. This amount represents all UQD from the 126 concept notes submitted to the Global Fund from May to October 2014 (Windows 1-4). Eligible requestsfor unfunded quality demand from the 16 regional concept notes and 33 disease-specific concept notes that were submitted in January 2015 (Window 5) will be included in the next version of the UQD register.

Most of the requests are related to joint HIV/TB (52%) or malaria (34%) programs. Single disease concept notes for HIV (7%) and TB (5%) comprise the majority of the rest, with just 1% of provisional requests made to support health system strengthening programming. The register is likely to grow as more concept notes are submitted.

The vast majority of the register is populated with requests from sub-Saharan Africa: some $1.5 billion from the region that is also the largest beneficiary of NFM funding. Uganda's request for an additional $188 million to further scale-up anti-retroviral treatment constitutes the largest single unmet need, representing roughly half of its $365 million UQD ask. Nigeria, which was allocated $1.1 billion under the NFM, has the second-largest composite UQD ask, for some $329 million.

Beyond the big-ticket items, the UQD register also provides insight into where the gaps are. Programming targeting key affected populations was championed as the NFM was in

development, and evidence is emerging that countries have conformed to the requirements that the groups most vulnerable to infection are at the center of planned interventions. Nevertheless, the UQD register shows a $44.37 million funding gap for KAPs across 11 countries, as shown by Table 1.

Table 1: Unfunded Quality Demand for Key Affected Populations

Country	Intervention	Amount (USD)
Bangladesh	Additional 14,300 MSM and 1,277 TG to be covered by HIV prevention programs, including condoms, HTC and STI screening.	$430,000
	Two new Opioid Substitution Treatment centers for prevention among PWID	$180,000
	Additional 9,600 sex workers to be covered by HIV prevention programs	$1,460,000
Cambodia	TB case detection, diagnosis and prison outreach	$1,140,000
Gambia	Behavioral change as part of HIV prevention programs for MSM and TGs	$450,000
Ghana	Condoms as part of programs for MSM and TGs	$1,670,000
Mauritius	Increase the target coverage of behavior change programs from 37% to 50% for MSM, and 43-64% for TG	$620,000
	Behavioral change as part of HIV prevention programs for PWID and their partners	$750,000
	Behavioral change as part of HIV prevention programs for sex workers and their clients	$520,000
Moldova	Behavioral change as part of HIV prevention programs for MSM and TG	$80,000
	Needle Exchange Program and Opioid Substitution Treatment for PWID	$1,150,000
Mozambique	Behavioral change as part of HIV prevention programs for sex workers and their clients	$1,550,000
	HIV Prevention programs for other vulnerable populations, including reaching 45% of 39,521 miners.	$620,000
Russia	Behavioral change as part of HIV prevention programs for PWID and their partners	$610,000
Sudan	MSM behavior change, condoms, HTC and STI treatment to increase national coverage to 49% by 2017	$2,090,000
	Sex worker client programs, condoms, HTC, STI treatment to increase national coverage to 35% by 2017	$4,780,000
	Behavior change, HTC and STI for internally displaced persons	$3,720,000
Tanzania	Condoms as part of programs for MSM and TGs	$840,000
	HIV testing and counseling as part of programs for sex workers and their clients	$1,800,000
Vietnam	Expand interventions to national scale for PWID	$18,710,000
	Equipment, training and resources to expand HTC for key populations nationwide plus operational pilot for HIV self-testing and linkage to service	$1,200,000
TOTAL		**$44,370,000**

HIV interventions make up the largest KAP-related gap included in the register. Within the key populations, activities targeting people who inject drugs comprise the largest deficit, with some $21.4 million led by Vietnam's request for $18.7 million to scale existing activities. Interventions focused on sex workers represent a $10.1 million gap, followed by interventions that target men who have sex with men (MSM) and transgender (TG) individuals ($6.1

million).

Sudan follows Vietnam with the second-largest unmet need for KAPs, with a gap of $10.6 million. Sudan's UQD includes the largest gap in funding for sex workers, internally displaced people, MSM and TG.

How can these gaps be addressed?

