Reproductive Health Commodity Security Status Assessment Report

Fiji Islands

October 2008
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The International Conference on Population and Development (ICPD) Programme of Action and the Millennium Development Goals (MDGs) both include universal access to reproductive health as a key target for achieving the goals. For reproductive health to be realised universal access to services and commodities is necessary. Reproductive Health Commodity Security (RHCS) is achieved when individuals are able to obtain and use the reproductive health commodities of their choice whenever they need them.

UNFPA’s Programme of Assistance includes the provision of contraceptives and reproductive health commodities to fourteen island countries, including Fiji Islands. The Pacific RHCS Plan of Action (PoA) was developed in 2003 and signed by the Minister of Health of Fiji. Key Strategies for improving RHCS were outlined in the PoA. This review was undertaken to determine progress towards achieving an enabling national policy and regulatory environment for RHCS; improved forecasting, logistics management and storage; and coordination mechanisms.

UNFPA would like to express its sincere gratitude to the Permanent Secretary of Health, Dr. Lepani Waqatakirewa for his support and to Dr Josiaa Samuela, National Adviser, Family Health Unit for his introductions and arranging the itinerary to the Western Health Service. Gratitude is also extended to all who have contributed to this report, including Mr Apolosi Avonisola, Acting Chief Pharmacist and the staff of the Pharmaceutical & Biomedical Services Centre, of the Ministry of Health, for commodity information and insights into the Fiji integrated medicines and medical supply system and the various officers of the primary care services: Dr Mere Turagabaci, and Sr Akeneta Matanitobua of the Oxfam Clinic; Dr Susana Makalevu at the Nausori Health Centre, Maternal Health Unit. At the Nadi District Hospital; Dr Tupo Raqona, O&G/Maternity Services and S/Nurse Isoa, and S/Nurse Filo of the Maternity Unit. In the Nadi health centre: Sr Amelia Railaka, Sister in Charge and S/Nurse Laukitu Tuicake. Dr T Ali of the Western Division Health Services, and Sr Filo of the Lautoka Health Centre with Staff Nurse Vani of the Yanuya Nursing Station.

Acknowledgement is also extended to Dr M Violet of the ‘Healthchek’ Drop-in Clinic (Marie Stopes International). The accessibility of reports commissioned or written by other developmental partners, especially UN agencies, WHO, and other NSAs whose ideas, experience and reports was invaluable to this consultancy.

Special thanks is extended to the consultant, Mr Ray Skinner, who undertook this review and wrote this report; the Technical Advisor for Health Systems and RHCS, Dr. Annette Sachs Robertson, who provided technical assistance; the RHCS Manager, Mr Peter Zinck and the Regional Communications Officer, Ms. Reethu Arjun, their input; and the Fiji Islands Programme Officer, Dr Adriu Naduva, for facilitating this review. Without the support and contribution of the aforementioned persons, departments and organizations this report would not have been possible.
### LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMC</td>
<td>Average Monthly Consumption</td>
</tr>
<tr>
<td>ATFF</td>
<td>AIDS Task Force of Fiji</td>
</tr>
<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>BPS</td>
<td>Bulk Purchasing Scheme</td>
</tr>
<tr>
<td>CBA</td>
<td>Child Bearing Age</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Commodity Manager</td>
</tr>
<tr>
<td>CMR</td>
<td>Consolidated Monthly Report</td>
</tr>
<tr>
<td>CST</td>
<td>Country Services and Support Team</td>
</tr>
<tr>
<td>CWMH</td>
<td>Colonial War Memorial Hospital</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple Years of Protection</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>DNHSS</td>
<td>Director of Nursing &amp; Health System Standards</td>
</tr>
<tr>
<td>DPH</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>ECP</td>
<td>Emergency Contraceptive Pill</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>FC</td>
<td>Female Condom</td>
</tr>
<tr>
<td>FMIS</td>
<td>Financial Management Information System</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPBS</td>
<td>Fiji Pharmacy and Biomedical Services</td>
</tr>
<tr>
<td>FNPF</td>
<td>Fiji National Provident Fund</td>
</tr>
<tr>
<td>FPS</td>
<td>Fiji Pharmaceutical Services</td>
</tr>
<tr>
<td>FSMSA</td>
<td>Fiji School of Medicine Students' Association</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund Against AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immuno Deficiency Virus/ Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>IC</td>
<td>Infection Control</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IPFF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LMIS</td>
<td>Logistics Management Information System</td>
</tr>
<tr>
<td>MC</td>
<td>Male Condom</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organisation</td>
</tr>
<tr>
<td>PICs</td>
<td>Pacific Island Countries</td>
</tr>
<tr>
<td>PLWA</td>
<td>People Living with AIDS</td>
</tr>
<tr>
<td>PoA</td>
<td>Plan of Action</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>RHC</td>
<td>Reproductive Health Commodities</td>
</tr>
<tr>
<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
</tr>
<tr>
<td>SDPs</td>
<td>Service Delivery Points</td>
</tr>
<tr>
<td>SOH</td>
<td>Stock on Hand</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VCCT</td>
<td>Voluntary Confidential Counselling and Testing</td>
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<tr>
<td>WHO / WPRO</td>
<td>World Health Organisation/West Pacific Regional Office</td>
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</table>
The mission was conducted in October 2008 with the following principal aims:

