Family Planning and Reproductive Health Commodities Needs Assessment

REPUBLIC OF FIJI

Ministry of Health and Medical Services
UNFPA Pacific Sub-Regional Office
ACKNOWLEDGEMENT

The consultant wish to express her appreciation to all who provided their time and contributed in the development of this needs assessment report. Special thanks to Ministry of Health Adolescent Health Development and Reproductive Health/Family Planning Program, the private sector and NGOs who participated in the group discussions, and UNFPA-PSRO for the up-to-date data and documents shared in the process. Your attention and support is much appreciated.
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ABBREVIATIONS

AHD  Adolescent Health Development
AMC  Average Monthly Consumption
ANC  Antenatal Care
ARV  Antiretroviral
ASFR  Age-Specific Fertility Rate
ASRH  Adolescent Sexual Reproductive Health
CMR  Consolidated Monthly Report
CPR  Contraceptive Prevalence Rate
DHS  Demographic Health Survey
DMPA  Depot Medroxyprogesterone Acetate
ECP  Emergency Contraception Pills
EMOC  Emergency Obstetric Care
EML  Essential Medicines List
FBO  Faith-Based Organization
FPBS  Fiji Pharmaceutical & Biomedical Services
FPBSC  Fiji Pharmaceutical & Biomedical Services Center
FEFO  First Expiry First Out
FLE  Family Life Education
FNU  Fiji National University
FP  Family Planning
GBV  Gender Based Violence
GP  General Practitioner
HD  Human Development
HDI  Human Development Index
HIS  Health Information System
HIV  Human Immunodeficiency Virus
ICPD  International Conference on Population Development
IEC  Information, Education and Communication
IUCD  Intra Uterine Contraceptive Device
IPPF  International Planned Parenthood Federation
KPI  Key Performance Indicator
LMIS  Logistic Management Information System
MDG  Millennium Development Goals
MCH  Maternal and Child Health
MHMS  Ministry of Health and Medical Services
MMR  Maternal Mortality Ratio
MoH  Ministry of Health
NGO  Non-Governmental Organization
NMA  National Medicine Authority
PHIS  Public Health Information System
PIC  Pacific Island Country
PLWA  People Living with AIDS
PMTCT  Prevention of Mother-to-Child Transmission
PoA  Plan of Action
PPF  Pacific Policy Framework
PSRO  Pacific Sub-Regional Office
QA  Quality Assurance
QI  Quality Improvement
QTO  Quantity to Order
RFHAF  Reproductive and Family Health Association of Fiji
RH  Reproductive Health
RHC  Reproductive Health Commodity
RHCS  Reproductive Health Commodity Security
RHTP  Reproductive Health Training Program
SBCC  Social and Behavior Change Communication
SDP  Service Delivery Point
SEED  Supply – Enabling Environment – Demand
SHI  Social Health Insurance
SOP  Standard Operating Procedure
SPC  Secretariat for the Pacific Community
SRH  Sexual Reproductive Health
STG  Standard Treatment Guideline
STI  Sexually Transmitted Infection
UNFPA  United Nations Population Fund
UNICEF  United National Children’s Fund
USAID  United States Agency for International Development
WHO  World Health Organization
YFHS  Youth Friendly Health Service
EXECUTIVE SUMMARY:

The Family Planning and Reproductive Health Commodity Security (RHCS) assessment in the Fiji Islands was conducted in collaboration with the Ministry of Health and Medical Services (MHMS).

The purpose is to determine the present status of Reproductive Health (RH)\(^1\) and the progress that has been made to achieve universal access to Reproductive Health within the Pacific Policy Framework (2008-2013).

The assessment proper was conducted in March 2014. A series of meetings with relevant staff, focus group discussions, interviews and observations at facilities were done to gather the necessary information for the report.

Discussions were held with Reproductive Health Program Managers, Service Providers, Pharmacists and the Private Sector\(^2\). The succeeding analysis and findings have been used to develop the Activity Plan\(^3\) to provide direction to the Fiji Islands Reproductive Health Program for the next five years.

Key findings of the assessment are summarized as follows:

Fiji Islands Reproductive Health Situation:

Fiji has a slow growing population where 29% is covered by the young age group. Fertility and mortality rates of the two dominating ethnic groups differ in that Indo-Fijians have lower fertility and mortality rates as compared to those of the I-taukei, which has the opposite trend. In general, fertility rates are slowly declining; however, teenage fertility rates remain relatively high, though have witnessed some declines. There are rising rates of Sexually Transmitted Infections and the Contraceptive Prevalence Rate has remained consistently below 50%.

The country’s commitment to achieve Millennium Development Goals (MDG) 5A looks encouraging; but as for achieving Universal Access to Reproductive Health services (which includes access to family planning information and services), this seems to have lagged behind in the agenda. Hence, Fiji needs to address this issue and scale up its effort at ensuring access to RH information and services are in place and provide special focus to the underserved, young people. This may pose some challenge considering the socio-cultural and religious structure of the nation and simply because RH and Family Planning information and services are basically advocated and offered to healthy individuals and couples.

However, addressing the issue would significantly contribute to the reduction of maternal and newborn mortality, improve maternal and RH status of the country and contribute to the improvement in education and economic wellbeing of future generations.

The policies and strategies are already in place but the operationalization of the policies into programs has not been successfully translated to actions in the field.

Some of the contributing factors to these are associated with the weak health systems, weak coordination within the health system, inadequate human and financial resources and existing policies posing as barriers to program implementation. Hence, all these factors need to be dealt with and worked together in order to move the agenda forward.

In summary:

- **On supply,** there is a well-established functioning health system in place. However, there is a need to reinforce the system, particularly in the area of pre-service training for nurses and in-service training, periodic supervision to service providers and reporting system.

- Family Planning methods are made available at each health facility level but service providers are prevented from delivering the service due to policy issues, inadequate number of health staff at the lowest service delivery point and inadequate space to conduct counseling. Integration of FP services on adolescent RH, postpartum and post-abortion care also needs to be improved.

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\(^1\) Reproductive Health includes Family Planning

\(^2\) See Annex

\(^3\) See Annex
FP clients favor more of the short acting methods such as injectables. A strategy to advocate use of longer acting methods would require fewer return visits, fewer logistic issues for service providers and at the same time improve procurement costs.

In providing an enabling environment, the Ministry of Health is committed to take the lead at improving access to SRH. RH Policy, strategies and activities are in place and serve as a road map for Reproductive Health. But the operationalization of the policy has not been well translated to realistic outputs in the field: developing activities that are credible, time-bound, achievable, based on available resources within the capacities of the health system and services that focus on targeted groups such as the young people, has been an area that still needs to be improved. Accountability measures need to be in place and a coordination mechanism involving diverse partners working on RH that will oversee the program progress needs to be established.

On the demand side, the NGOs role at creating demand at community level for RH/FP in Fiji has been notable. And linking of the public sector with these organizations has significantly contributed at improving access to the services especially to those underserved, hard-to-reach vulnerable groups. On the other hand, the contribution by the private sector at improving RH coverage is not being reflected and needs to be further explored. Social marketing of contraceptives, particularly condoms, at community level should be strengthened.

Active participation by community members in responding to their own Reproductive Health issues need to be intensified and partners working closely with the community should assist at identifying these RH needs and services and become conduit to raise it to relevant decision-makers in the MoH.

KEY RECOMMENDATIONS:

Enabling Environment:

- Develop a costing plan for the RH policy strategic activities.
- Develop accountability mechanisms in the RH policy and strategies to ensure actions are being undertaken and followed up.
- Activate a coordinating mechanism or a working group that will function to oversee implementation of the RH strategies and activities – this can be led by the public health director.
- Review policies that form a barrier to access to services where midwives and nurse practitioners are unauthorized to provide long acting methods (Jadelle implant).
- Update and finalize the Fiji service guideline to include counseling services and in order to conform with international standards.
- Strengthen the Health Information System by conducting workshops with RH/FP Program and service providers to roll out PHIS form and disseminate definitions of RH/FP identified indicators and improve the skills of health providers in the analysis of data they collect.
- Get the community engaged with the program through meetings with key community leaders, parents, youth groups in planning and organizing RH/FP activities in the community.
- Develop and disseminate informational materials on ECP at youth-friendly health service clinics to reinforce awareness of the commodity especially to the young people.

SUPPLY:

- Review policies to explore the possibility of task shifting.
- Strengthen pre-service and in-service training programs by review the pre-service curriculum for nursing to upgrade the counseling skills training. Evidence has shown that conducting counseling and clinical skills training that is competency-based, combined with the simulation processes of learning, is highly beneficial to improving confidence and producing more competent providers. And evaluate the RHTP program.
Develop short courses in service training on FP counseling and clinical skills for nurse practitioners already deployed at nurse stations.

Periodic refresher training should be conducted for all nurses working in the primary health care centers to ensure retention of skills and to update their knowledge on RH/FP services.

Evaluation of the RHTP program and review of the training curriculum for the RHTP program are necessary.

Identify the location and distribution of the RHTP certified nurses country-wide and conduct an evaluation to determine their added-value in the provision of the RH/FP services after the training.

Review the current method mix and develop strategies to advocate for use of long acting methods for young married couples with desire to delay pregnancy for first and second child and for women above 30 years of age.

Periodic supervision by competent supervisors to ensure service providers at primary health care centers remain motivated with work.

Develop supervision tools that will guide supervisors on how to conduct effective supervision at the health facilities.

Develop Key Performance Indicators (KPIs) that will measure performance of each health facility in providing RH/FP services and align it to the objectives of the RH/FP program.

Identify retired staff living in each division and explore the option of engaging them to serve as mentors of service providers.

Promote the use of long acting methods Jadelle implant or IUCDs for injectable users with two or more children and those who are more than 30 years. Such a move would not only lessen client visits to the facility but would also impact procurement costs, reduce requirement for injection Depo Provera and minimize logistic issues.

Strengthen postpartum FP services at health facilities by reinforcing FP postpartum counseling during training to midwives and nurses.

Reinforce to service providers the promotion of the dual protection function of condoms during STI/HIV counseling.

Reinforce clinical assessment for STIs during FP counseling for clients prior to offering FP methods.

A referral system within the community, linking with nearby health facilities should be developed.

Referral guideline to involve NGOs can be developed to assist the public sector deliver services when such services cannot be accessed from the public sector alone.

Form a forum/committee comprising of partners working on RH/FP that will serve as governing body to oversee and support RH/FP activities.

Continue partnerships with NGOs especially those working on SRH to assist the public sector at ensuring access to communities on RH/FP/AHD information.

Explore avenues that will provide private practitioners a role to support the public sector at improving RH/FP coverage.

Request monthly reporting on FP/SRH services provided by the private providers to integrate data to the national Health Information System.

Review the training curriculum of peer educators and include counseling training for other possible information providers such as health providers, teachers and community health volunteers.
Reinforce through counseling from health providers and peer educators a delay in the first pregnancy among young married couples and spacing of the second pregnancy for young couples with first child.

**DEMAND:**

- Conduct needs assessment for a national communication strategy and whether to go for a national strategy or a communication strategy specific for RH/FP that will facilitate programs in their effort to develop more effective communication materials for targeted groups and to create behavioral change.
- Conduct market segmentation analysis for social marketing strategies.
- Use the various forms of media that can assist to disseminate FP messages in a more cost-effective way yet capturing a wide audience. These would include adapting FP media materials from other countries or NGOs in Fiji on SRH/FP and customize them according to Fiji context. Radio/TV talk shows can also be good forums to discuss FP information with a wider audience.
- Regular forum with religious and community leaders can be a good entry point to involve the community in RH/FP program planning.
- Suggestion boxes can be disseminated in health facilities to determine the views of clients receiving SRH/FP information and services from health staff.
- Train more peer educators, counselors and teachers on Adolescent Reproductive Health.

**RHCs:**

- Forecasting training should be provided for staff at FPBSC together with the FP commodity coordinator to assess needs for essential medicines.
- Integrate FP commodities forecasting in the technical working team that carry out the forecasting for general medicine.
- Conduct monthly stocktake to ensure accuracy of stock-on-hand (SOH) (start with the fast moving stocks, then follow with the slow moving ones)
- Reinforce timely submission of logistic forms that should include data of Average Monthly Consumption (AMC), SOH and Quantity to Order (QTO).
- Training on Logistic Management Information System (LMIS) especially to health staff handling FP commodities in the health facilities.
- Develop Standard Operating Procedures (SOPs) on proper storage procedures for essential medicines and contraceptives.
- Include a list of commodities that were disposed because of expiration in the reports together with the cost to the program.
- Develop protocols regarding the redistribution of RH/FP commodities.
- RHCS level 1 training is needed by staff in this case.
- Explore possibilities to obtain monthly data of RH/FP commodity consumption from the private sector to be included in the public LMIS.
INTRODUCTION:

CONTEXT:

Fiji is an island nation located in the southwest Pacific Ocean. It covers about 1.3 million square kilometers of the Pacific Ocean with 330 islands, of which one third are inhabited. According to the 2007 Census, the population stood at 837,271. The ethnic composition is diverse, with 57% Indigenous Fijians (i-Taukei), 37% Indo-Fijian population and 6% others (including other Pacific Islanders, Chinese and those of European descent). Fiji has an increasingly urban population, with the Suva-Nasinu-Nausori corridor being the most heavily populated. This has been accompanied with an increasing urban unemployment.

Fiji ranks 96 in the overall Human Development Index (HDI) out of a total of 187 countries, and places above that of the Asia-Pacific region average. HDI is a widely accepted measure of a country’s progress in attaining satisfactory levels of education, health, and income. Within the classification of Human Development, Fiji is classified in the Medium HD group. The other three classifications are Very High HD, High HD and Low HD.

