RHCSAT

Reproductive Health Commodity Security Situation Analysis Tool

A Tool for Country RHCS Situation Analysis, Planning, and Implementation

Adapted from SPARCHS and LSAT
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Interview Guide

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

It is also a diagnostic and monitoring tool that can be used to complete an annual assessment or as an integral part of the work planning process. The information collected is analyzed to identify issues and opportunities and to outline further assessment and/or appropriate interventions.

As assessments are conducted and analyzed in successive years, the results can contribute to the monitoring, improvement, and sustainability of system performance; and provide critical non-logistics data that can identify a country's contraceptive security strengths and weaknesses.

Given the complexity of reproductive 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.

Benefits

Information collected using this instrument can:

- Provide stakeholders with a comprehensive view of all aspects of reproductive health commodity security.
- Be used as a diagnostic tool to identify logistics and contraceptive/other RH commodity security issues and opportunities.
- Raise collective awareness and ownership of system performance and goals for improvement.
- Be used by country personnel as a monitoring tool (to learn and continually improve performance).
- Provide input for work planning.

Overall Process

Assessment Period/Cycle

The assessment can be conducted annually or as agreed upon within selected countries, ideally, within the three-month period prior to work planning or strategic planning exercises.

Data Collection

There are two methods for data collection:

a. Discussion groups (preferred approach) involving either (1) a central-level discussion group and a separate lower-level discussion group (e.g., district representatives) or (2) a joint discussion group composed of central and lower-level participants. Plan to conduct, at a minimum, one discussion group of central-level people.

b. Key informant interviews can be conducted at both the central and lower levels using the instrument as a guide.

It is highly recommended that the discussion group participants or interviewer and interviewees complete a limited number of field visits. These visits can be made pre-data collection to sample current circumstances or post-data collection to follow-up on issues that arise during data collection.
Data Analysis and Recommendations for Work Plan

Data analysis and development of recommendations and a work plan should take place immediately following data collection. This process should include a thorough review of the country's RHCS strengths and weaknesses in order to develop and prioritize a set of objectives and interventions that will address issues raised during the assessment exercise.

Annual Learning and Performance Improvement

Each year, the findings from the current and prior year's assessments should be compared to measure progress. Likewise, the results of interventions and the assumptions they are based on should be examined so the experience can be applied to the coming year's work plan.

Planning for the assessment

Preparatory Research

Some aspects of the assessment should be researched in advance of the group discussion or interviews. This information should be presented and validated during the course of the assessment.

Choosing the data collection method

In consultation with program managers or country counterparts, agree on the approach to be used. Large discussion groups will require sessions that last two to three days to gain the breadth and depth of data required and to provide an adequate opportunity for full participation. If work planning is part of the exercise, it will extend the time needed with the participants.

Using this instrument as a guide for key informant interviews can take up to a week or more because of the time required to schedule and conduct multiple interviews with the people who have knowledge about the many components of the logistics system.

Option 1: Discussion groups

Joint discussion group

Both central-level and lower-level participants are brought together in one session. This session will probably include 20-25 participants and will require skilled facilitation. This will probably take two-three days to complete, depending on the number of participants and the level of work planning included in the exercise.

Separate central-level and lower-level discussion groups

Central-level: This group session should include 12-17 participants. (Seventeen participants are required if a separate person is needed to cover each of the 17 knowledge areas.) This discussion group is the minimum requirement when using this method of information collection.

Lower-level: If product selection, forecasting, procurement, and the organizational structure are defined and carried out at the central level, then only seven of the 17 topic areas need to be represented from the lower level. If these functions are decentralized to a lower level, the people with those knowledge areas should be included. This session should include 7–17 representatives who have that knowledge. Typically, this group is composed of a cross-section of units (e.g., districts) although it may be necessary to select a different subset, such as a particular geographic area or units under a particular set of circumstances. Be sure to document the rationale behind the selection of participants. This option will require at least one day to complete at each site.

If the method of data collection selected is the discussion group, the facilitator should send a copy of the instrument in advance to each of the selected participants.

Option 2: Key informant interviews

With this option, the instrument is used as an interview guide to collect information from key informants. Because this will involve interviewing numerous people, the interviewer(s) will need to consolidate and reconcile the results into one final assessment report. This entire process can take one week or more, depending on the number of people that need to be interviewed to cover all the topic areas.

