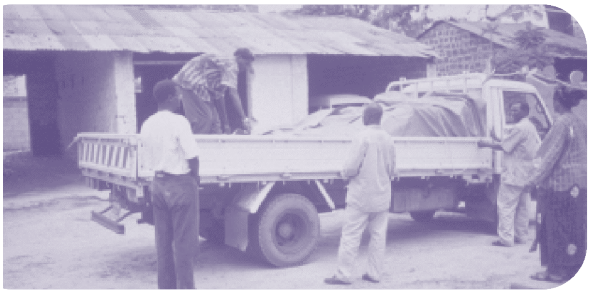

SPARHCS

Strategic Pathway to Reproductive Health Commodity Security

A Tool for Assessment, Planning, and Implementation

English, Spanish, and French language versions of this publication are available in print copy and on the World Wide Web at http://www.maqweb.org/sparhcs/index.shtml. They are also included as editable electronic files on the accompanying CD-ROM, along with additional resources listed under "Further Reading."

Users of this publication are invited to provide feedback so that future versions can be updated and improved. A tear-out feedback form is provided inside the back cover.

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SPARHCS

Strategic Pathway to Reproductive Health Commodity Security

A Tool for Assessment, Planning, and Implementation

2004

Foreword

The success of family planning programs, continued growth in the number of women of reproductive age, and the growing response to curb the HIV/AIDS pandemic are increasing demand for contraceptives, including condoms, worldwide. Countries are faced with the challenge of ensuring that this demand can be sustainably met. Financing is not keeping pace, while the problem is also often one of disruptions and vulnerabilities in the systems that need to work well, and work together, to ensure that supplies are **available** to people.

SPARHCS - The Strategic Pathway to Reproductive Health Commodity Security is a tool to help countries develop and implement strategies to secure essential supplies for family planning and reproductive health programs. SPARHCS is meant to bring together a wide range of stakeholders to initiate at the country level concerted efforts toward the goal of reproductive health commodity security. It is not a roadmap, or a fixed process. SPARHCS can be customized to a country's specific needs and resources. It can be used for contraceptives alone, for contraceptives and condoms for HIV/STI prevention, or for a still broader set of reproductive health supplies.

SPARHCS responds to the call from donors and countries for a common approach and framework to achieve reproductive health commodity security. USAID is part of this global effort and is pleased to have provided major support for the development of SPARHCS. I thank the many collaborating agencies for their contributions. SPARHCS is an important step in ensuring people can choose, obtain, and use the contraceptives and other essential reproductive health supplies they want. USAID looks forward to continued progress in this important endeavor.

Margaret Neuse
Director
Office of Population and Reproductive Health
U.S. Agency for International Development

In 1994, 179 countries committed themselves to the Programme of Action of the International Conference on Population and Development (ICPD). They called for universal access to reproductive health care by 2015. In 1999, the ICPD+5 revealed that although much progress had been achieved much remained to be done. The Millennium Development Goals (MDGs) call for drastically reducing maternal and child mortality, reversing the spread of HIV/AIDS, and markedly improving the health of the poor, all by 2015. However, neither the ICPD goals nor the MDGs will be reached without accelerated progress towards reproductive health commodity security, when individuals can choose, obtain, and use the reproductive health supplies they want.

Since the mid-1960s, use of contraception in developing countries has grown dramatically from approximately 10 per cent to almost 60 per cent. The number of contraceptive users is projected to increase further by more than 40 per cent to 2015 as a consequence of both population growth and an increase in demand for contraception. Meeting these supply requirements will require not only increased financing, but also improvements in logistics and service delivery systems already stretched to their limits. The urgent need to meet this challenge is particularly acute as the United Nations Population Fund (UNFPA) estimates that every $1 million shortfall in contraceptive supply assistance can lead to 360,000 unintended pregnancies, or 800 maternal deaths, or 11,000 infant deaths.

SPARHCS - The Strategic Pathway to Reproductive Health Commodity Security will help donors, countries, and other stakeholders develop in-country capacity to increase their reproductive health commodity security in a country driven and sustainable manner. UNFPA would like to express special appreciation to the many organizations and individuals that participated in the development of SPARHCS. Their contributions will no doubt help advance our collective efforts to achieve a comprehensive, long-term, and strategic approach to securing reproductive health commodities for all.

Mari Simonen
Director
Technical Support Division
United Nations Population Fund

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More than 100 experienced staff from dozens of agencies in 14 countries have applied SPARHCS in their programs. The content of the final version owes much to their comments and suggestions for improvements. Field tests were specifically conducted in Nigeria and Madagascar. Hany Abdallah, Nike Adeyemi, Richard Ainsworth, Sarah Alkenbrack, Nicolas DeMetz, John Durgavich, Charity Ibeawuchi, Luka Monoja, and Scott Moreland helped with the field tests.

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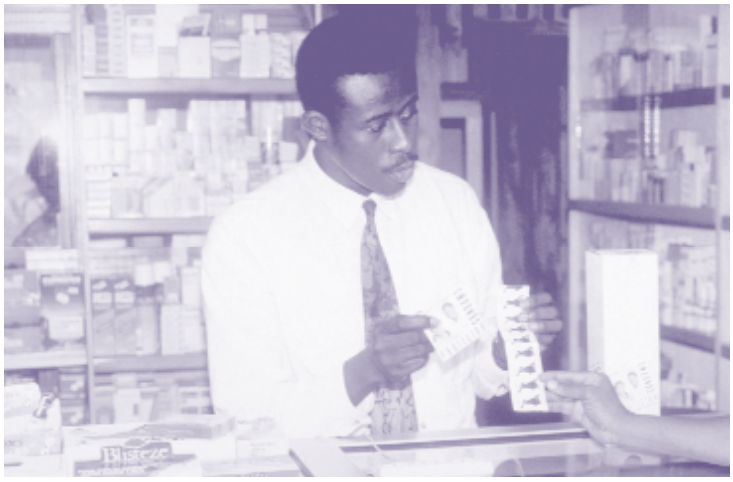
List of Acronyms

AIDS – Acquired Immunodeficiency Syndrome
BKKBN – Badan Koordinasi Keluarga Berencana Nasional (Indonesian Population and Family Information Network)
CPT – Contraceptive Procurement Table
CST – Contraceptive Security Team
DFID – Department for International Development
DHS – Demographic and Health Survey
DKT – DKT International
EDL – Essential Drugs List
EML – Essential Medicines List
FMOH – Federal Ministry of Health (Nigeria)
FP – Family Planning
GoG – Government of Ghana
HIV – Human Immunodeficiency Virus
IPPF – International Planned Parenthood Federation
IUD – Intrauterine Device
KfW – Kreditanstalt für Wiederaufbau (German Bank for Reconstruction)
LMIS – Logistics Management Information System
MOH – Ministry of Health
MIS – Management Information System
NGO – Non-Governmental Organization
OB/GYN – Obstetrician/Gynecologist
PRSP – Poverty Reduction Strategy Paper
PSI – Population Services International
RHCS – Reproductive Health Commodity Security
RH – Reproductive Health
SPARHCS – Strategic Pathway to Reproductive Health Commodity Security
STI – Sexually Transmitted Infection
SWAp – Sector Wide Approach
TFR – Total Fertility Rate
UNFPA – United Nations Population Fund
USAID – U.S. Agency for International Development
WHO – World Health Organization

1



SPARHCS and the Goal of Reproductive Health Commodity Security

Many countries face the challenge of meeting people's rising demand for contraceptives, including condoms[1], and other essential reproductive health supplies. Attention was first drawn to the challenge by projections of shortfalls in the financing required to pay for these supplies. The problem, though, is often not only one of financing, but also of disruptions and vulnerabilities in the many systems that need to work well, work together, and have the resiliency to adapt to changes to ensure that reproductive health supplies are available to people.

SPARHCS (pronounced "sparks") – **Strategic Pathway to Reproductive Health Commodity Security** – is an approach to help countries address these concerns and develop and implement strategies for reproductive health commodity security (RHCS).[2] During the 2001 conference *Meeting the Reproductive Health Challenge: Securing Contraceptives and Condoms for HIV/AIDS Prevention*, held in Istanbul, donors and countries called for a common approach and framework to operationalize RHCS. In response, under the leadership of the U.S. Agency for International Development (USAID) and United Nations Population Fund (UNFPA), a wide range of collaborating agencies provided technical inputs, participated in workshops, and assisted with field tests to develop SPARHCS.

Reproductive health commodity security (RHCS) exists when people are able to choose, obtain, and use the reproductive health supplies they want.

RHCS is not only a problem of increasing financing for supplies, but also of improving the systems needed to make them available to people.

[1] Condoms are singled out here for their dual role in family planning and HIV/STI prevention, but are henceforth included under "contraceptives."

[2] Because contraceptives and condoms are the *sine qua non* of family planning, are among the essential supplies for HIV/STI prevention, and have long been of special interest to the donor community, some agencies use "contraceptive security" (a term first coined by the Family Planning Logistics Management Project/John Snow, Inc. in 1998) to describe their work with reproductive health supplies. Others use "reproductive health commodity security." Regardless, all are dedicated to securing an adequate supply and appropriate range of RH supplies for developing countries.

RHCS is a long-term goal, requiring a multi-sectoral approach and continuous commitment.

The goal of RHCS and its translation into operational terms through SPARHCS focuses on supplies and is informed by decades of experience in supply chain management. From this basis, SPARHCS takes a strategic, long-term perspective to help a broad range of stakeholders understand their dependence on product availability and their role in ensuring it. SPARHCS embeds and links the traditional focus on "logistics" within a larger picture of what is needed to ensure supplies are available to clients: policies, financing, service delivery, advocacy, etc. It approaches reproductive health commodity security as a goal to strive for, requiring ongoing commitment and continuous progress. It defines RHCS from the client's perspective. Unless individuals can choose, obtain, and use the RH supplies they want, there can be no reproductive health commodity security.[3]

SPARHCS provides a framework and diagnostic guide to support assessment, planning, and implementation for RHCS.