POPULATION AND DEMOGRAPHIC TRENDS:

Fiji is estimated to have a population of 848,000 by 2014 with 29% younger than 15 years of age, and 8% older than 60 years. Fiji’s population is estimated to grow very slowly due to its relatively low level of fertility, and its high rate of negative net migration.

Figure 1 Population Growth in Fiji: Observed and Projected 1901-2060

Source: Population and Development Profile: UNFPA-PSRO

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4 Health Service Delivery Profile, Fiji, 2012
Fiji’s demographic transition has been slow, specifically among the indigenous Fijian population.

Figure 3 Fertility Trends 1967 - 2007

Indo-Fijians have lower fertility and mortality and higher emigration rates compared with indigenous Fijians, resulting in a declining population among this group. By contrast, i-Taukei population has higher fertility and mortality, a lower emigration rate, and thus a positive rate of population growth.

The Indo-Fijian population is well advanced in its demographic dynamics, with fertility and mortality rates comparable with the lowest in the Pacific.

Fiji’s fertility transition has been much slower than might have been expected despite establishment of Family Planning programs in the early 1960s. While the Total Fertility Rate (TFR) has declined from 2.7 in 1996 to 2.6 in 2007 at the national level, it is 3.2 among i-Taukei and only 1.9 among Indo-Fijians.7

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7 Ibid.
Emigration is a complex process in Fiji that needs monitoring. Marked losses of skilled personnel are occurring in the health and education sectors that negatively impact on the quality of services.

**REPRODUCTIVE HEALTH INDICATORS STATUS:**

Fiji has shown some improvements in Reproductive Health indicators over the past few decades, a consistently low maternal mortality, low fertility rates, and a steady increase in access to essential health services. With this in mind, progress toward the achievement of MDG 5A – maternal mortality – is encouraging; but for MDG 5B, progress remains mixed.

**Maternal Health Related Indicators:**

Since 2008, Fiji has maintained a high proportion of skilled birth attendance and antenatal coverage and a low Maternal Mortality Ratio (MMR). The significant increase in 2012 was due to four maternal deaths that markedly affected the rise. Nevertheless, it remains relatively low by international standards. Hence, MDG 5A appears to be on track.

<table>
<thead>
<tr>
<th>Table 1 Maternal Health Indicators for Fiji: 2008 - 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health Indicators</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maternal Mortality Ratio (per 100,000)</td>
</tr>
<tr>
<td>Number of Maternal Deaths</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (%)</td>
</tr>
</tbody>
</table>

Source: Public Health Information, Ministry of Health, Fiji

**Universal access to RH services:**

MDG 5B – To achieve universal access to Reproductive Health by 2015 – was first introduced to PICs in 2000. Supporting indicators include: Contraceptive Prevalence Rate; adolescent birth rate; antenatal care coverage and unmet need for FP.

Contraceptive rates have not significantly increased over the years which give the impression that not much scaling-up for RH/FP services has been done.

CPR has increased from 28.9% in 2009 to 44.3% in 2012. However, since the 1990s, it has not gone beyond 50%. The reported rate of 28.9% may be lower than the reality as it excludes non-governmental service providers.

**Figure 4; CPR 2008 - 2012**

Source: Health Information Unit, Fiji Ministry of Health

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8 Ibid.
Unmet need for Family Planning has not been used by the Fiji Islands to measure progress of their RH services. The Demographic Health Survey that could measure this indicator is planned for 2014. Thus, it is quite difficult to determine the number of women, couples or individuals that want to avoid or delay pregnancy but are not using any method of contraception.

In the absence of a reliable estimate of the unmet need, the adolescent fertility rate is used as proxy indicator to determine demand for FP. The adolescent fertility rate increased from 29% in 1996 to 36% in 2007, and was 30% and 42% in the urban and rural areas, respectively. This is not a surprise as access is commonly a problem in the remote and hard-to-reach regions.

**Figure 5: ASFR Pacific Island Countries**

<table>
<thead>
<tr>
<th>Adolescent fertility rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marshall Isl. 85</td>
</tr>
<tr>
<td>Nauru 81</td>
</tr>
<tr>
<td>Vanuatu 66</td>
</tr>
<tr>
<td>PNG 65</td>
</tr>
<tr>
<td>Solomon Isl. 62</td>
</tr>
<tr>
<td>Kiribati 49</td>
</tr>
<tr>
<td>Cook Isl. 46</td>
</tr>
<tr>
<td>FSM 46</td>
</tr>
<tr>
<td>Tuvalu 44</td>
</tr>
<tr>
<td>Tokelau 39</td>
</tr>
<tr>
<td>Samoa 39</td>
</tr>
<tr>
<td>Fiji 36</td>
</tr>
<tr>
<td>Tonga 30</td>
</tr>
<tr>
<td>Palau 29</td>
</tr>
<tr>
<td>Niue 17</td>
</tr>
</tbody>
</table>

Source: UNFPA PSRO Population and Development Profiles 2014

This chart shows the urgent need to scale up and strengthen SRH information and services in order to enable the youth to make informed RH choices and address the contraceptive needs of these young age groups.

Use of contraceptives is important for maternal and infant health, as it prevents unplanned or closely spaced pregnancies, and pregnancies in very young girls. Evidences have shown that teenage pregnancies run a higher risk of incurring obstetric complications and possibly death.

**Table 2: Achieve by 2015, Universal Access to Reproductive Health**

<table>
<thead>
<tr>
<th>Reproductive health Indicators</th>
<th>1990</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>MDG target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Prevalence Rate, CPR (%)</td>
<td>31</td>
<td>44.7</td>
<td>28.9</td>
<td>31.8</td>
<td>36.5</td>
<td>44.3</td>
<td>55 (ICPD target)</td>
</tr>
<tr>
<td>Unmet need for Family Planning (%)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Antenatal visit &gt;= 1</td>
<td>N/A</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Health Information Unit, Ministry of Health Fiji

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9 Ibid.
Other Reproductive Health Indicators:

The prevalence rate of HIV/AIDS is less than 0.1%, which is low by international standards, but cumulative incidence is rising rapidly and stood at 333 confirmed cases in December 2009 compared to four in 1989\(^{10}\). National data shows that the HIV epidemic is affecting the young population. New infections are an increasing trend in Fiji. From three new cases in 1990, it has gone up to 60 new cases in 2012. Among the age groups, the most number of reported cases are coming from the 20-29 years age group. In 2011, there were 53 new cases diagnosed of which 47% (n=25) were young people between the age of 20-29 years.

<table>
<thead>
<tr>
<th>Other Reproductive Health Indicators</th>
<th>1990</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence pregnant women 15-24 years* in percent</td>
<td>0.02</td>
<td>0.02</td>
<td>&lt;0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence among young people(^{11})</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported new HIV cases (20-29 years) in percent</td>
<td>66.6</td>
<td>51.6</td>
<td>34.9</td>
<td>46.7</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Prevalence of STI among men and women 15-24 years per 1,000</td>
<td>2.4</td>
<td>2.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Source: Annual Report, Ministry of Health Fiji

Health systems and Family Planning Program:

The Ministry of Health structure has six health services and the National Family Planning component is implemented under the Family Health Program of the Public Health service.

Figure 5: The Six Health Services of the Ministry of Health

The MoH is under the overall leadership of the Minister of Health while the Permanent Secretary of Health serves as deputy and reports to the Minister.

The leadership function of the Permanent Secretary is split into six health services:

- Hospital Services, headed by a deputy secretary
- Public Health services, headed by deputy secretary
- Admin and finance services, headed by a deputy secretary
- Nursing services, headed by a director
- Health Information and Research and Analysis, headed by a director
- Planning and Policy Development unit, headed by a director

\(^{10}\) World Bank Report, 2010
\(^{11}\) Ibid
The Hospital service is responsible for the overall management and operations of three major division hospitals and two specialized hospitals. Part of its role includes the Pharmacy and medical supply services under the Fiji Pharmaceuticals and Biomedical Services Center (FPBSC).

The National Programs under the Public Health service are divided to two units:

- I: Non-Communicable Disease, Communicable Disease, Family Health
- II: Oral Health (OH), Environmental Health (EH), Health Promotion (HP), Nutrition

The RH/FP program is under the Family Health where it is supervised by the Public Health services. Its main function is to manage, implement, monitor and evaluate programs pertaining to Maternal and Child Health (MCH), STI/HIV, RH and Communicable Disease.

The division is also under the Public Health services where it is headed by the division medical officer. Finally, the Human Resources unit reports to the Administration and Finance Division.

The Family Planning services are generally provided by the MoH Public Health Nurses through health centers and nursing stations, the Oxfam Clinic in Suva, and the HUB Centers in the Western and Northern Divisions with tubal ligations and sterilizations being provided at the division and sub-divisional hospitals.

Other major providers of FP services include the Reproductive and Family Health Association of Fiji (RFHAF), which is an International Planned Parenthood Federation (IPPF)-affiliated NGO with a SRH focus, Medical Services Pacific, and private medical clinics.

RH services in Fiji cover a wide area but the basic elements as reflected in the RH Policy and strategies are: Safe Motherhood, Infant and Child Care, adolescent health care, FP and abortion-prevention, STI/HIV prevention and management, and Basic Infertility services and management of gynaecological morbidity including reproductive tract cancers & infections.

All health facilities in Fiji offer preventive, promotive and curative services. However, the delivery of these RH services is divided into three tiers:

1. Nursing stations, which offer primary level of care
2. Health centers and subdivision hospitals, which provide primary and secondary level of care but limited secondary-level clinical care is provided.
3. Division hospitals, which offer tertiary level of care

The tier system describes the minimum RH services that each level can deliver.

**Rights-Based Approach to Family Planning:**

The International Conference on Population Development (ICPD) Plan of Action (PoA) affirms that reproductive rights embrace certain human rights that rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and RH. Fiji is one of the Pacific Island Country (PIC) signatories of the ICPD.

The RH Policy of Fiji explicitly supports the rights of all women, men, couples and children to have access to curative and preventive RH services. It also takes note of the rights of young people to have access to youth-friendly services, access to RH information that will help them make responsible choices and in particular prevent unplanned early pregnancy, STIs, HIV and sexual abuse.

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12 Evidence Based National guideline on Family Planning for Health Providers, in Fiji Islands 2011.
GOAL AND METHODOLOGY:


The Framework covers areas such as policy and structure, services, supply chain management and financing. It also identifies essential strategies that need to be supported to achieve Universal Coverage of RH services. These include: political will and action; RH commodity supply and management; resources for RH services and commodities; meeting clients’ needs; improving the information base for priority setting, program monitoring and service delivery; partnerships and collaboration; and human resource development. All these areas and strategies are included in the assessment report, which will inform the strategic direction of the Pacific Policy Framework (2014-2017).

Purpose

• To assess the progress that Fiji has made towards achieving Universal Access to Reproductive Health Services and Commodities within the Pacific Policy Framework 2009–2015 and the context to MDG targets related to RH, and commitments to the ICPD PoA.
• To identify areas of RH/FP and RHCs Program strengthening.

Methodology

• Preparation for the assignment was undertaken at the Pacific Sub-Regional Office (PSO) for the United Nations Population Fund (UNFPA) in Fiji.
• Desk review was done using published information and briefings were given by senior UNFPA staff. See Annex 3 for a list of documents reviewed.
• Four SEED data-collection tools were used for the following target groups:
  - Managers and other stakeholders at a central level
  - Service providers
  - Private sector
  - Community health workers and clients
  - For RHCS, two questionnaires were used with stakeholders and:
    - Site visits at the central level
    - Site visits at the facility level
• Meetings were held with MoH senior managers and private sector partners and a field visit carried out to meet with service providers who work with or benefit from the Reproductive Health Program.
• Information collected from the review of documents, discussions and questionnaires were analyzed using the Supply – Enabling Environment – Demand (SEED) framework to identify the issues in the Fiji RH/FP Program that require intervention or more in-depth assessment.

Limitations

• Availability of the relevant government staff and conflicting schedules made it difficult for the consultant to conduct the assessment as per the timeline, hence, the majority of the information and data gathered was deduced from a review of published documents from MoH and shared published documents by the UNFPA Pacific Sub-Regional Office and via the Internet.
• Inability to travel to more health facilities in the four divisions limited the opportunity to accurately determine RH commodity stock situation, Human Resource staffing shortages and health facility issues.
• The SEED tools and scope of the data collection were found to be too comprehensive for the time-frame, and the number of data collectors was inadequate. The tools appeared to be originally designed for use by a team of data collectors who undertake a full assessment over a 5-6 week time frame. Hence, it was difficult to collect the volume of information required for a full assessment. Furthermore, the time taken to triangulate the data and the broad scope of the assessment required the expertise of more than just one consultant.
Key Findings on Reproductive Health Services

**FINDINGS:**

The essential components from the SEED framework were used to analyze the data obtained and the information gathered during the assessment process. Findings of which are presented below.

**SUPPLY: Service Delivery**

Service number and type

The health services in Fiji are delivered mainly in the three divisions – Central/Eastern, Western and Northern division – through five division hospitals, 23 subdivision hospitals, 48 health centers and 100 nursing stations. They are also provided by the private sector through private hospitals.