One disadvantage to this approach is that it does not allow for group discussion between people working in different areas of the supply chain (during information gathering). If this approach is used, it is recommended that a stakeholders' meeting be held where the assessment findings are presented and discussed. A participatory group exercise can also be used during the "data analysis" portion of the assessment.

Selecting Discussion Group Participants/Interviewees

It is important to have the right set of people if you are to collect accurate data about the functioning of each aspect of the logistics system.
For the "discussion group" option, continue to include core group participants through the following years to build internal capability and to improve the reliability

of the data. Consider already existing groups (such as logistics committees) as a source of participants.

Each discussion group participant/interviewee should have:

- Good information about one or more of the knowledge areas covered in the instrument (see table 1)
- Hands-on experience with the functioning of the logistics system at the level the person is representing (central- or lower-level).

Program managers should be able to identify appropriate participants/interviewees. Consider international donors and/or the Ministry of Finance for the finance knowledge area. Include someone with policy expertise as a participant/interviewee, because policy questions are incorporated into several sections.

In selecting participants/interviewees, refer to table 1 to ensure the collection of the information required in the assessment**.**

Table1. Required Knowledge Areas of Participants and Interviewees

Knows About:	*Central Level**	*Lower Level*
Use of Contraception/commodities		
Service Access and Utilisation		
Commitment (including advocacy, health sector reform, development assistance)		
Capital/Finance		
Coordination		
Sources of Commodities		
Organization (Context, Structure) **		**
LMIS		
Product Selection**		**
Product Use		
Forecasting**		**
Procurement**		**
Inventory Control Procedures		
Warehousing and Storage		
Transport and Distribution		
Organizational Support		
(Processes, Supervision, Staff Development)		

Central-level discussion group or interviews should include participants or interviewees with a knowledge base in all areas.

If these logistics functions are centralized, these 4 areas may be excluded from the lower-level discussion group. If logistics functions are decentralized, lower-level discussion groups or representative interviews (e.g., district) need to be conducted to capture the knowledge base in all areas.

Option 1: Conducting group discussion sessions

Discussion group introductory comments: Set the tone for the session by explaining how the participants' input will be used and by expressing the desire to hear from each person about his/her area(s) of knowledge. Invite participants to write down points important to them during the discussion, as key points will be captured at the end of each module. Emphasize that the participants should take part in the entire session because the group needs not only their knowledge area expertise but also their insights on how the technical areas relate to and impact on one another.

Level-specific data: Central group participants will be most knowledgeable about the central level and the circumstances in the next level down. Utilize the lower-level focus group for more real-life responses to questions about district and SDP level settings and practices.

***Discussion group facilitation*:** It is recommended that the group have a skilled facilitator and at least one recorder who is very familiar with the tool. Field experience has shown that multiple recorders are beneficial for high-quality information.

Option 2: Using the instrument as an interview guide

***Presentation of the results**:* The information collected through key informant interviews should be presented in a meeting to in-country stakeholders. This will provide an opportunity to discuss findings and their implications. The facilitator or interviewer will also need to compile all the results in a report. The collected information should allow the identification of key strengths and weaknesses of the system. It should also lead to the development of the work plan by identifying objectives using the criteria described in the analysis section below.

Planning Field Visits

It is recommended that facilitators or interviewers, with discussion group participants or interviewees, make field visits, if applicable. Field visits made prior to the discussion sessions/interviews will provide a sample of the current context or circumstances, adding additional insight into the information collection.

Visits made following the discussions/interviews offer an opportunity for further exploration of issues identified during the discussions/interviews, enhance the quality of the information gathered, and allow for additional data collection. Those making the field visits can focus on unanswered assessment questions; mixed, unsure, or contested data; disparate or wide-ranging responses to questions; and a more in-depth look at particular areas. Program managers or country counterparts can help plan the appropriate number of field visits before and/or after the exercise.

Analysis of the Collected Information

The information collected through the instrument can be used both as part of the work planning process, and/or to monitor progress over time. These are discussed separately below.

Work Planning

To inform the work planning, users can review the strengths and weaknesses of the logistics system, and use the information to develop appropriate objectives and interventions as part of an effective work plan. If there is time, it is highly recommended that a participatory analysis of the instrument discussion results be done. This is especially recommended if a group discussion is used because the participants are already together, but the analysis can also be arranged if option 2 is used. The session can take up to a day, and it can occur on a separate day with a slightly different participant mix (most participants should attend both sessions). The main steps include:

- Develop a consolidated summary of the key points and observations (e.g., strengths and weaknesses).