SPARHCS takes a multidisciplinary, multistakeholder perspective to demonstrate the complex set of relationships inherent in reproductive health commodity security. It is built of three parts:

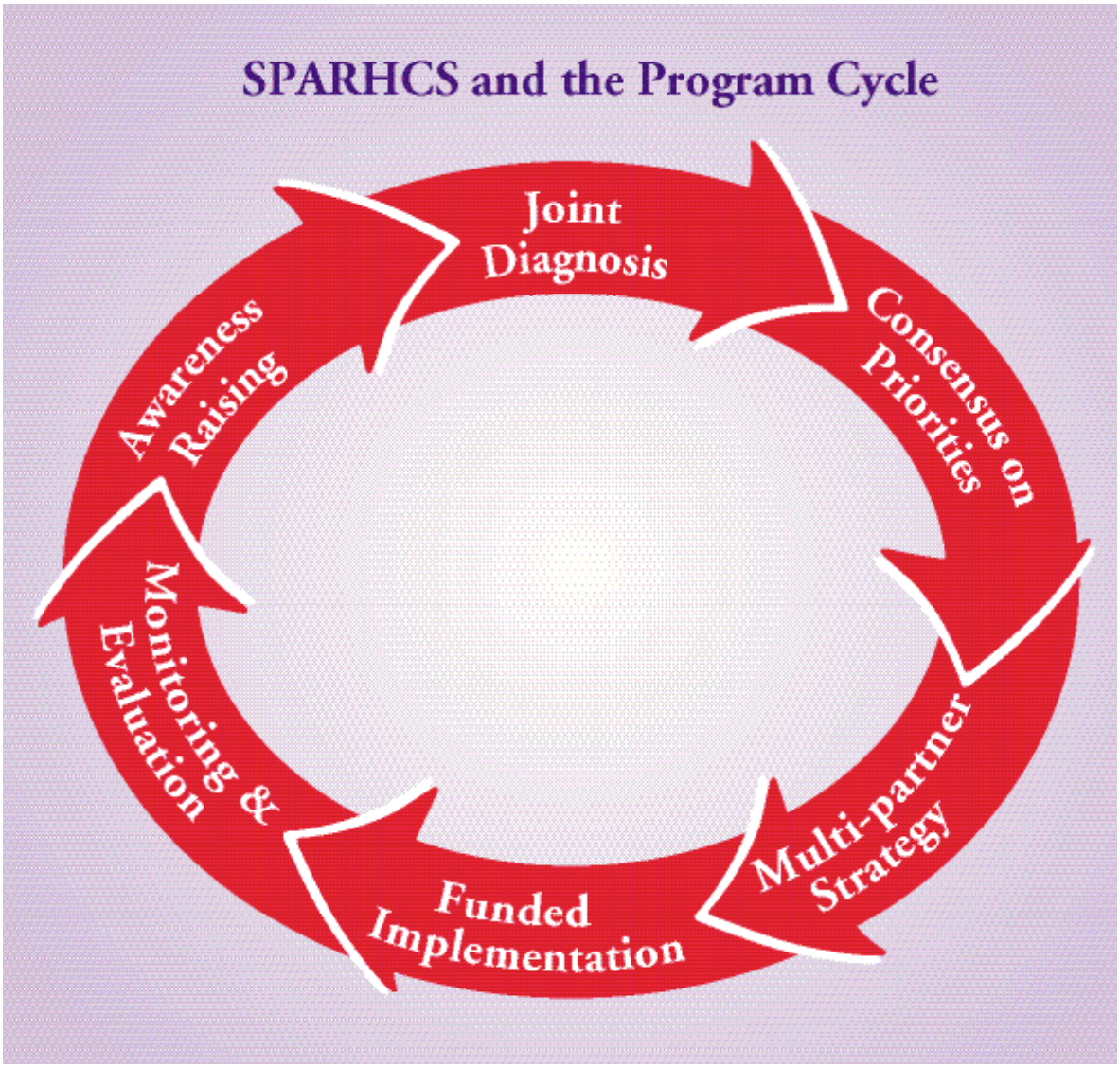
- A **goal statement**. Reproductive health commodity security exists when people are able to reliably choose, obtain, and use the contraceptives, condoms, and other essential reproductive health supplies they want.
- A **conceptual framework**. The framework identifies key elements that are involved in securing client access to reproductive health supplies and related services and that should be considered during country-level assessment, planning, and implementation for RHCS.
- And, a **diagnostic guide**. The guide follows from the goal statement and framework, and supports stakeholders to assess their present RHCS situation, define future expectations, and take into account trends from the past.

SPARHCS is meant to initiate concerted action toward the goal of people being able to choose, obtain, and use the reproductive health supplies they want. It is not a roadmap, nor a fixed process, but rather a guide that brings together the various factors that play a role in RHCS. As a "convener," SPARHCS can bring together a wide range of stakeholders to:

- establish and maintain multisectoral commitment to RHCS by raising awareness of and support for it as a public health objective;
- conduct a multisectoral, joint diagnosis of a country's RHCS status;
- identify factors that limit or enhance the prospects for RHCS;
- process those findings to reach consensus on priorities for improving RHCS;
- develop a comprehensive, multipartner strategy and action plan for RHCS that is evidence-based, fundable and feasible; and
- facilitate strategy implementation and guide ongoing monitoring and evaluation of results.

While the SPARHCS approach may appear linear, it is a continuous cycle (see figure, following page), akin to the typical program cycle (planning – implementation – monitoring and evaluation). Entry into the cycle can occur at a variety of points, from awareness raising to evaluation, depending on the country situation. At any of these stages, the application of SPARHCS is designed to develop a new or strengthen an existing reproductive health commodity security strategy and funded implementation plan.

[3] Henceforth, "reproductive health supplies" or "RH supplies" are used to refer to contraceptives and other essential reproductive health supplies. Other essential supplies can include, for example, supplies for maternal and neonatal health care and for prevention and treatment of reproductive tract infections (UNFPA and WHO, 2003).



As country examples[4] demonstrate, the SPARHCS approach is flexible and the level of effort it requires is variable, permitting countries to customize the approach to their own needs and resources. SPARHCS can be used for contraceptives alone, for contraceptives and condoms for HIV/STI prevention, or for a still broader set of reproductive health supplies.[5] It can be used at national or subnational levels; in countries more or less experienced in working on reproductive health commodity security; in countries not yet ready to phase out donor support or in countries planning for self-reliance; and in countries at different stages of health sector reform.

SPARHCS can be adapted to a wide range of country contexts and stakeholder interests.

[4] See **Section 4. SPARHCS Applied: Country Examples.**

[5] So far, SPARHCS has been applied mostly to contraceptives and condoms for HIV/STI prevention.

Notes

2

A Framework for Reproductive Health Commodity Security

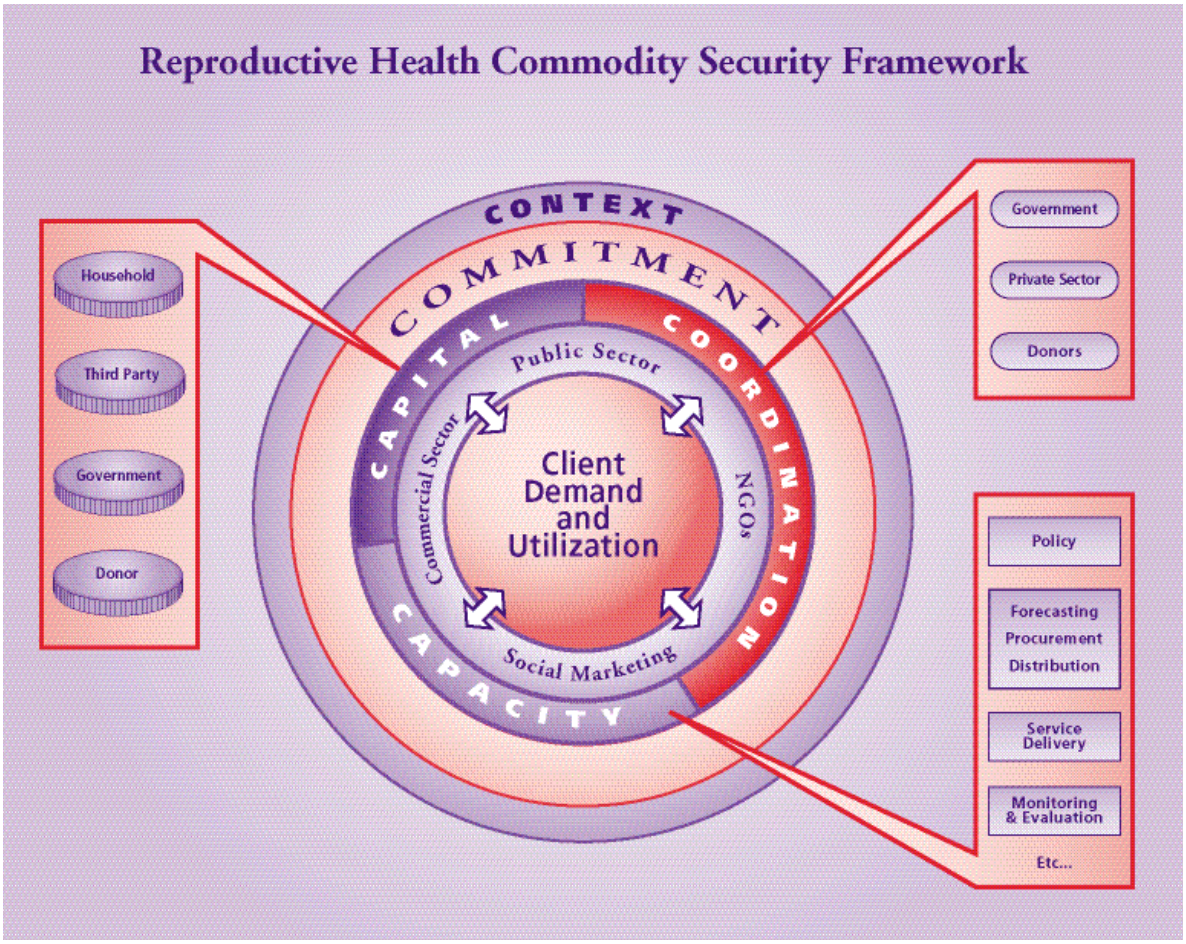
The SPARHCS framework – at the center of which is the client – highlights the many elements that are involved in securing reproductive health supplies and provides the conceptual basis on which to build a RHCS strategy. Let us begin with the outermost circle in the figure on the following page and move towards the client. In every country, there is a **context** that affects the prospects for RHCS – on the one hand, national policies and regulations that bear on family planning/reproductive health and particularly on the availability of RH supplies, and on the other, broader factors like social and economic conditions, political and religious concerns, and competing priorities. Within this context, **commitment**, evidenced in part by supportive policies, government leadership, and focused advocacy, is a fundamental underpinning for RHCS. It is the basis from which stakeholders will invest the necessary **capital** (financing), **coordinate** for RHCS, and develop the necessary **capacities** – the third circle in the figure.

The prospects for RHCS are affected by country contexts, within which RHCS requires commitment, capital, coordination, and capacities.