<table>
<thead>
<tr>
<th>Health facility type</th>
<th>Numbers</th>
<th>RH Services</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village Health Care Workers</td>
<td></td>
<td>Distribute condoms, first aid and referrals</td>
<td>Community Health care workers</td>
</tr>
<tr>
<td>Nursing Stations</td>
<td>100</td>
<td>Primary Health Care (PHC) which includes Safe Motherhood, Infant and Child Care, Adolescent health care and Family Planning</td>
<td>Registered Nurse (Public Health)</td>
</tr>
<tr>
<td>Health Centers</td>
<td>48</td>
<td>PHC and STI-HIV prevention management</td>
<td>Medical Officer or Nurse Practitioner plus 3-4 nurses</td>
</tr>
<tr>
<td>Sub-Divisional Hospitals</td>
<td>23</td>
<td>Prevention of abortion, STI/HIV prevention and management</td>
<td>Specialist doctors, general practitioners, midwives, nurses and other allied health staff</td>
</tr>
<tr>
<td>Divisional Hospitals and Specialized Hospitals</td>
<td>5</td>
<td>Basic Infertility services and Management of gynaecological morbidity including reproductive tract cancers &amp; infections</td>
<td></td>
</tr>
<tr>
<td>Total number of Service Delivery Points</td>
<td>178</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure: Network of Health Service Delivery System at Ministry of Health

13 Health Facility Data obtained from the Ministry of Health Fiji: March 2014.
**Service Type:** Hospital health services range from: Out Patient Department, MCH, oral health, pharmacy, lab, x-ray, physiotherapy, environmental, nutritional, outreach and special clinical services; while Primary Health care services delivered at the health centers and nursing stations provide routine antenatal and post-natal care, FP counseling and distribution of at least three modern contraceptive methods (injectable, pills and condoms) and developmental screening for children. At this level, the public health nurses serve as the frontline RH/FP service providers.

Maternity Services in Fiji are fairly well developed. While antenatal care coverage has reached more than 95% and many achieve more than four visits per pregnancy, the priorities are to ensure better antenatal care quality in terms of mothers being initially seen by a health care provider during the first trimester of pregnancy (less than 10% of women booking in the first trimester) and to have more goal-oriented antenatal care.

**Service Coverage:** The EmONC facility-based assessment conducted in 2008 found that FP services are provided in all participating health centers and nursing stations with at least three contraceptive methods (pills, injectables and male condoms) being available. However, there are insufficient FP services in the EmONC and non-EmONC hospitals as well as limited numbers of available FP methods at health centers and nursing stations. Moreover, in Sub-Division Hospitals and Division Hospitals FP Services are referred to nearby health centers. Hence, this is an area of concern as it inhibits access to FP.

\[
\frac{48 \text{ Health Centers and 100 Nursing Stations}}{178} = 83.1\% \text{ facilities provide FP services}
\]

Coverage of RH/FP health services are also being delivered down to the community through outreach activities where nurses are assisted by non-salaried village health workers in Fiji villages and community health workers in other rural areas to distribute contraceptives, particularly condoms, and to provide basic first aid and coordinate referrals to nursing stations. However, these outreach services are sometimes constrained due to transportation issues.

**Youth-Friendly Services:**

In the EmONC assessment in 2008, there were no special FP programs and services for adolescents and men in any health facilities. A survey in 2012 by UNICEF confirms that there are 25 Youth-Friendly health facilities provided in 23 sub-divisions from the sub-divisional hospitals.

\[
\frac{25}{178} = 14\% \text{ facilities provide youth-friendly service clinics}
\]

It was also noted that Emergency Contraceptive Pills (ECPs) are not available from any primary health care facility, nursing stations or health centers.

Clinical Outreach of the public health centers are complemented by several NGOs working on SRH like the Reproductive and Family Health Association of Fiji (RFHA) who also conduct advocacy activities and extend its services to the underserved population, particularly young people.

Discussions conducted with service providers raised issues on the delivery of FP services for new clients at the primary health care facilities. A registered nurse cannot dispense contraceptives for new clients unless a medical officer has carried out the medical eligibility criteria to the client. Hence, it is likely that these clients will be lost as they will still need to be referred before receiving the FP method of choice.

**Recommendations**

- Review the protocol regarding the use of the FP medical eligibility criteria by nurses at health centers to allow flexibility for health staff at primary health centers without a medical officer to use the tool and include it in the FP service guidelines.

- Link with NGOs working within the health facility catchment area to assist in transportation during the clinical outreach whenever possible can be an option.
Service Uptake and Utilization – Method mix of available FP methods

Service providers counsel the full range of FP methods to their clients even if the methods are unavailable in Fiji health facilities. Currently, there are 10 contraceptive methods being offered at the Oxfam Clinic. The services and methods include five hormonal, three barriers, one permanent and one alternate/natural. At the health centers and nursing stations, the FP methods offered include injectable, pills (Combined Oral Pills, Progestin Only Pills, emergency pills) and male condoms. While at the hospitals, all methods are offered and these are pills, injectables, male and female condoms, implants, IUCDs, permanent methods and natural methods.

Table 1: Family Planning Acceptors in percent per Method from 2008-2013

<table>
<thead>
<tr>
<th>Family Planning Acceptors % of Methods</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pills</td>
<td>20.9%</td>
<td>26.3%</td>
<td>28.8%</td>
<td>28.6%</td>
<td>43.2%</td>
<td>22.9%</td>
</tr>
<tr>
<td>IUCD</td>
<td>10.1%</td>
<td>3.37%</td>
<td>2.5%</td>
<td>7.8%</td>
<td>3.4%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Condoms</td>
<td>16.47%</td>
<td>20.5%</td>
<td>16.8%</td>
<td>19.8%</td>
<td>20.0%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Injects</td>
<td>24.56%</td>
<td>44.5%</td>
<td>49.3%</td>
<td>48.4%</td>
<td>31.5%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>19.98%</td>
<td>4.6%</td>
<td>0%</td>
<td>0%</td>
<td>0.00%</td>
<td>0%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>0.22%</td>
<td>0.05%</td>
<td>0.01%</td>
<td>0%</td>
<td>0.00%</td>
<td>0%</td>
</tr>
<tr>
<td>Implant</td>
<td>1.14%</td>
<td>0.8%</td>
<td>2.22%</td>
<td>0%</td>
<td>1.72%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Natural Method</td>
<td>6.63%</td>
<td>0.94%</td>
<td>0.22%</td>
<td>1.43%</td>
<td>0.12%</td>
<td>0%</td>
</tr>
</tbody>
</table>

| Protection rate                        | 44.7 | 28.9 | 31.8 | 35.5 | 35.7 | 44.3 |

Source: Health Information Unit, Fiji

Table 1 shows the FP acceptors per method as percentages. The data were collected using the old Consolidated Monthly Report (CMR), except for 2013, which was obtained from the new Public Health Information System (PHIS). In the table, the data only reflect primary health center data and do not include those from the hospitals, private sectors and NGOs. Hence, the prevalence rate shown is from complete data.

For the past five years, it appears that the preferred method in Fiji continues to be injections (47.4%) with pills running second (22.9%) and condom use (16.6%) ranking third. Injections fell in 2012 due to the stock-outs of the commodity globally during this time period. Implant acceptors are gaining popularity over IUCDs and would have shown a higher rate if not only for the policy for nursing practice inhibiting nurses to provide the method despite being trained and found competent to do so. At the Oxfam Clinic, the nurses have stopped inserting Jadelle implants and are constrained to refer clients to a medical officer. Such delay in delivery of the service to clients who choose such method often results to losing the client or the client shifting to whatever other method is available.

It appears that methods are supplied based on client preferences and with the introduction of Jadelle in 2012, there seems to be a growing acceptance of the commodity over IUCDs. A strategy to promote the use of long acting method to these injection users should not be that difficult and be considered for it will facilitate the work of service providers. Fewer return visits by the client will be expected, fewer logistical issues on the side of the provider and eventually procurement cost savings.
The FP referral system is functioning for those clients who wish to have tubal ligation or vasectomy done in the hospitals. For clients who choose the implant Jadelle, they are referred to health centers or subdivision hospitals with a medical officer capable to deliver the service (see recommendation under provider skills and training).

**Recommendation:**

- Promote the use of long acting methods Jadelle implant or IUCDs for Depo users with two or more children and those who are more than 30 years of age. Such a move will not only reduce client visits to the facility but also impact on procurement costs, reduce the requirement for injection Depo Provera and minimize logistic issues.

**Essential Infrastructure, Equipment, Staffing:**

In order to provide quality FP services and care to the clients, it is essential that qualified health staff have well-equipped, safe facilities that are adequately spaced and offer privacy for their clients. The only health facilities assessment that was ever conducted for the MoH included the EmONC assessment completed in 2008. Since then, there has never been a health services facilities assessment that would provide scope of the detailed functionalities of the infrastructure, equipment and staffing.

From observation during this Technical Assistance mission, the author notes that a number of the public health facilities in Fiji have deteriorated over time and the resources to maintain these health infrastructures remain a challenge to the MoH. Health budget allocated from Government has not significantly increased for the past few years despite the growing demands from the public health sector. Currently, CWM referral hospital is undergoing physical renovations. A visit to Naboro Health Center revealed inadequate space that compromises privacy of the clients while they are receiving the services.

**Clinical Instruments and Equipment (Non-drug Supplies)**

Local reports indicate that there are limited quantities of IUCD insertion sets, implant insertion sets and other basic clinical equipment for RH services, such as scissors, forceps, bowls, towels, etc. Annual reports are made by local facilities, with a list of claims to cover the need of replacements. These seem to be rarely met. There appears to be no national rolling program of small clinical equipment replacement, and these items are not included on local inventory lists – that is, they are not counted and reported the way consumable stocks are.

There appears to be a gap in the management of these items. Goods that are recurrent supply (drugs, consumables) are well considered by the Fiji Pharmaceutical Services and the national drug committee; as capital bio-medical goods are with the National Medical Equipment Committee. But it seems likely that the “minor” equipment is being given a low priority. It may be that the national equipment group only focuses on the major capitals items of biomedical diagnostic and therapeutic equipment. It is normal that there will be a budget limit, and thus a strong emphasis on priority setting for clinical equipment assets, usually big-ticket items.

The replacement need of small clinical equipment is a regular need. These items are expected to have a certain life, and there are genuine limitations on that life. That life may not fall within the 12-month accounting definitions of “recurrent cost” items, yet these are not ‘capital’ items, either. These types of items must have a regular replacement program, at least every two to three years, or there must be a mechanism with stock availability and a requisitioning method that allows them to be replaced as and when needed, as by way of a regular inventory check, and submission to the FPS (or any other appropriate agency/supplier as may be appointed).

In any facility, there will also be normal deterioration, or wear and tear, of fixtures, fittings, and furniture. There appears to be no comprehensive approach to a national rolling replacement program for these items, without which RH services cannot be provided to standard.

**RH Medicines and RH Commodities:**

RH services are integrated into the public-sector primary health care system. The public primary care framework includes pharmacy and medical supply services, operated by the FPBSC in Suva. RH items are a subset of the national list of essential medicines and supplies. The nationwide public supply of RHCs is integrated into the overall FPBS system, but the selected national list of FP requisites (including condoms) is ordered by the service delivery points on a separate form from ‘general’ medicines and supplies. FP items are also ordered more frequently (on a monthly basis compared to a quarterly basis for general items) and a more complex mode of stock review and order calculations is used, based
on the methods contained in the Pocket Guide to Managing Contraceptive Supplies, and incorporated into the routines of the Fiji medical supply system.

**Staffing:**

Assistant Director Primary & Preventive Health Services (Family Health) based at Ministry of Health Headquarters is responsible for the following:

- Liaising with World Health Organization for funding of the Family Planning Program in Fiji.
- Collaborating with Government Pharmacy in calculating the annual contraceptive requirement.
- Coordinating and evaluating the National Family Planning Program.
- Assisting and supporting Family Planning NGOs e.g. Fiji Family Planning Association, Soqosoqo Vakamarama, Responsible Parenthood Association, and Fiji Red Cross Society.
- Assisting the Contraceptive Selection Committee in making decisions regarding the introduction of new methods/brands and the continuing use of appropriate contraceptive method mix.

The shortage of staff at health facilities, especially in the rural areas and migrations of health professionals not only overseas but also from public to private sector, is an issue that MoH continues to face.

Under the National Health Strategic Plan 2011-2015, MoH has explored options of increasing the number of trainee doctors and nurses, revising bonding conditions and initiating annual registration of health professionals, and compulsory continued medical education. An additional nursing school was established in 2005 and a medical school, which opened at the University of Fiji in 2008. This is with the hope that in the coming years, Fiji will be able to experience an increase influx of these health professionals in the health system.

Some additional interventions to address the current shortage and encourage staff retention would be that medical, nursing and allied health professionals employed by the public sector in Fiji are given a ‘country allowance’ if they work in a rural area. Doctors are also offered an on-call allowance if they work in a rural or remote location. In these locations, housing is also provided. Unfortunately, even such incentives could not stop some staff from relocating as they find the allowance insufficient to augment and sustain their needs. Poor work conditions, inadequate facilities and supplies, weak support, supervision and management, heavy workload and mismatched skills and tasks are just a few of the other reasons for the continuous migration of health staff out of the health system.

Another major barrier to access that many of the nurse practitioners raised is the policy prohibiting nurses to provide long acting method (implant insertion). Such a constraint can lead the FP clients to choose an alternative method or just stop using a method altogether as these FP clients referred in hospitals are often made to wait long hours and are a low priority.

**Recommendation:**

- Explore the option of task shifting to respond to the chronic shortage of human resources at primary health facilities.
- Review the policy under the Nurse Practitioners Act regarding restricting provision of certain FP methods to the nurses and consider allowing trained and competent nurses to deliver long acting methods.
- Review and revise existing incentive mechanisms to attract new graduates to serve in the public sector and get assigned in the rural area for a minimum of two years under contract before they venture to the private sector if they decide to do so.
- Reinforce the role of Community Health volunteers to support nurse practitioners in the distribution of commodities during outreach.

**Provider training and skills:**

Service providers are expected to maintain the necessary technical skills to offer and provide the methods safely to their clients. Hence, continuity in harnessing their knowledge and skills ensures that competencies of the health staff working on RH/FP programs are kept and updated.
The Fiji School of Nursing under the Fiji National University (FNU) is the main training institute for nurses in the country. It offers a Diploma of Nursing, Certificate of Midwifery, Certificate of Public Health Nursing, a Certificate of Management and a Diploma in Advanced Nursing Practice (a course to train registered nurses with midwifery experience for work in primary care facilities). The nursing curriculum was revised in 2004 and the program includes 62% classroom learning and 38% clinical area visits. A balance between didactic and practical learning is crucial to ensure that necessary competencies of the nurse cadre are developed by the time they graduate from the training course and be deployed to the health facilities.

