USAID
FROM THE AMERICAN PEOPLE

LIBERIA: A CONTRACEPTIVE SECURITY ASSESSMENT

MARCH 2007
This publication was produced for review by the United States Agency for International Development. It was prepared by the DELIVER Project.

DELIVER
No Product? No Program. Logistics for Health

LIBERIA: A CONTRACEPTIVE SECURITY ASSESSMENT

DELIVER

DELIVER, a six-year worldwide technical assistance support contract, is funded by the U.S. Agency for International Development (USAID).

Implemented by John Snow, Inc. (JSI), (contract no. HRN-C-00-00-00010-00) and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], and Crown Agents Consultancy, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical management of USAID's central contraceptive management information system.

Recommended Citation

Kagone, Meba, Paul Dowling, Jennifer Antilla, and Ruth Cooper. 2007. *Liberia: A Contraceptive Security Assessment.* Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

Abstract

An assessment of the contraceptive security situation (CS) in Liberia was carried out by a team of DELIVER consultants working with the Family Health Division of the Ministry of Health and Social Welfare (MOHSW.) Using an adapted SPARHCS (Strategic Pathway towards Reproductive Health Commodity Security) framework and tool, the team reviewed documents, met with stakeholders and visited health facilities for the public, non-governmental and commercial sectors in five of the fifteen counties in Liberia. This assessment will serve as the basis for the development of a national CS strategy. Liberia is facing many challenges in rebuilding its health infrastructure following many years of conflict. Chief among these is the transition from emergency assistance provided by international non-governmental organizations, who essentially manage public health facilities, to a more sustainable development type assistance where help is channeled to the MOHSW with the goal of enabling that institution to provide services directly. This period of transition will be difficult and has implications for CS. There is a strong commitment to family planning at the highest levels of the Government of Liberia but there are significant challenges to be faced in translating that commitment into operational plans and delivery of products and services. A particular challenge will be to transition from an essentially vertical contraceptive supply chain to an integrated system with other essential drugs managed by the National Drug Services.

Cover Photo: Medicine shop in Robertsport, Grand Cape Mounty County, Liberia.

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

CONTENTS

Figures

Tables

ACRONYMS

ARV	antiretroviral
ATP	ability to pay
BCC	behavior change communications
BPHC	basic package for health care
CBD	community based distribution
CBDA	community based distribution agents
CHAL	Christian Health Association of Liberia
CHSWT	County Health and Social Welfare Teams
COC	combined oral contraceptive
CPR	contraceptive prevalence rate
CS	contraceptive security
DHS	Demographic and Health Survey
EHP	Essential Health Package
EU	European Union
FEFO	first-expiry first-out
FHD	Family Heath Division
FP	Family Planning
FPAL	Family Planning Association of Liberia
GFATM	The Global Fund To Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GOL	Government of Liberia
HIV/AIDS	human immune deficiency virus/acquired immune deficiency syndrome
ICB	International Competitive Bidding
IEC	information, education and communication
INGO	International Non-Governmental Organization
IPPF	International Planned Parenthood Federation
IPRS	Interim Poverty Reduction Strategy
IUD	intrauterine device
JSI	John Snow, Inc.
LIAT	Logistics Indicator Assessment Tool
LMIS	logistics management information system

M&E	monitoring and evaluation
MCH	maternal and child health
MMR	maternal mortality ratio
MOHSW	Ministry of Health and Social Welfare
MOS	months of stock
MoU	memorandum of understanding
NDS	National Drug Services
NEDL	National Essential Drugs List
NGO	non governmental organization
POP	progestin only pills
PR	Principal Recipient
SDP	service delivery point
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STI	sexually transmitted infection
TB	tuberculosis
TFR	total fertility rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WTP	willingness to pay

ACKNOWLEDGEMENTS

The authors would like to thank the many people who helped in this assessment and the writing of this report. Particular thanks go to the staff of the Family Health Division at the Ministry of Health and Social Welfare, and in particular Mrs. Nyapu Taylor and Mrs. Jestina Bardue-Johnson. We would also like to thank Dr. James Duworko of USAID for his help in facilitating our visit.

EXECUTIVE SUMMARY

Liberia faces significant challenges in strengthening contraceptive security (CS) to ensure that all Liberians can choose, obtain, and use the quality contraceptives they need when and where they need them. An assessment of the CS situation was carried out in February 2007 by a team of DELIVER advisors working with the Family Health Division (FHD) of the Ministry of Health and Social Welfare (MOHSW.) The assessment was based on an adapted Strategic Pathway Towards Reproductive Health Commodity Security (SPARHCS) assessment tool, which incorporates various components needed to ensure availability of, and access to, contraceptives, including client utilization and demand, commodities, commitment or leadership, capital or financing, supply chain, service delivery, coordination, and the socioeconomic and health context in a country. The assessment included a national contraceptive forecast and was used as the basis for the development of a national CS strategy led by the FHD, currently ongoing. The assessment team reviewed key documents, met with stakeholders representing various actors involved in the planning, programming and delivery of FP products and services, and visited service delivery points (SDPs) in five of the fifteen counties in Liberia. The assessment evaluated the CS situation for both the public and private (non governmental organization [NGO], faith based organization [FBO] and commercial) sectors although much of the emphasis was on the public sector and the public supply chain.

The years of conflict have greatly degraded the health infrastructure in Liberia and reduced the ability of the Government of Liberia (GOL) to provide needed health services to the population. A new democratically elected government is making great strides to scale up efforts. The GOL is demonstrating strong support for reproductive health and family planning. Family planning is an integral component of the new national health policy and plan and is part of the Basic Package for Health Care (BPHC) intended to be available to all Liberians. Many national policies and strategies note the importance of FP, including the national HIV/AIDS strategy. No major policy barriers to CS exist. As in most countries, there are restrictions in advertising drugs, and the regulations on duties on imports of commodities are unclear and inconsistently applied. While there are restrictions on the sale of hormonal contraceptives - they can only be dispensed through licensed pharmacies – in practice they are sold in most medicine shops which are normally restricted to over-the-counter formulations.

Currently, much of the health care delivery is being undertaken by international NGOs (INGOS), who manage and operate government owned facilities throughout the country as part of an emergency humanitarian assistance effort. The expectation is that the role of INGOs will change over the coming years as Liberia switches to development assistance and consequently, the MOHSW will play a greater role in healthcare service delivery. This poses major challenges for the MOHSW in the areas of finance, human resources and technical capacity. National NGOs, especially the Family Planning Association of Liberia (FPAL), formerly played a major role in delivering family planning services in government owned clinics. Services provided by these NGOs were also adversely affected by the conflict, thus they are also in a rebuilding mode and their future role is not clear. FPAL currently operates three clinics, two of them in Monrovia. The Christian Health Association of Liberia (CHAL), an association comprising of independently managed churches or missions, is probably better placed in the community to make an immediate impact in service delivery. There is a small commercial sector for drugs, including contraceptives, consisting of about 120 pharmacies and over 200 medicine stores. Most of these are located in Monrovia and none are outside of major urban areas. The sector is unregulated, and has little official access to affordable products. Yet the sector plays an important role in urban settings, managing to obtain leaked public sector products and selling them at – relatively – affordable prices. Social marketing could play an important role in strengthening CS through training providers, promotion to

clients, and providing access to subsidized and affordable products. In doing so, the market for leaked public sector products could probably be eliminated. There is currently no social marketing for contraceptives in Liberia.

Liberia is currently facing a general shortage of trained and skilled medical providers. Compensation levels are low - significantly lower than the NGO sector - and few providers are willing to work in rural areas. In addition, provider training levels are thought by most stakeholders to be inadequate. This situation has effected on both service provision and quality of care. For instance, IUD access is hampered by a lack of trained providers as well as equipment and facilities. No standard treatment guidelines for family planning are in place for providers' reference. Providers are often unaware of the similarities and differences between various brands of hormonal pills, as demonstrated by issue patterns and provider interviews indicating high dispensing of progestin only pills (POP) as opposed to combined oral contraceptive pills (COCs). Many providers reported a preference to dispense these less effective pills for younger women starting modern contraceptives for the first time.

There are no reliable national data on contraceptive prevalence, unmet need, fertility preferences, or market shares by sector etc. The last DHS in 1999/2000 is highly unlikely to represent the current situation. A new DHS is underway and preliminary data may be available in the summer of 2007. Anecdotally, stakeholders point to access (lack of facilities, poor roads), lack of knowledge, and cultural and social barriers as major obstacles to CS. Most current use comprises temporary methods, with hormonal pills, injectables and condoms the main methods used. Long term and permanent methods, including the IUD, are marked by their almost complete non-availability apart from a handful of larger service delivery points (SDPs.) Implants and emergency contraceptive pills are only available through a handful of NGOs and not at all through the public sector. There is little knowledge or promotion of the female condom; with significant stock available in the country, there are hopes to begin increasing awareness in the near future.

The overall pharmaceutical sector in Liberia is currently being strengthened with the national drug policy (2001) under review, the role of independent regulatory institutions like the Pharmacy Board established to regulate drug distribution being strengthened, drug quality assurance systems being established, and a new national essential drug list (EDL) and formulary prepared. The current EDL is out-of-date and does not include contraceptives. Absent an EDL, decisions on what to procure are based on past procurements, with decisions on newer commodities made on an ad-hoc basis. Responsibility for procurement, storage and distribution of essential drugs in the public sector rests with the National Drug Services (NDS), a semi-autonomous body largely under the authority of the GOL. As with many other policies in Liberia, the official status of the NDS is somewhat vague. Financed on an ad-hoc basis, the NDS receives a mixture of irregular government funding, donor support, in-kind donor contributions (fuel, vehicles etc.), and payments for handling and storing drugs from various programs and partners.

Contraceptives are being funded mainly by USAID at this time. USAID currently supply male condoms, Depo-Provera, Lo-Femenal, Ovrette and IUDs. UNFPA was a major financer in the past and still supports procurement of female condoms, reproductive health kits, and smaller quantities of pills (Microgynon and Microlut). The Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM) has previously financed male condoms and intends financing both male and female condoms in the future. The GOL currently does not support procurement of contraceptives. Many INGOs complement public sector supplies with various commodities, for example, the International Planned Parenthood Federation provides small quantities of a range of products to FPAL. Official policy for the next two years states that all essential drugs are to be provided free of charge to clients in public sector facilities; however, this may prove difficult to implement in public facilities functioning without NGO support and where staff often try to charge fees. FPAL and CHAL all charge for products but prices are generally low. Prices at commercial pharmacies and medicines stores are also low; this is possible since most of the products sold are leaked from the public sector. Given the lack of purchasing power, these prices, although low, are probably still

beyond the reach of most of the population. There is no significant third party financing of contraceptives or FP.

Drug forecasts are usually done directly by funders, with those for contraceptives most recently conducted by DELIVER in conjunction with FHD. In general, contraceptive forecasts have included little or no involvement from NDS. Reliable consumption data for contraceptives on which to base a forecast is unavailable. Forecasting was initially based on demographic data, but concerns about the quality of the data led to a subsequent forecast being based on central level issues. There is no funding available for future forecasts and little capacity incountry to continue to do contraceptives forecasts.

There is no sustained national essential drug financing or procurement. The GOL has only recently provided funding for "regular" essential drug procurement; NDS does do restricted tendering in some instances through suppliers like Mission Pharma and IDA. Otherwise, drugs are financed through a variety of mechanisms and funders, mainly the GFATM who fund drugs for HIV/AIDS, other sexually transmitted infections (STIs), opportunistic infections (OIs), and malaria. Decisions on the quantities of drugs to procure by NDS are based less on forecasted demand, and more on funding available and/or treatment targets combined with morbidity and epidemiological data, and historical consumption patterns. For contraceptives, procurement is undertaken directly by funders: USAID, UNFPA, and GFATM (through United Nations Development Programme the Principal Recipient in Liberia.)

NDS stores essential drugs in a large complex in Monrovia. There are a number of separate storage areas for GFATM commodities, vaccines (climate controlled), bulk essential drugs, and smaller quantities of essential drugs. In general, storage conditions are adequate, though there are limitations to the warehouse design and a lack of materials handling equipment and racking. Many "programme" commodities are stored separately. Nine out of fifteen counties have recently constructed drug depots financed by GFATM. It is not clear if these depots are intended to keep buffer stocks or are just cross docking facilities, who is responsible for managing them (the County Health and Social Welfare Teams [CHSWT] or the NDS), and what exactly can be stored in them (policy makers say all drugs at the CHSWT level, however this does not seem to be clearly communicated among all counties.) They are not currently being used to store contraceptives. At the central level, contraceptives are stored in a space adjoining the main NDS warehouse, rented from NDS for this purpose by UNFPA. UNFPA staff manages these products with little or no integration with NDS staff or systems. Products are stored on pallets, under generally adequate conditions and issued under First-Expiry First-Out principles. Additional climate controlled containers are used for bulky items, such as male and female condoms. Storage conditions for contraceptives at the county level are poor. Most counties store them in unsuitable rooms or offices. Most NGOs have adequate storage facilities at both national and regional levels. SDPs either store contraceptives in their dispensaries with a small supply in the reproductive health office or they store the entire supply in the reproductive health supervisor's office. Storage conditions in most SDPs are reasonable.

NDS has a fairly sophisticated inventory management system, but are required to manage separate databases based on the funding source for commodities. Inventory management at NDS is reasonable given the constraints they operate under; for instance, minimum/maximum stock levels are somewhat meaningless since they do not control what they order and have no real consumption data. Once drugs leave the NDS warehouse, there is no effective LMIS system. The UNFPA store has a computer and maintains electronic stock cards where receipts, issues, balance on hand, and losses and adjustments are noted. Orders are made on a requisition voucher and are theoretically approved by FHD though this does not always happen. Orders are supposed to be conditional on reports being made but this may not always be enforced. The report forms contain logistics data – quantity issued, quantity received, and opening and closing balances by brand – compiled by the counties from SDP reports, but data quality are poor, reporting rates low, and the data unreliable. NGOs operate modified systems and their reporting arrangements are unclear and inconsistent.