The boxes in the figure elaborate on each of these three components. Coordination involves government, the private sector, and donors to ensure more effective allocation of resources. Households, third parties (e.g., employers and insurers), governments, and donors are all sources of capital. And, capacities must exist for a range of functions – policy; forecasting, procurement, and distribution; service delivery; and monitoring and evaluation, to name a few.

Moving closer to the client in the figure, capital, coordination, and capacities form the basis for the public sector, NGOs, social marketing, and commercial sector to efficiently supply the needs of the whole market of client demand, from those who need subsidized products to those who are able to pay for commercial products. **Clients** (women and men) – at the center of the figure – are the ultimate beneficiaries of RHCS as product users and, as shown by the double headed arrows, the drivers of the system through their demand.

Clients are the ultimate beneficiaries of RHCS.



Each component of the SPARHCS framework is discussed in further detail below, starting with the center – clients – and ending with the contextual concerns that affect RHCS.

A. Client Utilization and Demand

How do clients vary in their met and unmet need for RH supplies?

In any country there is a multiplicity of reproductive health needs – for different products and services, at different prices, and from different sources. Met and unmet need vary by many client characteristics – income or standard of living, age, sex, parity, rural versus urban, religion, cultural expectations regarding sexuality and childbearing, state or province, source of method, etc. These variations must be understood in order to understand how progress can be made toward greater commodity security. The SPARHCS diagnostic guide poses such questions as: How is current use characterized? Who are current users of RH supplies? How is unmet need characterized? It also asks whether clients who want to use RH products have physical and economic access to them, what gender norms influence women's and men's abilities to use contraceptives and other RH commodities, and about contraceptive discontinuation rates among different groups.

Reproductive health commodity security exists for people when their demand is met. For individuals whose "needs" have turned into "demand" for services and products, and are currently satisfied clients, access must be maintained. For those *not* using services and products now but who want or intend to use them, access must be provided. Meeting client demand is critical in helping clients improve their reproductive health, and it is important from a financing perspective as well. As utilization grows and increasing demand is met, the requirements for funding and the options for funding, especially from individuals, also grow.

SPARHCS looks at how activities to increase use are affecting the demand-supply relationship. What is being done to enable people to access services according to their intentions and needs? SPARHCS also asks stakeholders to consider whether securing sufficient contraceptive supplies to satisfy low demand in low prevalence settings fully realizes their vision for RHCS.

How well is the whole market of demand for RH supplies covered by providers in the public and private sectors?

Reproductive health supplies are delivered to clients through a variety of **service channels**: the public sector, NGOs, social marketing programs, and the commercial sector. Rationalizing the market among these channels can increase access and the efficient use of resources to meet the full range of client demand. The SPARHCS framework and diagnostic guide look across the public/private spectrum, and ask: What roles do the different providers play? How do they relate to each other and coordinate to respond to the range of family planning and other reproductive health needs in a country? How well and how efficiently do providers collectively cover the whole market and its segments in terms of clients' socio-economic status, their gender-or age-related barriers, client location, the methods they want, and where they obtain them? Are some segments of the population left unserved?

B. Commitment

Ensuring that the different service channels have the capital, capacities, and are coordinated to respond effectively to clients' needs begins with commitment and leadership, particularly from governments, program planners, and key leaders. There needs to be a clearly articulated policy commitment to making and keeping contraceptives and other essential supplies available to people as a public health priority. Political and government leaders must demonstrate this commitment through budget increases, policy improvements, leadership of coordination, and RHCS strategies that are implemented. RHCS also depends upon influential

What is the commitment to RHCS in the public and private sectors?

people at all levels in the public and private sectors acting as RHCS "champions" – well-respected, dedicated individuals who advocate for commodity security and work to achieve high-level political commitment and adequate funding for ensuring a full supply of RH commodities. The SPARHCS diagnostic guide poses such questions as: What is the nature of the government commitment to RHCS? Who provides leadership? Where can "champions" for RHCS be found, or developed, in the public and private sectors? Are civil society organizations, particularly women's advocacy groups, and the media mobilized and do they have the capacity to advocate for commitment to RHCS?

What are the impacts on RHCS of health sector reforms and new development assistance instruments?

Further, is there commitment to RH commodities in the face of changes in development assistance and health sector reforms? Is there explicit attention to RH commodities in national strategies and assistance mechanisms for health and development, such as PRSPs and SWAps? To what extent are health sector reforms – like decentralization, privatization, and integration – either threats or opportunities for reproductive health commodity security? Are RH commodities being "orphaned" under these changes?

C. Capital

Current financing levels for reproductive health supplies are, in many cases, inadequate, unsustainable, or both. The SPARHCS framework and diagnostic guide consider financing from all sources. Households may purchase subsidized products, participate in the commercial marketplace, or pay other fees, such as user fees, insurance premiums, or co-payments. Governments may subsidize supplies and services with internally-generated revenues, donor grant funds, or loan credits. Donors may provide direct financing to support family planning programs or donate products. SPARHCS explores the importance of "capital" by raising such questions as: What are current arrangements for financing reproductive health supplies from these sources? What are the prospects for increasing (or in some cases lessening the need for) each? How are public funds used, and are there cost recovery mechanisms in place for supplies and services? What are the most reliable sources for commodity financing during the next five to ten years? And, what role do or could third parties, like employers and public or private insurers, and other alternative financing schemes, like community-based financing, play in financing commodities?

What are the prospects for financing of RH supplies by households, governments, donors, and third parties?

D. Capacity

Capacity in a number of critical functions directly affects clients' ability to choose, obtain, and use reproductive health supplies. **Service providers** can limit or promote RHCS. SPARHCS asks such questions as: Are providers' skills and service facilities adequate to satisfy clients' needs? Are providers well trained in clinical skills and counseling related to method choice? Are providers trained to identify and address gender-related barriers to contraceptive use and decision making? Do they have adequate equipment and supplies to offer good quality family planning and reproductive health services? Are providers trained in counseling for informed choice, taking into account barriers, like gender norms, to access and utilization of contraceptives and other products? How does provider capacity address barriers to access to and utilization of contraceptives and other products? Do providers show preference for or promote one method over another?

Service providers cannot do their jobs without the reliable operation of public and private sector **supply chains** delivering the "six rights": the right product, to the right place, at the right time, in the right quantity, in the right condition, for the right price. Critically, the right price may be different for different clients. Needed products must be on hand when clients come for them; having products at the central or regional warehouse does no good if there is a stockout at the service delivery point at the time of a client's visit. How effective, reliable, and efficient are logistics systems in ensuring product availability to clients who access different service delivery programs?

How developed are the human and systems capacities for RHCS, in service delivery, logistics management, forecasting and procurement, monitoring and evaluation, etc.?

In order to ensure that service providers and logistics systems have adequate quantities of supplies, timely and coordinated **forecasting** and **procurement** must take place, using financing from a variety of sources. Are programs able to forecast their product requirements for the near-, medium-, and long-term? Do they continuously update their projections with more current data? Increasingly, government and NGO programs are tasked with procuring products themselves. What is their capacity to conduct efficient and transparent procurements that result in the timely acquisition of the best quality products at the lowest possible price? Are they able to reliably comply with international competitive bidding procedures? Are programs able to select the appropriate products, prepare sound product specifications, conduct negotiations for financing and purchase agreements, and establish quality assurance throughout manufacturing and upon receipt?

The areas listed previously are not the only capacities needed for RHCS. Capacity for advocacy for RHCS is considered under the "Commitment" component of the SPARHCS framework. Capacities for the collection, analysis, and use of data are crucial for planning, monitoring, and evaluating progress towards RHCS. Governments need the capacity to determine areas of unmet need, to determine where they need to intervene and where they do not, and how to program their resources effectively. "Data for decision making" capacities are needed both for program design and management, and for policy analysis. SPARHCS asks whether programs collect appropriate data and information for decision making for RHCS, whether there is a management culture of evidence-based decision making, and how information is used for policy-level analysis and decision making.

E. Coordination

Reproductive health commodity security is based upon collaboration and joint action planning. Coordination is required at multiple levels and among different stakeholders – among donors internationally, and within a country among donors, between donors and government, within government, among programs, among technical agencies, and across sectors. Effective coordination helps avoid duplication of efforts and promotes information sharing across and between programs. SPARHCS asks such questions as: Does government play a central coordinating role? Are there mechanisms to ensure coordination happens? What are the specific outcomes expected from coordination (e.g., coordinated financing of different programs' needs, a more rational and sustainable segmentation of the contraceptive market)? SPARHCS also asks about the development and implementation of a coordinated RHCS strategy.

How do government agencies, donors, and the private sector collaborate and act jointly for RHCS?

F. Context

The contextual concerns that affect the prospects for RHCS can be approached at two levels. First, what national policies and regulations bear on the ability of public and private sector programs to secure and deliver RH supplies? Are there, for example, unnecessary

policy barriers regarding who can provide RH supplies and services? Are there unnecessary barriers on who is eligible for services, some of which may be the result of cultural norms and gender stereotypes (e.g., age, parity, marital status)? What policies affect particularly the private sector's ability to provide RH supplies? What service delivery policies and guidelines assure the capacity of providers to provide RH supplies?

Second, there are the broader factors: How does the level of socioeconomic development in a country affect resources available for reproductive health supplies? What percent of the population is rural versus urban (a factor affecting private markets)? What are levels of educational attainment for women (one of the best predictors of contraceptive use)? What is the burden of HIV prevalence (a higher burden can mean more competition for financial resources as well as contributing to higher levels of poverty and poorer health status)? And, what are other priorities that family planning/reproductive health must compete with for resources?

What is the context for RHCS of national policies and regulations, social and economic factors, and other health priorities?

Notes

3

The SPARHCS Diagnostic Guide

The SPARHCS diagnostic guide supports stakeholders in conducting a joint diagnosis of a country's reproductive health commodity security status. The guide presents a set of questions and tables to help stakeholders assess their present situation, define expectations for the future, take into account significant trends from the past, and make future projections. Through this process, they can identify and assess the range of challenges and opportunities for reproductive health commodity security.

The SPARHCS diagnostic guide facilitates joint assessment of a country's RHCS status.

Given the complexity of reproductive health commodity security, the guide is designed to facilitate diagnosis rather than be a checklist or questionnaire. Questions can be rewritten or deleted according to user needs; new ones can be added. The guide examines each element of reproductive health commodity security, as suggested by the framework: client utilization and demand, commitment, capital, capacity, coordination, context. A seventh section – commodities – is added to draw attention to the sources of RH commodities in a country.[6]

Although some questions could easily be answered with "yes" or "no," that is not the aim of the guide. Rather, the questions are meant as prompts for stakeholders to probe further and to create a dialogue around each element, asking:

- What are the key strengths as they relate to availability of RH supplies?
- Can each strength be leveraged to improve RHCS?
- How feasible will it be for strategies to build upon each strength?
- What are the key problems?