The Reproductive Health Training Program (RHTP) is a program established in 1999 in partnership with FNU. The objectives are to improve the knowledge and skills of mid-level service providers and managers working on RH, and to produce graduates better positioned to provide quality care and program management in SRH Care. Upon returning to the workplace, they should be able to assist in building capacities at every level of SRH, clinical services and management, including all aspects of Safe Motherhood, STI/HIV-AIDS prevention and management, operational research, collection of data, as well as transforming it into information that will inform policy development and SRH service provision. In 2008, the College of Medicine, Nursing and Health Sciences took over the governance and the full facilitation of the program. Since the program's inception in 1999, it has produced more than 300 RHTP health professionals in PICs.

In Fiji, the RHTP program is offered only to nurses. The selection of students to participate in the program is dependent on the divisional heads where one major selection criterion is the nurses' performance at the workplace. For other PICs, doctors and midwives are also invited. At the end of the program, those who successfully complete the course in Fiji are allowed to provide FP counseling, including the conduct of the medical eligibility criteria assessment which is not authorized to registered nurse practitioners who have not completed the program. Many graduates have stated that the program has given them the confidence to deliver RH/FP services competently.

The results of ad hoc program reviews in 2007 and 2008 revealed the curriculum program to be too lengthy and lacking a practical component. However, no thorough review of the curriculum has been carried out nor has an evaluation been conducted to provide information regarding the effectiveness of either the RHTP program or how much these certified RHTP graduates have contributed in providing quality RH/FP service.

One of the subdivision sisters raised concern during the Focus Group discussion that pre-service training for nurses does not develop the necessary competencies of students for FP counseling. She added that only some of them have the confidence to provide FP services at Primary Health centers. Such observation was attributed to the lack of clinical exposure as well as insufficient hands-on training by these nurse practitioners during their formative pre-service course.

Training on basic emergency obstetric care is conducted through on-going basic training in midwifery through the Fiji School of Nursing. However, these midwives are usually deployed in the maternity or subdivision hospitals. While for postgraduates in obstetrics and child health, training at the Fiji School of Medicine has improved the quality of skilled birth attendants, including those in rural health centers.

Recommendations:

- Review the pre-service curriculum for nursing to upgrade the counseling and clinical skills training. Evidence shows that conducting counseling and competency-based clinical skills training, combined with simulation processes of learning, is highly beneficial to improve confidence and produce more competent providers.

- Develop a short course in service training on FP counseling and clinical skills for nurse practitioners already deployed at nurse stations.

- Conduct periodic refresher training for all nurses working in the primary health care centers to ensure retention of skills and to update their knowledge on RH/FP services.

- Evaluate the RHTP program and review the training curriculum for the RHTP program.

- Identify the location and distribution of the RHTP-certified nurses country-wide and conduct an evaluation to determine their added-value in the provision of RH/FP services after training.

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Management, supervision, and Quality Assurance and improvement system

At the subdivisional level, it is the Subdivision Medical Officer and Subdivision Health Sisters that manage the integrated hospitals, health centers, nursing stations and community health services.

Supervisory visits are ideally done in a periodic manner; however, due to geographic issues and transportation problems, service providers especially in distant health centers do not get to receive adequate supervision from their superiors. Furthermore, such activity is being less prioritized due to the increase workload of supervisors. Supervision tools that will assist supervisors measure the performance of staff at health facilities are not available. KPIs that would be helpful in measuring effectiveness of a program or efficiency of health facilities at performing the RH/FP services are not in place.

Recommendations:

- Develop supervision tools that will guide supervisors on how to conduct effective supervision at the health facilities.
- Develop KPIs that will measure performance of a health facility in providing RH/FP services and align it to the objectives of the RH/FP program.
- Identify retired staff in each division and explore the option of employing them to serve as mentors of service providers.
- Conduct periodic supervisory visits to monitor the provision of the services by health staff in the facilities and provide immediate interventions whenever necessary.

Integration of Services

A "one stop shop" offered to clients in a health facility is probably a vision of every Ministry of Health. But how this can be achieved remains a question unanswered owing to shortage of human resources. Opportunities to deliver other services are usually missed out as some services are prioritized over others. For example, when clients come for delivery or immunization of their children, this is an opportune time to introduce FP counseling.

Family Planning is included under RH delivery of services and is provided throughout the divisions in a decentralized manner. However, the integration of FP services during postpartum, post-abortion care, STI/HIV counseling and in cases of GBV is not routinely practiced in the majority of primary health facilities. It appears that only in division hospitals is postpartum FP routinely being done since most of the deliveries happen in these centers. In one interview, it was noted that most abortion cases seen at the health centers are being referred to and managed at the hospitals so they are not generally handled in the primary health centers.

Integration of the services should be reflected in the minimum service package for primary health centers.

Recommendation:

- Strengthen postpartum FP services at all health/birthing facilities by reinforcing FP postpartum counseling during training to midwives and nurses.
- Reinforce to service providers at FP/STI trainings the dual protection function of condoms during STI/HIV counseling.
- Reinforce assessment for STI during FP counseling at FP/STI trainings for clients prior to offering FP methods

Highlight in the FP service guideline areas where integration of services can be applied and disseminate to service providers.

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15 Law in Fiji prohibits abortion and it is only when the life of the mother is being threatened can evacuation procedures be allowed.
Referral System

Referral System for Obstetric emergency cases seen at nursing stations and health centers are brought either to the subdivision hospitals which are expected to provide basic Emergency Obstetric Care services or they are brought to the division hospitals if caesarean section and blood transfusion might be necessary. The system is challenged, however, when cases being referred are coming from remote locations where transportation is a problem.

Referral system on FP is functioning and the process of referral is being done when methods are unavailable in the health facility or the provider is not competent to deliver the service. Referrals could be minimized if expansion of methods available in primary health facilities is reviewed, that is, to consider allowing long acting methods to be available at the lowest service delivery point and ensure that a trained competent nurse is also available.

Assistance from service providers should not commence only when the community seeks health support upon arrival to the health facility. Therefore, a referral system within the community linking with health staff in nearby primary health centers could help expedite the process. This can be reflected through the development of a referral guideline that could also include referrals from the NGOs.

Recommendations:

- Develop a referral system within the community and linking with nearby health facilities.
- Develop a referral guideline to involve NGOs in the assistance of delivery services when such services cannot be accessed from the public sector.

Private sector involvement

The MoH supports private sector collaboration. However, coordination with the public sector appears to be more individualized and direct in nature. A forum comprising of diverse partners working on SRH/FP could assist the program in planning approaches and strategies that would address SRH/FP issues and support activities and services to promote healthy behavior towards SRH.

In the private sector, a large part of health services are directly funded by households through out-of-pocket expenses. With increases in consultancy fees by General Practitioners (GPs) due to an unregulated market, households and individuals who can afford it are purchasing medical insurance schemes either through their employer or directly to avoid direct payments at the point of service.

Besides the public health sector, RH/FP services are being delivered by the private sector via the Suva Private Hospital and private clinics. There are approximately 180 registered GPs nationwide and all are located in urban centers. However, services delivered by the private sector are not reflected in the public HIS though there have been attempts made by both sides to include the data in the system.

Strengthening the private-public sector interface could improve coverage with affordable and quality assured health services and commodities, but identifying the right approach remains an issue.

Government health financing is geared towards the rural population. But increasing pressure is being placed to the MoH to modify the system because of the growing number of urban dwellers migrating from the rural areas, so a good private-public market mix should be considered.

A feasibility and desirability study on Social Health Insurance (SHI) in Fiji taking into consideration the concerns and values of government officials, the Peoples Charter, and human resource/economic capacities of the country, revealed that to introduce SHI in Fiji would not be wise at this stage for the following reasons:

1. It would not create substantial new funding to the health system, and
2. It would create inequity of access for free medical care for all Fijians.

16 National Health Account 2011-2012.
17 Dr Rosemary Mitchell, President Fiji College of General Practitioners, Interview meeting: March 2014.
Using SHI to increase funding for MoH services may make the Ministry of Finance more inclined to lower the budget allocation for MoH. Additionally, if SHI finances private practice, then Government would have to increase its allocation to health just to maintain equity. And thirdly, the document stressed that SHI would be most unlikely to increase efficiency of the health system as international evidence has shown it can be more costly than a tax-financing system because of difficulties in price control.

Hence, the study recommended to Government the following ways of public health financing that would be more beneficial:

- To continue to rely on general revenue financing while it builds a case for increased budget allocations for MoH,
- Intensify efforts in the short-term to address known inefficiencies in MoH, and,
- To complete the transition to competitive elections to provide the necessary public pressure and accountability that is needed to sustain improved efficiency of MoH delivery.¹⁸

On the other hand, there are several NGOs that work on SRH in Fiji and among them are the RFHAF, Fiji Red Cross, MSP, AIDS Taskforce of Fiji and the Homes of Hope considered a Faith-Based Organization (FBO).

The RFHAF has played a key role in shaping national family planning policy and in promoting SRH education, particularly among young people and communities where myths about the dangers of FP still prevail. For this year, they hope to supplement Government’s effort in advocacy as well as venture into providing clinical services in coordination with the MoH during their outreach activities. RFHAF has also undertaken joint national advocacy work with a particular emphasis on HIV/AIDS. To measure the efficiency of their program and advocacy interventions to the youth, quarterly reports to show progress of their activities and annual reports are submitted to the MoH to relay achievements made over the year. But to measure and report on the impact of their activities seems to be a challenge that they are still working on.

Home of Hope is a faith-based organization that deals with single parents, who are victims of sexual abuse, and sexually abused children. The organization has three programs they provide to individuals they have taken in who are reintegrated to their community three years later. They also have a network of community volunteers within Suva who help them identify the victims in the community. They have worked recently with MSP, who support these victims by providing clinical services such as STI/HIV counseling and treatment and SRH information that is disseminated with caution.

The focus group discussions highlighted that one challenge commonly faced during community outreach by NGOs is the limited options of contraceptive methods they can deliver to clients. NGOs are only permitted to distribute condoms to the community, and thus barrier to access becomes an issue.

**Recommendations:**

- Form a forum/committee comprising of partners working on RH/FP that will serve as governing body to oversee and support RH/FP activities.
- Continue good partnership with the NGOs specially those working on SRH to assist the public sector at ensuring access to communities on RH/FP and Adolescent Health Development (AHD) information.
- Explore avenues that will allow private practitioners to support the public sector’s improvement of RH/FP coverage.
- Develop a mechanism (monthly reporting) to integrate data on FP/SRH services provided by private providers to the national HIS.
Youth-Friendly Health Service

The MoH’s AHD program is a key component of the national RH program which aims to promote the health and development of youths by providing information, education, life skills, training and services to meet their needs. The program implements peer education programs in schools and at community level, supports youth-friendly facilities (AHD centers) in all the 19 subdivisions, and facilitates and conducts capacity building for peer educators and nurses in the key areas of AHD and SRH.

As of 2012, there were 25 Youth-Friendly Health Service (YFHS) facilities throughout Fiji designated to provide SRH services. There are three service delivery models: integrated, stand-alone and school-based models. The integrated model (n=19) includes AHD clinics/centers located within hospitals or health centers. These sites have peer educators for provision of information and education, while the clinical management is carried out by a health facility nurse or the medical officer. The stand-alone model, also called SRH clinics or Hubs (n=3), are in Lautoka, Suva and Labasa, situated outside health facilities and have full-time peer educators, nurses and some have medical officers. The school/tertiary institution-based AHD clinic/centers (n=3) have peer educators and matrons for clinical management. In Fiji, all YFHS facilities are government-owned and supported by the MoH.

Six national criteria are used to consider a facility to be a YFHS facility. These are adequate space to offer privacy, accessibility of the facility, service hours are convenient to youth clients, confidentiality, youth participation in service provision and availability of Information Education and Communication (IEC) materials.

Of the 25 identified YFHS facilities, only seven health facilities were assessed. Of these, three are stand-alone health facilities that met the criteria. The other facilities are integrated and fall short of the requirement.

Issues to determine the number of young people counseled and who availed of FP services at the health centers could not be collected with accuracy as conflicting schedules of peer educators with those of the clients needing counsel caused some clients to be lost or unaccounted.

Efforts have been made to make every health facility youth-friendly, but space remains inadequate to provide the proper services needed to ensure privacy. It was suggested in the assessment that with some rearrangements and structural modifications, most facilities may have the ability to offer private, comfortable and acceptable environment for youth clients.

Based on the YFHS assessment, the integrated sites where services are offered to all age groups didn’t have any arrangement to allocate specific hours to provide services to youth. Peer educators in these facilities refer youth clients to outpatient departments or FP services that are often crowded with clients of all ages. Most service providers reported that many young people are shy and embarrassed to access SRH services and that the space doesn’t provide adequate privacy for young people. There is thus a lack of a national guideline for YFHS delivery – a major gap found in the provision of standardized SRH services throughout Fiji.

Peer educators to play a crucial role in the delivery of SRH information to young people. However, in the assessment, most of the peer educators’ time is spent in schools and on outreach activities, thus providing little time for facility based youth counseling activities.

Health staff in the YFHS facilities do not have the necessary training on communication and counseling skills for young people. This affects the delivery of SRH services to this target group.

In general, the current YFHS delivery essentially offers an opportunity for further strengthening and scaling-up of available SRH services in Fiji.

Recommendations:

- Review the training curriculum of peer educators and include counseling training for other possible information providers such as to health providers, teachers and community health volunteers.
- Reinforce under the counseling component by health providers, peer educators, a delay in the first pregnancy among young married couples and the spacing of the second pregnancy for young couples with one child.