All of the interventions in the UQD register, including the ones in Table 1, will have a "shelf life" of up to three years. This transparency around unmet country need means that the UQD register may be a useful tool for additional resource mobilization. Already, resources from private donors -- including pledges of $30 million from Product (RED)™ and $12 million from the M·A·C AIDS Fund, GoodBye Malaria and Comic Relief -- are being committed to these requests. High-net-worth individuals from Indonesia, the Philippines and Vietnam have also expressed interest in making commitments towards funding UQD in their countries.

It is also possible for program needs to be addressed through synergies with regional applications that focus on KAPs. Rising domestic investment could also go towards bridging these gaps.

Shaun Mellors, associate director at the International HIV/AIDS Alliance, emphasizes the importance of developing a plan of action for the unfunded demand. "This pool is steadily growing and we need concrete proactive strategies from the Global Fund and other partners to address this increasing need," he said. "If not, it is going to impact on countries' willingness to express ambitious demand in future, especially for KAP programming."

[This article was first posted on GFO Live on 11 March 2015.]

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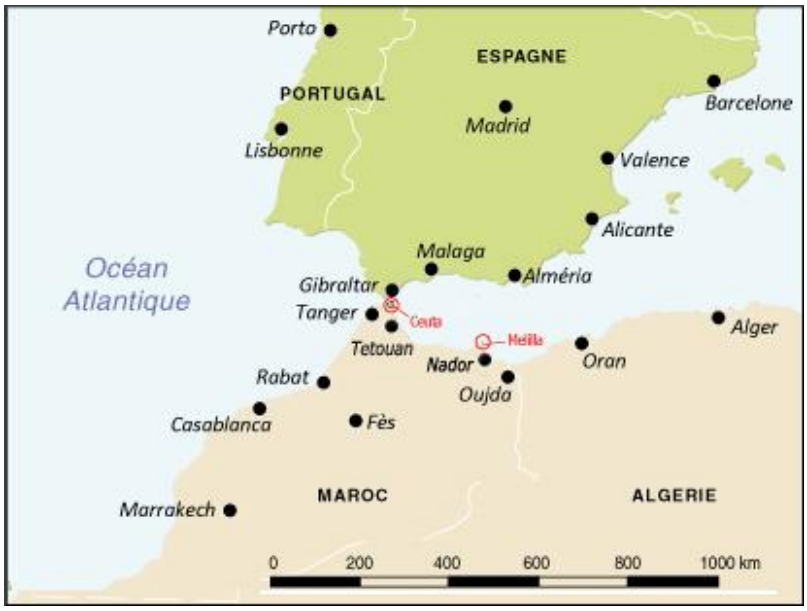
2. NEWS: In Morocco, inspiring others with harm reduction work among injecting drug users

Robert Bourgoing 12 March 2015

The country is a regional role model for an innovative approach to the twin threat of

HIV infection and intravenous drug use

Just a glance at a map is enough to determine why Morocco is in the throes of an epidemic of injecting drug use. Sitting at the gates of Europe, its northern-most cities of Tangier, Tetouan and Nador are but a stone's throw from the Spanish territories of Ceuta and Melilla: the crossroads of the African migration routes where all kinds of trafficking occur.



"There's cannabis leaving Morocco and other drugs coming in from abroad," explains Faoizia Bouzzitou, the educational coordinator for the Hasnouna Association to Support Drug Users (AHSUD in French).

In Tangier, AHSUD provides assistance to around 1,700 people who inject drugs, helping to dissuade them from sharing needles and engaging in other risky behaviors that put them at risk for HIV infection.

Such harm reduction programming is unique to Arab countries but has demonstrated results that show it can, and should, be replicated. HIV prevalence among the drug users of Tangier is just 0.4% -- in stark contrast to Nador, a city 400 km to the east that launched its harm reduction work a few years later, where HIV prevalence among drug users is above 20%.

The divergent figures contribute to a national estimate of 10% sero-positivity among injecting drug users.

AHSUD began its work in 2007 with a bio-behavioral survey and a mapping of the injection sites in Tangier, said Bouzzitoun. "We needed to know who were talking to, and the extent of the problem. You need an evidence base before you talk to decision-makers."

These data were also the basis for AHSUD's successful application for Global Fund support, to purchase injection kits to stock a mobile unit: a modest van into which four staffers would climb every day and prowl the squats and hidden spots where drug users would converge to get their fixes.