- to review the implementation of the recommendations of the Fiji Comprehensive Assessment of Reproductive Health Commodity Security (RHCS), 2005, hereinafter referred to as “the 2005 report”;
- to perform a rapid field assessment of RHCS at selected centres, and through review of available current strategic health plans, and by informal interviews with key personnel, and other information gathering;
- to propose appropriate strategies for national planning to improve the reproductive health commodities security in the Republic of Fiji Islands.

A regional expert on pharmacy and medical supplies policy and logistics was engaged as a short term Consultant to partner with the National Adviser on Family Health (Dr Josaia Samuela) of the Fiji Ministry of Health. Field visits were made to Service Delivery Points including hospitals and health centres on Viti Levu. Information and views were obtained from conversational interviews, health strategic plans (where available), and a mini-workshop held with Ministry of Health (MOH) officials and other Stakeholders. Findings from the field visits, discussions and other reports have been consolidated in this report.

The major recommendations of the 2005 RHCS Report were reviewed, together with the performance of the suggested Operational Plan. These were partially fulfilled. The performance was affected by recent health structural changes, and by shifts of health planning priorities across time. The recommendations of the 2005 report are replaced in this report by an up-to-date list of suggested action items (strategies) that should be considered when finalising a medium to long-term national Strategic (ie Action) Plan to improve RHCS in Fiji. Operational plans, or annual business plan, giving costed tasks for any one budget year, may be drafted and developed each year from the items of the strategic plan.

Suggested strategic and operational planning frameworks are given in the Annex to this report, which are parallel to those developed recently in conjunction with the Fiji Pharmaceutical and Biomedical Service (WHO, 2008).

The major field findings of the RHCS assessment review mission were:

1. This is high uncertainty in the long term as to health budgets, operational structures, and the status and utilisation of health strategic plans.

2. Absolute and relative poverty appear to have increased, which will affect access to health care services in both public and private sectors.

3. There is a significant national demographic shift, with distinct (not fully quantified) urban drift, plus raised out-migration from the country. These all have consequences on a changing future pattern of health care services and RHC utilisation.

4. Demand shifts for commodities, with some reproductive health commodities (RHC) showing greater demand than current supply, and others vice versa. The changing
use patterns may not have been reflected in procurement possibly leading to over/under stocks. Together with this, stock monitoring throughout the health chain is not routine, and procurement systems are not highly adaptive. The systemic response to shifting patterns of demand appears to be too slow to fully maintain all services. The mechanisms for ensuring appropriate local stock-holdings, and for flexibly altering the national quantities and times of procurement, need more specific attention.