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19 Report on Assessment of Facilities providing Youth Friendly Health Services in Fiji, August 2012.
ENABLING ENVIRONMENT:

Leadership and Management

The MoH is committed to upholding the principle of universal coverage and equal access to health services including RH services for all Fiji citizens.

The MoH’s vision is “a healthy population driven by a caring health care delivery system”, with a mission to “provide a high quality health care delivery system by a caring and committed workforce working with strategic partners through good governance, appropriate technology and appropriate risk management facilitating a focus on patient safety and best health status for the citizens of Fiji”.

Supporting policies, guidelines and regulations related to RH:

A number of government policies, strategies, decrees and acts provide the regulatory framework for the health system in Fiji and show where the RH program is integrated:

- Ministry of Health Strategic Plan 2011-2015
- Public Health Act (Cap. 111)
- Medical and Dental Practitioner Decree (2010)
- Medical Assistants Act (Cap.113)
- Pharmacy Profession Decree 2011
- HIV/AIDS Decree 2010
- Medicinal Products Decree 2011
- Dangerous Drugs Act (Cap. 114)
- Private Hospitals Act (Cap. 256A)
- Public Hospitals & Dispensaries Act (Cap 110)
- The Nurses Decree 2011
- The Allied Health Decree
- Standard Treatment guidelines
- National FP service guideline for health providers
- National RH Policy 2011
- National RH strategies 2011

Fiji has committed to international agreements relevant to RH where it has been integrated in the National Health strategic plans for 2011-2015 and these are:

- The International Conference on Population and Development Program of Action (ICPD PoA), 1994, of which Fiji is a signatory
- The Millennium Development Goals (MDGs), 2000

The National RH policy and strategies still need to be translated into concrete actions with progress measured by a governing body that serves to oversee the overall performance of the program.

Accountability measures are still not in place; hence, relevant staff and officials are not obliged to ensure that progress for RH/FP is achieved.

In the indicators for the MDG being tracked by Fiji, specific indicators to measure MDG 5B are not aligned under MDG 5 and the writer believes this is one reason why unmet need and Age-Specific Fertility Rates (ASFRs) are not given much priority. However, CPR is being tracked mainly to measure MDG 6.

Recommendations:

- Develop a costing plan for the RH policy strategic activities.
- Develop accountability mechanisms in the RH policy and strategies to ensure actions are being undertaken and followed up.
- Activate a coordinating mechanism or a working group that will function to oversee implementation of the RH strategies and activities – this can be led by the public health director.
Human and Financial Resources for RH/FP

The budget allocated to the MoH in 2011/2012 was FJ$256.8million, an increase of FJ$6.8million allotted in 2010/2011. In total, the MoH’s allocation has reached 6.8% of the total Government budget for this time period.20

Government funding allocation for health has remained relatively consistent despite increasing demand and cost for healthcare. In general, Government has allocated a proportion varied between 9% and 10% of its total yearly public expenditures on health care, except in 2012 when it dropped to 7%.

The funds for FP commodities and related supplies for Government are currently included under the Government budget through the MoH while the UNFPA has been a major funding provider of FP commodities and supports Government by procuring commodities on behalf of the MoH through third-parties. The process of carrying out advance payments for the procurement of FP commodities by Government, as per requirement from UNFPA, seems to be a problem from the Government as the release of public funds are often time delayed.

For NGOs, IPPF provides support in the procurement of FP commodities while ad hoc donor funding and voluntary donations of supplies are obtained from private groups and organizations. However, allocation for FP commodities by IPPF are also limited and do not entirely support the contraceptive needs requested by NGOs.

Recommendation:
• Funds allocated for RH should conform to the RH/FP needs of the people. So where public funds are insufficient, coordinating with other stakeholders and donor partners becomes essential to augment this funding gap. The health sector support group is the proper forum to raise this issue.

Evidence-Based Decision-making

Evidence-Based Guidelines:
The National Family Planning service guideline developed in 1994 for health providers serves as the reference guide for health workers at all service delivery points. The guide is currently in the process of revisions to include other newer methods available; the World Health Organization (WHO) medical criteria, and inclusion of standards and policies to clarify which service providers are allowed to deliver which types of FP services. However, during the site visit at one health center, the reference material was not found in the facility.

Health Management Information System

The Fiji HIS has replaced the Consolidated Monthly Reporting to the Public Health Information System (PHIS). In the new PHIS form, data collected and generated are limited to the following: new acceptors and total acceptors per modern method excluding permanent methods. The indicator being used to measure progress in the delivery of contraceptive services of the program is Couple Years of Protection (CYP), which has replaced CPR. The PHIS form is being filled monthly by the zonal nurses and submitted to the subdivision sisters and division medical officers then sent to the central Health Information Unit to process online. On the other hand, the subdivision sisters submit a quarterly report to the District Medical Officer (DMO). With the new PHIS form, only the zonal nurses encode the forms from those clients provided with FP services to all primary health care centers residing in their respective zones. However, those clients who receive contraceptives in the health center but are not from that area are not being included in their census, hence are lost data. Information on population statistics, CPR and fertility rates and defaulters are not included in the form making it difficult for health staff at the lower service delivery point to analyze the data and assess FP coverage in their area. Quarterly reports submitted to DMOs are underutilized by the Health Information Unit as it is left only up to the division level. Since PHIS can be accessed online, outputs may be available on demand, but analysis of the data by service providers and managers can be difficult as the indicator CYP was not clearly disseminated to them nor how its calculations are interpreted.

Recommendations:
• Update and finalize the Fiji service guideline to include counseling services and to conform to international standards; once finalized and approved, it needs to be rolled out to all health service providers, both national and expatriates.

20 Fiji Health Account 2011-2012, National Health Expenditure 2011-2012: Ministry of Health Fiji report.
• Conduct workshop with RH/FP program supervisors and service providers to roll out PHIS form, disseminate definitions of RH/FP identified indicators and provide guidance on how data should be collected.

• Skills of health providers need to be improved in the analysis of data.

Advocacy efforts

Advocacy activities to raise a level of awareness on RH/FP services are necessary if there is serious intention on the side of Government to ensure access to RH/FP information and services for all, especially to young people, the underserved and the remote and poor population. Using media can be a powerful, cost-effective tool that can assist in trying to capture target population, especially those in remote locations.

The MoH has used social media such as a Facebook to reach out to all Fijian citizens and this may have been a good approach to improve awareness to the youth. However, little is shown to promote FP. Most of the RH materials were information on antenatal care, birth preparedness plan, and male involvement during pregnancy.

Promoting FP during parliamentarians’ forum to sensitize them on the issue and gain their support on RH/family planning can also be a way of advocacy.

Recommendations:
• Use social media as an effective tool to disseminate RH/FP information to targeted groups like the young.

• Use special events such as national campaigns and international celebrations such as World Population Day and International Women’s Day as opportunities to advocate for RH/FP led by the Health Promotion Unit in coordination with the Public Health service and Family Health Unit.

Community Engagement

Under the Fiji National Health Strategic Plan 2011-2015, Strategic Goals 1 and 2 highlight the community as major beneficiaries of RH/FP services and to have communities include RH/FP activities in community plans is a step forward to show that the community is taking charge of their reproductive health. Getting community leaders to take the lead in advocating RH/FP would be beneficial as they can enlighten and influence other members of the community. And engaging health providers to coordinate with community health volunteers is one way of trying to expand coverage to as many community members as possible.

In Fiji, communities engage with RH/FP services through the outreach activities conducted by Government via peer educators and health services providers, as well as via NGOs that work on SRH and are assigned to certain communities.

Recommendation:
• Conduct meetings with community leaders, parents and youth groups to plan and organize RH/FP activities in the community.

Access for Vulnerable Groups

The Reproductive Health policy explicitly state the need to ensure that access to RH/FP services is made available to all, which includes the young. This has been approached via the MoH’s AHD program. The AHD program has been working on making SRH information and services available and accessible to this vulnerable group via the establishment of YFHS facilities; and equipping it with health staff capable of supporting the RH needs of the targeted group openly and without bias. But a challenge remains in that not all health staff have received adequate training that would allow them to communicate properly with young people. Information materials for young people and men are either insufficient or unavailable. Commodities such as Emergency Contraception Pills (ECPs) are still not readily accessible and need to be advocated to some service providers so they can be made available for vulnerable groups.

Recommendation:
• Develop and disseminate ECP information materials at YFHS clinics to reinforce awareness of the commodity, especially to young people.
DEMAND:

Strategies to reduce FP cost and increase demand

Some 99% of government health facilities provide RH/FP services and are free of charge, but services are costed at the private health facilities and cater mostly for those who are willing to pay or those clients that are covered by health insurance.

The FPBSC serves as a commercial arm to provide pharmaceutical supplies to external customers including other governmental departments, retail pharmacies, general practitioners, NGOs, and small Island States. This is to make available to all Fijians affordable quality drugs, including contraceptives sold in retail pharmacies.

Recommendation:

- Explore other social marketing strategies for contraceptives.

FP program and SBCC strategies

Currently, there is no existing RH/FP communication strategy in place to guide RH/FP program managers in the development of effective Information, Education and Communication (IEC) materials that can influence change in behavior for targeted audiences.

Though IEC materials such as brochures and posters have been produced in the past and have been adapted from materials that worked in other countries, none of these has been pre-tested in Fiji before being disseminated to the public.

Recommendation:

- There is a need to assess whether to have a national communication strategy or a communication strategy specific for RH/FP. Such a specific strategy would facilitate programs to develop more effective communication materials for targeted groups that are able to create behavioral change.

Commercial and Social Marketing

Social marketing has proven its effectiveness in distributing products and increasing demand, but initiatives tend to focus on the commodities end of the goods-services continuum (e.g., contraceptives), rather than offering clinical care services through social franchising models (e.g., TB treatment). Such initiatives have already been done for condom commodities. For example, FJN+, an NGO whose focus is on advocating for People Living with AIDS (PLWA), distributes condoms in nightclubs, hotels and to minors.

In three private pharmacies visited by the consultant, commodities are not put out openly on display, but discreetly distribute them upon request.

Recommendation:

- Conduct market segmentation analysis for social marketing strategies.

Mass Media

The use of the right media can be a very powerful communication tool to convey messages that will reach people in need of SRH/FP information. It can also be cost effective in reaching those in remote locations. This can be in the form of radio and television and via Internet social networks as well as through printed materials such as posters and pamphlets.

In Fiji, it doesn’t appear that mass media has been used extensively as an approach to disseminate SRH/FP information and services. Existing FP IEC materials in Fiji are insufficient and distribution is confined to health service delivery points.
In order to effectively capture a wide group of potential clients, it is essential that printed advocacy materials are adequate for distribution to all who would like to access them. It is also important that materials are available and accessible to all targeted groups, with FP messages translated and designed according to the target audiences. In YFHS centers, most IEC materials developed for youth contain easy-to-read content (HIV, STI, substance abuse), but for other information such as contraceptives, materials mainly cater for all age groups.

During outreach activities, some brochures are being made available for communities and such information materials are often obtained from NGOs conducting SRH advocacy forums in targeted locations.

Recommendations:

- Adapt SRH/FP media material developed in other countries or by NGOs operating in Fiji according to a Fiji context.
- Participate in radio/TV talk shows to discuss FP information with a wider audience.

Engaging communities and Champions for BCC

When communities are involved in the planning and coordination of RH/FP activities in their area, they are more likely to be motivated to seek RH/FP services and help them make informed choices. Involving community leaders to canvas their views during health program planning can also lead to their becoming potential advocates. This can highly influence decisions of its community members.

Community mobilization in Fiji for SRH/FP is seen most effectively in activities conducted by NGOs such as the RFHAF. Such organizations work closely with communities and conduct frequent SRH/FP advocacy activities.

Recommendations:

- Regular forums with religious and community leaders can be a good entry point to involve the community in RH/FP program planning.
- Suggestion boxes can be disseminated in health facilities to determine the views of clients receiving SRH/FP information and services from health staff.

Peer Education

Peer Education is an approach to health promotion where community members are supported to promote health-enhancing change among their peers. In Fiji, trained peer educators have been identified as key players in the provision of SRH information to the young people. They are situated in all 26 youth-friendly facilities and work with school health teams and health facility nurses. Normally, one peer educator is available in each subdivision, but in areas with a high population and owing to geographical distances, more than one peer educator can be made available.

The daily activity of a peer educators is mostly spent at primary schools together with the school health team and less time is spent at health facilities. The inadequate capacities of some health providers to identify RH needs of the youth is creating some burden to the peer educators as clients are sometimes lost when their needs could not be understood or entertained by these service providers.

The development of the Family Life Education program (FLE), in collaboration with Curriculum Development Unit at the Ministry of Education, has been institutionalised since 2006 whereby a Life Skills based FLE curriculum is taught in schools in an age appropriate manner. Training in Life Skills has resulted in youth trainers mastering the skills of delivering community-based training in Life skills in their respective communities.

Recommendations:

- Provide formal communication skills training for service providers, especially those in YFHS clinics, to facilitate their concerns in tackling specific youth issues such as sexual abuse, young clients’ physical, emotional and social development issues.
- Train more peer educators, counselors, teachers on Adolescent Reproductive Health.
REPRODUCTIVE HEALTH COMMODITIES

Fiji has a well-developed purpose-built pharmaceutical warehouse service that supplies all public health service delivery points with pharmaceuticals including RHCs. Store Officers, Medical Officers and Nurses in charge of hospitals and other health facilities are responsible for the day-to-day management of supplied pharmaceuticals.