- If an assessment has been done previously, compare findings of the current and prior year assessments findings and note the reasons for any significant changes, including assumptions that did not work.

- Identify key existing conditions or circumstances (the context) that will influence the choice of objectives and interventions.

- Identify your objectives or reevaluate objectives from last year. Describe the objectives as the desired state, to the extent possible. For each objective, generate intervention ideas by reviewing the assessment questions and responses in the areas identified as areas of strength or weakness.

- Select intervention ideas using the set of criteria provided in table 2.

- Use a scale of 1–3, lowest to highest, for each criterion per objective and per intervention selected. List as many objectives as participants think are necessary and as many interventions as necessary to achieve each objective.

- If advisors elect to use the assessment as the basis to begin a strategic planning process in commodity security, then it is likely that country stakeholders from other sectors, in addition to logistics, will need to be included as part of the main steps described above.

Use the following decision criteria to complete table 2:

- For *priority*, consider how large and wide the impact will be, whether this is an important pre-cursor/ first step, or synergism with other objectives/initiatives, and with funding source and MOH priorities. Score the objectives and then the interventions within each objective independently, by priority.
- For *feasibility*, consider the extent of political support, relevant policies, country and logistics system infrastructure, and cultural support. Independently score the objectives and then the interventions within each objective to reflect the feasibility of accomplishing the overall objective or intervention.
- For *resources*, consider if available resources (e.g., funds, materials, knowledge/skills) meet, exceed, or fail to meet resource requirements. The score assigned should reflect the level of resources available, compared to what is required to accomplish each intervention.

******(Insert suggested template for Strategic Action Plan)***

A. Context

The success of an 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.

A.1 Policies and Regulations

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

A.1.2 Are these supportive of securing reproductive health supplies? And if so, how?

A.1.3 Are they supported by adequate programs and funding? How are the policies and programs implemented? What are/have been the implications for supplies?

A.1.4 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?

A.1.5 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?

A.1.6 Are contraceptives and other reproductive health supplies on the national essential drugs or medicines list (EDL or EML)? Which RH products are included on the EDL or EML?

A.1.7 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")?

A.1.8 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?

A.1.9 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?

A.1.10 What policies affect, positively or negatively the private sector's ability to provide contraceptives and/or 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?

A.1.11 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.?

A.1.12 What are the training and certification requirements (pre- and in-service) specific to methods? Are the requirements enforced?

A.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 male literacy rate					
Adult female literacy rate					
Number and percentage of women of reproductive age					
Total fertility rate (TFR)					
HIV prevalence					
Infant mortality					

INDICATOR	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
Maternal mortality					
Average age at marriage for women and men					
Average age at delivery of first child					
Other					

B. 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.

B.1 Who Coordinates, How and Why

B.1.1 List the stakeholders who need their RHCS activities to be coordinated (donors; government agencies; public, NGO, social marketing, and commercial sector providers; technical agencies; etc.)?

B.1.2 Is there a committee or task force for coordinating RHCS activities? Who is the committee comprised of? Is there representation of disenfranchised groups?

B.1.3 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?)

B.1.4 Does the government, particularly the Ministry of Health, play a leadership role in coordinating key stakeholders?

B.1.5 Provide or map an organogram that includes the relationship among key stakeholders, including government units, donors, other cooperating agencies (in terms of responsibilities for RHCS) and clearly showing the information flows used to facilitate collaboration among stakeholders.

B.1.6 What are the existing and/or planned coordination activities and their expected outcomes?

B.1.7 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?

B.1.8 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?

B.1.9 Is the National RHCS/CS strategic plan fully financed/resourced? Is the National RHCS/CS strategic plan being implemented? How (e.g. nationally, regionally, locally)?

B.1.10 If there is no strategy, do stakeholders have the capacity to develop one and to monitor progress on RHCS and make adjustments?

B.1.11 Does the national level have a logistics management unit which focuses on RHCS? Is there a mechanism or a unit that currently coordinates procurement and product shipment with donors?

C. Commitment

Of all the elements in the RHCS 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 also 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, sector wide approaches (SWAps) and other aid effectiveness modalities.