NDS do not operate a regular delivery schedule to the counties. Deliveries are made on an ad-hoc basis and more often CHSWTs, NGOs and programs will collect themselves. NDS has one truck and two smaller pick-ups for deliveries but road conditions are terrible, particularly in the rainy season, making deliveries difficult. CHTs, NGOs, and some individual facilities pick up contraceptives from the UNFPA store. NGOs generally distribute supplies directly to the SDPs they support and some also maintain stocks at their national offices and some at the county level. SDPs that are not supported by NGOs generally must rely on irregular deliveries from their CHTs or pick up supplies from the counties. Generally, contraceptives are handled by the Reproductive Health coordinators from the CHSWTs – they order, store and distribute supplies at times, sometimes but not always in coordination with the in-charge for other drugs.

At the time of the assessment, Depo-Provera had just stocked out at the central level. Stocks of male condoms were low, although a supply was expected at any time. Other products were either stocked correctly or overstocked. Most facilities had 0-3 months of stock of the methods they supplied, with the Depo-Provera stock situation generally low.

A number of coordinating mechanisms exist for FP. There is a RH technical committee to discuss operational issues under the leadership of the FHD. The committee meets occasionally but needs to be strengthened. The technical committee is supposed to report to a RH steering committee chaired by the Minister of Health but this group is not operational.

As noted above, this assessment was intended to support the development of a national CS strategy for Liberia; at the time of writing (February 2007) this process was ongoing and a draft strategy was nearing completion.

INTRODUCTION

This assessment of the contraceptive security (CS) situation in Liberia followed an initial visit to Liberia by a DELIVER team in April 2006 to prepare the first national forecast of contraceptive needs as well as carry out an initial supply chain assessment. This CS assessment conducted in January- February 2007 updated the initial forecast and assessed the contraceptive security situation in Liberia including service demand and utilization, commodities, commitment, coordination, financing, logistics, service delivery, and the policy and regulatory environment. The results served as the starting point for the development of a national CS strategy for Liberia.

RATIONALE

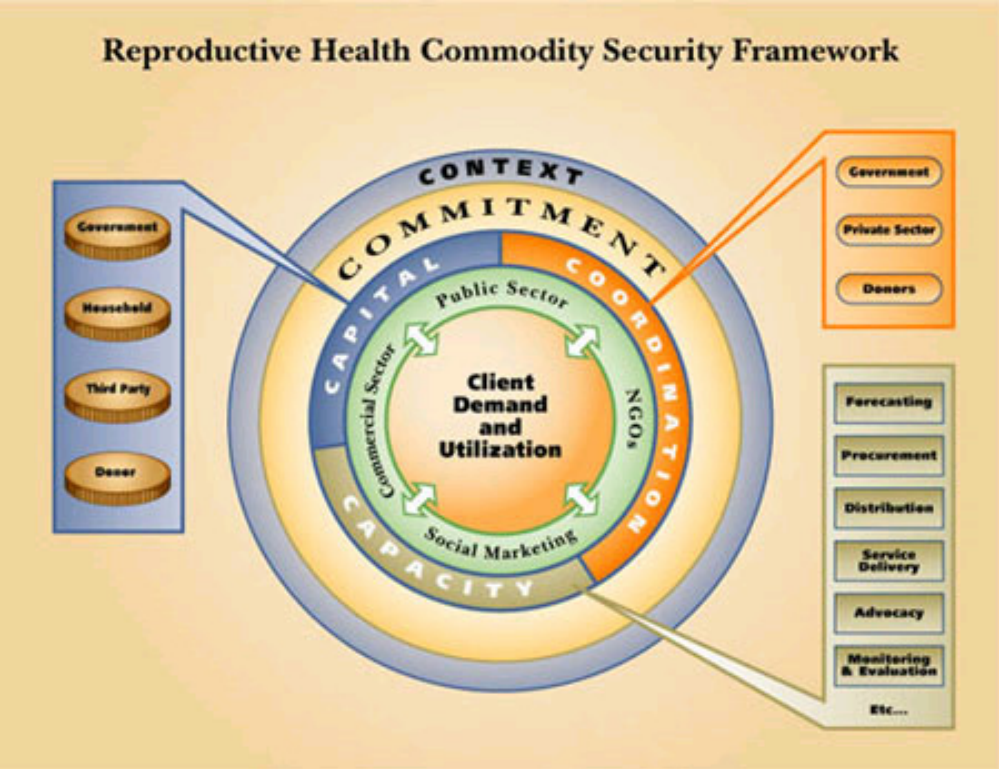
As Liberia recovers from years of conflict, the Government of Liberia (GOL) is engaged in a process of reconstruction and planning for future development. The Ministry of Health and Social Welfare (MOHSW) is currently developing its national health policy and plan, intended to ensure delivery of a basic essential health package to all Liberians. There will be a gradual transition from service provision by international Non Governmental Organizations (INGOs) as part of emergency humanitarian assistance to Liberia to the MOHSW. This time of transition and uncertainty makes the need for a comprehensive strategic plan for contraceptive security in Liberia pressing. Such a strategy will ensure that all Liberians can choose, obtain, and use the quality contraceptives and other reproductive health commodities they need when and where they need them. The purpose of this assessment is to inform and support the development of that strategy.

METHODOLOGY

A team of three DELIVER consultants, working closely with the Family Health Division (FHD) of the MOHSW and funded by the United States Agency for International Development (USAID), spent three weeks in Liberia from January 28 to February 16, 2007. The team reviewed major policy and planning documents and as well as logistics records (see References for a full list of documents), met with key stakeholders (see Appendix 2 for key stakeholders that were met), and visited service delivery points in the public, NGO and commercial sectors, in Montserrado County (Monrovia and environs) and four other counties – Grand Cape Mount, Bomi, Grand Bassa and River Cess (see Appendix 2 for list of sites visited.) These visits were not intended as a quantitative assessment of the stock situation nationwide; rather the objective was to better understand the general supply situation in the country. The counties chosen for visits were intended to represent a reasonable cross section of the country. The assessment did not visit the South Eastern counties for reasons of time: the supply and service delivery situation in these counties is expected to be significantly worse than the rest of the country due to their inaccessibility. Stakeholder meetings included both individual meetings and one initial day long workshop with key stakeholders (see Appendix 3 for participants) to present the objectives and methodology, get feedback and begin gathering information on the CS situation.

This assessment loosely follows the Strategic Pathway Towards Reproductive Health Commodity Security (SPARHCS) diagnostic guide (Hare 2004) which is in turn based on the SPARHCS framework (Figure 1).

Figure 1: Strategic Pathway to Reproductive Health Commodity Security Framework



The framework identifies the different elements that must be present in order to satisfy client demand for commodities – the center of the SPARHCS circle. Elements include commodities, capacity, coordination, capital or finance, and commitment or leadership, all of which take place in a legal, political and social environment. The diagnostic guide is based on this framework, and provides a series of questions and tables to help assess the current situation and make future projections. The DELIVER mission to Liberia in 2006 worked with local stakeholders to adapt the SPARHCS guide to the Liberian context and this was the tool used to guide this assessment (See Appendix 4 for a copy of the tool.)

Preliminary findings were presented to key stakeholders at the end of the assessment for comment and consensus on the main issues. This served as the starting point for the preparation of the national CS Strategy.

THE ASSESSMENT

1. CLIENT UTILIZATION AND DEMAND

The most recent national data available on the use of contraceptives comes from the 1999/2000 Demographic and Health Survey (DHS.) At that time, the contraceptive prevalence rate was estimated at 8.8 percent and unmet need at 13.6 percent. Since the DHS in 1999/2000, however, facilities offering contraceptives have probably decreased in number and there is little information available on family planning. It is likely that, with reduced access and availability of commodities and information, this DHS data does not accurately reflect the current situation. A number of smaller KAP studies have since been undertaken. In Grand Gedeh County, Merlin carried out a household KAP study, and of 256 respondents 16 percent were using family planning, with pills (8 percent) and injectables (6 percent) the most popular methods. However, these data are not national and the sample sizes are small.

The 1999/2000 DHS did not probe reasons for non-use of contraceptives. During the assessment, service providers and other stakeholders indicated three key barriers to client use of and demand for contraceptives: access to services, lack of awareness and knowledge about family planning methods, and spousal disapproval/religious beliefs.

Table 1: Prevalence for modern methods

Prevalence	1986	1999/2000
Modern methods	7.0	8.8
Pill	4.7	6.6
IUD	0.7	0.8
Injectables	0.3	0.9
Diaphragm, foam, jelly	0.1	0.5
Condom	0.2	1.5
Female sterilization	1.0	0.6
Male sterilization	0.0	0.4

Source: DHS 1999/2000

Access to services was thought to be the main reason for low usage. Road conditions and the decreased number of facilities providing services, including contraceptives, have made it difficult for clients to obtain the method they want as well as the information required for proper use. In addition to access, many service providers perceive a general lack of awareness and a scarcity of information about FP among the population. They consider this a significant contributing factor to low contraceptive use. The Merlin KAP study in Grand Gedeh asked non users of FP the reasons why. No knowledge of FP or no access was the second most popular reason for non-use cited by 17 percent (the most common reason was desire for more children cited by 21 percent.) Spousal disapproval and religious beliefs were also cited by providers as barriers to contraceptive use. Service providers gave examples of women asking friends to keep their contraceptive pills for them or passing them as vitamins after removing them from their original packaging in order to hide their use from their spouses.

Table 2: Unmet need from 1999/2000 DHS

Unmet need	2000
for spacing	10.2
for limiting	3.4
Total	13.6

A draft strategy for Information Education and Communication (IEC) and Behavior Change Communication (BCC) includes some plans for increasing knowledge about family planning. Despite this development, there have been no significant

IEC campaigns and there are no signs of media campaigns in the form of pamphlets, posters, or radio messages are in evidence in urban or rural areas.

The method mix currently available in Liberia is limited in the main to short term methods: pills, injectables, and condoms. Focus group discussions with providers indicate that most women use contraceptive pills, followed by injectables, which are rapidly increasing in popularity. Providers report that injectables are almost as popular as pills; certainly much more popular than the 2000 DHS suggests, where pill users outnumbered injectable users by more than 8 to 1 (Table 1.) Access to long term and permanent methods is very limited, as the number of facilities and service providers capable of inserting IUDs is low, implants are not available, and few facilities outside of Monrovia offer either male or sterilization as an option.

Use of progestin only pills (POP) is particularly high in Liberia. While the consumption data available are unreliable the consumption patterns for POP pill versus COC are high: much higher than in most other countries. Many providers reported dispensing POP pill not only to lactating mothers but also to adolescents and younger women starting modern contraception for the first time. In most other countries, COC are normally the first oral method of choice for non-lactating women.

Data collection for a 2007 DHS was ongoing at the time of this assessment; preliminary data is expected to be available in the summer of 2007. At that point it will be important to review data on client utilization and demand and, based on the results, implement the activities outlined in the IEC/BCC strategy.

KEY RECOMMENDATIONS: CLIENT UTILIZATION AND DEMAND

- Increase access to long term and permanent methods particularly the IUD which is already part of the method mix. Train providers and provide equipment and materials. Initial training should include actual IUD insertion and given the almost complete non-access to IUDs in Liberia initial training will need to take place in a neighboring country

- Increase training levels for all providers on FP and contraceptives. This should include all sectors – public, NGO and commercial (pharmacists and dispensers.) This training could be combined with dissemination of the new (proposed) Standard Treatment Guidelines (STGs.) Efforts will need to include training of trainers – there is a shortage of trained trainers and general capacity to do training in Liberia.

2. COMMODITIES

2.1 METHODS AVAILABLE

The public sector offers a full range of temporary methods – oral pills, injectables, male and female condoms. There are no long acting or permanent methods available in the public sector apart from female sterilization available in some hospitals. Male sterilization was cited by a number of interviewees as a popular FP choice for Liberian couples before the war. Male sterilization is not believed to be currently widely available but many stakeholders believe that with promotion it could again become popular. A small number of NGO supported clinics provide implants and IUD insertion but implants are not part of the public sector method mix, and very few providers have been trained in IUD insertion. While IUDs are available at the NDS store, none were distributed between 2005 and 2006. The public sector does not offer emergency contraceptive (EC) pills apart from a number of NGO supported clinics supplied directly by the NGOs or UNFPA. FPAL offers a full range of temporary and LAPM methods in its three clinics.