Selection of RHC:

The National Medicinal Product Policy was approved in 2012 and the objectives of the policy are to ensure accessibility, quality and the rational use of medicines for health professionals and consumers. It covers aspects on selection of essential medicines including RH/FP commodities, procurement and sale of medicines, storage, inventory and distribution of medicines, the rational use of medicine and advertising and promotion of medicines.

The National Medicine Authority is comprised of the Clinical Products Committee, National Medicines & Therapeutic Committee, and National Biomedical Committee. The NMA is in-charge of making decisions pertaining to the essential medicines selection, including FP products.

The RHCs are listed in the Fiji Essential Medicines List. The same RHCs are also included in the National Evidence-Based Guideline on Family Planning for Health Providers.

There have been no reported cases of complaints regarding defects found in contraceptives procured for the country for the past year.

Forecasting:

Predicting future contraceptive needs are necessary in order to get the right quantity and commodity required in health facility operation.

At FPBSC, though there is a technical working group tasked to calculate essential pharmaceutical needs, including the annual forecasting needs for RH/FP commodities. Knowledge and skills in forecasting RH/FP commodities is weak and technical assistance is required to assist this working group.

MoH have assigned the national EPI coordinator to provide oversight and to supervise and coordinate this function as the FP commodity coordinator. Her responsibility includes estimating the annual vaccine requirement and also to estimate the annual RHC requirements. To date, the current data she uses to estimate the commodity requirements are based on issue data coming from health facilities. Issue data do not reflect current utilization uptake trends and as such need to factor health services data and population data also. The final estimate will factor in consumption, health services and population data.

Recommendations:

- Forecasting training should be provided for staff at FPBSC to forecast needs for essential medicines together with the FP commodity coordinator.
- Advice to integrate FP commodities forecasting in the technical working team forecasting for general medicine needs.

Procurement:

The FPBSC manage storage and distribution of medicines and therapeutic goods that includes RHCs. Within FPBSC is a procurement and logistic team that manages all procurement and logistics activities including strategic sourcing, purchasing, logistics, inventory management and accounts payable manages RHCs also.

MoH has allocated a budget line item for the purchase of FP commodities through the “UNFPA Access RH initiative” which operates third-party procurement for FP commodities.

Annual procurement orders are placed once a year. Annual stocktake is a requirement under the financial act to monitor the accuracy of all medicines including FP stock-on-hand to determine the value of the contraceptives on hand before the end of the year. The current stockholding assists in the following year’s budget allocation for RHCs.
However, the current annual stock monitoring is risky as it presupposes that current monthly consumption that led to the current annual procurement orders will remain the same. For this reason, the frequency of increasing reporting to twice-yearly or quarterly would mitigate this risk. The UNFPA PSRO has also recommended an increase in the reporting frequency to quarterly.

At times, there has been a need for an ad hoc order to supplement current stock. Such emergency procurement of contraceptives can be attributed to poor data provided by SDPs regarding monthly consumption that results in inaccurate information being collected and collated at the central level.

**Recommendation:**
- Conduct monthly or quarterly stocktake to ensure accuracy of stock-on-hand (start with fast-moving stock, followed by slow moving ones).

**Distribution:**

FPBSC uses a distribution method called Imprest Stock system, which distributes medicines to hospitals where supply replenishment is driven by Pharmacy Departments. The efficiency and effectiveness of the Imprest Stock system hinges on the ability of the Pharmacy Departments to service the hospital wards at regular intervals to replenish stocks.

This same Imprest Stock system is used to supply the 170 service delivery points outside the hospital around the country. The system’s success relies heavily on the reporting from the nurses at SDPs. This system of information reporting requires wider policy discussions with FPBSC and MoH.

The Logistic Management Unit is responsible for organizing, monitoring and supporting all activities within the logistics system and improves communications between FPBSC and health facilities. This involves collecting, collecting consumption data from the EPICORE system, health services data from the PATIS system and validating demand estimates.

Whilst this unit has only recently been established, it needs assistance from donor agencies like WHO, UNICEF and UNFPA to map the current commodities and information flow from FPBSC to service delivery points. This supply chain management configuration is essential in order to factor transport variability to align the inventory estimates at buffer level at Service Delivery point level is readjusted and is reset correctly.

Though there are reports of values of stock-outs of all medicines, it could not be determined in this assessment how much of the reported value of stock-outs are from RH/FP commodities. It is also quite difficult to determine how many of the health facilities are incurring a stock-out for the preceding six months as this is not routine indicator collected.

**Recommendations:**
- Review the Imprest Stock system and SOP to reinforce timely submission of logistic forms that should include essential data of AMC, SOH and QTO.
- Encourage the use of the following indicators to be collected by the Family Planning Coordinator:
  - % of SDPs offering at least 3-5 modern types of RHCs
  - % of Primary SDPs reporting no stock-out of RHCs in the preceding six months.
- Explore targeted training to facilities that continue to report stock-out on SCM/RHCS level 1 training on a case-by-case basis.

**Storage:**

Proper storage and handling of FP commodities are necessary to ensure that quality of contraceptives are always maintained and protected.

The FPBS warehouse serves as the storage facility for all essential medicines including contraceptives. Inside the warehouse, FP commodities are stored upon receipt and inspection from the supplier of the commodities.

First Expiry First Out (FEFO) is being practiced at the central level but it could not be determined if this is being done at all lower service delivery points. Stock records are not regularly available in every facility (showing AMC, #dispensed, #issued, stock on hand, min-max level are reflected-central level). But emergency orders are easily made by the FP
coordinator and approved by the Chief Pharmacist. Protocol on proper storage of medicines for lower health facility level doesn’t appear to be practiced by lower SDPs.

**Recommendation:**
- Disseminate SOPs on proper storage procedures for essential medicines and contraceptives to all health facilities.

**Logistics Management related to Reproductive Health Commodities:**

LMIS is a system that plans, implements, and controls the efficient, effective, forward, and reverse flow and storage of goods, services, and related information between the point of origin and the point of consumption in order to meet customer requirements. It is a stock-monitoring reporting requirement of the inventory management system.

In Fiji, there is a health facility stock report that is submitted on a monthly basis from divisional hospitals and selected subdivisional hospitals. The remaining subdivisional hospitals, health centers and nursing stations reports are submitted quarterly.

The system currently being used at FPBS is the EPICORE system and does not support staff in the ordering of commodities at SDPs as it mostly focuses on the financial processes of purchasing the commodities. The system operating at service delivery point is the PATIS information system that captures utilization data of medicines and commodities that are dispensed to users. Discussions on linking and mapping the two data systems to utilize the health services data of PATIS and the consumption data of EPICORE has not been explored.

Analysis and proper reporting of the stocks at SDPs requires strengthening.

The FP commodity coordinator has noted that reports from the facilities up to the central level are not regularly received on time, thus affecting distribution of the needed stocks. It was also noted that data entered in the logistic form are sometimes incomplete. The question regarding whether the health staff are clear with the definitions of the logistic terminologies needed to be collected was also not clear to the FP coordinator. Hence, there is a need to review the form and improve their knowledge on the logistic data terminologies and on how to subsequently calculate each item.

**Recommendations:**
- Training on LMIS is crucial especially to all health staff handling FP commodities in the health facilities.
- Explore working with 23 subdivisional hospitals and 48 health centers that have PATIS and linking the current PATIS distribution system to generate inventory replenishment.
- Explore data mapping of EPICORE and PATIS to drive replenishment to SDPs.

**Waste Management:**

There is a guideline in place on waste management of pharmaceuticals including RHC products. Disposal of expired products written off from the stocks are done dependent on the bulk of expired pharmaceuticals to be disposed. According to the 2012 MoH’s Annual Report, FPBS was able to reduce the cost of wasted pharmaceuticals from $3million in 2011 to less than $1million in 2012. It could not be determined from the report, however, which commodities had the biggest wasted cost and how much of it were RH/FP commodities.

**Recommendations:**
- A list of commodities that were disposed because of expiration should be included in the reports together with the cost to feedback to programs.
- Disseminate protocols on redistribution of RH/FP commodities.
Private Sector Collaboration on RH Commodities:

Private sector involvement in the delivery of RH/FP services contributes to access to RH/FP services, especially for populations in the urban areas.

However, they are continuously perceived to be unmonitored as data on consumption of their commodities/dispensed to users are not regularly reported in the LMIS of the public sector. With this in mind, in theory, if they do monitor and keep such records then it should not be difficult to request for the logistics data.

FPBS coordinates the bulk-purchasing scheme of medicines and therapeutic goods for the private sector and other PICs. In this manner, price of medicines including contraceptives are regulated in a way that will be more affordable for the paying patients and clients.

Recommendation:

- Explore possibilities to obtain monthly data of RH/FP commodity consumption from private sector to be included in the Public LMIS.
CONCLUSION:

The Family Planning and Reproductive Health Commodity Assessment is conducted to evaluate the current situation of the FP program and progress made by Government at ensuring Universal Access to RH services. It also seeks to identify issues that hinder progress, find interventions and develop a plan that will direct the government as it tries to achieve universal access to RH services.

The Government, via the MoH, has made great efforts to improve the health systems, but many barriers still exist. The ‘Supply’ side faces several barriers, including health staff shortages. A broad range of FP methods is being offered but capacities to deliver quality RH/FP services needs to be strengthened; access to services for vulnerable groups remains inadequate despite a public-led AHD program and the establishment of several YFHS centers nationwide. The integration of FP services with postpartum, HIV/STI and adolescent RH is not being carried out in many health centers due to multiple tasks that one health staff has to do, while management and supervision are weakened by geographic and transportation issues.

On ‘Enabling Environment’, supportive policies and regulations are in place and leaders have shown commitment to support FP with the presence of the RH policy and strategies, but operationalizing the policy into actions on the ground has not been successful. There is no clear coordinating body that is directly overlooking the progress of the RH/FP program. Public financial resources for the program is limited, existing service guidelines are underutilized and health information collected for program planning does not capture all the data needed. On the ‘Demand’ side, the private sector has significantly contributed to assisting the public sector in creating awareness on FP at community level. They have been effective at collaborating and advocating with influential figures in the community and capturing more youths to access their SRH/FP services. Hence, this partnership with them should continue. Community engagement needs to be strengthened through the use of strong media. Both the public and private sectors need to assist the community identify their RH needs and services and work together to find culturally appropriate and rights-based communication interventions that will empower the community to make informed choices. Finally, RH/FP services cannot be complete without ensuring that RH/FP commodities are always available, accessible, in sufficient quantities and of good quality to those who wish to use them. Therefore, weak forecasting skills need to be strengthened through formal training, and FP commodities should be quantified together with the essential medicines. A procurement plan for FP commodities needs to be submitted in a timely manner, the distribution system needs to be reinforced with the regular use of stock cards to avoid the over- or under-stocking of commodities. Storage standards for commodities should be observed at all health facility levels and disposal of expired contraceptives by all facilities need to follow proper procedure as directed under the Waste Management Act.
SUMMARY RECOMMENDATIONS:

SUPPLY:

- Review the protocol regarding the use of the FP medical eligibility criteria for nurses at health centers to allow flexibility for health staff at primary health centers without a medical officer to use the tool and include it in the FP service guidelines.

- Link with NGOs working within the health facility catchment area to assist in transportation during the clinical outreach whenever possible.

- Adapt, replicate and customize to country-context international job aids to support FP service provision of health staff in health facilities.

- Review the pre-service curriculum for nursing to upgrade the counseling skills training.

- Develop short course RH/FP in service training course for public RH nurses newly deployed in lower SDPs.

- Review and evaluate the RHTP program and training curriculum.

- Periodic refresher training should be conducted for all nurses working in the primary health care centers to ensure retention of skills and to update their knowledge of RH/FP services.

- Map out the RHTP-certified nurses country-wide and conduct an evaluation to determine their added value in the provision of the RH/FP services after training.

- Conduct regular supervision by competent supervisors to ensure service providers at primary health care centers remain motivated.

- Develop supervision tools that will guide supervisors on how to conduct effective supervision at the health facilities.

- Develop KPIs that will measure performance of health facilities in providing RH/FP services.

- Identify retired staff situated in each division and explore the option of employing them to serve as mentors of service providers in distant health clinics.

- Technical group to review the current method mix and develop strategies to advocate the use of long acting methods for young married couples with a desire to delay pregnancy for the first and second children, and for women above 30 years of age.

- Promote the use of long acting methods Jadelle implant or IUCDs for injectable users with two or more children and those who are more than 30 years of age.

- Draft a guideline for the strategy implementation and disseminate via media and promotional materials.

- Develop FP integration of services guideline in coordination with MCH, AHD, HIV/STI and GBV program.

- Monitor implementation of the integration of health services guide.

- Reinforce clinical assessment for STI during FP counseling for clients prior to offering FP methods.

- Reinforce promotion of the dual protection of condoms during STI/HIV counseling.

- Strengthen postpartum FP services at health facilities by reinforcing FP postpartum counseling during training to midwives and nurses.
• Coordinate and develop with community leaders a referral system within the community to link with nearby health facilities.

• Referral guideline to involve NGOs and the community to be developed to assist the public sector deliver services.

• Adapt and implement effective social marketing strategies initiated by NGOs for community based distribution of commodities.

• Revitalize Community Health worker role in community based distribution of FP commodities.

• Develop incentive mechanisms for Community Health Workers for Community Based distribution of FP commodities.

• Explore avenues to reflect private practitioners contribution and to help the public sector improve RH/FP coverage.

• Develop a monthly reporting mechanism of FP services delivered by private providers and integrate in PHIS form.

• Improve the skills of health service providers on counseling adolescents/young people in FP.

• Develop skills of teachers and facilitators via formal and informal education, to deliver information on FP including dual protection.

• Develop and disseminate informational materials on ECP at YFHS clinics to reinforce awareness of the commodity, especially for the young people.

• Commence costing plan to improve infrastructure of health facilities especially those designated YFHS delivery points.