C.1 Commitment in the Public and Private Sectors

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

C.1.2 Who are key leaders/champions for reproductive health commodity security within government? At what levels?

C.1.3 How does leadership initiate and support efforts to achieve reproductive health commodity security?

C.1.4 Are leaders committed or opposed to using government funds to support reproductive health commodity security?

C.1.5 Is there a budget line item for contraceptives and/or other reproductive health supplies?

C.1.6 Has government funding for them and related services increased or decreased over time?

C.1.7 Why are leaders motivated to support RHCS? How deep is their commitment to meeting women's and men's RH needs?

C.1.8 Are there leaders/champions within the private sector, for example among major employers or labor organizations?

C.2 Advocacy

C.2.1 Are civil society (NGO, CBO, women organizations, etc.) mobilized by government and other stakeholders and do they have the capacity to advocate for reproductive health commodity security?

C.2.2 Are they able to act as sources of information for decision making. Do they act as "watchdogs" for improvements in RHCS?

C.2.3 Are all segments of society, particularly the disenfranchised, represented by civil society organizations that are advocating for RHCS?

C.2.4 Are RH commodity issues regularly included in broader health advocacy efforts and civil society dialogues?

C.2.5 Are forecast data used to advocate for resources to ensure full supply (for those products that required it)?

C.2.6 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 addressed in the 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 within the sector programme?

C.3.3 Are family planning/reproductive health services explicitly addressed in the UN Programming processes (CCA, UNDAF)?

C.3.4 Are family planning/reproductive health services explicitly addressed in other existing aid effectiveness modalities (Budget support, programme based approaches, etc)?.

C.3.5 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?

C.3.6 Is the provision of reproductive health and family planning services and supplies explicitly addressed under these reforms? Or, are they being "orphaned"?

C.3.7 What are the effects of shifting decision making responsibilities from central to local levels? Is the burden of public sector financing also shifting?

C.3.8 What kinds of partnerships is the public sector building with the private sector for provision of health services (e.g., contracting)?

D. Capital

This section examines the full range of current and potential financing for RH commodities: government, 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
GOVERNMENT BUDGET[1]					
Internally generated funds					
Loan credits					
Other donor funds (e.g., grants)					
Drug revolving fund					
DONOR[2]					
UNFPA					
USAID					
DFID					
KfW					
Other					
OTHER INTERNATIONAL FUNDING SOURCES					
IPPF					
Other					
TOTAL FUNDING					

[1] Where "Government Budget" refers to financing through government budget processes. "Government" can refer to national, state, provincial, or other local authority.
[2] 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?

D.1.2 What is the share of family planning/reproductive health as a percentage of the total government health budget?

D.1.3 What is family planning as a percentage of the reproductive health budget? What are RH commodities as a percentage of the family planning budget?

D.1.4 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.1.5 Are public funds used to provide supplies or subsidize services through private providers (e.g., NGOs, social marketing programs)?

D.1.6 What contraceptive/commodity financial data do key decision makers have? How do they use it?

D.1.7 Does the program's budget include line items for logistic activities such as: products, warehousing/storage, logistics management information system, transportation, logistics staff development, salaries for logistics staff, waste management?

D.1.8 What is the program's annual budget and expenditure for drug budget, contraceptive budget and logistic budget?

D.1.9 Who finances the program's annual budget? What process is used to develop the program's budget?

D.1.10 What percentage of the cost of products procured is locally financed? Estimate the percentage of products bought from domestic versus international suppliers.

D.1.11 Are clients charged for services and/or commodities? What approximate percentage of costs is recovered (e.g., through user's fees)? If possible, separate by commodity versus logistics.

D.1.12 Are revenues generated from the cost recovery system used for commodity costs, logistics costs or other RH related costs?

D.1.13 Are any products procured through a basket funding mechanism? Specify which products are procured through basket funding. Describe the process (e.g., timing, donors, etc).

D.1.14 What are the program's future plans for local financing? Are there plans by donors to phase out or reduce donations during the next five years?

D.2 Current and Future Funding

D.2.1 How adequate is current funding for contraceptives and other reproductive health supplies? What is the current funding gap?

D.2.2 How adequate is current funding for other reproductive health supplies? What is the current funding gap?

D.2.3 How dependent are social marketing organizations, NGOs and others on government and donor subsidies?