Our sons and daughters

"We started downtown, in the M'sallah quarter, where most of the heroin users stay. They were shooting up in front of people's houses, leaving their syringes where kids could play with them. Some young girls were even using the syringes to give henna tattoos," recalled Bouzzitoun. "So part of the early effort was to work with drug users to change their behavior. We gave them single-use, sterile needles. We taught them about the risks of infection, and other risks like TB, or HIV or Hepatitis C. And we showed them how to shoot up in the least risky way, and avoid overdose and how to figure out an alternative when they don't have works to fix. We are trying to point them towards health centers."

It is there that the association finds some of its biggest challenges, confronting the stigmatization of injecting drug use. Be it by health professionals, including doctors and pharmacists, police, or the general public, they are finding it a painstaking and slow process to change people's minds. With door-to-door campaigns, field teams gently demonstrate the importance of harm reduction to Tangier's citizenry.

"It's because drug users are someone's sons, someone's daughters," said Bouzzitoun, that it boils down to a simple choice: "do you want them to be able to inject safely, with a chance to get off the drugs, or do we want them to be exposed to Hepatitis C, to HIV, and to risk spreading these illnesses to society?"

AHSUD has also opened a field office in Hasnouna, providing a quiet and clean place for drug users to take a shower, wash their clothes, have a cup of coffee and, hopefully, participate in a support group session.

Morocco's journey to realizing the benefits of harm reduction programming has been a long and slow one. In 2010, opioid substitution therapy with methadone was launched in Tangier, Rabat and Casablanca: another program that received funding from the Global Fund as well as the Ministry of Health. And while methadone is no silver bullet, it helps reduce the risk of disease simply because it isn't consumed intravenously. "So for 48 hours, a drug user can work, or shower, or eat -- basically functioning like a regular person," said Bouzzitoun.

The light at the end of heroin's tunnel

Today, by broad consensus, AHSUD's work is bearing fruit. "People we interviewed [for this documentary] say that it is not like it was before; there are fewer users, fewer drug injectors, less crime and less theft," Bouzzitoun says proudly.

Also evolving is the mentality and attitudes of those who operate in the drug users' orbit -- specifically the police. "Now when a drug user is arrested, we get notified automatically by the police, who ask us to come and see if he needs treatment," she said.

Risky behavior among drug users is also on the wane. Almost all of the injecting drug users supported by AHSUD use the kits of works they are given -- syringe, spoon, filter, cotton and sterile water -- and regularly participate in needle exchange. Among them are 400 people enrolled in a methadone program at the Medical Psychological Center next door.

These measures have really made the difference in helping bring down the HIV prevalence in Tangier's drug-taking community. Also a contributing factor, said Bouzzitoun, is the HIV testing that around 80% of the people in the program have undergone. "We've done regular testing twice a week, every week, since 2008," she said.

Now that the Tangier program has demonstrated such positive results, it was only natural that the program be extended to other major cities, beginning with Tetouan in 2009 and now Nador, Casablanca and Rabat.

But that doesn't mean that all of the problems associated with injecting drug use have been resolved. Hepatitis C, which afflicts more than half of the people who inject drugs, remains a threat. AHSUD has yet to be allowed into prisons and new drug users -- kids aged 15 and 14 and, sometimes, even 13 -- aren't getting access to the group's kits because they will require parental consent.

Even the methadone program, despite its excellent results that allow more than two-thirds of participants to return to a regular life once they've kicked their habits, is coming up short, not able to meet the needs. In Tangier alone the waiting list is more than 900-strong.

"Most users want to get off the drugs," AHSUD said, but there aren't enough services available to them in the region: not enough treatment, not enough staff and not enough options within the health system to meet demand. The Medical Psychological Center, which works alongside AHSUD, must oversee the methadone treatment of 350 people and is not accepting new clients.

Tangier, MENA's harm reduction laboratory

The first country in the Middle East and North Africa to introduce both harm reduction and methadone programs, Morocco is now sharing its experience through a training center also run by AHSUD in Tangier.

In addition to providing technical support to their colleagues in Tetouan and Nador, AHSUD has brought in groups from Tanzania, Senegal, Tunisia, Algeria and Libya, sharing the experiences and lessons learned since 2007 with doctors, decision-makers and representatives from civil society.