**ENABLING ENVIRONMENT:**

• Review and update the national RH strategy and develop a short- to medium-term strategic implementation plan with cost estimates.

• Set up a coordinating working group led by the Public Health director, family health program manager, MCH, FP, STI-HIV and AHD program officers comprising of diverse partners to assist in the overseeing of the planning and implementation of RH/FP program.

• Call for regular meetings to support implementation and assess progress.

• Review the nurse practitioner policies that inhibit FP service provisions by nurse practitioners for long acting methods (Jadelle implant).

• Funds allocated for RH should conform to the RH/FP needs of the people. So where public funds are insufficient, coordinating with other stakeholders and donor partners becomes essential to augment this funding gap. The health sector support group is the proper forum to raise this issue.

• Update and finalize the Fiji service guideline to include a separate module for counseling services specific to target groups and with all conforming to international standards.

• Orient and disseminate the updated service guideline to all health service providers, both national and expatriates.

• Conduct a dissemination workshop for RH/FP program managers and service providers to roll out details of PHIS form.
• Improve the skills of health providers in the analysis and interpretation of RH/FP data.

• Use social media to disseminate RH/FP information to targeted groups like the young.

• Use special events such as national campaigns and international celebrations such as World Population Day and International Women’s Day as opportunities to advocate for RH/FP led by the Health Promotion Unit in coordination with the Public Health Service and Family Health Unit.

• Equip community leaders, parents, youth groups with knowledge and information regarding the elements and benefits of FP.

• Involve the community on the planning and organizing RH/FP activities in the community.

• Allow community leaders to participate in decision-making plans for the FP program.

DEMAND:

• Create a consensus forum to discuss the need for the development of either a national communication strategy or a communication strategy specific for SRH/FP.

• Conduct an assessment on the knowledge, attitude and behavior of women, men and young people together with health staff, FBOs and community members.

• Develop the RH/FP SBCC strategies based on the results of the assessment.

• Develop SBCC activities and materials based on the formed strategies.

• Monitor the implementation.

• Collect and review all existing media materials developed and utilized in health facilities.

• Identify which information materials are most effective in building demand for FP.

• Reproduce and redesign media materials.

• Evaluate the disseminated media materials.

• Regular forum with NGOs, religious and community leaders identified as agents of change.

• Identify outreach activities effective at creating demand for FP.

• Develop suggestion boxes to be disseminated in the community and health facilities.

• Update the knowledge and skills of existing peer educators through refresher training.

• Identify and train more potential peer educators and program councilors that can support school-based and outreach services.

• Periodic monitoring of peer educators and YFHS health centers.
REPRODUCTIVE HEALTH COMMODITIES:

- Conduct training for staff at FPBS in charge of forecasting needs for essential medicines, together with the FP commodity coordinator.

- Advocate to integrate FP commodities forecasting in the technical working team that forecast general medicines.

- Conduct a quarterly stocktake of commodities and include RH commodities to ensure accuracy of SOH.

- Periodic monitoring of stocks at SDPs.

- Reinforce timely submission of logistic forms.

- Training on RHCS level 1 is needed by staff.

- Disseminate SOPs on proper storage for essential medicines and contraceptives.

- Develop protocols regarding redistribution of RH/FP commodities.

- Include monitoring during supervision visits conducted by the FP program.
## ANNEX 1: SCHEDULE DURING THE FIJI ASSESSMENT

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<tr>
<td>Prepare agenda for Fiji FGD and share with PSRO for distribution</td>
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<tr>
<td>FGD1 for CENTRAL AND FACILITY LEVF: RHC Coordinator, PHC Coordinator, Pharmacists [Public and Private Sector]</td>
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<td>FGD2 FOR HEALTH MANAGERS/HEALTH PROMOTION STAFF- Group 2: Health Promotion Staff, AHD Coordinator, RHC Coordinator</td>
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<td>FGD3 FOR NGO/TFCH ORG: Technical Organizations (Faith Based Organizations, NGOs/NGO)</td>
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<td>Transcription of responses based on questions and place in excel sheet</td>
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<td>Compile, analyze and synthesize in excel spreadsheet</td>
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<td>Site visit Fiji health facilities (Nausori Nursing station and Nabara HC and Home of Hopes)</td>
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<td>Enter in the narrative document</td>
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<td>Meeting with RHTP programme</td>
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<td>Continue narrative report writing Fiji</td>
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## ANNEX 2: LIST OF PEOPLE MET

<table>
<thead>
<tr>
<th>NAME OF PEOPLE MET</th>
<th>POSITION</th>
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</thead>
<tbody>
<tr>
<td>Mr. Peter Zinck</td>
<td>Health Systems/RHCS Specialist UNFPA PSO Fiji</td>
</tr>
<tr>
<td>Virila Raitamata</td>
<td>UNFPA-PSO Assistant Representative</td>
</tr>
<tr>
<td>Mr Isikeli Vulavou</td>
<td>UNFPA-PSRO Program Associate</td>
</tr>
<tr>
<td>Sr Talico Vakololai</td>
<td>Division Health Sister, Town</td>
</tr>
<tr>
<td>Sr Penina Dmavesi</td>
<td>Division Health Sister, Central</td>
</tr>
<tr>
<td>Sela S. Samuelo</td>
<td>Health Division Sister Representative</td>
</tr>
<tr>
<td>Mr Masi Niucavu</td>
<td>MoH National HIV Project Associate</td>
</tr>
<tr>
<td>Mr. Junaisa Drivatiyawe</td>
<td>FJN+ Program Officer</td>
</tr>
<tr>
<td>Mr Sera Waqa</td>
<td>MoH STI/HIV Technical Assistant</td>
</tr>
<tr>
<td>Ms Litiana Volavola</td>
<td>National EPI Coordinator</td>
</tr>
<tr>
<td>Alvish Pillai</td>
<td>Senior Pharmacy Officer, CWM Hospital</td>
</tr>
<tr>
<td>Mr Sepesa Rasili</td>
<td>MoH Adolescent Health Development Coordinator</td>
</tr>
<tr>
<td>Sr Alumita N. Bulicokocoko</td>
<td>Reproductive Health Training Program</td>
</tr>
<tr>
<td>Ms Atelita Seva</td>
<td>Executive Director, RFHAF</td>
</tr>
<tr>
<td>Ms Ani Dulaki</td>
<td>Executive Director, FJN+</td>
</tr>
<tr>
<td>Mr. Takuro Steele</td>
<td>Medical Service Pacific, Monitoring and Evaluation Officer</td>
</tr>
<tr>
<td>Ms Viatea Raioka</td>
<td>Peer educator</td>
</tr>
</tbody>
</table>
ANNEX 3: LIST OF REFERENCES/ DOCUMENTS


- Fiji Reproductive Health Policy, 2011.


- Health Service Delivery Profile Fiji 2012, Compiled in collaboration between WHO and Ministry of Health, Fiji.


- Republic of Fiji Ministry of Health National Strategic Plan on HIV and STI 2012-2015.

- Assessment of Social Health Insurance Feasibility and Desirability in Fiji, Ministry of Health Fiji: June 2013.


- Report on Assessment Of Facilities Providing Youth Friendly Health Services in Fiji, September 2012.


- UN: ICPD Programme of Action, 1994 (specific references to Principle 8, para 53 and 58).


### Annexe 4: RH Strategic Action Plan

**Enabling Environment Outcome 1:** Policy, program and community environments, plus social and gender norms support functioning health system and facilitate healthy behavior

**Outcome Indicators:**

- Existence of policies in place that takes into consideration rights-based and total market approaches to family planning
- Existence of a 3-5-year medium-term plan for FP, with rights-based and total market approaches, is being implemented
- Availability of national SRH and RR guidelines and protocols that include rights-based approach to RHCS family planning issues

<table>
<thead>
<tr>
<th>OUTPUT</th>
<th>Activities</th>
<th>Output Indicators</th>
<th>Means of Verification</th>
<th>Responsible person</th>
<th>Timeframe</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Enabled environment for RH commodities including Family Planning | • Review and update the national RH strategy and develop a short to medium-term strategic implementation plan with cost estimates.  
• A coordinating working group led by the Public Health director, family health program manager, MCH, FP, STI-HIV and AHD program officers comprising of diverse partners to assist in the overseeing of planning and implementation of RH/FP program.  
• Call for regular meetings to support implementation and assess progress.  
• Review the nurse practitioner policies that inhibit FP service provision by nurse practitioners for long acting methods (Jadelle implant). | • Existence of a functional national RH/FP coordination mechanism  
• Existence of a 3-5-year medium-term plan for FP, with rights-based and total market approach is being implemented  
• Minutes of planning meetings  
• Feedback and monitoring reports | Public Health Director  
Family Health Program manager  
MCH, FP, STI/ HIV and AHD program officers  
Partners working on SRH/FP | Public Health Director  
Family Health Program manager  
MCH, FP, STI/ HIV and AHD program officers  
Partners working on SRH/FP | Q1-Q4 2015 | • Collaboration with existing coordinating bodies such as for STI/HIV and MCH will lessen development of more working groups and foster better planning for integration of services  
• Regular coordination creates accountability mechanisms in the RH policy and strategies and ensures actions are being undertaken and followed up. |
<table>
<thead>
<tr>
<th>Program decision-making is evidence-based and Health Information system is reliable</th>
</tr>
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<tbody>
<tr>
<td>· Update and finalize the Fiji service guideline to include a separate module for counseling services specific per target groups and with all conforming to international standards.</td>
</tr>
<tr>
<td>· Orient and disseminate the updated service guideline to all health service providers, both national and expatriates.</td>
</tr>
<tr>
<td>· Conduct a dissemination workshop for RH/FP Program managers and service providers to roll out details of PHIS form.</td>
</tr>
<tr>
<td>· Improve skills of health providers in the analysis and interpretation of RH/FP data.</td>
</tr>
<tr>
<td>· Percentage of service providers delivering quality RH/FP services based on standards</td>
</tr>
<tr>
<td>· Percentage of SDPs that access FP data for program intervention and planning</td>
</tr>
<tr>
<td>· PHIS monthly reports</td>
</tr>
<tr>
<td>· Service guidelines available in all SDPs</td>
</tr>
<tr>
<td>Public Health Director</td>
</tr>
<tr>
<td>Family Health Unit manager</td>
</tr>
<tr>
<td>FP Program officer</td>
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<tr>
<td>Q3-Q4 2014</td>
</tr>
<tr>
<td>· Dissemination of PHIS form should involve an explanation of data to be collected and provide definitions of RH/FP identified indicators to the collectors of data</td>
</tr>
<tr>
<td>· Use of CYP</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Advocacy efforts support the FP program.</th>
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<tbody>
<tr>
<td>· Use social media to disseminate RH/FP information to targeted groups like the young age group.</td>
</tr>
<tr>
<td>· Use special events such as national campaigns and international celebrations like World Population Day and International Women’s Day, as opportunities to advocate for RH/FP led by the Health Promotion Unit in coordination with the Public Health service and Family Health Unit.</td>
</tr>
<tr>
<td>· Proportion of social events celebrated to promote RH rights and FP.</td>
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<tr>
<td>· Social media materials disseminated</td>
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<tr>
<td>· National campaigns celebrated</td>
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<tr>
<td>Public Health Director</td>
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<tr>
<td>Family Health program manager</td>
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<tr>
<td>Health promotion FP program officer</td>
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<tr>
<td>Working group</td>
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<tr>
<td>2015</td>
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<tr>
<td>· Proportion of social events celebrated to promote RH rights and FP.</td>
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<tr>
<th>Communities are engaged in addressing barriers to FP use.</th>
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<tr>
<td>· Equip the key community leaders, FBO, parents, youth groups with knowledge and information regarding the elements and benefits of FP.</td>
</tr>
<tr>
<td>· Involve the community in planning and organizing RH/FP activities in the community.</td>
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<tr>
<td>· Allow community leaders to participate in decision-making plans for the FP program.</td>
</tr>
<tr>
<td>· Percentage SDPs that involve community participation during planning of FP outreach activities</td>
</tr>
<tr>
<td>· Community council coordination minutes</td>
</tr>
<tr>
<td>Community leaders, Youth heads, parents FP managers</td>
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<tr>
<td>Ongoing</td>
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</tbody>
</table>
### SUPPLY Outcome 2: Quality services are accessible, acceptable and accountable to clients and communities services

**Outcome Indicators:**
- Percentage of tertiary and secondary level service delivery points offering at least five modern methods of contraceptives
- Percentage of Primary level SDPs that offer at least 3 types of modern types of contraceptives
- Percentage of SDPs that are birthing facilities with seven life-saving maternal/RH medicines from the WHO list (which must include Magnesium Sulfate and either Misoprostol or Oxytocin or both) are available in all facilities providing delivery services (disaggregated for urban-rural and type of SDPs)

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<tr>
<th>Output</th>
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<th>Responsible Person</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>2.1</td>
<td>Facilities are strengthened to provide quality RH/FP services.</td>
<td>The number of SDPs that offer at least 3 types of modern types of contraceptives</td>
<td>Training plan to support in-service training implemented · Job aids adapted and used at health facilities</td>
<td>State Coordinators National Coordinators Partners</td>
<td>Q1 2015</td>
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</table>
### Output Indicators:
- Percentage of Primary level SDPs that offer at least five modern methods of contraceptives
- Percentage of SDPs that are birthing facilities with seven life-saving maternal/RH medicines from the WHO list (which must include Magnesium Sulfate and either Misoprostol or Oxytocin or both) are available in all facilities providing delivery services (disaggregated for urban-rural and type of SDPs)

### Activities
- Review the pre-service curriculum for nursing to upgrade the counseling skills training.
- Develop short course RH/FP in service training course for public RH nurses newly deployed in lower SDPs.
- Review and evaluate the RHTP program and training curriculum.
- Periodic refresher training should be conducted for all nurses working in the primary health care centers to ensure retention of skills and to update their knowledge of RH/FP services.
- Map out the RHTP-certified nurses all over the country and conduct an evaluation to determine their added value in the provision of the RH/FP services after training.