Table 3: Methods available by sector with brands (Black indicates non availability)

Method	Public sector, CHAL	NGO supported public sector, FPAL	Commercial
Combination pills	✓ (LoFemenal, Microgynon)	✓ (LoFemenal, Microgynon, Nordette, Marvelon, Regividon etc.)	✓ (Oralcon, Microgynon*, LoFemenal*)
Emergency contraception pills		✓ (Postinor-2, Optinor)	✓ (Postinor-2)
Progestin only pills	✓ (Ovrette, Microlut)	✓ (Ovrette, Microlut, Exluton)	✓ (Hyan, Ovrette*, Microlut*)
Injectable	✓ (Depo-Provera)	✓ (Depo-Provera)	✓ (Depo-Provera – very limited)
Male condoms	✓ (generic)	✓ (generic)	✓ (Casanova, Durex, Playsafe, Kama Sutra etc.)
Female condoms	✓ (limited)	✓ (limited)	
Implants		✓ (Norplant: very limited)	
IUD		✓ (Copper-T: very limited)	
Female Sterilization	✓ (very limited)	✓ (very limited)	

* Products almost certainly leaked from the public sector

2.2 BRANDS AVAILABLE

A multiplicity of brands of COC pills and POP exists in the public sector. For combination pills, the public sector offers both LoFemenal (procured by USAID) and Microgynon (procured by UNFPA.) NGO facilities (both national and public sector facilities supported by INGOs) also offer various other brands of COC pills procured directly or supplied by their partners. These include Nordette, Regividon, and Roselle. For POP, the public sector supplies both Ovrette (USAID) and Microlut (UNFPA). Depo-Provera is the only brand of three month injectable noted. While providing a choice of brands is laudable,

in cases where products are equivalent and resources and capacity low, brand proliferation can create problems. Providers and client may not realize products are equivalent, forecasting becomes difficult, and products may be overstocked leading to expiration and waste. Given the limited financial resources and system capacity, the MOH should try as much as possible to provide a minimum number of brands and also avoid changing brands frequently, thus confusing providers and customers.

2.3 SOURCES OF COMMODITIES

There are no data available on the market share of the different sectors – public, NGO, FBO, and commercial – for contraceptives in Liberia. The 1999/2000 DHS did not record this information. The market is currently dominated by the public sector, although most of the public facilities supplying contraceptives have significant support from INGOs, including Africare, International Medical Corps (IMC), International Rescue Committee (IRC), World Vision, Christian Children's Fund (CCF), Medecins Sans Frontieres (MSF), Merlin, and Northwest Medical Teams. FPAL, an International Planned Parenthood Federation (IPPF) affiliate, operates three clinics (two in Monrovia), one of which is a youth friendly clinic.

2.4 SUPPLY SITUATION

There are no data on the availability of contraceptives or essential drugs at the county or SDP levels. At the time of the assessment, the central level was stocked out of Depo-Provera. During 2006, shortages of male condoms were noted, but no other stockouts at the central level were in evidence. This assessment included visits to five counties and found a complete stockout of all methods for one county (at the county level), while the others had adequate quantities of all methods stocked apart from Depo-Provera, where stocks were low (generally 0 – 1 months of stock [MOS]). Note that no counties had reliable issues or consumption data and therefore stock levels were based on staff estimates as to how long supplies would last. Most facilities had 1-3 MOS of most methods, again except for Depo-Provera. Note that in general, female condoms and IUDs were not available: few facilities have either the capacity to insert IUDs or stock available, and female condoms are not being distributed regularly until a promotion strategy is developed.

2.5 COMMODITY REQUIREMENTS (FORECAST)

The table below shows the forecasted commodity requirements for 2007 – 2009 along with the actual 2006 issues. This forecast was prepared by DELIVER in February 2007. Due to the lack of reliable consumption or demographic data, the forecast was based on issues data from the central level. Issues data are not considered a very reliable proxy for consumption; therefore, this forecast needs to be carefully monitored. Section 4 of this report on financing contains data on the financial requirements for the forecast.

Table 4: Consumption (issues as a proxy) for 2006 and forecasted consumption 2007 - 2009

Method	2006 (issues)	2007*	2008	2009	Total
Depo-Provera	79,822	95,786	105,365	115,902	317,053
Combination pills	321,239	399,413	407,000	428,000	1,234,413
Progestin only pills	151,036	142,020	114,600	120,300	376,900
Male condoms	5,718,000	6,861,600	8,233,920	9,880,704	24,976,224
Female condoms	53,000	63,600	76,320	91,584	230,904
IUDs (Copper T)	0	1,344	1,692	1,776	4,812

Source: 2007 CPTs. Procurements either planned for 2006-2008 or already received. Total for male condoms includes public sector only
* 2007 figures for 11 months only, February - December

2.6 PRODUCT QUALITY

Responsibility for drug quality currently rests with the Pharmacy Board. Currently, the board has no capacity to do drug testing but there are plans to invest in personnel and equipment to enable it to carry out this function. The National Drug Policy (2001) lays out the creation of a new body, the Drug Regulatory Authority (DRA), to carry out this function (as well as drug registration, surveillance); however, the Pharmacy Board will most likely continue to play this role for the immediate future, including testing and post marketing surveillance. NDS reports carrying out visual inspection of incoming drugs and requires certificates of analysis for each batch of product received.

2.7 PRODUCT REGISTRATION

As noted above, the National Drug Policy sets out the creation of an independent DRA to carry out drug registration, but apparently this responsibility will now rest with the Pharmacy Board who intend reinstating a drug registration process. There is currently no drug registration in Liberia. Drug importers submit documentation relating to imports to the Chief Pharmacist at the MOHSW for his approval but many importers, particularly INGOs, do not follow this requirement.

2.8 LOCAL MANUFACTURING

There is no pharmaceutical manufacturing in Liberia and there is unlikely to be any investment in this area in the near or medium-term.

2.9 DONOR SUPPORT

There are currently three main donors for contraceptives:

- USAID currently provides most of the contraceptives used in the public sector. They provide male condoms, Depo-Provera, IUDs, and pills (LoFemenal and Ovrette). USAID also procures technical assistance to prepare forecast and procurement planning.
- UNFPA, while they have provided significant quantities in the past, hope to concentrate their resources on other RH commodities, although they intend to continue to support female condom procurement for at least the near future. UNFPA currently procures small quantities of pills and female condoms.
- The Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM) procured about 1 million male condoms in 2006. Although they have no plans to procure condoms for 2007, they have budgeted for about 4 million condoms in 2008, approximately half the quantity required, as part of the current Round 6 Global Fund approved program.

In 2006, USAID supplied contraceptives valued at about US$489,000, UNFPA supplied US$200,000 worth, and GFATM about US$43,000 worth. Note that this was higher than the actual funding need for 2006 since most of the UNFPA supply was of female condoms for which an estimated several years supply was provided.

In addition the following also supply smaller quantities of products:

- IPPF procures small quantities of pills, injectables, condoms and IUDs for FPAL.
- Other NGOs ship contraceptives to their organizations to supplement the central supplies. These include MSF-Belgium, MSF-Netherlands and Merlin. MSF commodity support is expected to decline over the near future and IPPFs support to FPAL is not expected to grow significantly. The Christian Health Association of Liberia (CHAL) facilities receive supplies from the National Drugs Services (NDS). While CHAL facilities are privately owned and may have their own funding source, they are not believed to procure contraceptives from other sources. Most of the INGOs operating in Liberia have supplied contraceptives in the past but currently rely mainly on the NDS supply. Their funding and

activities are expected to decline over the coming years as Liberia transitions from emergency to development assistance, and they expect to rely increasingly on NDS commodity support.

2.10 THE COMMERCIAL MARKET

There are no data on the size of the commercial market for drugs including contraceptives. The market for contraceptives is not believed to be significant given the lack of purchasing power in the local population, lack of infrastructure, and the absence of outlets, particularly outside of Monrovia. Officially, there are 120 registered pharmacies in Liberia, virtually all of them in Monrovia. There are also about 250 registered medicine stores, about 200 of them in Monrovia, licensed to sell over-the-counter (OTC) drugs though since regulation is weak, this is not enforced. Officially, medicine stores these are licensed to registered nurses. There may be more unapproved outlets and the problem of illegal sale of drugs is said to be significant but there are no data on the scale of this. Officially, medicine stores are not allowed to sell hormonal contraceptives although many do.

There are 17 drug importers in Liberia, although only 8 are said to be significant. One importer is importing contraceptives – Famy Care products from India – generic COC pills, POP, and emergency contraceptive pills. The same importer wholesales and retails those products but sales are low. They retail at about L$40 per cycle (about US$0.67.) The company says that sales are low and that they are selling at virtually no profit. The same company also imports combination pills manufactured by Cipla, but these retail at L$220 /cycle (about US$3.67) and the company reports that sales are negligible.

Many other pharmacies visited in Monrovia were selling public sector brands – Microgynon, LoFemenal, Microlut and Ovrette – all retailing at around L$40/cycle. Most, if not all, of these are leaked public sector products. In most cases, retailers professed ignorance as to the source of these products. While product leakage is generally undesirable, it does increase access. On the negative side, individuals are profiting from donated commodities and commercial importers (such as the importer of the relatively affordable Famy Care products) are being discouraged from entering the market. One individual pharmacy was importing branded contraceptives from Western manufacturers but these were expensive and targeting expatriates.

An important precondition of establishment of a commercial sector for contraceptives is an adequate infrastructure, including personnel. Currently, only 30 pharmacists are registered in Liberia (most are pharmacists-in-charge for several pharmacies.) The Pharmacy School at the University of Liberia has 33 students enrolled in their first year; currently only one or two graduate per year, meaning that it will be at least three years before significant numbers of newly-trained pharmacists enter the field. There has been no formal training program for pharmacy dispensers, although the Pharmaceutical Association of Liberia hopes to reintroduce a formal training program.

There is no private sector distribution of drugs. Almost all pharmacies and most medicine shops are located in Monrovia, and a wholesaler interviewed reported that all customers – including those upcountry – collect their supplies.

Current income levels in Liberia are extremely low and will hamper the growth of a significant commercial sector for contraceptives and other drugs. Per capita incomes in 2005 were US$163 per annum. Social marketing can play an important role in developing a commercial market for contraceptives and improving access. Subsidizing products can mean they are financially accessible for a section of the Liberian market; advertising and IEC activities can increase demand; and the use of private sector distribution channels increases access. Charging for products provides a margin for wholesalers and retailers as well as an incentive to distribute the products. Any social marketing project that may be established in Liberia should pay sufficient attention to partnering with existing contraceptive importers and distributors to ensure sustainability, and have plans for an eventual phasing out of their activities in favor of a fully commercial market. The table below shows some indicators for the potential of a commercial market in Liberia. As can be seen, virtually all of the countries in the region have social

marketing projects, with many including a range of temporary methods in addition to male condoms. While the low income levels, shortages of pharmacists and small population size, greatly hinder the attractiveness of the market for commercial entities, nevertheless social marketing could play a role in increasing demand and reducing the burden on the public sector

Table 5: Population, health and economic indicators for selected West African countries

Indicator	Liberia	Benin	Burkina Faso	Cote d'Ivoire	Ghana	Guinea	Sierra Leone	Togo
Population, mid 2006 (millions)	3.2	8.7	13.6	19.7	22.6	9.8	5.7	6.3
CPR	No reliable data	9%	7%	7%	19%	6%	4%	9%
Unmet need	No reliable data	27%	29%	28%	34%	24%	NA	32.3%
GNI per capita (PPP), 2005	NA	$1,110	$1,220	$1,490	$1,920	$2,370	$780	$1,550
Private sector share (MWRA receiving FP through private sector)	NA	29%	22%	47%	47%	34%	NA	14.8%
Number of pharmacists per 1,000 people	0.01	0.00	0.03	0.06	0.06	0.06	0.07	0.03
National Social marketing for FP	N	Y ▪ male condom ▪ pills ▪ injectable ▪ IUD	Y ▪ male condom ▪ pills	Y ▪ male condom ▪ female condom ▪ pills	Y ▪ male condom ▪ pills ▪ injectable	Y ▪ male condom ▪ pills ▪ injectable	Y ▪ male condom	Y ▪ male condom ▪ female condom ▪ pills ▪ injectable

CPR, unmet need, and market shares from DHS (year in brackets). Population data from UN. GNI data from World Bank. Pharmacist data from WHO (2004). Pharmacy market share is included in private medical share.

2.11 MARKET SEGMENTATION

There are no data on either the market shares of the different sectors in Liberia or the profiles of users or non-users. The 2007 DHS will provide some of these data.

KEY RECOMMENDATIONS: COMMODITIES

- Stock status at SDPs should be regularly surveyed – stock on hand, consumption, receipts, losses and adjustments, storage conditions, record keeping etc. Ideally, this should be done for all essential drugs for a list of tracer commodities – including contraceptives – developed in consultation with all stakeholders, the MOHSW, and technical partners.

- FHD should decide on their policy regarding brands, particularly those of pills. Do they want to continue to supply multiple brands of POP and COC pills? If not, then they should try as much as possible to consistently procure the same brand. Providers need to be trained on the equivalence of various brands and IEC may be needed to convince clients of brand equivalency.
- FHD should work with the Pharmacy Division at MOHSW and the Pharmacy Board to ensure that current methods available in Liberia are included on the revised EDL. They should investigate the possibility of adding EC pills to the new EDL and the method mix for the public sector.
- FHD division should, in collaboration with partners such as UNFPA, FPAL, CHAL and INGOs, prepare a strategy to increase access to IUDs and other neglected methods such as female condoms and male and female sterilization. IUDs should receive particular attention regarding training staff, upgrading facilities and providing the equipment and materials needed.
- Social marketing for male condoms and other contraceptives, particularly pills, should be investigated by FHD and presented to donors as a priority for Liberia. A social marketing effort should include both products and promotion. Funders should coordinate on this (for example GFATM plans on funding a social marketing IEC effort for condoms.)

3. COMMITMENT

3.1.1 POLICIES FAVORABLE TO CONTRACEPTIVE SECURITY

While several policies are being developed, others have already been adopted which call for support to family planning services and availability of contraceptives. For example, the health policy and health plan make provisions for family planning in the basic health package in two areas: safe motherhood and youth sexual reproductive health. The health plan also stresses the importance of distributing contraceptives at SDPs.

Likewise, the drug policy makes mention on several occasions of actions in favor of family planning products. It recommends that there will be no tax on condoms and IUDs and authorizes the private sector to procure contraceptives. Additionally, the Reproductive Health policy advocates for availability of contraceptive and a strong supply chain to ensure availability of FP products at SDPs. Finally, the National HIV/AIDS strategy explicitly mentions provision of FP services to all as part of its overall strategy.