They exhort the need for an evidence base, and provide guidance on how to forecast and plan to ensure that donors see the possibility for results. But mostly they plead for interlocutors to remember that people who inject drugs are just that: people. "We are trying to teach people how to approach users, how to talk to them and earn their trust," said Bouzzitoun. "Because that is the only way you can reach them."

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3. NEWS: ATHENA Network flags gender challenges in Global Fund concept notes

Owen Nyaka 12 March 2015

The Global Fund's efforts to put women and girls at the center of its interventions in HIV, TB and malaria have yet to bear significant fruit at the country level, according to the ATHENA Network.

In an interview with Aidspan, Luisa Orza, director of programs for the network, said that there was still a critical disconnect in many of the concept notes presented to the Global Fund, between the narrative analysis of gender-related issues and an actual programmative prioritization of activities focusing on women and girls. This is also having a financial impact, she said, as the budgeting of concept notes failed to demonstrate prioritizing of gender-specific interventions. The Network is releasing this paper in March to delve deeper into these concerns.

The lack of prioritization may be due in part to the roots of concept notes: within the national strategic plans (NSP) are developing for their own response to HIV, TB and malaria. As NSP tend to be "quite bio-medical in approach" they can be weak in "preventing and addressing violence, and again where linkages are made between HIV and violence, there is often a failure to back these up with costed programs and budgets in the operational plan, or to include them in accountability frameworks," she said.

Orza's comments reflected some of the concerns flagged by the Technical Review Panel in its recent report (see article here), and the absence of a clear gender integration strategy in most concept notes already submitted.

The problem, according to Orza, is deep-seated, beginning with the composition of country coordinating mechanisms (CCM) in countries. While there are now representation requirements

for women on CCMs, this has not translated into women being more engaged in decision-making. Furthermore, she noted, women are not as well-represented among the seats in CCMs reserved for key populations. This is particularly problematic with respect to CCM representation for people living with the diseases, Orza said, which can mean that a "huge raft of issues pertaining to women living with HIV may be missed."

"There [in some CCMs] may only be one seat for key populations. If the person on that seat comes from the men-who-have-sex-with-men community, how are they going to speak to the issues affecting women who do sex work, or women who use drugs?"

Another problem stems from a lack of capacity, Orza said. "Just because a woman is a woman, it doesn't mean she has a good understanding of 'gender' as a socio-structural determinant of well-being. So there is a need to ensure gender expertise among CCM members, be they men, women or transgender people, as well as representatives of women as women."

These representatives of women as women also need to be able to make a delineation between programs focused on pregnant women and women who are not pregnant but still requiring access to health services. There has been so much rightful emphasis on prevention of vertical transmission of HIV and reducing the risk of malaria for pregnant women that sometimes women who are not actively childbearing are forgotten.

So in working to prevent babies from acquiring HIV, most vertical transmission programs fail to encompass what Orza called a "broader sexual and reproductive health and rights agenda for the mother".

She called the WHO's four-pronged approach to preventing vertical transmission acceptable and "more holistic" but said it still fell short of a "comprehensive sexual and reproductive health rights agenda". Yet in most concept notes submitted to the Global Fund, she noted that, to their detriment, most programs were narrowly focused on Prong 3: PMTCT.

"These programs can be astonishingly gender blind, even though it's hard to imagine how, and with a push to achieve high targets in this area, women can be pushed into mandatory testing and treatment programs, even if they don't feel ready to do so," she said. "One of the implications of this is that you often see quite high rates of loss-to-follow-up among women who have been 'forced' to test, or start treatment for life before they are ready."

In some countries, including Malawi and Uganda, this has translated into much higher rates of women defaulting on treatment -- particularly among those women who begin treatment very soon after their positive diagnosis.

Another consequence of this rush to treatment has been a higher potential for domestic abuse among women who have been encouraged, or, as Orza firmly stated "pushed into disclosing their status to partners".

"This can be a trigger for violence, and the fact of testing positive can result in them encountering all sorts of rights violations within maternal health services," she said.

The problems with gender integration into programming are deep-seated but by no means insurmountable, Orza said. Some critical and immediate changes to how programs are measured and evaluated will go a long way towards addressing the gender imbalance -- beginning with the essential need for a disaggregation of data by sex.