### Output Indicator
#### Output
- % of competent service providers able to deliver quality RH/FP services

### Means of Verification
- Training certificates
- Evaluation report for RHTP

### Responsible Person
- Local training institution
- TAs

### Timeframe
- 2015-2016

**Evidence has shown that conducting counseling and clinical skills training that is competency-based, combined with simulation processes of learning, is highly beneficial to improving technical confidence and produce more competent providers.**
SUPPLY Outcome 2: Quality services are accessible, acceptable and accountable to clients and communities services

Outcome Indicators:

- Percentage of tertiary and secondary level service delivery points offering at least five modern methods of contraceptives
- Percentage of Primary level SDPs that are offer at least 3 types of modern types of contraceptives
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</table>
| 2.3    | Management supervision and Quality assurance are functioning | · Conduct regular supervision by competent supervisors to ensure service providers at primary health care centers remain motivated at work  
· Develop supervision tools that will guide supervisors on how to conduct effective supervision at the health facilities.  
· Develop KPIs to measure performance of health facilities in providing RH/FP services.  
· Identify retired staff in each division and explore the option of employing them to serve as mentors of service providers in distant health clinics. | · % of SDPs supervised using the supervision tools  
· Supervision tools  
· Supervision reports | Health facility supervisors | Q1 2015 |          |
**SUPPLY Outcome 2: Quality services are accessible, acceptable and accountable to clients and communities services**

**Outcome Indicators:**

- Percentage of tertiary and secondary level service delivery points offering at least five modern methods of contraceptives
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<tr>
<td>2.3</td>
<td>Management supervision and Quality assurance are functioning</td>
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| 2.4    | Broad Mix of FP Methods are made available | · Set up a technical group to review the current method mix and develop strategies to advocate the use of long acting methods for young married couples with desire to delay pregnancy for first and second children and for women above 30 years of age.  
· Promote the use of long acting methods Jadelle implant or IUCDs for injectable users with two or more children, and those who are more than 30 years.  
· Draft a guideline for the implementation of the strategy and disseminate via media materials. | · Percentage of SDPs offering long acting methods | · Data on contraceptive mix, methods and usage  
· Use of supplies | Technical working group led by Public Health director | Q3-Q4 2014 | · Such efforts not only reduce client revisits to the facility but also impact procurement costs, reduce requirement for injection Depo Provera and help logistic issues. |
**SUPPLY Outcome 2: Quality services are accessible, acceptable and accountable to clients and communities services**

**Outcome Indicators:**

- Percentage of tertiary and secondary level service delivery points offering at least five modern methods of contraceptives
- Percentage of Primary level SDPs that are offer at least 3 types of modern types of contraceptives
- Percentage of SDPs that are birthing facilities with seven life-saving maternal/RH medicines from the WHO list (which must include Magnesium Sulfate and either Misoprostol or Oxytocin or both) are available in all facilities providing delivery services (disaggregated for urban-rural and type of SDPs)

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<th>Comments</th>
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| 2.5    | Integration of FP Services with other health services is improved | • Develop FP integration of services guideline in coordination with MCH, AHD, HIV/STI and GBV program.  
• Monitor implementation of the guide.  
• Reinforce clinical assessment for STI during FP counseling for clients prior to offering FP methods. | • Proportion of postpartum mothers able to receive quality FP services  
• Proportion of clients treated for STI during FP consultation | Clinic registry | RH/FP Service providers | 2015 | • Reinforce promotion of the dual protection of condoms during STI/HIV counseling  
• Strengthen postpartum FP services at health facilities by reinforcing FP postpartum counseling during training to midwives and nurses. |
| 2.6    | A functioning Referral system at health delivery points and community exist | • Coordinate and develop with community leaders a referral system within the community to link linking with nearby health facilities.  
• Develop a referral guideline to involve NGOs and the community to assist the public sector to deliver services. | • Number of SDPs that practice the referral  
• Disseminated referral guide | Technical Working group on RH/FP Community leaders | Q1 2015 | • Referral system within the health service delivery levels exists but it is usually the link from the community to the SDPs that needs to be strengthened. |
### SUPPLY Outcome 2: Quality services are accessible, acceptable and accountable to clients and communities services

**Outcome Indicators:**
- Percentage of tertiary and secondary level service delivery points offering at least five modern methods of contraceptives
- Percentage of Primary level SDPs that are offer at least 3 types of modern types of contraceptives
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<th>Timeframe</th>
<th>Comments</th>
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</thead>
</table>
| 2.7    | The private sector is involved in the provision of FP services. | · Adapt and implement effective social marketing strategies initiated by NGOs for community based distribution of commodities.  
· Revitalize Community Health worker roles in community-based distribution of FP commodities.  
· Develop incentive mechanisms for community health workers.  
· MoH to reflect private practitioners contribution and support to the public sector at improving RH/FP coverage.  
· Develop monthly reporting mechanism of FP services delivered by private providers and integrate in PHIS form. | · Minutes of meetings  
· NGO Social marketing Reports shared  
· Monthly reports of FP services by private providers | Public Health Director  
Family Health Program Manager and FP program officer NGOs  
Private practitioners HIU | 2015-2016 | · Coordination with NGOs’ assist the public sector at ensuring access to communities on RH/FP/AHD information |
### SUPPLY Outcome 2: Quality services are accessible, acceptable and accountable to clients and communities services

**Outcome Indicators:**
- Percentage of tertiary and secondary level service delivery points offering at least five modern methods of contraceptives
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>2.8 FP services are available to the youth</td>
<td>Improve the skills of health service providers on counselling adolescents’ young people in FP.</td>
<td>· Percentage of SDPs providing FP information to young people</td>
<td>· Training certificates</td>
<td>FP program Trainers</td>
<td>Ongoing</td>
<td>Technical Assistance from UNICEF on Peer education can be requested</td>
</tr>
<tr>
<td></td>
<td>Develop skills of teachers and facilitators via formal and informal education to deliver information on FP including dual protection and services.</td>
<td>· Percentage of SDPs providing FP information to young people</td>
<td>· Inclusion of FP information in the FLE curriculum</td>
<td>AHD program</td>
<td></td>
<td>Reinforce delay in first pregnancy among young married couples and spacing of second pregnancy for young couples with first child.</td>
</tr>
<tr>
<td></td>
<td>Develop and disseminate informational materials on ECP at YFHS clinics to reinforce awareness of the commodity, especially to the young people.</td>
<td></td>
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<td></td>
<td>Initiate improving health facilities especially those designated YFHS facilities</td>
<td></td>
<td></td>
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### DEMAND Outcome 3: Individuals, families, and communities have knowledge and capacity to ensure sexual and reproductive health and seek services/care

#### Outcome Indicators:

- Evidence of specific national initiatives and implementation plans to improve FP access for the poor and marginalized women and girls
- Evidence of country level partners implementing specific initiatives to reach the poor and marginalized women and girls

#### Output Indicator

<table>
<thead>
<tr>
<th>Activities</th>
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<th>Responsible Persons</th>
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<tbody>
<tr>
<td>A National SBCC strategy for FP is in place.</td>
<td>SBCC Strategy document</td>
<td>SBCC Strategy</td>
<td>Public Health Director</td>
<td>2015</td>
</tr>
<tr>
<td>A communication strategy can facilitate programs in their effort to develop more effective communication materials for targeted groups and to create behavioral change.</td>
<td>Existence of the SBCC strategy</td>
<td></td>
<td>National Program Partners</td>
<td></td>
</tr>
<tr>
<td>Create a consensus forum to discuss the need for the development of either a national communication strategy or a specific communication strategy for SRH/FP.</td>
<td>Conduct an assessment on the knowledge, attitude and behavior of women, men and young people together of health staff, FBO and community members.</td>
<td>Developed the RHFP SBCC strategies based on the results of the assessment.</td>
<td>Developed SBCC activities / materials based on the formed strategies.</td>
<td>National Program Partners</td>
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<td>Collect and review all existing media materials developed and utilized in health facilities.</td>
<td>Identify which information materials are most effective in building demand for FP.</td>
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<td>Participate in radio/TV talk shows that can be a good forum to discuss FP information with a wider audience.</td>
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<td>Media products</td>
<td>Media products</td>
<td>Public Health Director</td>
<td>2015</td>
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<td>A communication strategy can facilitate programs in their effort to develop more effective communication materials for targeted groups and to create behavioral change.</td>
<td>disseminated</td>
<td>available at SDP</td>
<td>National Program Partners</td>
<td>2015-2016</td>
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<tr>
<td>Perform a needs assessment of the audience to develop effective messaging.</td>
<td>Evaluation of implemented media products</td>
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<td>Technical assistance</td>
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### DEMAND Outcome 3: Individuals, families, and communities have knowledge and capacity to ensure sexual and reproductive health and seek services/care

#### Outcome Indicators:

- Existence of specific national initiatives and implementation plans to improve FP access for the poor and marginalized women and girls
- Evidence of country level partners implementing specific initiatives to reach the poor and marginalized women and girls

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| 3.3    | FP program engages the community in SBCC | · Regular forum with NGOs, religious and community leaders that are identified as agents of change  
· Identify outreach activities effective at creating demand for FP.  
· Develop suggestion boxes to be disseminated in the community and health facilities. | · Percentage of SDPs involving community in FP activity outreach planning | FP program NGOs  
Community leaders  
Religious group  
FP Program service providers | Ongoing | · Suggestion boxes to determine the views of clients receiving SRH/FP information and services from health staff and FP information providers |
| 3.4    | Implementation of Peer Education to disseminate FP information | · Update the knowledge and skills of existing peer educators through refresher training.  
· Identify and train more potential peer educators and program councilors that can support school-based and outreach services.  
· Periodic follow-up monitoring of peer educators and youth friendly health. | Percentage of competent peer educators working in health facilities | Peer Educators | Ongoing | |
**OUTPUT INDICATORS**

**Demand Outcome 3:** Individuals, families, and communities have knowledge and capacity to ensure sexual and reproductive health and seek services/care

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**Output Activities**

**Output Indicator** | Means of Verification | Responsible Person | Timeframe | Comments
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3.3 | FP program engages the community in SBCC | · Regular forum with NGOs, religious and community leaders that are identified as agents of change · Identify outreach activities effective at creating demand for FP. · Develop suggestion boxes to be disseminated in the community and health facilities. | Percentage of SDPs involving community in FP activity outreach planning | FP Program · Minutes of meeting of forums conducted · Suggestions and comments collected from the drop boxes | Ongoing · Suggestion boxes to determine the views of clients receiving SRH/FP information and services from health staff and FP information providers

**Output Activities**

**Output Indicator** | Means of Verification | Responsible Person | Timeframe | Comments
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3.4 | Implementation of Peer Education to disseminate FP information | · Update the knowledge and skills of existing peer educators through refresher training. · Identify and train more potential peer educators and program councilors that can support school-based and outreach services. · Periodic follow-up monitoring of peer educators and youth friendly health. | Percentage of competent peer educators working in health facilities | Peer Educators · Peer educator training certificates · Records of peer education in schools | Ongoing · Start stocktake with the fast moving stocks followed by slow moving ones · Logistic forms should include data of AMC, SOH and QTO

**REPRODUCTIVE HEALTH COMMODITIES Outcome 4:** Quality RH/FP commodities are accessible and available when and where it is needed

**Outcome Indicators:**

- Percentage of SDPs where seven life-saving maternal/RH medicines from the WHO list (which must include Magnesium Sulfate and either Misoprostol or Oxytocin or both) are available (disaggregated for urban-rural and type of SDPs)

**Output Activities**

| Output | Activities | Output Indicator | Means of Verification | Responsible Person | Timeframe | Comments
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**Forecasting of RH commodities capacities enhancement** | · Conduct training for staff at FPBS in charge of forecasting needs for essential medicines, together with the FP commodity coordinator. · Advocate the integration of FP commodities forecasting in the technical working team forecasting general medicine. | · Forecasting of commodities uses 3-source data | Training certificates | FPBS Chief Pharmacist | Q1 2015 | 

**Improved management of RH commodities at the central warehouse** | · Conduct quarterly stocktake of commodities to include RHCs to ensure accuracy of SOH. · Periodic monitoring of stocks at SDPs | Stocktake reports | FPBS | Ongoing | · Start stocktake with the fast moving stocks followed by slow moving ones · Logistic forms should include data of AMC, SOH and QTO

**Strengthened management of RH commodities at SDPs** | · Reinforce timely submission of logistic forms · Training on RHCS level 1 is needed by staff in this case | Number of SDPs reporting no stock-outs of RHCs in the last 6 months | Commodity Stock reports | FPBS Chief of Pharmacist FP Programme DMOs | 2015-2016 | · LMIS is included in the RHCS level 1 training and should be provided especially to all health staff handling FP commodities in the lower service delivery points. |
**REPRODUCTIVE HEALTH COMMODITIES** Outcome 4: Quality RH/FP commodities are accessible and available when and where it is needed

**Outcome Indicators:**
- Percentage of SDPs where seven life-saving maternal/RH medicines from the WHO list\(^8\) (which must include Magnesium Sulfate and either Misoprostol or Oxytocin or both) are available (disaggregated for urban-rural and type of SDPs)

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| Standard Operating Procedures reinforced in health facilities | • Disseminate SOPs on proper storage for essential medicines and contraceptives.  
• Develop protocols regarding redistribution of RH/FP commodities.  
• Include monitoring during supervision visits conducted by the FP program. | Percentage of SDPs observing standard procedures for storage and waste disposal | • Supervision reports  
• SOPs available and accessible in health facilities | | Q3-Q4 2014 | • A list of commodities disposed because of expiration should be included in the reports together with the cost to feedback to programs. |