[6] The questions in the guide are organized by these elements. Using the CD-ROM and web versions, users can easily reorganize the guide to mirror how they are adapting the reproductive health commodity security framework. For example, as used in Madagascar the framework identifies demography, policy, demand, service delivery, and finance as key elements. In Nigeria, they are finance, policy, logistics, service delivery, demand, and coordination. And, at the district level in Indonesia, they are service delivery, policy, financing, logistics, and supply.

- What would be the impact on RHCS of addressing each?
- How feasible will it be to address each problem, and what will be required?

Identifying key strengths and weaknesses and their impact on RHCS helps build consensus on priorities for a RHCS strategy.

Identifying key strengths indicates pockets of opportunity on which strategies can be built. Weaknesses define areas for assistance and improvement. Identifying opportunities and weaknesses is only one part of a SPARHCS diagnosis. Assessing the likely impact of each weakness on RHCS will facilitate building consensus on strategic priorities. Determining the feasibility to address each weakness helps ensure that a strategy gains the commitment of partners and funding for implementation. Some weaknesses will be easier than others to address, as some strengths will be easier to capitalize on.

The timeframes used for gathering and analyzing information vary. Commodity and financing requirements are typically projected three-years out. Forecasts for longer periods will be less reliable, but longer timeframes (e.g., ten years hence) may be good for contemplating systemic changes required for reproductive health commodity security. It is also important to identify certain trends from the past, as they provide a base from which to project into the future.

The time and level of effort required for a SPARHCS diagnosis will vary according to its purpose and scope.[7] It can be used to:

- conduct a baseline assessment,
- guide a longer process of inquiry and strategic planning,
- launch or revitalize interest in efforts to improve RHCS,
- build consensus around new priorities, or
- monitor, evaluate, and adjust ongoing activities.

SPARHCS integrates data from many different sources into a coherent "story."

A SPARHCS diagnosis may involve some combination of local or international consultants to provide technical assistance, gather and analyze data, and facilitate stakeholder discussions. A considerable amount of data gathering and analysis can be completed through desk-based review of survey reports, contraceptive procurement tables (CPTs), and other reports/publications, and through analyses done specifically for the assessment. Further work may require some combination of key informant interviews[8], focus groups, field visits to supply chain points and service delivery sites, and stakeholder briefings or workshops to present and discuss findings. The last are particularly important to build ownership and commitment to the process, and should include a full range of providers and NGOs, including women's advocacy groups.

SPARHCS identifies areas that need further study to support strategic planning.

The SPARHCS diagnostic guide is presented on the following pages. Though many questions are written specifically for contraceptives and condoms – a reflection of how SPARHCS has so far been most commonly applied – they can be modified for other reproductive health supplies. The answers to some questions may not be known. These will help identify priorities for new data collection and analytical work to support strategic planning. These could include, for instance, a logistics assessment, market segmentation analysis, willingness/ability to pay study, or national reproductive health account sub-analysis.

[7] As a rough guide, two-to-three weeks in-country is a reasonable allowance for a SPARHCS diagnosis, allowing for data collection, analysis, and stakeholder discussions.

[8] Key informants can include, to name a few, donor representatives, policy makers, program managers, service providers, logistics managers, advocates for family planning/reproductive health, and clients (women, men, married and unmarried, in a range of age groups).

A. Client Utilization and Demand

This section develops profiles of clients (current and potential) for reproductive health products. It examines distributions of use and unmet need by age, residence, education, standard of living, etc. It also asks questions about how efficiently providers are serving the whole market of clients, as well as about access, discontinuation, and the impact of activities to increase demand for products. This information will help determine strategies to, for example, expand method mix, address unmet need, and better target financial resources to ensure maximum reach.

The tables and questions focus on contraceptives, but can be modified for other RH supplies. They are meant to give users overviews of use and unmet need. Data about past trends and the present may be available from national surveys, like the Demographic and Health Surveys or Reproductive Health Surveys, though perhaps with secondary analysis. Future estimates provide important information for planning commodity requirements. They can be more difficult to obtain and require new analytical work specifically for the assessment.

Users can modify the tables – deleting some cells or adding new ones – using the CD-ROM or web versions of the guide.

A.1. Use of Contraception

CONTRACEPTIVE PREVALENCE[9]	10 YEARS AGO	5 YEARS AGO	CURRENT	5 YEARS FROM NOW	10 YEARS FROM NOW
ALL METHODS					
BY METHOD					
Traditional methods					
Modern methods					
Pill					
IUD					
Injectables					
Implants					
Male condom					
Female condom					
Vaginal method					
Emergency contraception					
Female sterilization					
Male sterilization					
BY AGE					
<15					
15-19					
20-49					

[9] Percentage of married women, or women of reproductive age, using contraception. Where data is available, users of the guide can examine contraceptive use by sex and marital status, adding rows to the table using the CD-ROM or web versions. Access to and use of condoms by men can be a special concern for HIV prevention programs.

CONTRACEPTIVE PREVALENCE	10 YEARS AGO	5 YEARS AGO	CURRENT	5 YEARS FROM NOW	10 YEARS FROM NOW
BY PARITY					
BY RESIDENCE					
Urban					
Rural					
BY GEOGRAPHIC AREA (e.g., province, state)					
BY EDUCATION					
No education					
Primary					
Secondary					
BY WEALTH QUINTILE					
1					
2					
3					
4					
5					
PERCENT OF USERS OF MODERN METHODS, WHO OBTAIN THEIR METHOD FROM:	**10 YEARS AGO**	**5 YEARS AGO**	**CURRENT**	**5 YEARS FROM NOW**	**10 YEARS FROM NOW**
Public sector					
NGO provider					
Social marketing program					
Commercial sector					

A.1.1. Is method use tilted towards short-term, resupply methods? Or, long-term and permanent methods? What are the implications of the method mix for RHCS? For example, short-term methods require more frequent and reliable systems of forecasting, financing, procurement, and distribution to supply programs.

A.1.2. What is the profile of users in each sector (public, NGO, social marketing, commercial) according to their age, income/standard of living, residence, and education?

A.1.3. How well and how efficiently do service providers collectively cover the whole market in terms of clients' income, their location, the methods they want, and where they prefer to obtain them? Is each provider type serving the client groups and supplying the RH products that fit best with the provider's comparative advantage and objectives?

- Is the public sector concentrating its resources on serving the poor, or where there are no private sector alternatives?
- Is the widespread availability of free or subsidized products interfering with expansion of commercial markets?
- Is there access to affordable, quality services for clients who are able and willing to pay for RH supplies?

A.1.4. Are there differences in coverage by public and private sector programs that may limit client choice? For example, are clients in rural areas limited to public sector sources?

A.2. Unmet Need for Contraception

UNMET NEED FOR FAMILY PLANNING[10]	10 YEARS AGO	5 YEARS AGO	CURRENT
For spacing			
For limiting			
Total			
TOTAL UNMET NEED[11]			
BY AGE			
<15			
15-19			
20-49			
BY PARITY			
BY RESIDENCE			
Urban			
Rural			
BY GEOGRAPHIC AREA (e.g., province, state)			
BY EDUCATION			
No education			
Primary			
Secondary			
BY WEALTH QUINTILE			
1			
2			
3			
4			
5			

A.2.1. What is the percentage of current non-users of contraception who intend to use a contraceptive method in the future?

A.2.2. Of the total demand for contraception (current use plus unmet need), what percentage is being satisfied?[12]

A.2.3. What are the main reasons for unmet need (e.g., fear of side effects, perceived spousal objections, religious reasons, lack of access, etc.)? Do gender and ethnic norms create barriers to women's and men's use of contraceptives and other RH commodities? And, if so, how?

[10] Definitions of unmet need for family planning vary. In the Demographic and Health Surveys, unmet need refers to fecund women who either wish to wait two or more years before having another child (spacers) or wish to stop childbearing altogether (limiters), but are not using a contraceptive method. Broader definitions can include, for example, women who are using a method of family planning, but are in need of a more effective or preferred method.

[11] This table examines the distribution of total unmet need. The distribution of unmet need for spacing versus limiting can be of interest as well. Need for spacing versus limiting can shift significantly according to certain client characteristics, for example, age and parity, with implications for method availability.

[12] The percentage of total demand for contraception that is satisfied can be examined in more detail according to demand for spacing versus limiting as well as by client characteristics. Examples can be found in reports of the Demographic and Health Surveys.

A.2.4. What are the key activities (current and planned) to address unmet need? What are their results to date? What future results are expected? How are they expected to affect use of public versus private sources?

A.3. Service Access and Utilization

A.3.1. Do all clients who want contraceptives and other RH supplies have physical access to them? If not, what and where are the main shortcomings in the public sector, in the private sector, in urban vs. rural areas, in different geographic regions?

A.3.2. How often are clients turned away or referred to other facilities because basic services or products (as expected according to norms and standards) are not available at their preferred source? Or, because a provider of the preferred gender is not available?

A.3.3. What are contraceptive discontinuation rates among different groups (e.g., by age, socioeconomic or education status)? What are the reasons for discontinuing use of contraceptives (e.g., lack of satisfaction, side effects, spousal objections, lack of physical access to a facility or other resupply source, lack of product, financial constraints, did not get preferred method)?

A.3.4. Where total demand for family planning (met need plus unmet need) remains low, will securing sufficient supplies to satisfy this level of demand fully realize stakeholders' vision for RHCS? How will activities to increase use of family planning affect the demand-supply relationship? Is supply keeping up with new demand? Will future supply keep pace?

B. Commodities

This part examines the sources of RH commodities in a country and the relative contributions of different public and private sector channels. The table considers past trends and asks about future expectations; it may need to be duplicated for each of the different commodities under consideration in the assessment (contraceptives, STI drugs, etc.). Such an analysis can help determine each sector's role in the provision of RH commodities. Questions are also asked about how stockouts are prevented, how product quality is ensured, and how products are registered.

B.1. Sources of RH Commodities

QUANTITIES OF COMMODITIES PROCURED BY:	10 YEARS AGO	5 YEARS AGO	CURRENT	5 YEARS FROM NOW	10 YEARS FROM NOW
Government[13]					
UNFPA					
USAID					
DFID					
KfW					
IPPF					
PSI or DKT					
Other					
Other					
PERCENT OF DISTRIBUTION OR SALES PROVIDED BY:	**10 YEARS AGO**	**5 YEARS AGO**	**CURRENT**	**5 YEARS FROM NOW**	**10 YEARS FROM NOW**
Public sector					
NGO provider					
Social marketing program					
Commercial sector					
Other					

B.1.1. What family planning methods does each program – public, NGO, social marketing, commercial – offer?