"Without sex disaggregation we have no evidence base from which to begin to explore and address gendered aspects and impacts of the epidemic and the response," she said. "In terms of accountability to women and girls, I'd almost see this as a prima facie step."

Also important is a disaggregation of data by age to reveal trends and risk areas, particularly with respect to HIV data collection due to the disproportionate impact on young women of HIV infection. In sub-Saharan Africa, women aged 15 to 24 are three times more likely to acquire HIV than their male age-mates, she said, and there has been little research to unpack why this disparity is so pronounced.

The Global Fund is one among a panoply of technical agencies collaborating with civil society to find answers to these questions and address the gaps in gender integration in health programs.

"I do feel like we are seeing some changes at the international level … but these are taking time to trickle down to the ground to where they are needed most, and that needs an even greater injection of not only will but resources," she said. While the Global Fund's gender strategy was developed in 2008, it remains mostly unimplemented (see commentary here), lending a sense of urgency to the need to include a more focused, nuanced, actionable and funded gender plan of action in the Fund's next strategic plan.

"The current Global Fund strategy runs out this year, even though the operational plan for the gender strategy runs till 2017, and planning for the next institutional strategic plan is already underway," Orza said. "It's really important that addressing gender remains a priority in the next strategic plan."

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4. NEWS: Training in EECA to encourage better targeting of women with Global Fund interventions

Tinatin Zardiashvili 11 March 2015

The Eurasian Women's Network on AIDS carried out the training for representatives from 11 countries in Eastern Europe and Central Asia

Participants from around Eastern Europe and Central Asia gathered in Georgia in late February for a three-day training designed to improve the integration of gender-specific approaches in national responses to HIV and AIDS.

The Eurasian Women's Network on AIDS received a grant from UN Women to carry out the training that should help ensure that women and girls are not left behind in concept notes for access to Global Fund support to fight the three diseases.

Workshops focused specifically on gender-sensitive and gender-transformative programming, with an emphasis on key populations, as well as how to ensure appropriate budgeting for women-specific activities.

The Global Fund developed a Gender Equality Strategy in 2008 but it has never been fully implemented. A push to invigorate the strategy accompanied the roll-out of the new funding model (NFM), supported by advocates for women and children (see article here). Still, there are considerable gaps in concept notes with respect to targeted activities, advocacy and outreach to women -- all of which have been identified by the Technical Review Panel as they sift through the proposals.

EWNA's training is being touted as a building block for countries needing a more inclusive approach in the concept note development process. According to regional coordinator Svetlana Moroz, the idea for the training has been germinating since the informal founding of the group in 2013 because of the realization that without a strong network advocating on their behalf, women were at risk of being sidelined in the programs being proposed to the Global Fund. Delegates from three states in the Caucasus, four in Central Asia, Russia, Ukraine, Belarus, Moldova and Estonia are represented in EWNA.

“The Global Fund has worked to empower affected communities to participate in the HIV and TB response, and to promote state-level advocacy to increase domestic contributions [to the disease response]," she told Aidspan. "But there has not been the same effort to empower women, to get them involved in CCMs, to be bolder in discussions in community-level NGOs, to be engaged on the front-line of the HIV response in the region. We think that being involved in the Global Fund processes is a great opportunity to promote leadership by women and to foster a new approach that ensures there is gender-responsiveness in health programming and financing."

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5. NEWS: Grant Management Solutions pilots PR management dashboard

Angela Kageni 11 March 2015

Technology provides at-a-glance insight into how grant implementation is going -- and where the red flags should be raised

Grant Management Solutions is piloting a new management dashboard for principal recipients that will provide users with an at-a-glance overview of the operations and progress towards grant implementation.

Development of the technology was a collaboration between GMS, the Global Fund and SAP SE: a private-sector global developer of enterprise application software that has been part of the Fund's Innovation Coalition since 201x?

The PR dashboard is a single screen Excel-based application, available in English, French or Spanish. It will provide a comprehensive window into how grant implementation is unfolding over the length of the grant, and at a given point of time. The primary aim is to help grant managers identify and rapidly solve issues related to sub recipients (SRs) and other implementing partners. It also tracks compliance issues, audits and grant performance ratings.