5. Product quality queries have been experienced. This affects confidence in both the products and the services, and may induce alternative (and less appropriate) demand.

6. Inventory classifications are tending to dis-integrate supply services. Specifically, there is an artificial separation of family planning goods, which are not the only goods for reproductive health (RH). Other commodities that are involved in RH are listed as general health stocks, because they have multiple medical applications: eg sutures, dressings, antibiotics, gloves etc. Having three different supply systems – for FP requisites, for general health goods, and for cold-chain items, impairs the coherence of health supply, and RHCS, and better integration is required to service RH needs.

7. Different supply methods are used for the different stock lists of goods. There is a monthly system for the supply of ‘Family Planning’ requisites, and a quarterly general health supply – some of those goods servicing RH needs. Besides the multiplicity of orders produced, with implications for tracking and monitoring, it is not at all clear that the different methods are appropriate to service the Fijian logistical situation. Trials are needed to show how best to gain improvements in supply by integrating FP, medicines, and other health supply on a single set of order forms with a shorter order interval (also recommended under a draft Pharmaceuticals Strategic Plan).

8. Local distributive services of family planning requisites from Health Centres to their ‘dependent’ Nursing Stations appears to have worked well as to commitment, regular supply, and enhanced communication. The lessons learned from this can be adapted, together with the supply methods trials mentioned at No 6, above, to examine the potential for decentralising: transferring the immediate supply function to the primary health facilities from the Fiji Pharmacy Services (FPS). FPS Suva may continue to supply Central/Eastern, but strengthening/improving Divisional medical stores at Lautoka and Labasa should, at the very least, be examined for feasibility - which study should project the capital costs of improvement across a valid facility life, and the recurrent costs, versus the benefits to be gained.

9. Past recommendations from the 2005 Report and the draft Action Plan have not been much implemented – a Coordinating group needs to be re-formed, one that will address RHCS issues, or perhaps one which will lead improvement of Reproductive Health services including the betterment of RHCS.

There are many recommended items for Action Planning to improve Reproductive Health commodities security in Fiji, for 2009 et seq. These are presented in Boxes allied to the appropriate text in the Report, and a convenient Summary is presented as Chapter 3.
1. INTRODUCTION

1.1 GENERAL GEOGRAPHIC & DEMOGRAPHIC

The Republic of the Fiji Islands has a population in 2007 of 827,900\(^1\), a net growth population of 52,823, or 6.8% over the 1996 census.\(^2\) (Govt of Fiji, Preliminary 2007 Census figures). The islands of Fiji make up a land area of 18,272 km\(^2\), scattered over an ocean area of about 1.28 million km\(^2\). Most of the population lives on the two larger islands, Viti Levu and Vanua Levu. Shifts in land-holding with urban drift has meant that the urban population grew by 61,591\(^3\), a figure greater than the total 10 year overall population growth. Birth rates are shown in Table 1, and would normally have indicated a larger net % population growth. Out-migration is altering the total, and the major ethnic proportions; the Indo-Fijian segment declining by more than 27,000, while the Indigenous Fijian segment, in the same period, grew by over 80,000\(^4\).

In common with other Pacific Island Countries (PIC) the small populations on Fiji’s widely dispersed smaller islands, and in the interior of the main islands, continue to pose immense logistical challenges to the effective delivery of reproductive health care services, and in equitable distribution of reproductive health commodities.

1.2 HEALTH CARE SERVICES AND SUPPLY

Essential and basic health care is provided through a decentralised network of government-run service delivery points that comprises three divisional hospitals, three specialised and sixteen sub-divisional hospitals, seventy-four health centres, a hundred nursing stations, three area hospitals, three old people’s homes and seventeen local nursing stations. Health care services are free-at-point-of-use.