D.2.4 What are the expected significant changes in funding – sources and type?

D.2.5 What are the expected/most reliable sources of funding over the next five to ten years, and what amount will each contribute?

D.2.6 What will be the financing requirements for contraceptives, other supplies, operations, and capacity improvements to meet future demand? What is the expected gap?

E. 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.

E.1 Sources of RH Commodities

QUANTITIES OF COMMODITIES PROCURED BY:	5 Years Ago	2 Years Ago	Current	2 Years from Now	5 Years from Now
Government[3]					
UNFPA					
USAID					
DFID					
KfW					
IPPF					
PSI or DKT					
Other					
Other					
PERCENT OF DISTRIBUTION OR SALES PROVIDED BY:	5 Years Ago	2 Years Ago	Current	2 Years from Now	5 Years from Now
Public sector					
NGO provider					
Social marketing program					
Commercial sector					
Other					

E.1.1 What family planning methods does the program offer? (public sector and NGO) List the products by method, brand and provider

E.1.2 List the RH products that are subsidized and who subsidizes them

E.1.3 What are the policies that affect importation of contraceptives and other RH supplies? Are tariffs applied to imported RH supplies?

E.1.4 What are the procedures for product registration/licensing? Are they well understood, transparent, and efficient?

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

E.1.5 Are the time and costs required for registration perceived by the private sector as “normal” or unduly burdensome? Could they be streamlined?

E.1.6 Are there local manufacturers of any RH products? Which RH commodities are manufactured locally?

F. 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 – as they see fit for their particular country situation.

F.1 Use of Contraception

CONTRACEPTIVE PREVALENCE[4]	5 Years Ago	Current	5 Years from Now
All methods			
BY METHOD			
Traditional methods			
Modern methods			
Pill			
IUD			
Injectables			
Implants			
Male condom			

[4] *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[4]	5 Years Ago	Current	5 Years from Now
Female condom			
Vaginal method			
Emergency contraception			
Female sterilization.			
Male sterilization			
BY AGE			
<15			
15-19			
20-49			
>49			
BY PARITY			
BY RESIDENCE			
Urban			
Rural			
BY GEOGRAPHIC AREA (e.g., province, state)			
BY EDUCATION			
No education			
Primary			
Secondary			
Tertiary			
Other			
BY WEALTH QUINTILE			
Low			
Medium			
High			
PERCENT OF USERS OF MODERN METHODS WHO OBTAIN THEIR METHOD FROM	5 Years Ago	Current	5 Years from Now
Public sector			

CONTRACEPTIVE PREVALENCE[4]	5 Years Ago	Current	5 Years from Now
NGO provider			
Social marketing program			
Commercial sector			

F.1.1 What are the commonly used commodities and what are their logistic implications for RHCS.

F.1.2 Is the public sector concentrating its resources on serving the poor, and providing services to areas where there are no private sector alternatives?

F.2 Unmet Need for Contraception

UNMET NEED FOR FAMILY PLANNING[5]	5 Years Ago	Current	5 years from Now
For spacing			
For limiting			
Total			
TOTAL UNMET NEED[6]			
BY AGE			
<15			
15-19			
20-49			
BY PARITY			
BY RESIDENCE			
Urban			
Rural			
BY GEOGRAPHIC AREA (e.g., province, state)			

[5] *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.*

[6] 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.

UNMET NEED FOR FAMILY PLANNING[5]	5 Years Ago	Current	5 years from Now
BY EDUCATION			
No education			
Primary			
Secondary			
Tertiary			
Other			
BY WEALTH QUINTILE			
Low			
Medium			
High			

F.2.1 What are the main reasons for unmet need (programmatic, operational, cultural, religious, price. others)?

F.2.2 What are the key activities (current and planned) to address unmet need?

F.3 Service Access and Utilization

F.3.1 What and where are the main shortcomings in the public sector in terms of *Service Access and Utilization (* in urban vs. rural areas, in different geographic regions)?

F.3.2 What are contraceptive discontinuation rates among different groups (e.g., by age, socioeconomic or education status)?

F.3.3 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)?

G. Capacity

G.1 Product Use

G.1.1 Do written standard treatment guidelines exist for conditions that are treated with commodities in the supply chain being assessed? Are guidelines distributed to all the service delivery points?