The 2007 Liberia interim Poverty Reduction Strategy does not make explicit mention of family planning or contraception. It also does not explicitly mention the supply chain for essential drugs. It does mention the primacy of the basic package (which contains family planning.) According to the plan some of the health priorities are infectious disease (HIV/AIDS, malaria, tuberculosis, cholera), immunization, nutrition, maternal and child mortality, infrastructure, training of health staff, and financial sustainability. A final Poverty Reduction Strategy Paper was scheduled for completion in February 2007 but was not available during the assessment.

3.2 ALLOCATION OF FINANCIAL RESOURCES TO PURCHASE CONTRACEPTIVES.

The GOL has only recently begun allocating funds for essential drug procurement with an initial allocation of US$350,000. None of this money has been allocated for contraceptives; the GOL considers them to be covered by donors. Although the money allocated is for essential drug in general, in the event of a shortage of contraceptives, the MOHSW can authorize NDS to purchase contraceptives out of the funds allocated. However, government plans to continue to advocate with donors for continued support in contraceptive purchase.

3.3 CHAMPIONS AND LEADERSHIP FOR FAMILY PLANNING

From the key informant interviews and site visits, two national NGOs emerged as champions for FP in Liberia: FPAL, who provides FP leadership in the country, and CHAL, which has an important network of health services providing family planning. FPAL are currently focusing their efforts on rebuilding their capacity to provide services.

The role of INGOs, including such organizations as Africare, Merlin, MSF, CCF, IRC, IMC, also needs to be highlighted in this area. RH and FP are important elements of these organizations' work, and are seen as an integral part of their efforts to rebuild service delivery and their work on gender issues, particularly gender-based violence stemming from the years of conflict.

4. FINANCING (CAPITAL)

4.1 GOVERNMENT FUNDING

Currently, there is no GOL funding for FP commodities. The GOL has begun funding essential drug procurements: a sum of $350,000 has already been allocated to NDS for procurement and the Pharmacy Division has proposed a further budget of $1 million for procurement. In these amounts there are no provisions for family planning commodities which are believed to be funded by external donors. This amount of money is provided by the central government to purchase products for the entire country. County level managers will make requisitions according to the allocation provided to them. A specific financial allocation will be made to counties to purchase drugs through NDS.

The MOHSW provides a limited amount of money to NDS for its operational costs. NDS reports having received $50,000 for this year (this figure was not verified). NDS charges a handling fee – typically 10 percent - for certain commodities based on drug value to cover its costs. The fee is charged when drugs are delivered to counties. Note that while drugs are supposed to be free for users, counties are charged against their MOHSW budget for the drugs they receive. No handling fees are charged for contraceptives, partly because they are donated, but also in part because they are not in truth handled by NDS; UNFPA pays the salaries for the contraceptive stores staff and rent for the storage space. NDS also receives rent from Africare in return for storage space. Other NDS partners provide limited funding for its operations. In the past, the EU was a major funder for their operational costs but that was interrupted by the most recent fighting and has not resumed, although there are hopes for further funding from this source. GFATM does not pay a handling fee but provides funding in the form of vehicles, money for fuel to transport medicines to the counties, and construction costs for the drug depots etc.

4.2 HOUSEHOLD FUNDING

The national drug policy includes a provision for cost recovery for drugs, but this provision has been suspended in the national health policy for a two year period. It is worth noting that this new policy is not being fully implemented: while INGO supported public facilities provide commodities free of charge, those not supported by donors often charge for them. This should not be surprising given the precarious funding arrangements for facilities and extremely low staff salaries. In addition, national NGOs like FPAL and CHAL charge fees – albeit usually subsidized - for their products (see Table 6 below.)

Commercial pharmacies and medicine stores stock and sell contraceptives – mainly oral pills and male condoms – though prices are relatively low (Table 6), almost certainly due to the fact that most products are leaked free products from the public sector.

There is a certain level of willingness to pay but it is difficult to know the extent to which or which segment of the population is able to pay. Clearly, however, in a country where per capita income levels are only US$163 (2005), 75 percent of people live below the poverty line of US$1.00 (L$60) per day, and about half of the nation exists in abject poverty of less than US$0.50 (L$30) per day, any price paid will

be onerous for most, and cost recovery efforts will be limited. A study on willingness to pay to determine the exact situation may be appropriate in the next two years.

The table below shows the retail prices for contraceptives in various sectors. Note again that while contraceptives are theoretically free in public sector facilities in practice this is probably true only for those facilities supported by INGOs. Each CHAL facility sets their own prices, but they are not expected to vary greatly from the prices shown. Commercial prices are surprisingly constant; most of the outlets visited were charging around L$30 to L$40 per cycle of pills. Depo-Provera was found in only one out of around ten outlets visited and so the price shown was that charged in that facility. Condom prices did vary significantly by brand; the price shown was for the cheapest commercial brand found (L$40 per pack of five.)

Table 6: Unit price (L$) and CYP Cost for various sectors

Method	FPAL		CHAL		Commercial	
	Unit Price	CYP Cost	Unit Price	CYP Cost	Unit Price	CYP Cost
Oral pills (all types)	25	375	20	300	40	600
Injectables (Depo-Provera)	50	200	25	100	25*	100
Male condoms	0	0	0	0	8	960
IUD	150	43	NA	NA	NA	NA

Note: CHAL prices are for one facility only and vary slightly by facility. Commercial prices median prices found except for condoms which are lowest price found. Prices for FPAL and CHAL do not include an initial registration fee which some facilities may charge
*Depo-Provera found in one site only.
CYP cost based on 1 CYP = 15 cycles of pills, 4 vials of Depo, 120 condoms; and 1 IUD = 3.5 years

4.3 DONOR FUNDING

Currently, no formal commitment has been made by donors to provide all needed contraceptive commodities to Liberia in the right quantity and at the right time. While IPPF will continue to support its FPAL affiliate, other NGOs such as MSF are pulling out and their contributions need to be taken over by other organizations. The biggest donors of contraceptives, USAID and UNFPA, have yet to confirm their commitment for the 2007 - 2009 requirements. A new GFATM proposal has been approved and while there are no plans to procure condoms for 2007, they have budgeted funds to procure 3.8 million male condoms and 78,000 female condoms for 2008. GFATM budgets are quite flexible, introducing the possibility that their condom contributions could be changed to help cover any gaps. The MOHSW should formally discuss with donors to secure their commitment to purchase all contraceptives for a clearly determined period of time.

The current funding levels needed are not huge, mainly due to the low demand for contraceptives, but with the recovery of peace, revitalization of health services, and increases in information on family planning, the demand for contraception, and consequently the requirements for family planning products, will increase. Thus, GOL should develop a financial sustainability plan for contraceptives to better prepare for withdrawal of humanitarian NGOs as well as possible future withdrawal or scale back of current major donors of contraceptives. With recovery and development of health services, the role of NDS will grow, therefore requiring more resources to meet the needs of the health system in commodities. MOH should assess the status of NDS and adapt it to the growing challenges that it is facing.

There is no significant health insurance scheme in Liberia. Respondents noted the existence of such a scheme before the conflict (all GOL employees were covered, for example), but since the war this has disappeared.

4.4 OVERALL FUNDING REQUIREMENTS

Based on the 2007 forecast, Table 7 below shows the funding requirements for 2007 to 2009. Note that these estimates are based on the quantities of commodities that need to be procured to fulfill demand taking into account stocks currently on hand, products already in transit, and safety stock levels required. This explains for example why the quantity of Depo-Provera needed is less in 2008 than 2007: Depo-Provera is currently stocked out and so additional quantities are required to build up a safety stock. The estimates are based on current USAID prices for contraceptives; actual prices will depend on the funding source. Prices include estimates for shipping costs.

Table 7: Quantities and funding requirement (US$) for contraceptives, 2007 - 2009

Method	2007		2008		2009		Total	
	Quantity	Cost	Quantity	Cost	Quantity	Cost	Quantity	Cost
Depo-Provera (vials)	177,088	$186,687	114,400	$121,807	132,000	$140,546	423,488	$449,040
Combination pills (cycles)	0	0	201,643	$49,083	409,857	$99,765	611,500	$148,848
Progestin only pills (cycles)	59,289	$14,126	118,271	$28,474	124,100	$30,207	301,660	$72,807
Male condoms (pieces)	8,282,040	$311,694	9,583,128	$367,732	10,840,223	$415,971	28,705,391	$1,095,397
Female condoms (pieces)	0	0	0	0	47,524	$30,060	47,524	$30,060
IUDs (Copper T) (units)	0	0	1,000	$1,634	2,000	$3,268	3,000	$4,902
Total	-	**$512,507**	-	**$568,730**	-	**$719,817**	-	**$1,801,054**

KEY RECOMMENDATIONS: FINANCING

- FHD to convene regular forecast and procurement plan reviews with major technical partners, including NDS, as a forum to obtain funding commitment for contraceptives
- Advocacy for the inclusion of contraceptives – even a modest amount – in government essential drug procurements. This could be in the form of a budget line for contraceptives or an internal line for contraceptives when NDS and the Pharmacy Division at MOHSW prepare their essential drug financing requests
- Donors, such as USAID and UNFPA, should target their resources for procurement towards those contraceptives (hormonal products and IUDs) that the GFATM are unlikely – certainly over the short to medium term - to procure. There is a willingness on the part of the GFATM to procure male and female condoms; the best allocation of resources on the part of other donors would be to concentrate on pills, injections and IUDs.

5. SUPPLY CHAIN CAPACITY

After years of conflict and consequent deterioration in services, the national public sector supply chain is extremely weak. Compounding the situation is the limited capacity in logistics within the MOHSW and at NDS. Many INGOs and externally funded vertical programs (EPI, HIV/AIDS, malaria) operate their own supply chains, often in parallel to existing and limited public sector supplies. This leads to much duplication, overlap, and confusion on supply chain issues. Strengthening the capacity of NDS is a priority of many stakeholders in Liberia, including the MOHSW and the GFATM. The current Round 6 GFATM grant for HIV/AIDS envisages an assessment of NDS to determine their needs for technical assistance.

The contraceptive supply chain is primarily vertical, with separate forecasting and donor procurement, separate storage at central and county levels, and with distribution being mainly handled by RH staff at the county level. Even storage at SDP level is often handled directly by staff responsible for RH. The following sections describe the supply chain by component. Figures 3 and 4 below summarize the information. Decisions and actions are made on an ad-hoc basis; the descriptions describe as far as possible what seems to be happening with all the inconsistencies associated with this.

5.1 FORECASTING

Liberia currently has little capacity to conduct forecasts. All forecasts for contraceptives thus far have been completed by DELIVER with USAID funding. While these forecasts were done in conjunction with the FHD of the MOHSW, they did not involve NDS. One person at NDS has done forecasting for essential medicines; however, this resource is not being used for contraceptives. In addition, little donor and government involvement in the forecasting process has taken place. Forecasts have also been conducted for several vertical programs – HIV/AIDS and malaria for example – by outside consultants funded by UNDP (Principal Recipient [PR] for the GFATM). However, these consultants did not consult with NDS in developing these forecasts. Where NDS does forecasts, Decisions on the quantities of drugs to procure are based less on forecasted demand, and more on funding available and/or treatment targets combined with morbidity and epidemiological data and historical consumption (in fact issues) patterns.

Accurate forecasts generally rely on consumption data; however, there are no reliable consumption data currently available from the facility level. The contraceptive forecast conducted by DELIVER in March/April 2006 used demographic data for its projections; the most recent forecast, done in February 2007, considered issues data available from the records kept by the NDS/UNFPA Reproductive Health Store manager. Since NGOs have begun collecting contraceptives from the County Health Teams or NDS, these forecasts included their needs as well; however, the forecast does not take into consideration any contraceptives brought into Liberia by the NGOs themselves. The assumption is that 1) quantities of contraceptives imported directly are small and, 2) are likely to continue at a similar level in 2007 to 2009.

Given the uncertainty around current consumption, and the changing situation in Liberia with the expectation that more Liberians will access services as they become aware of their availability, the forecast requires consistent and frequent monitoring. There are currently no plans to review the existing contraceptive forecast or to conduct additional forecasts.

5.2 PROCUREMENT

NDS is the national agency responsible for drug procurement for the public sector. Currently, procurement of contraceptives is done by donors: USAID, UNFPA and UNDP (in their capacity as PR for the GFATM.) NDS has never been involved in contraceptive procurement.

NDS has limited experience in procurement of essential drugs. During and after the years of conflict, most procurement has been by donor funded vertical programs – for example HIV/AIDS and other STIs, and malaria – through third party procurement agents. NDS has done some procurement recently using GOL funds. Most procurement has been by restricted tendering from a list of pre-approved suppliers with

two of the major suppliers being Mission Pharma and IDA. NDS report that restricted-tender cycle times can be around six months. Other donors – for example, Saudi Arabia - have also funded essential drugs, with NDS arranging the procurement but with money being transferred directly from the donor to the supplier. According to NDS, they have done open tendering in the past to World Bank procurement standards; however, this was not verified. There is a Procurement Focal Group at NDS, consisting of the Managing Director, his deputy/Chief Pharmacist, and the Financial Controller. Absent an updated EDL, decisions on what to procure tend to be made on an ad-hoc basis.

The Round 6 GFATM grant for HIV/AIDS envisages NDS assuming responsibility for drug procurement from UNDP by Year 3 (sometime during 2009.) Consequently, GFATM will invest in strengthening the procurement capacity at NDS, including forming a dedicated procurement unit.