Reproductive health (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 Fiji Pharmaceutical & Biomedical Services Centre in Suva (FPBS). Items for reproductive heath services (RH items) are really a subset of the national list of essential medicines and supplies, although they are not at the moment flagged in the FPBS information system, and so consolidated reports on the movements of RH items are not easy to compile. The nationwide public supply of reproductive health commodities is integrated into the overall FPBS system, but the selected national list of Family Planning requisites (including condoms) is ordered by the service delivery points on a separate form from ‘general’ medicines and supplies. Family Planning items are also ordered more frequently (on a monthly basis, where for general items the interval is quarterly), 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\(^5\), and incorporated into the routines of the Fiji medical supply system.

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1.3 KEY STATISTICS: HEALTH, FP AND RHCS

1.3.1 Population and Maternity-related indicators

Table 1 shows the recent population and pregnancy/birth-related statistics. Trends and implications are discussed in the Field Findings section of the Report. The downturn in the expected total population has been mentioned above.

Table 1: Selected Population & Health Statistics, Fiji, 2003 – 2007

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (italicised were projected from 1996 Census, otherwise actual from Census)</td>
<td>C-1996 775,077</td>
<td>849,361</td>
<td>868,488</td>
<td>C-2007 827,900</td>
<td></td>
</tr>
<tr>
<td>Total live births</td>
<td>17,714</td>
<td>17,826</td>
<td>18,394</td>
<td>19,298</td>
<td></td>
</tr>
<tr>
<td>Crude birth rate [per 1000 pop.]</td>
<td>20.87</td>
<td>20.99</td>
<td>21.00</td>
<td>22.20</td>
<td></td>
</tr>
<tr>
<td>Crude death rate</td>
<td>6.63</td>
<td>7.02</td>
<td>7.10</td>
<td>9.80</td>
<td></td>
</tr>
<tr>
<td>Rate of natural increase</td>
<td>1.42%</td>
<td>1.40%</td>
<td>1.40%</td>
<td>1.20%</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate [per 1000 live births]</td>
<td>22</td>
<td>17.84</td>
<td>20.76</td>
<td>19.50</td>
<td>18.40</td>
</tr>
<tr>
<td>Perinatal mortality rate [per 1000 live births]</td>
<td>19.30</td>
<td>22.50</td>
<td>19.40</td>
<td>15.80</td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate [per 1000 live births]</td>
<td>10.50</td>
<td>15.37</td>
<td>11.30</td>
<td>11.90</td>
<td></td>
</tr>
<tr>
<td>Post neonatal mortality rate [per 1000 live births]</td>
<td>7.79</td>
<td>5.39</td>
<td>8.20</td>
<td>6.50</td>
<td></td>
</tr>
<tr>
<td>Under-five mortality rate [per 1000 live births]</td>
<td>22.52</td>
<td>25.81</td>
<td>25.80</td>
<td>22.40</td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio [per 100,000 live births]</td>
<td>38</td>
<td>33.87</td>
<td>50.49</td>
<td>43.50</td>
<td>31.10</td>
</tr>
<tr>
<td>Gross fertility rate/1000 CBA</td>
<td>105.56</td>
<td>97.25</td>
<td>96.90</td>
<td>104.10</td>
<td></td>
</tr>
<tr>
<td>Family planning protection rate (Contraceptive Prevalence Rate)</td>
<td>42</td>
<td>45.92</td>
<td>42.48</td>
<td>49.10</td>
<td>43.00</td>
</tr>
<tr>
<td>Proportion of births attended by skilled health staff</td>
<td>98.6</td>
<td></td>
<td></td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Prevalence of anaemia in pregnancy at booking</td>
<td></td>
<td></td>
<td></td>
<td>9.2</td>
<td></td>
</tr>
<tr>
<td>Teenage pregnancy rate [per 1000 CBA pop]</td>
<td></td>
<td></td>
<td></td>
<td>8.5</td>
<td></td>
</tr>
</tbody>
</table>

1.3.2 Contraceptive Uptake Indicators

The uptake of contraceptives in 2003 and 2007 are listed in Table 2. Trends and implications are discussed in the Field Findings section of the Report.