G.1.2 Are there written procedures for monitoring and supervising prescribing practices (e.g., monitoring number of products/drugs prescribed/dispensed per prescription)? Are the procedures distributed to service providers at all levels?

G.1.3. Do written universal safety precaution guidelines exist (e.g., disposing of used needles, washing hands before and after contact with patient)? Are precaution guidelines distributed to service providers at all levels?

G.1.4 What mechanisms and resources are in place to ensure the implementation of standard treatment guidelines and universal safety precautions? To what extent are they followed? If not followed, what are the barriers to putting them into practice?

G.1.5 Are commodities provided only to facilities that have staff trained and equipped to use them (e.g. IUDs only to sites with trained providers)?

G.1.6 Are prescribing practices monitored and compared to standard treatment guidelines? If so, how often? And By whom?

G.1.7 Are there behavior change communication campaigns underway (or undertaken in the previous 2–3 years) that encourage the use of modern contraceptive methods, especially long-term and/or permanent methods? If yes, describe campaigns and specify who is responsible for these activities.

G.1.8 What factors are barriers or limit client access to services that use products from the supply chain being studied today? (Programmatic, operational, cultural, religious, price, other?) Is access to the program services negatively affected by perceptions of quality at the provider sites? What problems are most commonly expressed by clients?

G.1.9 Is there market segmentation of contraceptives?

G.2 Logistics Management Information System (LMIS)

G.2.1 Is there a logistics management information system? Please describe the system.

G.2.2 Is logistics information collected through another information system (e.g., HMIS)? Describe briefly.

G.2.3 Does the information system (LMIS, HMIS, other) include stockkeeping records (e.g., inventory control cards, bin cards, stock registers) at all

levels, requisition and issue records (e.g., bills of lading, shipping records, requisition/issue vouchers) at all levels, dispensed-to-user records at service delivery points, summaries of consumption data at levels above service delivery points (e.g., districts, regions, central, etc.)

G.2.4 Do information system reports at all levels of the system show all essential logistics data elements (inventory balance or stock on hand, quantity dispensed or issued during a specified reporting period, losses and adjustments, quantities received)

G.2.5 Do LMIS or other information system reports received at the central level provide information on stock status at the SDP level (i.e., do central level staff have accurate routine information on which SDPs are stocked out, understocked, adequately stocked, or overstocked)?

G.2.6 How often are reports sent to each higher level of the system? Map the report flow.

G.2.7 How do managers monitor reporting rates and follow-up to obtain missing logistics reports?

G.2.8 What is the approximate percentage of information system reports received in time to be used for logistics decisions (ordering, distribution, etc.) at all levels (Central, Regional, District) If below 100% at any level, explain why facilities don't report or don't report on time.

G.2.9 Are information system records reconciled against physical inventories at each level? If yes, how is this done and how often?

G2.10 Are issues data or dispensed-to-user data cross-checked against other data sources (e.g., service statistics, demographic surveys, etc.)? What type of data are they checked against? (service statistics, demographic statistics, survey data, supervisors reports, other) How often are they checked against each data type? (quarterly, semi-annually, annually, other) Who is responsible for cross-checking?

G.2.11Is the information system automated at all levels? (Central, Regional, District, Service delivery points) Briefly describe the functions and processes that are automated.

G.2.12 How is logistics data recorded, managed, analyzed, and used at each level?

G.2.13Is technical assistance provided to manage the information system? If yes, by whom, what assistance and how is it provided.

G.2.14Is the information system used to monitor and evaluate the program's performance? What indicators related to logistics and/or product availability does the information system track (e.g., stockout rate, percentage of reporting, rational prescribing practices, etc.)? Who tracks these indicators? How often?

G.2.15 What feedback mechanisms are in place to channel logistics information back to lower levels? (telephone, reports, meetings, supervisory visit, other or none)

G.2.16 Is logistics information provided to appropriate decision makers for logistics planning (e.g., Ministry of Health, Ministry of Finance, UNFPA, USAID, World Bank, NGOs)? What information is provided? Who provides the information? Who receives the information? How often? (monthly, quarterly, semi-annually, annually, other) How is the information used?

G.3 Forecasting

G.3.1 Who is responsible for forecasting and what skills and training do they have? Do they require technical assistance for completing their forecasts?

G.3.2 Describe the forecasting process. Who initiates it? How often does it take place? What is the role of regional or lower levels in the forecasting process?