5.3 TRANSPORT AND DISTRIBUTION

The road infrastructure in Liberia seriously impacts commodity availability particularly during the long rainy season, and particularly in the south-eastern counties which at the best of times can take several days to reach from Monrovia and can be cut-off during the rainy season. This affects every level of drug distribution: from the central level to the counties and from the counties to facilities.

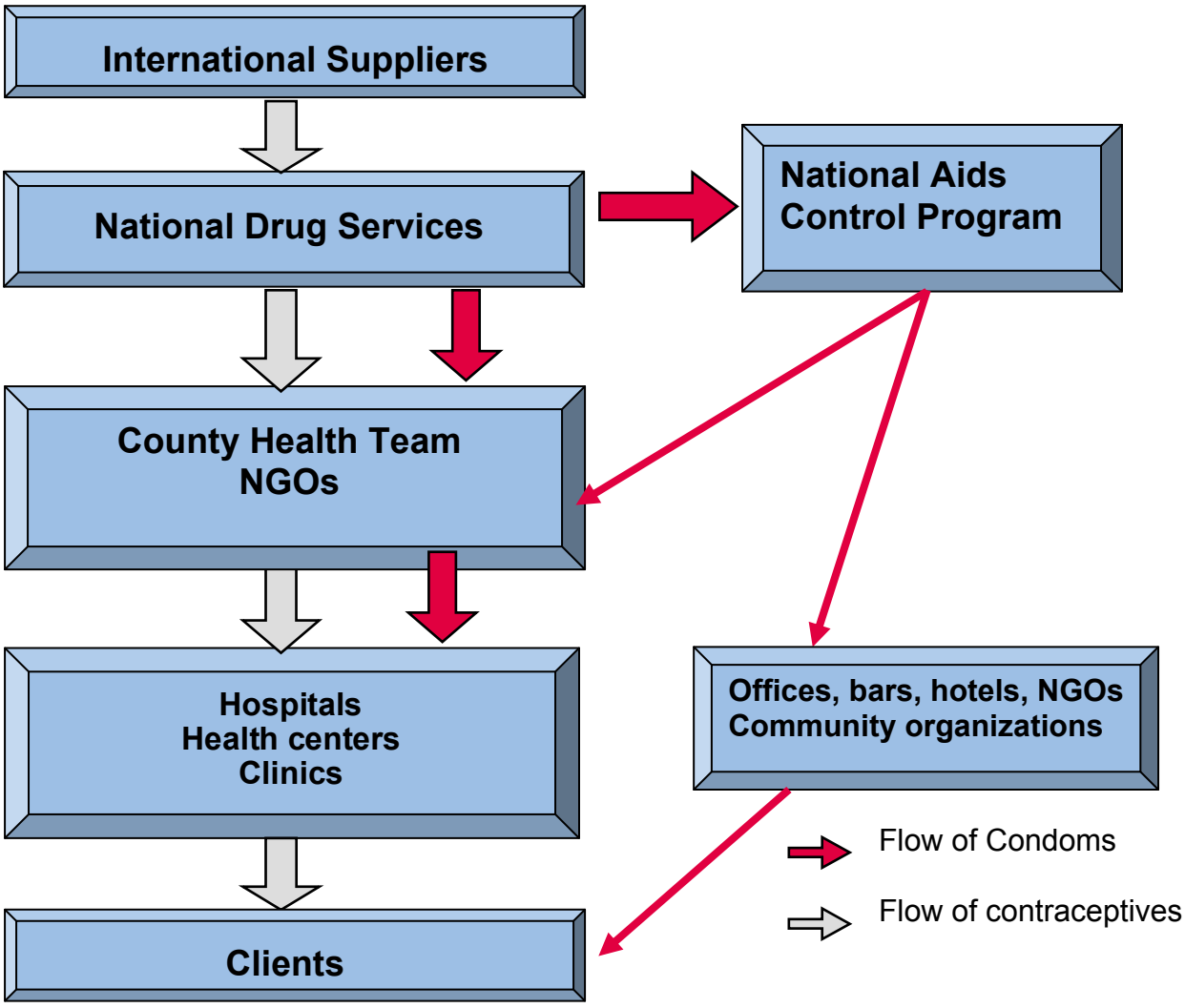
Contraceptive distribution in Liberia can be characterized by one word – ad-hoc. INGOs pick up commodities from NDS and distribute to facilities, counties pick up from NDS and either deliver to facilities or facilities collect. Sometimes contraceptives are distributed with essential drugs but in many cases separately. In addition, about 80 percent of condoms are distributed through the National Aids Control Program (NACP) to NGOs, companies, ministries and individuals, with the remainder flowing through the national public-sector pipeline.

Regular distribution schedules for any drugs are not in place; active distribution by NDS takes place on an occasional basis whenever significant quantities of commodities are available. NDS has a large truck as well as two pick up trucks that are used for deliveries. NDS has no refrigerated transport, using cold boxes to transport heat sensitive commodities. Typically, NDS does not deliver contraceptives as part of their deliveries, although there is no reason why they could not do so if the counties requested it. How NDS determines where and when to distribute supplies is unknown.

In the past, NGOs operating in areas where there is government presence have gone directly to NDS to collect the contraceptives they require. In recent months, NGOs have been asked to collect their supplies from the counties en lieu of going to the central level, although many continue to collect from NDS. NGOs tend to have their own vehicles which regularly transport commodities, including contraceptives, to the facilities they support.

Similarly, the County Health and Social Welfare Team's (CHSWT) Reproductive Health Supervisors collect supplies for their counties from the NDS, theoretically once they have submitted their requisition form to the FHD. Counties have pick-up trucks available for this purpose, though they are multipurpose vehicles and not just for transporting drugs. Some counties report consolidating collection at NDS and picking up contraceptives at the same time as they collect essential drugs; this is not consistent however. Most facilities pick up their supplies from the counties or try to arrange a delivery but it doesn't appear that counties carry out regular scheduled deliveries of essential drugs, including contraceptives, to the facilities. Few facilities have their own transport which means this is a major headache for providers.

Figure 2: Movement of contraceptives in public health sector



5.4 STORAGE AND INVENTORY MANAGEMENT

At the central level, contraceptives are stored in a warehouse adjoining, but separate from, the essential medicines stores at NDS, and are managed by UNFPA staff. The storage area is kept cool and boxes are kept on pallets, arranged according to product name and by expiry date. Products are issued following First-Expiry First-Out (FEFO) practices. The UNFPA staff recently began keeping electronic stock cards using an Excel spreadsheet. There is inadequate space for bulky items, such as male and female condoms, and bulk quantities of these are stored in temperature controlled container units on the NDS complex.

NDS has a number of separate warehouses in their complex. Many vertical programs require separate storage and separate inventory control systems. Most essential drugs for general use are stored in two older warehouses: one bulk warehouse, and one for smaller quantities of drugs from where orders are filled. There is one separate refrigerated area for vaccine storage funded by UNCIEF, and a separate newer building which houses two floors of warehousing with a top storey for new offices. Storage space is generally adequate, however, the newer storage space is poorly designed; for instance ceilings are too

low to accommodate forklifts, and pallets must be hauled up a long ramp using a pallet truck to reach the second storey warehouse. The low ceiling height is currently somewhat of a moot point, since NDS does not possess any forklift or automated pallet lift; pallets must be loaded and unloaded manually. There is also a shortage of shelving and racking in the newer areas and cartons tend to be packed very high on pallets on the ground. Apart from the vaccine area, cold storage space is limited though a number of refrigerators were recently purchased using GFATM money to alleviate this.

Inventory management at NDS is reasonable given the constraints the organization must work under. Minimum and maximum stock levels are not respected, but this is understandable given the financial constraints on procurement. Vertically funded programs carry out their own forecasting and procurement and other essential drugs are under-funded so NDS has little control over what is ordered. The Round 6 GFATM grant intends carrying out an assessment of overall NDS inventory management systems to decide on priorities for strengthening to build their capacity to assume overall management of the GFATM supply chain.

At the counties, contraceptives tend to be stored separately from essential drugs in the Reproductive Health office under poor storage conditions – inadequate space, no stock records, and no shelving. Nine out of fifteen counties have newly-constructed depots for essential drugs; financed by GFATM. Some depots are intended to service several counties. Two of these depots were visited during the assessment and had just received their first deliveries - mainly of STI drugs and antimalarials. The depots visited were generally adequate, with some shelving though one was still awaiting more shelving and a second had no stock cards. While the official policy is that these depots are for storing all essential drugs, there may be some confusion on this point at the county level: at least one county reported being told that only GFATM commodities could be stored there. It is also not clear who is ultimately responsible for managing these depots – the counties or NDS? In one depot the County Health Officer intended storing his drug supply in the depot, and it's the stated intention of NDS to keep a buffer stock of essential drugs at these locations. However, since commodities will be charged to the counties' account at NDS, it is not clear how this will work if the county is managing the stores: ownership of commodities and management responsibility for them need to rest with the same body. Similarly, it needs to be determined if depots storing drugs for more than one county will have separate storage areas for each county.

Table 8: Location of new drug depots

Location	Counties served
Tubmanburg	Bomi, Grand Cape Mount, Gbarapolu
Buchanan	Grand Bassa, River Cess
Bong	Bong
Nimba	Nimba
Voinjama	Lofa
Zorzor	Lofa
Greenville	Sinoe
River Gee	River Gee
Harper	Maryland, Grand Kru

Note: Monstserrado and Margibi counties to be serviced directly from NDS.

Inventory control systems allow facilities to monitor their stock and avoid stock outs as well as expiries by setting minimum and maximum stock levels. Facilities visited did not have any inventory control system in place. Some facilities visited were stocked out of all contraceptives, and had been for at least one month. None of these facilities indicated that they placed emergency orders or knew how to prevent future stock outs.

No formal systems or procedures to handle damaged or expired products were found. NDS reported having no incineration facilities for disposal and having to resort to burning and burying in pits outside Monrovia.

5.5 LOGISTICS MANAGEMENT INFORMATION SYSTEM

The MOHSW currently has a skeleton Health Information System to collect service statistics. Forms currently used in the system that collect logistics data include: Monthly Reproductive Health MCH/Family Planning Report, Requisition and Issue Form, Daily Activity Registers in the form of ledger books, and stock cards at the central level.

The FHD uses the Monthly Reproductive Health MCH/Family Planning Report. Health facilities submit this report on a monthly basis to their county health team, and the counties in turn submit their reports to the FHD on a quarterly basis. Since some NGOs began obtaining their contraceptives from the county health teams, they have been asked to submit this report as well. Review of several reports during site visits found that these reports are not usually completed fully or correctly. Furthermore, the FHD does not receive the majority of reports expected to be submitted. Nor are the reports analyzed or the data used to inform decision-making.

The data provided by these reports include: antenatal care, deliveries in the clinic, deliveries at home, postnatal care, and family planning. Under family planning, facilities report on new and revisiting clients, beginning balance, supplies received, supplies issued, and balance on hand. The reports collect consumption and balance on hand; however, losses and adjustments as well actual stock on hand is not. Facilities assume that their balance on hand accurately reflects their physical stock levels. In addition, the data collected on these forms are not reliable.

The only ordering form used in the public sector system is the Requisition and Issue Voucher, available at the FHD. This form provides information on quantity requested, quantity approved, and quantity issued. The Requisition and Issue Voucher is used by CHSWTs, who submit their order via this form to the FHD for approval. Consumption data is not used to determine order quantities; instead, the quantities are arrived at by guesswork or by ad-hoc estimates of future demand. The system cannot be truly described as either push or pull; nevertheless from the central to the counties and NGOs it functions mainly as a pull with lower levels estimating their need and ordering accordingly, whereas from counties and NGOs to facilities it is primarily push with the higher level determining how much to send based on a combination on consumption reports, intuition, and quantity of stock available.

NGO supported facilities keep similar MCH reporting forms, although there are variations by organization; facilities report to the NGO, which in theory should report to the counties. In practice, a variety of reporting practices seem to occur, reducing the likelihood of reporting to MOHSW or introducing duplicate reporting where the NGOs report both to the counties and directly to the MOHSW.

NDS has a sophisticated Access- based inventory management system with separate databases for commodities financed by different donors including GFATM and the normal essential drug system. Stocks are managed separately, creating a situation where the same commodity can be present in two different databases, depending on how it was financed. This assessment noted a situation where a commodity – paracetamol – was stocked out as an “essential drug” but was in stock as an “OI drug” financed by GFATM. Another potential scenario, where a county can order a drug for their essential drug program to be told it is stocked out while the same drug may be overstocked in the GFATM funded program, can also easily arise. Since, in theory, once the drug arrives at a facility, it may be used for any purpose – provided it is clinically indicated - this makes little sense.

KEY RECOMMENDATIONS: LOGISTICS

- Forecasting: FHD to ensure that the current forecast is reviewed six months from now with a key goal of the review to train incountry stakeholders, particularly NDS and FHD, in forecasting and quantifying contraceptive needs.
- Forecasting: Institutionalize a specific forecast review meeting, once the forecast is prepared, with key donors – USAID, UNFPA, GFATM (UNDP/MOHSW GFATM coordinator) – to share the findings and confirm their commitments for commodity procurement
- Integration: FHD and NDS, in collaboration with key donors – USAID and UNFPA – to determine their roles and responsibilities for the contraceptive supply chain. They should describe and begin implementation of their "ideal" supply chain, while recognizing that currently, given the limited capacity and uncertain environment, there will be exceptions made to ensure products are available. For illustrative purposes only, the table below describes how responsibilities could be divided in an integrated system:

Function	**Responsibility**
Selection	Pharmacy Board and/or Pharmacy Division on advisement from FHD
Forecasting	NDS with input from FHD
Procurement	NDS
Storage	NDS, CHSWT
Distribution	NDS, CHT
M&E	NDS, FHD, CHSWT
LMIS	NDS, FHD, Pharmacy Division, CHSWT
Finance	NDS, FHD, CHSWTs

  Ideally, selection should be done jointly between FHD and the Pharmacy Board (with the FHD recommending to the Board what methods should be part of the EDL), forecasting should be a joint exercise between FHD and NDS, procurement (when not carried out by donors) should be an NDS responsibility, storage should be integrated at NDS and the counties with other essential drugs, distribution should be integrated with NDS delivering when possible and counties collecting with other essential drugs, and there should be an integrated LMIS for all essential drugs managed jointly by NDS (central level) and the Pharmacy Division at MOHSW (counties – SDPs.)