<table>
<thead>
<tr>
<th>Table 2: Contraceptive Uptake Indicators</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>% Acceptors using injections</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>22.5</td>
</tr>
<tr>
<td>% Acceptors using pills</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>17.5</td>
</tr>
<tr>
<td>% Acceptors using condoms (male or female)</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>15.4</td>
</tr>
<tr>
<td>% Acceptors using IUCD</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>11.2</td>
</tr>
<tr>
<td>% Acceptors using hormonal implants</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>0.25</td>
</tr>
<tr>
<td>% Acceptors having Tubal Ligation</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>25.9</td>
</tr>
<tr>
<td>% Acceptors having Vasectomy</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>0.41</td>
</tr>
</tbody>
</table>

Sources: as Table 1

1.3.3 Other RHCS health-related statistics and Indicators

Some key disease and primary health statistics are shown in Table 3, these are relevant as indicators of need for items to diagnose and treat diseases affecting the reproductive system, and/or relating to managing primary health care issues that are directly relevant to women, the young, or in adolescent reproductive health (ARH).

It may be noted that the 6th highest cause of morbidity in Fiji recorded in 2007 was ‘other conditions originating in the perinatal period’. This category was, perhaps more alarmingly, also the 7th highest cause of mortality. The 10th highest cause of mortality was ‘neoplasm of female genital origin’, informally understood mostly to be cervical cancer, in the development of which prior chronic (untreated) STIs, specifically Human Papilloma Virus infections, have been implicated. Thus, there are both short and long-term health benefits to be gained in the treatment and control of STIs. Moreover, the likelihood of HIV transmission is increased where an STI is present, so untreated STIs increase national vulnerability.

<table>
<thead>
<tr>
<th>Table 3 : Other selected Statistics with RHCS Implications</th>
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<tr>
<td></td>
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<tr>
<td>Reported new cases: gonorrhoea</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>1355</td>
</tr>
<tr>
<td>Reported new cases: syphilis</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>910</td>
</tr>
<tr>
<td>Reported new cases: Herpes Zoster (genital)</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>43</td>
</tr>
<tr>
<td>HIV+ Incidence (new cases per year)</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>31</td>
</tr>
<tr>
<td>% of one-year old fully immunized (MRI)</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>80.6</td>
</tr>
</tbody>
</table>

Sources: as Table 1

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6 MoH Annual Health report, 2007, page 43
No data has been found for important indicators on good prescribing for STIs, or on the rate of successfully completed STI treatments. There also do not appear to be formal indicators and monitoring at the local level to monitor RH commodity stocks. Although the overall medical supply system appears to be data-rich, due to all the health facilities’ periodic stock reports being entered in the central LMIS (for supply purposes), these data have not been routinely tapped to reveal the patterns of stock usage nationwide (ie overall), or in comparative local studies on stock-outs.

1.4 ECONOMIC AND LOGISTICAL

Fiji is one of the higher earning economies in the Pacific. Its GDP in 2005 was over FJD5bn, on a consistent, slow, upward trend from FJD2.98bn in 1996. National total income still looks as if it is rising slowly, but the population continues to rise also. The per capita Gross Domestic Product (GDP, at constant prices) was stated in the 2005 RHCS Assessment Report to be US$1315, but in the Key Statistics it is given for 2004 as FJD3544 (c.USD1984), and in 2006 it is given as FJD 3636 (USD2036). This looks positive, at first, and the GDP growth rate in 2006 also looked mildly positive at 3.6% (ibid). However, with recent instability in the world commodity and financial markets, prices reportedly rose very sharply in 2007-2008, the rate of inflation having jumped from 2.5% in 2006 up to 4.8% in 2007, and jumped again to 5.9% by mid-2008 (ibid). Overall, incomes would appear to be degrading, and, with poverty indicators increasing, there is probably an adverse shift in wealth distribution.