G.3.3 Are forecasts developed using: (dispensed-to-user data, distribution/issues data, stock on hand) at all levels? Are forecasts developed using the following: (demographic data or disease prevalence/morbidity, service statistics) Are forecasts validated by comparing previous estimated consumption with actual consumption?

G.3.4 Do forecasts take into account programmatic plans (e.g., expansion of service outlets, training, IEC or behavior change campaigns, other organization's activities, etc.)?

G.3.5 What other factors are considered in the preparation of forecasts (e.g., consolidating decentralized forecasts or quantifications, seasonal and regional variations, standard treatment guidelines, national essential drug list, stockout periods, etc.)?

G.3.6 How many products had serious forecasts discrepancies in the past 2 years (+/- 25%)? Which ones? Which products had the smallest forecast discrepancies? Is technical assistance provided to develop correct forecasts? If yes, by whom? Are forecasts updated at least annually?

G.3.7 Are forecasts prepared on a schedule coinciding with local budgeting and procurement cycles? Are long-term (e.g., 3 or more years) forecasts prepared? Are forecasts costed out and incorporated into budget planning by the MOH and/or donors? Explain.

G.4 Obtaining Supplies/Procurement

G.4.1 Does the government procure RH commodities? If yes, which RH commodities does government procure (family planning etc). If not why?

G.4.2 What are the procedures for government procurements (e.g., issuing tenders, evaluating bids, monitoring supplier performance)? Do they comply

with the international competitive bidding procedures of funders? What are lead times for government procurements? Are they reasonable for programs to work with effectively?

G.4.3 Who is responsible for procurement planning, and ordering and scheduling of shipments (e.g., logistics unit, procurement unit) at appropriate levels? What kind of procurement training do they receive, if any?

G.4.4 Describe the coordination between staff or unit(s) responsible for logistics activities and procurement staff.

G.4.5 Are procurement plans based on forecasted needs?

G.4.6 Are procurements limited to pre-qualified suppliers and/or products on the national essential drugs list?

G.4.7 In general, are the correct amounts of all products procured and obtained at the appropriate time at the following levels: (Central, Regional, District, Service delivery point?) Specify the products, if any, that do not arrive in a timely manner or in appropriate amounts and why.

G.4.8 What are the procedures and time frames for ordering products from suppliers and donors, Do these take into account trade, regulatory, and currency restrictions? How? What is done to monitor/manage the coordination of procurement plans among suppliers/donors?

G.4.9 Is pipeline status regularly monitored so that procurement decisions can be made and actions can be initiated in time to avoid stockouts? If yes, who does this and how?

How effective has this monitoring been? Explain.

G.4.10 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?

G.4.11 Does the program have written procedures for ensuring that products meet defined standards of quality?

G.4.12 What are the procedures for quality assurance, who is responsible, and how often are they done?

G.4.13 Is there a procedure for recording and reporting complaints about product quality to suppliers? What other actions are carried out to ensure product quality?

G.5 Inventory Control Procedures

G.5.1 Specify what type of inventory control system is used (e.g., push, pull, etc.) and describe the system. Draw a diagram showing the relationships between the various levels.

G.5.2 Are there guidelines and established policies for maximum and minimum stock levels at which full supply products should be maintained (please note current maximum and minimum levels in comments section)? (At the Central level, Regional level, District level, service delivery point level?)

G.5.3 Are the inventory control guidelines for full supply products respected at all levels so stock levels generally fall between maximum and minimum? If no, why?

G.5.4 Are stock levels (maximum and minimum) for full supply products reviewed periodically? Do reviews take into account changes in transport and information availability?

G.5.5 How are products that cannot be maintained in full supply allocated at the following levels: (Central, Regional, District, Service delivery points?)

G.5.6 Are there written provisions for the redistribution of over-stocked supplies? How are stock imbalances handled by supervisors/managers at the following levels: (Central, Regional, District, Service delivery points?)

G.5.7 Does the program have a policy of storing and issuing stock according to first-to-expire, first-out (FEFO) inventory control procedures at all levels? If no, what system is used? In practice, does the program manage and issue stock according to FEFO inventory control procedures at all levels? Describe.

G.5.8 Are damaged/expired products physically separated from inventory and removed from stock records at the following levels: (Central, Regional, District, Service delivery points?)