  Again note that these assignations are illustrative and any actual decisions as to responsibilities in any future integrated system would need to de developed through consultation.

- Inventory Management: Requiring NDS to manage essential drugs vertically by program puts major strains on the resources of NDS as well as being wasteful and inefficient. If there are concerns about the ability of NDS to manage these commodities, addressing them as part of an overall system strengthening is more appropriate than trying to isolate particular commodities - or even particularly funded commodities - within the NDS system.

Figure 3: Summary of Supply Chain for Contraceptives

Level	Supply Chain Element						
	Selection	**Forecasting/Quantification**	**Procurement**	**Storage**	**Distribution**	**Inventory Management**	**LMIS**
Central	▪ Unclear (ad-hoc) ▪ Loosely based on old NDS catalog/order form	▪ FHD organize using external consultants funded by USAID ▪ Current forecast based on central level issues	▪ Donors ▪ Some NGOs (complement donor supplies)	▪ NDS (separate storage area for contraceptives managed by UNFPA staff)	▪ Counties collect ▪ NGOs collect	▪ Vertical system tracks Receipts and issues; occasional physical inventories ▪ Min 6 MOS, Max 12 MOS but no oversight	▪ None
County	NA	NA	▪ RH Supervisors order for County ▪ NGOs branches order for their facilities ▪ Unclear for both what criteria are for determining how much to order	▪ RH Supervisors offices/separate storage area ▪ NGO store (may serve more than one county)	▪ SDPs collect (usually) or CHSWT delivers ▪ NGOs deliver	▪ Generally none at the CHSWT ▪ NGOs operate their own systems	▪ Counties report HIS including some logistics information to FHD but data are irregular and poor quality ▪ NGOs report to head office but inconsistently to FHD
SDP	NA	NA	▪ OIC/RH provider orders May be reviewed by RH Supervisor or NGO office but unclear what criteria are used	▪ Pharmacy and/or RH Providers cabinet	▪ Delivered by NGOs. CHT either delivers or facilities collect	▪ Stock cards often but not always used ▪ No real inventory management	▪ HMS reports some logistics data to counties and NGOs

Figure 4: Summary of Supply Chain for Other Essential Drugs

Level	Supply Chain Element						
	Selection	**Forecasting/Quantification**	**Procurement**	**Storage**	**Distribution**	**Inventory Management**	**LMIS**
Central	▪ Unclear (ad-hoc) ▪ Loosely based on old EDL but EDL rarely available	▪ Programs – malaria, HIV/AIDS/STI/OIs – organize external consultants using GFATM funds ▪ Essential drugs by NDS based on variety of data: targets, available funding, epidemiological, historical "consumption"	▪ UNDP for HIV/AIDS/STI/ OIs and malaria ▪ NDS using restricted tendering for GOL money also some other donor money ▪ NDS reviews orders from CHOs (review varies depending on funding source)	▪ NDS. Separate storage areas for number of programs by funder: EPI, malaria, HIV/AIDS/STI/OI, leprosy ▪ Most NGOs have own central stores	▪ Counties collect ▪ NGOs collect ▪ NDS delivers occasionally to depots/counti es	▪ No Min/Max used ▪ FEFO as part of LMIS ▪ Computerized system with separate databases by funder ▪ Stock cards also kept for most commodities ▪ NGOs have inventory management systems	▪ NDS System tracks SOH, expiries, losses, issues, receipts, again by funder
County	NA	NA	▪ CHO compiles, reviews and places orders from facilities ▪ NGO branches order for their facilities	▪ MOH/NDS Drug depots in 9 counties ▪ Other CHTs have very limited and inadequate storage capacity ▪ Many NGOs have own "county"/ "regional" storage	▪ SDPs collect (usually) or CHSWT delivers ▪ NGOs deliver	▪ Some have stock cards ▪ NGOs operate their own systems	▪ Programs gather their own data ▪ No logistics data reported to NDS
SDP	NA	NA	Unknown	▪ Pharmacy/dispensary	▪ Delivered by NGOs. CHSWT either delivers or facilities collect	▪ Stock cards often used ▪ No real inventory management	Unknown

6. SERVICE DELIVERY CAPACITY

Although the number of facilities, managed by either NGOs or the MOHSW, dropped during the past years of conflict, family planning services remained available to some Liberians. Those local NGOs who managed to provide such services on a more limited basis maintain a strong presence and reputation in the country, putting them in a good position to respond to the changing service environment.

As Liberia moves out of the emergency response phase and into a more development oriented environment, significant concerns have emerged regarding how the transition of services from INGOs to the MOHSW will effectively occur. This is particularly evident in one of the key issues among government service providers: low salaries. Those nurses who are trained at the nursing schools often obtain employment with INGOs because they are offered a salary up to 150 percent more than the public sector. And if they seek employment with the MOHSW, they choose not to accept the rural postings they do receive. Currently, salary levels in the public sector are extremely low; while the GOL hopes to increase these in the future, such an increase is dependent on obtaining new funding since internal resources are currently inadequate to do this.

Additionally, those currently providing services do not receive regular supervisory visits. One county provider explained that she occasionally conducts supervisory visits, but the transportation situation is such that these visits are conducted jointly; as a result, she does not have the flexibility to respond to issues before they happen. Regular visits can be an opportunity to monitor ongoing activities, identify potential problems as well as provide on-the-job training and thus refine capacity.

6.1 SERVICE PROVIDER NUMBERS AND CAPACITY

Skilled service providers are currently lacking since many fled the country during the war and have not returned. The Round 6 Global Fund proposal summarizes the acute shortage of medical personnel:

> *"A rapid assessment of the health workforce conducted in 354 health facilities by the Ministry of Health in June 2006 showed that Liberia has only 122 doctors (51 Liberians/naturalized Liberians, 71 foreign nationals working for INGOs), 668 nurses of all kinds, and 297 certified midwives. WHO estimates based on a target density of 2.28 doctors, nurses and midwives per 1,000 population project that Liberia should have 1,094 doctors, 5,549 nurses, and 1,634 midwives (see Table 3). In other words, Liberia should have 9 times as many doctors, 8 times as many nurses and 6 times as many midwives to reach the minimum threshold for effective health care delivery."*

At the moment, little training has been conducted to increase capacity outside of the nursing and pharmacy schools. This introduces a greater possibility that clients will receive poor quality services. However, the lack of trained providers is as much of a concern as the limited capacity to train a new cadre of providers or provide quality refresher trainings. Although several examples of family planning – related curricula under development were given in focus group discussions, skilled trainers must be available to conduct the finalized courses effectively. As previously mentioned, the method mix is limited to short term methods: pills, injectables, and condoms. In addition to an absence of service providers trained in IUD insertion and sterilization techniques, space in and equipment with which to perform such procedures is lacking.

KEY RECOMMENDATIONS: SERVICE DELIVERY

- There are no standard treatment guidelines for FP. Guidelines should be developed, disseminated and providers trained in their application

7. COORDINATION

The MOHSW views coordination and partnership as an important part of its strategy to leverage resources, improve communication among stakeholders, and strengthen the implementation of health programs. For example, the policy document clearly states that the public health sector shall work in close partnership with all stakeholders in health including private medical practitioners and non-governmental heath care providers at both the national and peripheral levels, allocating adequate resources, expertise and attention to improving coordination. For reproductive health programs, the following are the existing coordination mechanisms described in the policy documents:

Reproductive health steering committee: The RH steering committee provides policy direction and guidance to the reproductive health program and advises the MOHSW on policy matters related to RH programming. The committee reviews the overall progress of the national RH program. The committee also provides opportunities for consultation among agencies involved in RH in Liberia. It is expected to promote collaboration and mobilize resources.

The RH steering committee has decision making power and is chaired by the Minister of Health. The Head of the FHD acts as secretary to the RH steering committee. It is composed of high level officials in the MOHSW, directors of large national NGOs, and top representatives of the donor community as well as high level officials of relevant other departments of the GOL. The RH steering committee is not yet functional.

Reproductive health technical committee: The RH technical committee is appointed by the Minister of Health and comprises selected experts in reproductive health and representatives of relevant organizations and MOHSW service divisions. The technical committee provides technical advice and guidance to the FHD on program implementation. Chaired by the Head of the FHD, it is tasked to:

- Review technical documents,
- Review research protocols and proposals,
- Develop technical guidelines, and
- Advise on implementation of programs.

RH technical committees are envisaged at both national and county level. The RH technical committees at county levels have not been formed. However, the need for coordination at county level is important and, in light of the scarce resources that needed to be use on a rational manner, urgent at this time.

Although the RH policy was adopted in 2001, the structures described above – apart from the office of NGO coordinator - have not been fully operational. For example, during the April 2006 contraceptive security sensitization workshop, the issue of coordination was discussed and organization members of the RH technical committee present at the workshop were not aware of the role that the RH technical committee should play. During the workshop, a recommendation was made to revitalize the RH technical committee. The RH committee is expected to meet every month, but it does not meet regularly; the most recent meeting was in November 2006. However, the committee was able to start discussions on the development of a RH road map and a first draft of the road map has been produced. The RH technical committee has met to contribute to the assessment of the contraceptive security situation and is expected to meet to set priority issues regarding contraceptive security and develop the strategic plan for contraceptive security for Liberia.

NGO coordinator: An NGO coordinator has been appointed at the MOHSW to coordinate NGOs activities. Coordination between MOHSW and INGOs is a major concern in Liberia. According to the 2006 Rapid Assessment of health services, 28.8 percent of health facilities in the country are managed by

GOL through the MOHSW, and 45.5 percent by NGOs (mainly INGOs.) Most of these NGOs operate government owned facilities. It is expected that these INGOs will gradually scale back their support (of course there will be some exceptions to this) and the MOHSW will gradually assume responsibility for these facilities. This will require significant planning to ensure a seamless transfer – NGOs have their own operating systems, their supply chains, and supervisory structures, and they pay salaries directly to staff at significantly higher levels than the MOHSW.

KEY RECOMMENDATIONS: COORDINATION

- FHD to ensure regular meetings of the RH technical committee, with minutes, and ensure the committee considers commodity security issues as part of its mandate
- NGOs and the MOHSW to coordinate around the specific issue of transfer of facilities from NGO management to MOHSW

8. CONTEXT: ENVIRONMENT, POLICIES AND REGULATIONS

8.1 SOCIO ECONOMIC

Before the war, Liberia enjoyed relative prosperity among the ECOWAS countries with a GDP of US$1269 in 1980. After the war, this fell to US$163 in 2005, leading to widespread poverty. Seventy-five percent of the population earns less than US$1 a day.

The population, dispersed in internal camps, is now returning to their locations of origin – or in many cases moving to Monrovia - to face the challenges of rebuilding their lives. Roads are in very bad condition preventing rapid communication and provision of urgently needed goods and services. However, security is increasing in rural areas. In 2005, a democratic government was elected. The people of Liberia expect from the newly elected government a great deal of improvement in their lives.

As of 2007, Liberia is still transitioning from emergency assistance to recovery, reconstruction and development. The challenges facing the country during this transition period stem from the withdrawal or scaling back operations of humanitarian organizations that have been assisting the Liberian people during the war. Their programmed withdrawal will create a huge gap that must be filled by the GOL. An alternative form of external assistance is urgently needed for an extended period since the government alone is not in a strong position to meet the needs of the people.

8.2 HEALTH SITUATION IN LIBERIA

The years of conflict severely disrupted the delivery of healthcare in Liberia. Reconstruction of facilities and revitalization of services has begun, but significant challenges remain to strengthening the physical infrastructure, human resources and institutional capacity to provide basic services to the population. The situation can also be characterized by a lack of data on the health situation with only piece-meal surveys for particular conditions. Malaria, acute respiratory infections, diarrhea, tuberculosis, sexually transmitted infections (STIs), worms, skin diseases, malnutrition and anemia are the most common causes of morbidity and mortality. Malaria accounts for over 40 percent of out-patient attendance and up to 18 percent of inpatient deaths. Diarrheal diseases are the second leading causes of morbidity and mortality while the best available estimate of HIV prevalence is around 5.2 percent (National Health Policy.)

Disruptions of health services by conflict have greatly affected access to health services. Data are unreliable but the Interim Poverty Reduction Strategy reports that only 41 percent of the population has access to health services. The situation is believed especially bad in the South Eastern region.

Other health indicators[1] are as follows:

- Infant Mortality Ratio: 157/1,000
- Under five /child mortality: 235/1,000
- Maternal mortality ratio: 578/100,000

Some of these indicators are among the highest in sub-Saharan Africa.

Significant displacement of the population occurred during the conflict and whole areas have been depopulated with many moving to the Monrovia area. A census is planned for later in 2007, though many estimate that between one third and one half of the population of around 3.2 million now resides in Monrovia.