- Are some sectors largely oriented towards resupply methods (e.g., pills, condoms, injectables) and hence more dependent on frequent and reliable financing, procurement, and distribution to keep programs in full supply?
- How many different brands for a given method are being subsidized – whether by government or donors – through public, NGO, and social marketing programs?
- How are they differentiated? Are they all actively considered necessary by some constituency and by what criteria?

B.1.2. Are products that should be maintained at full supply? Or, does rationing occur?

- Have stockouts of products occurred within the last year in any of the programs?
- If so, which products, what programs, at what level(s) in the supply chain, for how long, and why?

B.1.3. How reliable are supplies in each program? Is supply reliability limiting program expansion?

B.1.4. Have significant amounts of any products in any program expired within the last year? Which products, what programs? Where in the supply chain? And, why?

B.1.5. What policies and quality control procedures and capacities are in place to ensure product quality for each product, in each program, and throughout each supply chain?

- How are complaints about product quality handled and investigated?

[13] Where "Government" can refer to national, state, provincial, or other local authority. Users can use the CD-ROM and web versions to modify the table accordingly.

B.1.6. What are the policies that affect importation of contraceptives and other RH supplies? Are tariffs applied to imported RH supplies?

B.1.7. What are the procedures for product registration/licensing?

- Are they well understood, transparent, and efficient?
- Are the time and costs required for registration perceived by the private sector as "normal" or unduly burdensome? Could they be streamlined?

B.1.8. Are there local manufacturers of any RH products? Which ones?

B.1.9. Which donors have been or are involved in supplying RH commodities? What products have each provided last year, this year, and next year? Are there any long-term donor commitments or plans for supplying RH commodities? By who and for what products?

B.1.10. For the commercial sector, what is the percentage of total revenue from family planning and other RH commodities? What is the investment in them (marketing, innovations)? What are local manufacturers' plans for expanding their production capacity or distribution base? Does the commercial market have the willingness and potential to expand? What are the barriers to expansion?

B.1.11. For NGO and social marketing programs, what is the percentage of total revenue from family planning and other RH commodities? What cost recovery systems (e.g., pricing, fees, cross-subsidies) do they have in place or intend to implement? Are there waiver systems for the poor? What are their plans to expand family planning and other reproductive health services and associated products in their programs?

B.1.12. Who is the intended market for each private sector provider, both current and planned?

C. Commitment

Of all the elements in the SPARHCS framework, commitment is perhaps the most difficult to assess by itself. Rather, the best evidence may be when other elements are in place. When, for instance, there is a supportive policy and regulatory environment, sufficient capital to meet client needs, and the necessary human and systems capacities. Still, there are some questions that can be asked about political commitment, commitment from within the private sector, and capacity for advocacy for RHCS. It is important to keep in mind that commitment to RHCS is not the same as commitment to family planning/reproductive health. Rather, it is about the policy level embracing the need to make and keep *supplies* available to clients, both women and men.

This section also looks at the extent to which there is commitment to RHCS under health sector reforms and development assistance for poverty reduction and sector wide approaches.

C.1. Commitment in the Public and Private Sectors

C.1.1. What is the political commitment to reproductive health commodity security?

- Who are key leaders/champions for reproductive health commodity security within government? At what levels?
- How does leadership initiate and support efforts to achieve reproductive health commodity security?
- Why are leaders motivated to support RHCS? How deep is their commitment to meeting women's and men's RH needs?
- Are leaders committed or opposed to using government funds to support reproductive health commodity security? Is there a budget line item for contraceptives and/or other reproductive health supplies? Has government funding for them and related services increased or decreased over time?

C.1.2. Are there leaders/champions for RHCS from within the private sector, for example among major employers or labor organizations?

C.2. Advocacy

C.2.1. Are civil society organizations mobilized and do they have the capacity to advocate for reproductive health commodity security?

- Are they able to act as sources of information for decision making. Do they act as "watchdogs" for improvements in RHCS?
- Are all segments of society, particularly the disenfranchised, represented by civil society organizations that are advocating for RHCS?
- Are RH commodity issues regularly included in broader health advocacy efforts and civil society dialogues?

C.2.2. How often and how well do the media cover family planning/reproductive health issues? Is reproductive health commodity security covered?

C.3. Health Sector Reform and Development Assistance

C.3.1. Are family planning/reproductive health services **and** supplies included in a Poverty Reduction Strategy Paper (PRSP)?

C.3.2. Are family planning/reproductive health services explicitly addressed in a SWAp? Is financing for contraceptives, condoms, and other supplies included?

C.3.3. What is the impact of health sector reform on provision of reproductive health and family planning services and supplies, including decentralization, health systems integration, and private sector involvement?

- What are the effects of shifting decision-making responsibilities from central to local levels?
- Is the burden of public sector financing also shifting?
- What kinds of partnerships is the public sector building with the private sector for provision of health services (e.g., contracting)?
- Is the provision of reproductive health and family planning services and supplies explicitly addressed under these reforms? Or, are they are being "orphaned"?

D. Capital

This section examines the full range of current and potential financing for RH commodities: government, household, donor, and third party. It looks at recent financing trends as well as future expectations. Importantly, it asks whether future financing will be adequate to ensure products are available to clients who want them. If, for example, donor support is declining, stakeholders should investigate what other sources of financing are able to keep pace with demand. A strategy can then be developed to ensure adequate funding is available to meet client demand. As for the table in the commodities section, the table may need to be duplicated for different commodities.

D.1. Government, Donor Funding

SOURCE	AMOUNT OF FUNDING FOR COMMODITIES					
	5 YEARS AGO	LAST YEAR	THIS YEAR	NEXT YEAR	5 YEARS FROM NOW	10 YEARS FROM NOW
GOVERNMENT BUDGET[14]						
Using internally generated funds						
Using loan credits						
Using other donor funds (e.g., grants)						
DONOR[15]						
UNFPA						
USAID						
DFID						
KfW						
Other						
Other						
OTHER INTERNATIONAL FUNDING SOURCES						
IPPF						
Other						
TOTAL FUNDING						

[14] Where "Government Budget" refers to financing through government budget processes. "Government" can refer to national, state, provincial, or other local authority. Users can use the CD-ROM and web versions to modify the table accordingly.
[15] Where "Donor" refers to direct donor financing of commodities, generally through donor procurement mechanisms.

D.1.1. What is the current amount of public funding available for RH commodities? What are the expenditures?

- What is the share of family planning/reproductive health as a percentage of the total government health budget?
- Family planning as a percentage of the reproductive health budget?
- RH commodities as a percentage of the family planning budget?

D.1.2. What are the public sources of financing for contraceptives and other RH commodities, and what percentage of the total expenditure do each represent?

- How much is spent by the central government? Local government? Social security?
- How are the funds used?
- Are public resources being targeted to the poorest of the poor?

D.1.3. Are there cost recovery systems in place for public sector services and supplies? How do these systems function and how are the funds used? Is there a waiver system or other safety net for the poor?

D.1.4. Are public funds used to provide supplies or subsidize services through private providers (e.g., NGOs, social marketing programs)?

D.1.5. What contraceptive/commodity financial data do key decision makers have? How do they use it?

D.2. Household Funding

D.2.1. What are out-of-pocket expenditures on contraceptives, other RH commodities, and family planning/reproductive health services? How much are users paying for services and supplies, and what are they charged for?

- By standard of living or income?
- By rural-urban?
- By method?
- By source (public, NGO, social marketing, commercial)?
- By geographic area?
- Do women and men pay differentially for services?

D.2.2. Do women and men have equal access to household funds? If there are inequalities, what are the impacts for household funding of FP/RH services and supplies?

D.2.3. What is the ability- and willingness-to-pay among current users, as well as among clients with unmet need, for family planning/reproductive health supplies? By provider (public sector, NGO, social marketing, commercial)? By client characteristics (income/standard of living, rural-urban, education, etc.)?

D.3. Alternative Financing Mechanisms

D.3.1. What are the third party/health insurance schemes including social/national insurance, private insurance, and employer coverage?

- Who are the main third party payers? What kinds of individuals are covered by each? Who is eligible? How many people do they cover? How much do they spend?
- What is the coverage for family planning and other reproductive health services and commodities?

D.3.2. What alternative financing mechanisms are available to finance commodities (e.g., community-based financing)?

D.4. Current and Future Funding

D.4.1. How adequate is current funding for contraceptives and other reproductive health supplies?

- What is the current funding gap?
- How dependent are social marketing organizations, NGOs, and others on government and donor subsidies?

D.4.2. How adequate will future funding be?

- What are the expected significant changes in funding – sources and type?
- What are the expected/most reliable sources of funding over the next five to ten years, and what amount will each contribute?
- What will be the financing requirements for contraceptives, other supplies, operations, and capacity improvements to meet future demand?
- What is the expected gap?

E. Capacity

This section focuses on the service provider, logistics, forecasting, procurement, and monitoring and evaluation capacities that are necessary for RHCS. All of these are necessary, whether for the public sector, an NGO, a social marketing program, or the commercial sector. Unless otherwise indicated, the questions should be asked separately for any program of national importance.

Other capacities that are critical for RHCS are addressed elsewhere in the guide. Advocacy is addressed under **C. Commitment**, capacity to develop supportive policies is addressed under **G. Context**, while coordination is its own section (**F.**).

E.1. Service Provider Skills

E.1.1. What percent of clients, with what profile, use different kinds of providers (OB/GYNs, general practitioners, midwives, nurses, community-based deliverers, pharmacists, drug store clerks)?

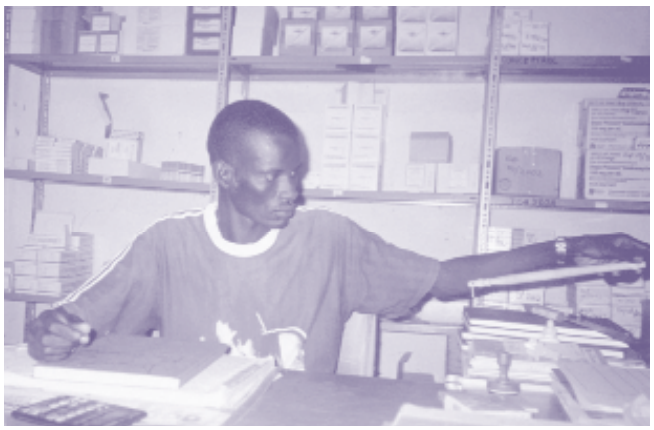
- For which supplies and services?
- How medicalized is the provision of contraceptives? What are the implications for access to contraceptives and program costs?
- Do the characteristics of providers, (e.g., the mix of female and male providers) match with clients' needs and preferences?