G.5.9 Does the program have a system for tracking product losses and other adjustments? Are there significant losses and adjustments? If yes, how are they investigated? Are appropriate actions taken to prevent recurrence?

G.5.10How does each level of the system calculate resupply quantities? (Central, Regional, District, Service delivery points?) Are there established procedures for placing emergency orders?

G.5.11Have stockouts occurred for any product in the last 12 months at the following levels: (Central, Regional, District, Service delivery points?)

G.5.12 Which products stockout most frequently? How long do the stockouts normally last? What causes these stockouts? At which levels or what parts of the country do most stockouts occur?

G.5.13 How did the stockouts affect program services and performance (specify which products and levels)?

G.5.14 Has there been expiration of any products in the program within the last

year? If so, which products expired, where in the supply chain did the expirations occur and why did the products expire?

G.5.15 Note the approximate quantities of products that expired within the past two years.

G.6 Warehousing and Storage

G.6.1 Does the program have written guidelines for storage and handling of all products, at all levels of the system (e.g., manuals, posters, etc.)?

G.6.2 Are there written guidelines for disposal of sharps, biohazardous material, and other medical waste?

G.6.3 Does the program conduct at least one physical inventory of all products every year at storage facilities at the following levels: (Central, Regional, District, Service delivery points?)

G.6.4 Are there cold chain requirements in this supply chain? Are cold chain storage resources (e.g., refrigerator, paraffin/kerosene, and temperature chart) available at all levels of the system, where appropriate? How is the cold chain monitored to ensure that products are consistently maintained at appropriate temperatures? (written guidelines, supervision, temperature log sheets, other)

G.6.5 Is the existing storage capacity adequate to handle the current quantities of products at the following levels: (Central, Regional, District, Service delivery points?

G.6.6 How does the program cope with inadequate storage space at the following levels: (Central, Regional, District, Service delivery points?)

G.6.7 Can the existing storage capacity handle all the quantities needed to ensure that no stockouts occur at the following levels? (Central, Regional, District, Service delivery points?)?

G.6.8 Does the program have plans for meeting storage requirements for at least the next five years. Describe the program's plans for accommodating growth (e.g., infrastructure, distribution, etc.). Specify storage conditions that need improvement, if any (e.g., cleanliness, organization, temperature, building structure, etc.).

G.6.9 Are visual quality assurance inspections of products conducted at the storage facility at the following levels: If so, how often? (Central, Regional, District, Service delivery points?)

G.6.10Are there written procedures or guidelines for destroying damaged and expired products? If yes describe the written procedures/guidelines for destroying damaged and expired products.

G.6.11In practice, are damaged and expired products destroyed according to the

program’s disposal guidelines at the following levels: (Central, Regional, District, Service delivery points?)

G.6.12 Describe notable problems encountered in the past year, if any, regarding wastage due to damage or expirations. Please note product, level, location, approximate amount of goods, and actions taken.

G.7 Transport and Distribution

G.7.1 Does the program’s budget have a line item for: (vehicles, fuel, spare vehicle parts, vehicle maintenance and repair, per diem, salaries for drivers?)

G.7.2 Are any of the above items supported by external funds? If yes, how much? By whom? Are there plans to phase out or end this support?

G.7.3 Do written procedures specify what type of distribution system should be used to distribute products between each level?

G.7.4 How are products delivered between each level of the system (include frequency and means of transportation)? Specify between which levels.

G.7.5 How are routes determined? Is there a documented distribution schedule for all levels?

G.7.6 Which essential health products are distributed together (e.g., contraceptives, essential drugs, TB drugs, STI and HIV test kits and drugs, laboratory supplies, etc.)? Specify by level.

G.7.7 Are a sufficient number of functioning vehicles available, with available petrol and drivers, at appropriate levels, to meet the desired product distribution schedule? Are vehicles regularly available for supervision?

G.7.8 Are vehicles available for biohazardous material and sharps waste transport?

G.7.9 Are vehicles used effectively for routine and emergency deliveries at all levels? Explain (e.g., maximum use of vehicle capacity, coordination of distribution routes, etc.).

G.7.10 Are all vehicles in running order? How is vehicle maintenance handled at the different levels?

G.7.11 In general, are orders delivered as scheduled at the following levels: (Central, Regional, District, Service delivery points?)

G.7.12 Is transportation outsourced at any level of the system? If yes, how effective has it been?