The Liberian health care system has endured all the socio economic hardship caused by the war and will face major challenges in the future. During the emergency period, health care continued to be delivered by humanitarian organizations throughout the country. Healthcare delivery currently remains heavily dependent on donor funded vertical programs and international Non Governmental Organizations (INGOs). In most cases, INGOs have replaced the government in managing health services. Disease prevention and control programs exist for malaria, TB, and HIV/AIDS, while a variety of INGOs support service delivery through public sector facilities, mainly in the most war affected areas. Local NGOs, which were very active in the prewar era, have witnessed their operations shrink considerably. For example, FPAL, the main provider of family planning services in the country, offered FP services in over 120 – mostly GOL owned - clinics. The number now has dropped to three. In the public sector, the MOH Rapid Assessment conducted in 2006 has shown that out of 521 existing health facilities, 300 are assisted by INGOs in a humanitarian mode, 132 are non functional and 89 facilities functioning without INGO assistance. Among the functioning facilities, 46 percent have no water supply and 88 percent have no vehicle for emergency evacuation. Health manpower in the public sector consists of approximately 4,000 full time and 1,000 part-time staff. A significant proportion of these health professionals lack the skills and experience necessary to manage the facilities and deliver services efficiently. In general, staff has very low morale due to poor compensation packages and inadequate conditions to perform their duties. INGOs pay significantly more and offer better working conditions than the GOL. As INGOs scale back their activities and switch from emergency relief to development, there is a danger that service delivery will weaken in these areas as the government is not yet prepared to take over from the humanitarian NGOs.

The national health system is comprised of the following three levels of care: primary, secondary and tertiary:

- The primary level of care, comprises of clinics and small health centers
- The secondary level of care, encompasses large health centers and county hospitals
- The tertiary level of care is represented by the JFK Medical Center in Monrovia, an autonomous body managed by its hospital administration department under the supervision of a board of directors.

Overall, the health care system is uneven and lacks equity among geographical areas and most programs are vertical. Challenges to rebuilding the health system include: expansion of access of basic package of health care, improving the availability of essential drugs including contraceptives and other reproductive health products, improving the health management information systems, improving access to safe water and sanitation, and improving health workers skills to provide services and supervise service providers.

[1] All indicators from 2000 DHS cited in Liberia Interim Poverty Reduction Strategy

8.3 POLICIES AND REGULATIONS

The MOHSW has a draft national health policy dated January 2007 aimed at reforming the sector to effectively deliver quality health and welfare services to the people of Liberia. The MOHSW is dedicated to equitable, accessible and sustainable health promotion and protection and the provision of comprehensible and affordable health care and social welfare services.

Among the guiding principles of the policy are:

- Equity, gender and poverty focus,
- Efficiency and sustainability,
- Decentralization, and
- Partnership.

At the operational level, the County Health and Social Welfare Administration is the operational management structure, which includes the CHSWT. County health authorities manage county health facilities, including county hospitals. Proper administrative structures and management tools will be introduced at county level, to make health authorities truly autonomous. They will be responsible for financial and asset management and personnel and will be truly accountable to local constituencies as well as overseeing public bodies.

Concurrently with the development of the National Health Policy, a National Health and Social Welfare Plan is being drawn up. The latest draft seen, from November 2006, serves to implement the national health policy. Some of the key provisions of the plan include:

- Improvement of staff motivation, morale and productivity by addressing the issues of lack of career plan, poor compensation package, and lack of job descriptions.
- A focus on restoring the health infrastructure, mostly at health centers and clinic levels, but also to benefit counties and hospitals. This will be implemented in 2007 and 2008.
- Decentralization of health support systems including drugs and medical supplies, health management information system, stakeholders coordination and other support systems.

Decentralization is an important issue with consequences for CS. The table below shows two examples of decentralization of support systems taken from the health plan:

Table 9: Examples of proposed decentralized systems

Support systems	Central	County	District	Community
Drugs and Medical supplies	Develop policy and system for ordering and distribution of essential drugs and supplies	Develop a county system to receive and distribute essential drugs and supplies	Coordinate distribution and supervise drugs and supplies in clinics and health centers	Encourage the care seeking behavior for proper treatment at health facilities
Stakeholder coordination	MOH aligns counties with a donor/projects that provide county wide support	County coordination Meetings coordinate county plan and resources, including NGO-managed projects	District Health Committee and/or Community development Committee coordinate local stakeholders	Community Health Committee coordinates local resources, e.g. CHWs, TTMS, building staff housing

Pharmaceutical and health commodities policy

Overall responsibility for pharmaceutical management in Liberia is currently being reviewed. At the moment, three entities manage pharmaceuticals: the Pharmacy Division, Pharmacy Board, and Pharmacists' Association. Their intertwined roles and responsibilities include the registration of pharmacists, licensing of pharmacies and medicine stores, authorizing imports, ensuring quality control of imported drugs, registering drugs. There is a desire to strengthen structures independent of the MOHSW such as the Pharmacy Board and to clearly delineate their role and responsibility vis-à-vis the Pharmacists' Association and the Pharmacy Division at the MOHSW.

To ensure access to efficacious high quality, safe and affordable medicines for the majority of the people, the MOHSW adopted a National Drug Policy (NDP) in 2001, which is based on the following main elements: adoption of an Essential Drugs list, Standard Treatment Guidelines, Drug Formulary and other instruments to promote the use of generic medicines of proven efficacy at low cost. Currently, the Pharmacy Division is reviewing the 2001 policy to determine what, if any, changes need to be made. The consensus seems to be that the 2001 policy is reasonable and may only need minimal updates and implementation. The essential drugs list, guidelines and formulary will be updated to ensure consistency with the BPHS. The current EDL has not been updated in some years and is not available in any facility. A priority for the Pharmacy Division at the MOHSW is to prepare a new list; this is expected to be completed over the next few months. The old list does not contain contraceptives; the list simply refers the reader to the FHD. The order list for NDS (which is used to order contraceptives) is the only list as such which contains a list of products, in certain cases by brand. There is no commodity list associated with the BPHS.

The 2001 policy also provides information on some regulations regarding drug distribution area that impact contraceptive security: These include:

- Ban on advertisement of drugs
- Restrictive dispensing regulations. For example, no hormonal contraceptives should be sold in medicine stores.

In the pharmaceutical area, policy implementation is weak and regulations regarding private pharmacies, medicine stores and NGOs activities are not enforced. In the current situation, medicines stores sell products that are not in their list (for example, hormonals) and NGOs import products without the knowledge of the authorities. There also leakage of products from the public sector to the private sector.

Reproductive Health Policy

A Reproductive Health Policy was developed in 2001.The goal of the RH policy is to enable couples and individuals, including adolescents, achieve quality reproductive health. The RH Policy created two levels of coordination: RH committee and RH steering committee to coordinate RH activities in the country

The RH policy stresses the need to strengthen procurement of family products and the contraceptive logistics system, including logistics information system. However, the RH policy does not expand enough on key issues regarding family planning service delivery. During discussions with key informants and through the site visits, the need for clear and detailed policy in family planning was clearly expressed.

CONCLUSIONS & KEY RECOMMENDATIONS

Liberia faces many challenges in strengthening contraceptive security. The strong government commitment that exists for reproductive health, including family planning, needs to be translated into operational policies that strengthen commodity availability and service delivery. The situation for contraceptive security reflects the national situation: strong where NGOs are complementing the public sector, weak where they are not, and worrisome for the future as INGOs scale back. Absence of data makes it difficult to draw strong conclusions on unmet need, but clearly the almost complete non-availability of long term methods is a significant problem. It is also clear that there is strong demand for FP and that demand is currently being translated into temporary methods only. Access to services and commodities is a significant problem; the national NGOs, particularly FPAL, face significant challenges in regaining their strong position in service delivery, while the commercial sector is under-developed and suffers from lack of regulation and limited access to affordable products. Social marketing could play a significant role in developing the commercial sector and increasing access, particularly for male condoms, but also for other temporary methods.

For maximum sustainability and efficiency, partners need to work towards integrating contraceptives into the national supply chain for essential drugs. Doing so will require significant strengthening of the capacity of NDS and the CHSWTs to manage the drug supply. Donors should coordinate their activities to strengthen the overall system rather than introducing piecemeal initiatives targeting one set of commodities. For the short term, the contraceptive supply chain needs to be flexible since it will take time to strengthen the national supply chain.

Below are the key recommendations from the various sections of the report.

- *Service Delivery/Client Utilization and Demand*: Increase access to long term and permanent methods particularly the IUD which is already part of the method mix. Train providers and provide equipment and materials. Initial training should include actual IUD insertion and given the almost complete non-access to IUDs in Liberia initial training will need to take place in a neighboring country
- *Service Delivery:* Increase training levels for all providers on FP and contraceptives. This should include all sectors – public, NGO and commercial (pharmacists and dispensers.) This training could be combined with dissemination of the new (proposed) Standard Treatment Guidelines (STGs.) Efforts will need to include training of trainers – there is a shortage of trained trainers and general capacity to do training in Liberia.)
- *Supply Chain:* Stock status at SDPs should be regularly surveyed – stock on hand, consumption, receipts, losses and adjustments, storage conditions, record keeping etc. Ideally, this should be done for all essential drugs for a list of tracer commodities – including contraceptives – developed in consultation with all stakeholders, the MOHSW, and technical partners.
- *Client Demand Utilization/Service Delivery:* FHD should decide on their policy regarding brands, particularly those of pills. Do they want to continue to supply multiple brands of POP and COC pills? If not, then they should try as much as possible to consistently procure the same brand. Providers need to be trained on the equivalence of various brands and IEC may be needed to convince clients of brand equivalency.

- *Selection:* FHD should work with the Pharmacy Division at MOHSW and the Pharmacy Board to ensure that current methods available in Liberia are included on the revised EDL. They should investigate the possibility of adding EC pills to the new EDL and the method mix for the public sector.
- *Client Demand Utilization/Service Delivery/Policy:* Social marketing for male condoms and other contraceptives, particularly pills, should be investigated by FHD and presented to donors as a priority for Liberia. A social marketing effort should include both products and promotion. Funders should coordinate on this (for example GFATM plans on funding a social marketing IEC effort for condoms.).
- *Finance/Forecasting:* FHD to convene regular forecast and procurement plan reviews with major technical partners, including NDS, as a forum to obtain funding commitment for contraceptives
- *Finance:* Advocacy for the inclusion of contraceptives – even a modest amount – in government essential drug procurements. This could be in the form of a budget line for contraceptives or an internal line for contraceptives when NDS and the Pharmacy Division at MOHSW prepare their essential drug financing requests
- *Finance/Procurement:* Donors, such as USAID and UNFPA, should target their resources for procurement towards those contraceptives (hormonal products and IUDs) that the GFATM are unlikely – certainly over the short to medium term - to procure. There is a willingness on the part of the GFATM to procure male and female condoms; the best allocation of resources on the part of other donors would be to concentrate on pills, injections and IUDs.
- *Forecasting:* FHD to ensure that the current forecast is reviewed six months from now with a key goal of the review to train incountry stakeholders, particularly NDS and FHD, in forecasting and quantifying contraceptive needs.
- *Supply Chain: Integration:* FHD and NDS in collaboration with key donors – USAID and UNFPA – to determine their roles and responsibilities for the contraceptive supply chain. They should describe and begin implementation of their "ideal" supply chain recognizing that currently given the limited capacity and uncertain environment there will be exceptions to ensure products are available. Ideally selection should be done jointly between FHD and the Pharmacy Board (with the FHD recommending to the Board what methods should be part of the EDL), forecasting should be a joint exercise between FHD and NDS, procurement (when not carried out by donors) should be an NDS responsibility, storage should be integrated at NDS and the counties with other essential drugs, distribution should be integrated with NDS delivering when possible and counties collecting with other essential drugs, and there should be an integrated LMIS for all essential drugs managed jointly by NDS (central level) and the Pharmacy Division at MOHSW (counties – SDPs.)
- *Inventory Management*: Requiring NDS to manage essential drugs vertically by program puts major strains on the resources of NDS as well as being wasteful and inefficient. If there are concerns about the ability of NDS to manage these commodities, addressing them as part of an overall system strengthening is more appropriate than trying to isolate particular commodities - or even particularly funded commodities - within the NDS system.
- *Service Delivery/Policy:* There are no standard treatment guidelines for FP. Guidelines should be developed, disseminated and providers trained in their application
- *Coordination:* FHD to ensure regular meetings of the RH technical committee, with minutes, and ensure the committee considers commodity security issues as part of its mandate
- *Coordination:* NGOs and the MOHSW to coordinate around the specific issue of transfer of facilities from NGO management to MOHSW

REFERENCES

Global Fund to Fight AIDS, Tuberculosis and Malaria, Liberia Round Six Proposal

Hare, L., Hart, C. Scribner, S., Shepherd, C., Pandit, T. (ed.) and Bornbusch A. (ed.). 2004. *SPARHCS Strategic Pathway to Reproductive Health Commodity Security: A Tool for Assessment, Planning and Implementation*. Baltimore, MD: Information and Knowledge for Optimal Health Project/Center for Communication Programs, John Hopkins Bloomberg School of Public Health.

International Monetary Fund. 2007. Liberia Interim Poverty Reduction Strategy Paper. IMF.

Merlin Liberia. 2006. *Knowledge, Attitudes and Practice Survey in Grand Gedeh County, Liberia*. Monrovia, Merlin.

Merlin Liberia. 2006. *Knowledge, Attitudes and Practice Survey in Maryland County, Liberia*. Monrovia, Merlin.

Ministry of Health and Social Welfare. Undated. *Reproductive Health IEC and Advocacy Strategy.* Ministry of Health and Social Welfare and UNFPA.

Ministry of Health and Social Welfare. 2001. *National Drug Policy* Monrovia, Ministry of Health and Social Welfare.