In the 2005 RHCS Assessment report it was stated that approximately 25 percent of the households have per capita incomes below the national basic needs poverty line. The Strategic Development Plan of 2006 quoted 34.4% (Page 185, KPIs 7.1.1). Given the present economic data it is likely the situation has further deteriorated. It is more important than ever for prices of private health goods and services to be optimised, and for the Heath Ministry to maintain its operational share of national expenditure in order to protect health services, especially to the more vulnerable who appear to be getting more numerous. In this the record seems good: since 2001 Health has had a share of not less than 8% of the total Government budget, standing at a high of 10.84% in 2007, from 9.5% in 2006, having previously peaked at 10.25% in 2004.

In medical supply, however, though the budget figures have not been fully investigated, the FPBS seems to be getting roughly the same annual $ amount. It does not appear to have retained a proper % share of the health budget, though Health has done reasonably well in its share of the National budget. Pressure on procurement of medicines and medical supplies has naturally resulted. In conversations with the officers of the FPBS, it would seem that a far greater flexibility in managing the procurement side of medical supply must be recommended if they are to develop better, more responsive procurement strategies, in order to even to maintain stock levels on a falling budget (falling in real terms, that is). Meeting new demand, or unmet previous need, arising from a larger, poorer population is another matter. This may become a critical issue for RHCS, since Fiji has been purchasing contraceptives and RH items as part of its general medical supply allocations. Following the 2005 RHCS assessment, UNFPA has been the main supplier, in the role of a Third Party Procurement service.

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8 MoH Annual Report, table on Page 75
The arrangement seems to have worked well, within the product estimates and order allocations. But, according to FBPS records, further orders for FP items were assigned to other sources in times of shortage; ie, where UNFPA delivery was not soon expected, combined with a constantly growing demand (outstripping the previous quantifications, or estimations), and where rapid airfreight delivery of a more ‘local’ supply was required.

Because of its central location, Fiji is the regional base of many UN and other development partner agencies, and for Pacific regional organisations and non-governmental organisations (NGOs). The idea that the Fiji Pharmaceutical Service would supply medicines and supplies to Small Islands States is an established idea, though not as much utilised as it might be. There has been a more recent study on the feasibility of pooled pharmaceutical and medical supply procurement for a larger group of Pacific Island Countries (WHO, 2007). Options for this type of pooled procurement are still being examined, as there are significant implications for prior work to be completed in the harmonisation of drug selection, quality approaches, quantification, medicines control, and other areas of pharma-policy. Even though a future larger role is not yet determined, Fiji retains its importance in regional supply under various bilateral aid and international programs, including stocks of vaccines, ARV drugs, and as a buffer or supplier of general items to the smaller Islands countries (including the ongoing potential to be a major buffer of, or central supply depot for, RH commodities).

1.5 ASSESSMENT OF STATUS: REPRODUCTIVE HEALTH COMMODITIES SECURITY

In 2005 a comprehensive assessment was made of Reproductive Health Commodities Security in Fiji. This was in line with outcomes of the Auckland Ministers of Health Meeting in 2003, and the subsequent Reproductive Health Commodity Security Plan of Action (PoA) for the Pacific⁹. In line with the requirements for updates on RHCS in PIC for the upcoming Forum Health Ministers Meeting, 2008, this report reviews the RHCS status in Fiji as at October 2008.

A number of recommendations and an outline plan of action were included in the 2005 assessment. The present assessment attempts broadly to review the progress of those items; to identify areas of weakness that need to be strengthened; and what fresh opportunities may be arising in the present circumstances.

1.6 CONSTRAINTS IN THE CONSULTANCY

The Consultancy for this report was constrained in a number of ways. Firstly, the field work only had one working week, and this, unfortunately, included a national public holiday, Fiji Day, curbing the availability of both public service personnel and private sector business people, though it allowed more time for reading.

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Secondly the limitations of travel prevented a late-planned visit to the Northern Health Division. Data sources are thus confined to centrally available publications, and the limited interviews that were possible with officers and organisations located within a short travel time from Suva and Nadi (eg, Suva-based private services, and limited Central and Western Health Service facilities). Given that previous reports had indicated wide Divisional differences in health indicators and services, this could be important, and extrapolating the current findings may be less feasible, especially with social and population shifts looking increasingly important as a current feature. Balancing this lack of wider data gathering is the depth achieved in the short time. Interviews that were held were felt to be extremely productive, raising very relevant issues that will doubtless have a very wide applicability across the nation (eg product quality issues).