SRs are required to complete a template and share it with the PR, which will then input the data into the color-coded platform. Poor achievement against performance indicators is flagged for

further review or assistance, which should help not only improve performance by the individual SRs but also impact of the programs they are implementing.

Figure 1 is a fictionalized depiction of the dashboard's home page for any given PR.

Seven PRs in six countries -- Côte d'Ivoire, Dominican Republic, Senegal, South Africa, Uganda -- with 84 sub-recipients in total are piloting the dashboard.

At the country level, there are equal parts skepticism and enthusiasm about the dashboard. Country-level users have expressed concerns that the dashboard is too transparent and too comprehensive -- meaning that some of the problems SRs may be facing will be made public before much of an effort is put in to resolve them. The visual depiction of success and failure has also been slightly off-putting, particularly because it is possible to compare the performance of grants and PRs against each other.

Other concerns have to do with data management, particularly with respect to data quality. Some PRs had difficulties in tracking procurement indicators that were either not entered correctly or were not reviewed in a consistent way.

End users have also signaled their preference for the existing CCM dashboard platform which was initiated in 2010. Also highly visual, the CCM dashboard provides a strategic summary of key financial, programmatic, and management information drawn from existing data sources (PU/DR) for each Global Fund grant.

In response, the developers confirmed that the existing CCM dashboard will be updated to incorporate some of the new elements of the PR management platform. More training in data management and use will also be provided to PRs.

But as to the concerns about transparency and competition, the developers remained optimistic that a little friendly competition is healthy and should be encouraged as a way to boost morale, performance and, ultimately, impact. They observed that during the piloting phase, some SRs were keen to see how other organizations were performing and drawing lessons from those who were doing well. The other big benefit of the openness of the platform is that grant implementation will feel better owned by participants, with everyone able to better visualize and thus work towards the same goals of alleviating the burden of disease.

The software is being made available to interested PRs at a discounted rate: part of the $4 million commitment by SAP to the Global Fund through 2017. Training is included in the price of the package, which is available through the GMS website.

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6. NEWS: Aidspan finds elements of improved participation by key populations in CCMs in southern Africa

Angela Kageni and Kate Macintyre 12 March 2015

Communication and technical barriers continue to hamper their participation

In a study published in early March, Aidspan found that participation by representatives of key affected populations in country coordinating mechanisms (CCMs) in southern Africa has somewhat improved, although barriers to participation remain related to professional and technical capacity and a lack of experience in policymaking.

The research was driven by a lack of clarity as to how representatives from KAP groups are able to effectively participate in the decision-making at the CCM level. There is good evidence that CCMs have and continue to recruit members of key populations, both before and in line with Global Fund new requirements that came into effect in January 2015.

Traditionally, key population representatives work from within networks of persons living with or affected by the diseases: either individuals who themselves are members of these groups or their representatives. However, they have rarely held leadership positions in the CCM and have often been seen as somewhat token members. Their participation and influence in the CCM processes remains unclear.

Aidspan did a rapid survey in 2014, and used short semi-structured interviews to ask questions about recent experiences of key population representatives about their engagement with the work of the CCMs. The CCMs in this study include those in Botswana, Lesotho, South Africa, Swaziland, Zambia and Zimbabwe.

The results aim to advise CCMs themselves, their supporters and any group with a stake in how the CCMs function and what they produce. There is a continued need for improved communications between the KAP constituencies and their CCM representatives. Other findings show a need for improved professionalization among KAPs represented in CCMs to ensure they are fully present, and fully briefed, to participate in CCM meetings.

Stigma faced by many of those representing key populations remains a major challenge. Indeed some KAPs reported feeling safer in the context of CCMs, and able to speak about their community's issues, than outside. CCMs may not necessarily be the place to solve this problem, but it was suggested that thought-leaders and community influencers be engaged to on the CCMs to further address the stigma felt in societies.

All of these findings demonstrate that evolving the CCM model is a process that will take time. Noticeable progress in the last year, coinciding with the roll-out of the NFM, should be seized as momentum for bigger, bolder changes in the ways CCMs conduct business and integrate the needs and agendas of all of its members -- including representatives of the very groups that the Global Fund investments are designed to support.