E.1.2. What is the level of provider skill by service provider?

- Does provider training include counseling for informed choice, taking into account gender norms, logistics/reordering, and appropriate technical skills (e.g., IUD or implant insertion and removal)?
- Are facilities stocked with the appropriate contraceptives and other supplies given the skill level of health personnel to provide services according to standards of care?
- Is there provider bias against particular client groups or methods? If so, what are the implications for client access to contraceptives or other products?

E.1.3. Do supervisors check the quality of the providers' work and provide on-the-job training to improve their skills in counseling including attention to gender issues, storage, ordering, record-keeping, etc?

E.2. Logistics



E.2.1. For each program, how does the distribution system work and what capacities exist?

- Is the logistics system "push" or "pull"?
- How many levels are there in the supply chain? Can they be reduced?
- Is a maximum/minimum inventory control system in place? How much stock is held at each level?
- Are the storage conditions throughout the system adequate to manage the product load and prevent loss through damage and theft?
- Is transportation adequate at all levels?
- Is the distribution schedule appropriate?
- Is there a system where timely and accurate data on stock on hand and consumption are collected and used for reporting on use, for ordering resupply, and for making shipments at all levels?
- Are there guidelines/systems in place for inventory management and for handling expired or defective products?

E.2.2. For the public sector, is the contraceptive logistics system stand alone or integrated with other products? If donor resources diminish, can it be sustained?

E.2.3. What is the future capacity of each distribution system?

- Is the distribution infrastructure improving or deteriorating?
- Are the demands on the system likely to increase? Can the system expand to accommodate the increase?
- Do weaknesses in infrastructure (e.g., bad roads or too few wholesalers) limit the availability of supplies?

E.3. Forecasting

E.3.1. Are program commodity needs forecast two to five years in advance?

E.3.2. What data are used for forecasting need? (e.g., consumption, losses/adjustments, stock on hand, sales data, demographic data, service statistics)? How reliable are the data?

E.3.3. How often are forecasts updated?

E.3.4. Who is responsible for forecasting and what skills and training do they have? Do they require donor assistance for completing their forecasts?

E.3.5. Are forecast data used to advocate for resources to ensure full supply (for those products that require it)?

E.4. Procurement

E.4.1. Who is responsible for procurement of contraceptives and other RH supplies? What kind of procurement training do they receive, if any? Is there coordination between logistics and procurement staff?

E.4.2. What data are used for procurement plans? Are appropriate products procured to address forecast need? Prevent stockouts?

E.4.3. How effective is donor coordination for procurement? Are there obstacles? Are donor lead times for procurements reasonable for programs to work with effectively?

E.4.4. Have there been donor-related disruptions in supply to programs? For what reasons? What is being done to avoid them in the future?

E.4.5. What are the procedures for government procurements (e.g., issuing tenders, evaluating bids, monitoring supplier performance)? How transparent, timely, and efficient are they? Do they comply with the international competitive bidding procedures of funders? Where do government procurements typically source contraceptives and other RH supplies? What prices are they paying? Do they have access to hard currency? What are lead times for government procurements? Are they reasonable for programs to work with effectively?

E.4.6. Have there been disruptions, or the threat of disruptions, in supply to programs due to delays or other difficulties in government procurements? For what reasons? What is being done in the future to avoid them?

E.4.7. What procedures are in place to assure product quality?

E.4.8. Is there scope for efficiencies and cost savings by reforming or centralizing procurements across programs? For example, is one financing source paying more than another for the same product?

E.5. Monitoring and Evaluation

E.5.1. Do programs routinely collect appropriate data and information for management decision making, monitoring, and planning for RHCS? Is the data appropriately disaggregated by client characteristics (e.g., age, sex, location, etc.)? Is there a management culture that supports evidence-based decision making?

E.5.2. Is there a functional MIS for each program? Does it receive policy-level attention and support? Do higher levels provide feedback to lower levels about performance based on MIS data?

E.5.3. Does the policy level receive appropriate information? How? Does the policy level use it for analysis and decision making?

E.5.4. Is population-level data collected at an appropriate frequency, reported, and used to measure overall program performance and to make adjustments? Is it disaggregated by respondent characteristics (e.g., age, sex, location, socioeconomic status, etc.) and used to monitor inequalities in reproductive health, and in access to and use of FP/RH services and supplies?

F. Coordination

This section addresses the need for coordination among a wide range of stakeholders and at multiple levels to achieve reproductive health commodity security. It asks questions about who should coordinate, how they coordinate, and what have been the results.

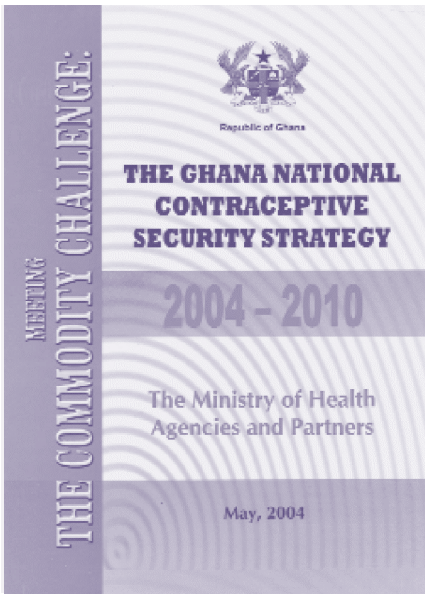
F.1. Who Coordinates, How, and Why

F.1.1. Who are the stakeholders that need to coordinate their activities (donors; government agencies; public, NGO, social marketing, and commercial sector providers; technical agencies; etc.)?

F.1.2. What formal and informal coordination mechanisms exist? What is the willingness to foster coordination?

- Among donors?
- Within government?
- Between donors and government?
- Among service providers in different sectors?
- Between government and service providers?
- Between government and civil society organizations?
- Among technical agencies?

F.1.3. Is there a committee or task force for RHCS? How influential is it? Who is it comprised of? Is there representation of disenfranchised groups?



F.1.4. Does the government, particularly the Ministry of Health, play a leadership role in coordinating key stakeholders? In particular, how well do different parts of the government coordinate for RHCS (e.g., Ministries of Health and Finance)?

F.1.5. What are the information flows that facilitate coordination?

F.1.6. What are the existing coordinated activities and their expected outcomes, such as better coordination of donor procurements or more rational and sustainable segmentation of the contraceptive market?[16]

F.1.7. To what extent and how are stakeholders involved in policy development? In advocacy and work with the media? Which stakeholders?

F.1.8. Have key stakeholders come together to develop a joint strategy for RHCS?

- Is the strategy generally known and supported in the government and among key stakeholders?
- Is it included in a broader strategy (e.g., a health sector program) or does it stand alone?
- Who led its development and who was involved?
- Who has responsibility for coordination and oversight of the implementation of the strategy?
- If there is no strategy, do stakeholders have the capacity to develop one? To monitor progress on RHCS and make adjustments?

G. Context

The success of a RHCS strategy depends on a range of contextual factors affecting individuals' ability to choose, obtain and use RH supplies. To define the broader health, political, and economic environment as it affects RHCS, this section considers:

- policies and regulations that bear on the ability of public and private sector programs to secure and deliver reproductive health supplies; and
- basic demographic, health, and other development indicators.

G.1. Policies and Regulations

G.1.1. What are the official population or family planning/reproductive health policies and other stated positions?

[16] Market segmentation is addressed in more detail under **A. Clients,** the public sector's role in enabling other sectors to function more effectively in providing RH supplies is addressed under **G. Context**, and coordination of procurements is addressed under **E. Capacity**.

- Are these supportive of securing reproductive health supplies? And if so, how?
- Are they supported by adequate programs and funding?
- How are the policies and programs implemented? What are/have been the implications for supplies?

G.1.2. Does the HIV/AIDS policy formally link to the population/family planning policy? Does it explicitly mention securing adequate supplies of condoms or other commodities?

G.1.3. For family planning/reproductive health and HIV/AIDS commodity issues, how are decisions made and who is involved? Are civil society groups, for example, women's health advocates, included?

G.1.4. Are contraceptives and other reproductive health supplies on the national essential drugs or medicines list (EDL or EML)? Which ones? Does being on the list bring any special status, such as waiver of duties, priority in budgeting or resource allocation decisions, waiver from procurement restrictions (e.g., "buy local")?

G.1.5. Are there age- or parity-related restrictions, requirements for parental or spousal consent, prescription requirements, or other policies or other restrictions that limit access and choice of contraceptives?

G.1.6. What policies affect, positively or negatively the private sector's ability to provide contraceptives? Other reproductive health supplies?

- Are there price controls?
- Are there limitations on distribution?
- Are there taxes and duties (excise, import, value-added tax) or exemptions that affect the private sector?
- Is there a ban or other restrictions on advertising?
- Are there other operational policies or regulations that adversely or positively affect the private sector?

G.1.7. What other regulations or operational policies affect delivery of supplies and services?

- Are there restrictive licensing requirements?
- Are there any restrictive dispensing regulations?
- Are there limitations by specific cadres of health professionals?

G.1.8. Do policies assure the capacity of service providers to provide contraceptives and other supplies?

- Do service delivery guidelines, protocols, norms, and standards specify appropriate products? Do they include quality assurance procedures and basic logistics principles such as ordering, recording, storage, handling, etc.?
- What are the training and certification requirements (pre- and in-service) specific to methods? Are they enforced?

G.1.9. What are the policies and regulations regarding distribution of public funds for family planning and reproductive health? What is the process for determining annual funding, levels and allocations?

G.1.10. Are there policies that restrict or regulate fees for family planning and other reproductive health services (levels, exemptions)? For contraceptives and other supplies?

- What financial management policies and guidelines exist for retention of fees, management of funds, facility budgeting, local procurement?

G.2. Demographic, Health, and Development Indicators

INDICATOR	10 YEARS AGO	5 YEARS AGO	CURRENT	5 YEARS FROM NOW	10 YEARS FROM NOW
Total population					
Percent of population that is urban					
Percent of population that is rural					
Population growth rate					
Per capita income					
Adult literacy rate					
Number of women of reproductive age					
Total fertility rate (TFR)					
HIV prevalence					
Infant mortality					
Maternal mortality					
Average age at marriage for women and men					
Average age at delivery of first child					
Other					
Other					

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4

SPARHCS Applied: Country Examples

Examples of the different ways SPARHCS has been applied come from Madagascar, Indonesia, Latin America, and Nigeria. They illustrate the flexibility of SPARHCS, particularly in how the diagnostic guide can be applied, and – in the case of Nigeria – how a SPARHCS assessment can be used to develop a national strategic plan for RHCS.[17]

A. Conducting a Reproductive Health Commodity Security Assessment in Madagascar

SPARHCS has been applied in a wide range of countries to support programs at district, country, and regional levels.