Ministry of Health and Social Welfare. 2006. *Rapid Assessment of the Health Situation in Liberia.* Monrovia, Ministry of Health and Social Welfare.

Ministry of Health and Social Welfare. 2006. *National Health and Social Welfare Plan (2007- 20011).* Monrovia, Ministry of Health and Social Welfare.

Ministry of Health and Social Welfare. 2007. *National Health Policy.* Monrovia, Ministry of Health and Social Welfare.

National HIV/AIDS Strategy 2003 -2007. Monrovia. National AIDS Control Program.

APPENDICES

1. LIST OF SITES VISITED DURING ASSESSMENT

National Drugs Services, Monrovia

Merlin National Warehouse, Monrovia

Montserrado CHSWT

New Kru Town Clinic, New Kru Town, Montserrado

Shan Pharmacy, New Kru Town, Montserrado

Sleepway Clinic, Monrovia

Salman Pharmacy, Monrovia

Town Center Pharmacy and Wholesalers, Monrovia

Lloydsville Clinic (Merlin), Lloydsville, Grand Bassa

Pharmacy, Buchanan, Grand Bassa

Medicine Store, Buchanan, Grand Bassa

Merlin County HQ, Buchanan, Grand Bassa

St Francis Hospital, Cestos City, River Cess

OBS Clinic (CHAL), Guein, River Cess

Bomi CHSWT, Tubmanburg, Bomi

Medina World Vision Clinic, Medina, Bomi

Grand Cape Mount CHSWT, Sinje, Grand Cape mount

Sinje Health Center, Grand Cape Mount

Gbah Medcine Stores, Grand Cape Mount

Sinje Pharmacy, Sinje, Grand Cape Mount

Hassans Medicine Stores, Robertsport, Grand Cape Mount

2. LIST OF KEY CONTACTS

Name	Organization	Position	Contact Information
Dr. Khalipha Bility	MOHSW	Coordinator, LCM Sec. GFATM	06 535991 kbility@hotmail.com
Yolanda Fortes	UNDP	GFATM Officer	
William Martin	MOHSW	Senior Advisor to the minister	231 – (0) 6 816 261 billscusa@aol.com
Mae Podesta	Clinton Foundation	Country Director	06-630-854 mpodesta@clintonfoundation.org
Rose Gakuba	UNFPA	Resident Representative	06 435159 gakuba@unfpa.org
Lwopu Mae Bruce	NACP	Deputy Program Manager	06 553322 lwopubruce@yahoo.com
Urban Grudeborn	EU	Senior Advisor TA to MOH	06 617862 ugrudeborn@hotmail.com
Tommy Gulley	NDS	Managing Director	06 523530 tngulley@ndsliberia.com
Bernard Osmond	Euro Health Group	Pharmaceutical Chemist	06 696390 bernard.pharmcon@ntlworld.com
Miatta Karen Kiawu	Executive Director	FPAL	06 590434 mkiawu@yahoo.com
Jessie Ebba Duncan	Asst. Minister for Preventive Services	MOHSW	06 517797 jsesbba@yahoo.com
Bernice Dahn	Deputy minister, Chief MO	MOHSW	06 557636 bernicedahn@yahoo.com
S. Tornorlah Varpilah	Deputy Minister for Planning, R&D	MOHSW	06 599546 stvarpilah@yahoo.com
Sonja Van Osch	Country Director	Merlin	
Tracy Crawford	Project Coordinator, Grand Bassa	Merlin	06 490502

3. LIST OF ATTENDEES AT VARIOUS WORKSHOPS

1. INITIAL STAKEHOLDER MEETING 1/29/07

Participant Name	Title	Organization	Telephone
Amos K. Uaruly	Acting Coordinator	NACP/MOH	06583049
George Kaine, Jr	IMCI Clinical Coordinator	Northwest Medical Teams International	06558769
Fatu H. Sheriff	RH Supervisor	Bomi County Health Team	04781901
Clarence Massaquoi	Project Coordinator	PMU Lib	06550053
Cecilia Morris	Dean	CUS	06522833
Virginia O. Howard	Registered Nurse	FHD/MOH	04760410
Ellen B. G. Williams	Executive Director	CHAL	06518757
Janice Nanka	Response Manager	CCF	06437907
Claressa Howard	RH Supervisor	WVL	06536564
Rose Giddiny	Project Coordinator	BAG	06520041
Patricia Kamara	Coordinator RH	SHD/MOE	06633783
Alfred G. Doe	Coordinator	PHC/MOH	06481857
Jestina B. Johnson		FHD/MOH	0651394
Harry J. Gysore	IMCI Focal Point	FHD/MOH	06511479
Nancy T. Nhorg	Program Officer	LPMM	0656157
Sarah Hodse	RH Manager	Merlin	06578541
Rev. Tijli Tarty Tyee	Chief Pharmacist	MOH/Pharmacy	06558097
Chris Dougodu	Director	NHP/MOH	
Mercy Travers	Accounts/Logistics Officer	FPAL	077568459
Wuo Gartei	Assistant Administrator/INIMA	INIMA	06553073
Marie P. Byepu	CM	Benson Hospital/MSF Spain	06680044
Ruth S. Cooper	RH Focal Point	FHD/MOH	06515257
Courtney Blake	Grants Officer	IRC	06685407

2. PRESENTATION OF ASSESSMENT FINDINGS 2/9/2007

Participant Name	Title	Organization	Telephone
Amos K. Varuly	Acting Coordinator	NACP/MOH	06583049
Nancy J. Gaysoe	CM	Cape Mount CHT	06823891
Fatu H. Sheriff	RH Supervisor	Bomi County Health Team	04781901
Ellen B. G. Williams	Executive Director	CHAL	06518757
Eleanor Sampson	PA/Supervisor	WVL	06554180
Derege Terefe	CD	IMC	
Caroline Akin Nenefuille	Program Advisor	IMC	
Mitra Feldman	Health Development Officer	Merlin	06835081
Jessie E. Duncan	Assistant Minister: Preventive Services	MOH	
Lwopu Bruce	Acting Program Manager	NACP	06553322
Patricia Kamara	Coordinator RH	SHD/MOE	06633783
Claudette Bailey	Chief of Party	Africare	06530765
Jestina B. Johnson		FHD/MOH	0651394
Harry J. Gysore	IMCI Focal Point	FHD/MOH	06511479
Wuo Gartie	Assistant Administrator	INIMA	
Roger Bunting	EU Consultant	EU	06698573
Eric Nyandeh			06519875
Mercy Travers	Accounts/Logistics Officer	FPAL	077568459
Stenly Sajiv	RH/GBV Coordinator	UNFPA	06826185
Ruth S. Cooper	RH Focal Point	FHD/MOH	06515257

3. STRATEGIC PLANNING

Day 1 2/13/2007

Participant Name	Title	Organization	Telephone
Amos K. Varuly	Acting Coordinator	NACP/MOH	06583049
George Kaine, Jr	IMCI Clinical Coordinator	Northwest Medical Teams International	06558769
Fatu H. Sheriff	RH Supervisor	Bomi County Health Team	04781901
Clarence Massaquoi	Project Coordinator	PMU Lib	06550053
Cecilia Morris	Dean	CUS	06522833
Virginia O. Howard	Registered Nurse	FHD/MOH	04760410
Ellen B. G. Williams	Executive Director	CHAL	06518757
Janice Nanka	Response Manager	CCF	06437907
Claressa Howard	RH Supervisor	WVL	06536564
Rose Giddiny	Project Coordinator	BAG	06520041
Patricia Kamara	Coordinator RH	SHD/MOE	06633783

Alfred G. Doe	Coordinator	PHC/MOH	06481857
Jestina B. Johnson		FHD/MOH	0651394
Harry J. Gysore	IMCI Focal Point	FHD/MOH	06511479
Nancy T. Nhorg	Program Officer	LPMM	0656157
Sarah Hodse	RH Manager	Merlin	06578541
Amos K. Varuly	Acting Coordinator	NACP/MOH	06583049

Day 2 2/14/2007

Participant Name	Title	Organization	Telephone
Amos K. Varuly	Acting Coordinator	NACP/MOH	06583049
Margaret Togba	RH Supervisor	MCHT	077524429
Linda Birch	CHO	Bomi County Health Team	06558547
John K. Kollie	CHD Director	Bomi County Health Team	04714734
Cecilia Morris	Dean	CUS	06522833
Sarah Hodse	RH Manager	Merlin	06578541
Ellen B. G. Williams	Executive Director	CHAL	06518757
Patricia Kamara	Coordinator RH	SHD/MOE	06633783
Claressa Howard	RH Supervisor	WVL	06536564
Ruth S. Cooper	RH Focal Point	FHD/MOH	06515257
Mercy Travers	Accounts/Logistics Officer	FPAL	077568459
Klomah I Seeblee		NHPD	06547211
Caroline Akroi	Neuferlle	IMC	06513875

4. FINAL DEBRIEFING/FORECAST PRESENTATION 2/16/2007

Name	Organization	Contact Info
Ruth S Cooper	FHD/MOHSW	06515257
Claudette Bailey	Africare	077013160
James Duworko	USAID	077085836
Beyan Johnson	NDS	06550345
Samuel Bogar	UNFPA/NDS	06527633
Rev. Tijli Torty TyleR	Pharmacy D. MOHSW	06558097
Dr. Diarra Lamar	Clinton Foundation	06679127
Emily Wu	Clinton Foundation	06634871
Bernard Osmond	E.U Consultant	06696390
Jennifer Antilla	USAID|DELIVER PROJECT	
Meba Kagone	USAID|DELIVER PROJECT	
Paul Dowling	USAID|DELIVER PROJECT	
Dr. M Dukuly	HSD/MOHSW	06523105
Lawrence	UNFPA	

4. ADAPTED LIBERIA SPARHCS TOOL USED FOR THE ASSESSMENT

SPARHCS

Strategic Pathway to Reproductive Health Commodity Security

A Tool for Assessment, Planning, and Implementation

The SPARHCS Diagnostic Guide

LIBERIA: Adapted (Workshop on CS April 4 and 5,2006 in Monrovia)

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.

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. 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. [2]

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?
- 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 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.

---

[2] 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.

The time and level of effort required for a SPARHCS diagnosis will vary according to its purpose and scope.[3] 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.

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[4], 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.

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 subanalyses.

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.

---

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

[4] 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).

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[5]	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
All methods					
BY METHOD					
Traditional methods Withdrawal Safe Method Periodic Abstinence LAM					
Modern methods					
Pill					
IUD					
Injectables					
Implants					
Male condom					
Vaginal method					
Emergency contraception					
Female sterilization.					
Male sterilization					
Female condom					
By Marital status					
Married					
Not Married					

[5] 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[5]	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
BY AGE					
<15					
15-19					
20-49					
BY PARITY					
No-Child					
1-3 children					
4 and above					
BY SEX					
Male					
Female					
BY RESIDENCE					
Urban					
Rural					
BY GEOGRAPHIC AREA (e.g., province, state)					
District					
County					
BY EDUCATION					
No education					
Primary					
Secondary					
Terciary					
BY Income Level QUINTILE					
1					
2					

CONTRACEPTIVE PREVALENCE[5]	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
3					
4					
5					
Employed					
Self Employed					
Unemployed					
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 /Privatesector					
CBD/CBO					

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/Private) according to their age, sex 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 providers' 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[6]	10 Years Ago	5 Years Ago	Current
For spacing			
For limiting			
Total			
TOTAL UNMET NEED[7]			
BY AGE			
<15			
15-19			
20-49			
BY Marital Status			
Married			
Not Married			
By SEX			
Female			
Male			
BY PARITY			
No Child			
1-3 Children			
4 and above			

[6] 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.

[7] 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[6]	10 Years Ago	5 Years Ago	Current
BY RESIDENCE			
Urban			
Rural			
BY GEOGRAPHIC AREA (e.g., province, state)			
County			
District			
BY EDUCATION			
No education			
Primary			
Secondary			
Terciary			
BY Income Level QUINTILE			
1			
2			
3			
4			
5			
Employed			
Self Employed			
Unemployed			

A.2.1. What is the percentage of current non-users of contraception who intend to use a contraceptive method in the future?(sources for information: Client data, surveys and focus group discussion

A.2.2. Of the total demand for contraception (current use plus unmet need), what percentage is being satisfied?[8] (Sources for information: Service statistics)

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?

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?

[8] 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.

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[9]					
UNFPA					
USAID					
IPPF					
Other:Firestone Hospital					
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:Community based Distribution					

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?

[9] 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.1.3. 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?

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(consumer) 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 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 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[10]						
Using internally generated funds						
Using other donor funds (e.g., grants)						
DONOR[11]						
UNFPA						
USAID						
Other						
Other						

[10] 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.

[11] Where "Donor" refers to direct donor financing of commodities, generally through donor procurement mechanisms.

SOURCE	AMOUNT OF FUNDING FOR COMMODITIES					
	5 years ago	Last year	This year	Next year	5 years from now	10 years from now
OTHER INTERNATIONAL FUNDING SOURCES						
IPPF						
Other						
TOTAL FUNDING						

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 RH/FP 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 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/income level, go to different kinds of providers (OB/GYNs, general practitioners, midwives, nurses, community-based deliverers, pharmacists, drug store)?

- 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 quality of products?

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) and used to monitor inequalities in reproductive health, and in access to and use of RH/FP 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? 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?[12]

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?

[12] 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.**

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?

- 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					

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

For more information, please visit http://www.deliver.jsi.com.

DELIVER

John Snow, Inc.

1616 North Ft. Myer Drive, 11th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

Fax: 703-528-7480

www.deliver.jsi.com