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7. COMMENTARY: It's time to change the approach to capacity-building on supply chain management

Lloyd Matowe 11 March 2015

Access to essential medicines remains a challenge in most developing countries and is among the Millennium Development Goal targets. Over the past decade, international organizations including the Global Fund, the World Bank, USAID have invested in improving access to essential medicines.

Laudable as these efforts are, making commodities available is not enough to improve the quality of life for most communities. Access must be tied to functional supply chain management systems, which enable efficient procurement, distribution and rational use of life-saving medicines.

These systems remain weak in many resource-limited countries, particularly in sub-Saharan Africa, despite years of investment in their improvement.Whether it is technical assistance, for system strengthening or capacity building, these investments have had limited impact in improving supply chain efficiency.

Perhaps it is time to consider a deviation from the traditional pathways, noting the lessons learned from successes around sub-Saharan Africa. Such successes may be attributed to local efforts (political will) married with technical and financial support from partners who have long supported supply chain programs at the central level.

Yet the challenges in supply chain systems are not limited to medical stores: on the contrary. In most countries, supply chain management systems continue to lack the requisite human resources. With the exception of South Africa, most countries in the region rely on inadequately trained or qualified personnel to carry out core duties in managing medicines and related commodities.

In Malawi, medicines are dispensed by assistants with no training in dispensing functions, while in Liberia some of the dispensers who manage medicines at service delivery points have less than seven years of formal education. Nurses and midwives shoulder most of the supply chain functions at the health facility level, yet the majority of them have not receive any training on how to manage medicines. Most of the skills and functions are learned on the job. Over the years TA agencies have often intervened with short training courses. It now appears, however, that those courses have had limited long-term impact.

Supply chain management requires both technical and managerial skills. Technical skills focus on product handling, while managerial skills deal with planning and managing the resources. Both of these sets of skills rely on complete and reliable data: another major hurdle limiting the efficiency of supply chains and having resultant consequences for policymaking, forecasting and budgeting. Many countries are hampered by a system-wide lack of reliable data, from the central down to the smallest service delivery units.

Accurate quantification of needs is critical to ensure that sufficient stocks are available at the right price and in good time.

For the Global Fund and other donor-funded programs, the preparation of procurement and supply management plans (the key tool to monitor the performance of grants) require that commodity needs are quantified based on consumption data. Yet analysis of existing grants shows that many countries still use issues data as a proxy for consumption to quantify needs.

The time for a paradigm shift is now.

Global advocacy for supply chain efficiency is high, with strong champions in the People that Deliver Initiative and the Reproductive Health Supply Coalition.

Most crucially, implementing countries are demanding change and demonstrating their willingness to contribute to new solutions to their old supply chain management problems. Rwanda, for example, has designed an integrated supply chain system that manages most commodities from a central repository down to the service delivery points. This approach seems to be serving the country well with few to no stockouts of essential medicines and related commodities at facilities.

Lastly, there must be a new approach to capacity-building. Technical assistance must invest more in data management for commodities to improve service delivery and forecasting. The current approach to capacity-building in supply chain management relies on workshops and training. In reality, individual skills are only one of the ingredients contributing to capacity to perform certain functions effectively and consistently over time. Individual health workers, no matter how skilled, are unlikely to deliver essential medicines or services effectively without adequate supplies and equipment, proper motivation and management support, and a good relationship with the community served. Capacity-building services are required for all of these areas to ensure performance goals are achieved.

Translating skills learned into sustained performance often requires new or improved capabilities in individuals and organizations alike. Capacity in this sense represents the potential to use resources effectively and to maintain gains in performance with gradually reduced levels of external support. The success of capacity-development efforts is limited by a focus on technical factors, while critical social and political barriers are ignored.

Training is not a "magic bullet" but it is still important. In building capacity in supply chain management, sustainable training should begin with developing appropriate curricula for different performance levels and targeting the various cadres involved in supply chain functions. These include pharmacy programs, pharmacy technician programs, and, in some instances, nursing programs.

Dr. Lloyd Matowe is the executive director of Pharmaceutical Systems Africa, an international consultancy supporting developing countries to strengthen their supply chains and address system and managerial challenges. The opinions contained herein are his own.

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