Madagascar continues to face serious health problems. Child and maternal mortality rates are among the highest in sub-Saharan Africa, while contraceptive prevalence is just over 12 per cent. The new government, which took office in 2002, has placed health improvements among its top priorities. Commitment to family planning and reproductive health is now being expressed at the highest levels.

To support this renewed commitment, local experts and international consultants teamed together to conduct a comprehensive assessment of the country's reproductive health commodity security. The Ministry of Health first convened a national stakeholders' workshop with various ministries, UNFPA, donors, and other public and private sector stakeholders. The workshop renewed interest in reproductive health commodity security, gave an overview of what was known about it in Madagascar, and developed an approach for the assessment.

Over the following two weeks, five working groups – corresponding to the five components in Madagascar's reproductive health commodity security framework (demography, policy, demand, service delivery, finance) – conducted a diagnosis of their respective components using the SPARHCS guide (reorganized around these components). Each group – led by a

[17] Readers who want more details about each example, including in-country contacts, should contact the USAID Contraceptive Security Team or UNFPA Commodity Management Unit.

local expert and international consultant – used some combination of document review, data analysis and modeling, key informant interviews, focus group discussions, and field visits. The assessment concluded with a second national workshop where the groups presented their findings. Small group discussions identified priority areas of action and made recommendations for the development of a strategic plan.

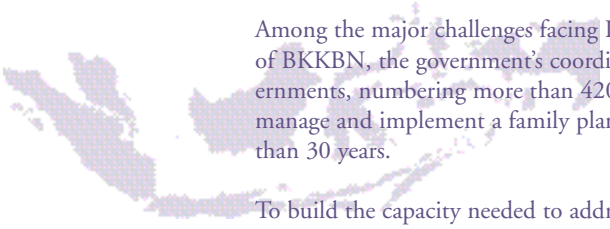
The SPARHCS framework and diagnostic guide proved flexible enough to allow Madagascar to customize their assessment with minimal effort. The assessment:

- reinforced stakeholders' commitment to reproductive health commodity security;
- increased participation among interested stakeholders;
- provided a detailed look at existing strengths and weaknesses for reproductive health commodity security, as well as at historical trends and future projections affecting contraceptive and condom use;
- developed a one-year plan of action for RHCS that was accepted by the Ministry of Health; and
- defined a broad outline for the next steps of developing a longer-term strategic plan.

By establishing a working group for each component in Madagascar's RHCS framework, the data collection process permitted more focused inquiry within each component. The national workshops helped stakeholders integrate across components and develop a coherent "story" on reproductive health commodity security in Madagascar.

Based on the recommendations made during the assessment's concluding workshop, three studies – a contraceptive stock status survey, willingness-to-pay survey, and market segmentation analysis – have since been conducted to help the government develop a contraceptive financing strategy as part of a broader national RHCS strategy. In addition, RHCS workshops have been held in two provinces to raise awareness of RHCS, disseminate information from the national assessment, and lay a foundation for later development of regional RHCS action plans.

B. SPARHCS Under Health Sector Reform in Indonesia



Among the major challenges facing Indonesia's family planning program is decentralization of BKKBN, the government's coordinating agency for family planning activities. Local governments, numbering more than 420 districts and municipalities, now have responsibility to manage and implement a family planning program that has been highly centralized for more than 30 years.

To build the capacity needed to address contraceptive security issues in this new environment, BKKBN and partners – comprising a central Contraceptive Security Team (CST) – have adapted and streamlined the SPARHCS framework and diagnostic guide for use by district stakeholders. The CST has developed a process in which:

- District stakeholders are first introduced to the concept of contraceptive security, awareness is raised of the need to address contraceptive security at the district level, and the adapted diagnostic guide is reviewed.

- Two-person teams, composed of people from the public and private sectors, use the questions in the guide to collect data over two weeks. Each team focuses on one of five components: service delivery, policy, financing, logistics, supply.

- After data collection, a three-day "District Contraceptive Security Strategy Development Workshop" is held at the district level to review the findings, compare the current situation in each component with a desired status, and create two priority lists according to how serious a component is in preventing a district from achieving contraceptive security and how able a district is to address a component on its own. This forms the basis for a comprehensive district strategy that addresses the five components. The workshop is conducted by a Contraceptive Security Task Force consisting of provincial-level public and private stakeholders whose role it is to provide technical assistance to districts.

The tools to support this process have been compiled into a *Contraceptive Security Tool-Kit* and tested Central and East Java. The results demonstrate that the SPARHCS framework and guide can be adapted and made feasible at local levels, where there are few resources. They enable stakeholders to gain a realistic picture of their contraceptive security situation and empower districts to address contraceptive security issues without central involvement. SPARHCS can thus support shifting responsibility and ownership for contraceptive security from central to local governments, while highlighting where local level actions, for example, in advocacy, can help propel needed changes at the central level.

C. SPARHCS as a Tool for Regional Planning in Latin America

In 2003, USAID and partners began a two-year study to determine how contraceptive security could be addressed in Latin America and the Caribbean through a regional approach. The study was designed to answer:

- What are the priority contraceptive security issues that are shared by countries in the region?

- What regional interventions might be most effective in addressing these shared contraceptive security issues?

- How could regional assistance efforts be structured to produce maximum benefit?

The study was launched by a three-day conference in Nicaragua. Teams from nine countries were introduced to the SPARHCS framework and used it to begin their own situation analyses. The introduction of SPARHCS provided a common language and conceptual framework for five in-depth country assessments that followed the conference. This facilitated identification of crosscutting issues, as well as similarities and differences among countries that may need to be addressed at the regional level. This common approach also empowered country stakeholders to see themselves as part of a regional network of activists with a common agenda.

A number of countries formed or strengthened national contraceptive security committees or working groups after the conference. The working group in Peru, for example, is chaired by the Ministry of Health and includes representatives from divisions in the Ministry as well as the social security health system, armed forces and national police, NGO service providers and social marketing programs, UNFPA, USAID, and technical assistance agencies.

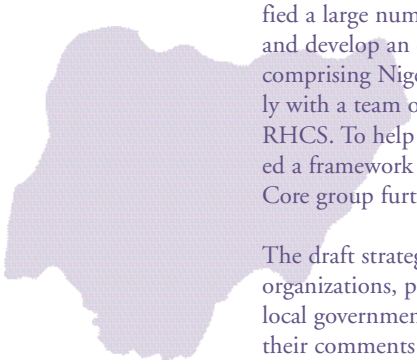
The first of the five SPARHCS assessments that followed the workshop was in Peru.[18] Its assessment investigated issues of general concern in the region, while also raising awareness about contraceptive security and generating practical recommendations for action by country stakeholders. A four-person team of two international and two local consultants:

- carried out a desk-based literature review and analysis of available data (e.g., from the Demographic and Health Survey, DHS, and Peru's logistics management information system or LMIS),
- projected future commodity and financing requirements, and
- interviewed key informants in Peru, made field visits, and held briefings with USAID/Lima and Peru's Contraceptive Security Committee (the in-country part of the assessment was done over a two-week period).

The assessment covered all of the SPARHCS components, but gave priority to issues of special concern in Peru as already determined at the regional workshop: the policy environment and high level leadership/commitment, advocacy, financing, targeting public subsidies, the private sector's role in contraceptive supply, and procurement and logistics.

In conjunction with the assessment, a market segmentation analysis was conducted. Its findings – disseminated to MOH officials, technical agencies, NGOs, and civil society leaders – showed that a significant proportion of those who receive free contraceptives from the public sector are from the topmost economic quintiles. Based on these findings, political will has grown within the MOH to consider strategies to direct public sector resources to the poor, and strengthen and stimulate private sector supply of contraceptives for clients who can afford to pay. Targeting of family planning services may be piloted in two regions, and the MOH is considering a service exchange/reimbursement agreement with the Social Security Institute for the substantial numbers of social security beneficiaries who receive free contraceptives from the MOH.

D. A National Reproductive Health Commodity Security Strategy for Nigeria



In 2002, the first field test of SPARHCS was conducted in Nigeria. The assessment identified a large number of improvements needed to strengthen RHCS in Nigeria. To prioritize and develop an organized response to the improvements identified, a Technical Core group, comprising Nigerian stakeholders and decision makers in reproductive health, worked closely with a team of international consultants to develop a five-year national strategic plan for RHCS. To help focus the efforts of the Technical Core group, the international team provided a framework with some example objectives and activities for the strategy; the Technical Core group further developed the strategy adding additional objectives, activities, and detail.

The draft strategy was disseminated to a broad group of stakeholders, including civil society organizations, private sector representatives, and public sector officials from the federal to local government area levels for their comments. The Technical Core group incorporated their comments into a revised strategic plan. This plan was reviewed by policy makers during a four-day National Contraceptive Security Strategic Planning Workshop, where it was

[18] The other assessments were in Bolivia, Paraguay, Nicaragua, and Honduras.

formally adopted by the Federal Ministry of Health. Having a broad group of stakeholders review the strategic plan prior to sharing it with policy makers for approval built awareness of and support for RHCS in different sectors. These stakeholders, to varying degrees, have become champions for RHCS in their respective areas of influence. Next steps following the plan's adoption include disseminating it country wide, presenting the plan to the National Legislative Committee on Population, and holding a donors conference to identify additional funding for the plan.

The strategic plan covers contraceptives and condoms for HIV/STI prevention, collectively referred to as RH commodities. For each of six components in Nigeria's RHCS framework – finance, policy, logistics, service delivery, demand, and coordination – the plan presents an overall strategic objective that describes the broad level of accomplishment desired within the component. Each strategic objective is broken down into a number of objectives that give details of the expected accomplishments for each component. Each objective is described in terms of:

- specific problems or opportunities on which the objective focuses,
- activities necessary to achieve the objective,
- agencies responsible for completion of the required actions,
- estimated budget,
- time when the activities are planned to be completed,
- output indicators that monitor completion of the activities,
- outcome indicators that describe the overall results once the products of the activities have been realized, and
- assumptions about preconditions, requirements, and circumstances that must exist for the successful implementation of the activities.

For example, the Finance Component has the strategic objective "to promote the provision of secure and permanent financial support for contraceptives among governmental, non-governmental and private organizations and individuals." It has three objectives, one of which is to ensure that decision makers are provided with current and reliable data on RH commodity financial requirements. The following page, reproduced from the strategic plan, shows how this objective is described in detail.

Objective 1.1 from Nigeria's National Reproductive Health Commodity Security Strategy

Component:

1.0 Finance

Objective:

1.1 To ensure that key decision makers and financial managers at national, state, and local levels are provided with current and reliable data related to contraceptive security financial requirements.

Issues Addressed:

- Validity, reliability and comprehensiveness of financial data;
- To ensure that key policy/decision makers make use of the financial data in planning;
- Evidence based planning and decision making.

Coordinating Agency:

FMOH/DCDPA

Assumptions:

- Favourable political environment
- Continued donor support
- Positive response from the key policy makers
- Collaboration between various levels of government and NGOs/private sector
- Financial management

Activities and Subactivities	Implementing Agencies	Estimated Budget (Naira)	Timing	Output Indicators	Outcome Indicators
Activity					
1.1.1 Develop financial management information system (FMIS) for effective planning, monitoring and evaluation of CS	FMOH, DCDPA, HPR	Total: 28.3m		• % of states and LGAS effectively using FMIS • Structures developed and maintained at State and National levels	• Financial data used to secure funding from government and donors
Subactivities					
1.1.1.1 Set up a committee to determine needs of CS financial information system	"	1.2m	4th quarter 2004	• Needs for FMIS identified and National levels	
1.1.1.2 a) Develop RHCS financial information system in response to identified needs	"	12m	4th quarter 2004	• FMIS developed	
1.1.1.2 b) Provision of forms and stationery for FMIS		2.0m		• Forms and stationery supplied	• % of States and LGAs with adequate forms and stationery
1.1.1.3 Develop FMIS training curriculum	DCDPA, HPR, LGAs, SMOH	0.5m	1st quarter 2005	• FMIS training curriculum developed	
1.1.1.4 Train Financial Managers on FMIS	DCDPA, HPR, LGAs, SMOH	9.6m	1st quarter 2005	• No. of financial managers trained in the use of FMIS	• % of States and LGAs with manager trained in FMIS
1.1.1.5 Generate quarterly and annual reports on the financial status of commodities	DCDPA, HPR, SMOH, LGAs, NGOs	1.0m	2005 quarterly	• No. of financial managers who make quarterly reports using the FMIS	• % of states and LGAs which have a functioning effective FMIS
1.1.1.6 Review the FMIS periodically	DCDPA, HPR, SMOH, LGAs, NGOs	2.0m	2006 yearly		

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5

Further Reading

Ashford, L. 2002. *Securing Future Supplies for Family Planning and HIV/AIDS Prevention.* Washington, D.C.: MEASURE Communication/Population Reference Bureau. (http://www.prb.org/pdf/SecFutureSupplies_Eng.pdf). [A short policy brief that describes the growing gap in contraceptive supplies and actions needed to bridge the gap.]

Caro, D., with Schueller, J., Ramsey, M., and Voet, W. 2003. *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action.* Washington, D.C.: Population Reference Bureau (for the USAID Interagency Gender Working Group). (http://www.phishare.org/files/1683_ManualIntegrGendr.pdf). [Orients program managers and technical staff on how to integrate gender concerns into program design, implementation, and evaluation.]

Deliver Project/John Snow, Inc. and Policy Project/Futures Group International. 2004. *Contraceptive Security Index 2003: A Tool for Priority Setting and Planning*. Arlington, VA: Deliver Project/John Snow, Inc. (http://deliver.jsi.com). [An updated and revised tool for measuring a country's level of contraceptive security and monitoring it over time.]

Family Planning Logistics Management/John Snow, Inc. 2000. *Programs that Deliver: Logistics' Contributions to Better Health in Developing Countries.* Arlington, VA: Family Planning Logistics Management/John Snow, Inc. (http://deliver.jsi.com/2002/Pubs/Pubs_Policy/Programs_That_Deliver/index.cfm). [First published document to introduce and describe the concept of contraceptive security, providing an overview of "how to do logistics" within a broader, customer-centered perspective of how quality logistics programs benefit health and family planning programs.]

Finkle, C. 2003. *Ensuring Contraceptive Supply Security.* Outlook Vol 2, No 3. Seattle, WA: PATH. (http://www.path.org/files/eol20_3.pdf). [Discusses the global status of contraceptive funding, causes of shortages, challenges to contraceptive security, and steps being taken to improve coordination at country and global levels.]

Setty-Venugopal, V., Jacoby, R., and Hart, C. 2002. *Family Planning Logistics: Strengthening the Supply Chain.* Population Reports Vol 30, No 1. Baltimore, MD: Population Information Program/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health. (http://www.jhuccp.org/pr/j51edsum.shtml). [Reviews the essentials for strengthening contraceptive supply chains.]

Sine, J. and Sharma, S. 2002. *Policy Aspects of Achieving Contraceptive Security.* Policy Issues in Planning and Finance No 1. Washington, D.C.: Policy Project/Futures Group International. (http://www.policyproject.com/pubs/policyissues/PI_Eng.pdf). [An overview of contraceptive security needs in awareness raising, advocacy, policy dialogue, planning, building an information base, and capacity building.]

United Nations Population Fund (UNFPA). 2001. *Reproductive Health Commodity Security: Partnerships for Change. A Global Call to Action.* New York, N.Y.: UNFPA. (http://www.unfpa.org/upload/lib_pub_file/135_filename_rhcstrategy.pdf). [Proposes a global strategy for reproductive health commodity security that calls upon a variety of partners to undertake focused and coordinated work, principally in advocacy, national capacity building, and sustainability.]

United Nations Population Fund (UNFPA). 2001. *Reproductive Health Commodity Security: Partnerships for Change. The UNFPA Strategy.* New York, N.Y.: UNFPA. (http://www.unfpa.org/upload/lib_pub_file/133_filename_strategy.pdf). [Describes UNFPA's contribution to the strategy outlined in its global call to action for reproductive health commodity security.]

United Nations Population Fund (UNFPA). 2002. *Reproductive Health Essentials: Securing the Supply.* New York, N.Y.: UNFPA. (http://www.unfpa.org/upload/lib_pub_file/39_filename_securingsupply_eng.pdf). [An overview of reproductive health commodity security, focusing on contraceptives for family planning, condoms for HIV/AIDS prevention, ensuring supplies in disaster and conflict situations, and UNFPA's contributions.]

United Nations Population Fund (UNFPA) and World Health Organization (WHO). 2003. *Essential Drugs and Other Commodities for Reproductive Health Services.* New York, N.Y.: UNFPA, Geneva: WHO. (http://www.unfpa.org/upload/lib_pub_file/198_filename_commodities_rhs.pdf). [A draft discussion document intended as a guide regarding which essential commodities are necessary for quality reproductive health care.]

U.S. Agency for International Development (USAID). 2004. *Contraceptive Security: Ready Lessons.* Washington, D.C.: USAID.
(http://www.dec.org/pdf_docs/PNACW660.pdf)
(http://www.dec.org/pdf_docs/PNACW661.pdf)
(http://www.dec.org/pdf_docs/PNACW662.pdf)
(http://www.dec.org/pdf_docs/PNACW663.pdf)
(http://www.dec.org/pdf_docs/PNACW664.pdf)
(http://www.dec.org/pdf_docs/PNACW665.pdf)
[Provides practical "how to" information and examples to help countries and their development partners plan and implement activities for contraceptive security.]

In addition, a set of reports was produced for the 2001 meeting, "Meeting the Reproductive Health Challenge: Securing Contraceptives and Condoms for HIV/AIDS Prevention," held in Istanbul. The reports were produced by the Interim Working Group on Reproductive Health Supplies (IWG), a collaborative effort of John Snow, Inc. (JSI), Population Action International (PAI), the Program for Appropriate Technology in Health (PATH), and Wallace Global Fund.

The full set can be found at

http://www.populationaction.org/resources/publications/commodities/

Individual titles are:

Overview: The Need for Security in Reproductive Health Supplies. [An overview of reports in the set.]

Meeting the Reproductive Health Challenge: Securing Contraceptives, and Condoms for HIV/AIDS Prevention. Istanbul, Turkey, 3-5 May 2001. Report on the Meeting. [An account of the proceedings of the Istanbul meeting.]

Contraceptive Projections and the Donor Gap. [One of the first and most widely cited analyses to draw attention to the financing gap for contraceptives and condoms.]

Donor Funding for Reproductive Health Supplies: A Crisis in the Making. [Profiles bilateral and multilateral donors' reproductive health commodity assistance programs, specifically for contraceptives.]

Financing Contraceptive Supplies in Developing Countries: Summary of Issues, Options, and Experience. [A review of options to increase government, donor, household, and private sector financing.]

Gauging Awareness, Assessing Concern: Focus Group Findings on Reactions to Contraceptive Supply Shortages. [Presents the results of four focus groups held with attendees of the "Beijing+5: Women 2000" conference to gauge awareness of and concern about impending shortages of donated and subsidized contraceptive supplies, and to explore ideas for addressing them.]

Defining Reproductive Health Supplies: A Survey of International Programs. [Based on a survey of 64 organizations, develops a working list of supplies that health professionals consider essential to reproductive health and family planning services in developing countries.]

Contraceptive Security: Toward a Framework for a Global Assessment. [First effort at creating a contraceptive security index for countries].

Country Perspectives on the Future of Contraceptive Supplies. [Based on a survey of family planning programs in 13 countries, describes developing country perspectives on current and future contraceptive supply issues, including trends in commodity forecasting, funding, procurement, and delivery, and donor coordination.]

Issue Profiles: Lessons Learned from Five Countries. [Describes lessons learned, with case profiles, in five issue areas: donor phase-out, funding for countries in crisis, procuring supplies, delivering quality products, health sector reform.]

6

Further Assistance

The USAID Contraceptive Security Team works to advance and support planning and implementation for contraceptive security in countries by:

- developing and supporting the use of appropriate strategies and tools for contraceptive security,
- improving decision making for contraceptive security through increased availability and analysis of data, and
- providing leadership at the global level.

The team provides technical assistance to USAID Missions and country partners in research and analysis, strategic planning, monitoring and evaluation, and implementation of field activities.

For information and assistance:
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The UNFPA Commodity Management Unit:

- provides donor coordination and advocacy to improve the supply and coordination of reproductive health commodities and associated technical backstopping,
- develops national capacity in logistics management and distribution, and
- helps achieve sustainability to make affordable products and services accessible to users in developing countries.

For information and assistance:
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1	2	3	4

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   1._____

   2._____

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   1._____

   2._____

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1	2	3	4

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1	2	3	4

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