Thirdly, a planned mini-workshop, to be facilitated by the Consultant, which would have attempted to address progress on major items since 2005, did not eventuate. Mainly this was because key long-serving senior Health personnel were unavailable. That was due either to clashes with other urgent meetings (some crucial Health Reform meetings were due), plus there were some officers on annual leave, etc. This prevented a truly insightful review into progress with the items of the 2005 Action Plan. Of those interviewed, few had been in their present post as far back as 2005, or even when they had been, they had not been involved in developing the original plan, and were largely unaware of it. This was an important issue raised: few health staff at the local level were aware of, nor are they helped to utilise, national health program strategic plans (of which there are many). Thus, many felt they had little by way of a current, coherent, policy/strategic context to guide their local planning. Few felt themselves to be truly part of a genuine network of parties working together to hit the common targets – indeed a good knowledge of the national targets did not seem to be filtering through to the local planners.
2. SITUATION ANALYSIS AND ISSUES

2.1 CLIENT UTILISATION AND DEMAND

2.1.1 Demographics and demand

Overall demographic shifts are arising in Fiji with increased out-migration and leasing changes in land-holding and usage. Out-migration is affecting the population total – it is slowing the overall growth, but the total is still growing. Birth rates remain high and death rates have been falling, and family size appears to be changing in favour of continued larger Fijian families and smaller family sizes in other groups, leading to a significant change in the national ethnic proportions. Overall demand for RH services and commodities therefore continues to grow steadily. Uptake rates for contraceptives still appear to be relatively low, but performance is not measured as uptake targets for year-on-year increases do not appear to have been set in the national health program.

Figure 1

Trend in Contraceptive Prevalence Rate for Fiji Islands 1975 - 2007

Source: MoH statistics

Increase in the uptake rates, per se, in the sense that more people are demanding more services, appears only to be a very slow change. From Figure 1, it appears that a slow increase in contraceptive prevalence rate has occurred over the past three decades, with a rate of greater than 40% being sustained from 1996, with the exception of 2002. These rates are amongst the highest in the Pacific. Research and monitoring of this trend at the local level seems to be sparse – if only because the local usage figures derived from the monthly consolidated health reports is not being analysed at the local level or fed back to the local level quickly and widely.
This will be dealt with below. Awareness is reportedly growing, and presumably Fiji will see a similar trend as other Pacific countries, with the 18-29 year group leading the way in the increased use of condoms, and with younger families being more prepared to consider more options. Taking control is becoming economically important.

With the added economic pressures mentioned in the Introduction, those who have more involvement in the cash-based secondary economy will be worse affected than those who still have the majority of their subsistence in a milieu of primary agro-economic living. In spite of this, the current phase of land use change is helping to fuel a significant, and not fully quantified, urban drift. This migration into townships brings a changing pattern of health care services utilisation. Those who successfully leave the land for town life, but coming under the more severe financial pressures, are more likely to change their traditional lifestyle and delay child bearing, and/or limit the family size. Small changes in the birth rates in urban populations, by ethnic group, would seem to bear this out. Informal reports by the local health staff also show that urban families are searching at an earlier stage than before into options for longer-term contraception, and/or sterilisation.

The reported rate of teenage pregnancy remains above a national target of 8 per 1000 women of child bearing age (CBA) (target of KPIs 7.2.3 of the National Strategic Plan - the measure there is stated somewhat differently from that of the Ministry of Health annual report). The need of further education and awareness, with better contraceptive uptake, continues.

As FP and other health education services continue, and school curricula are adjusted more towards options in modern living, one may suppose uptake trends will increase with time. But cultural adjustment is slow, and within a 5-year planning timeframe changes in demand, though they are evidently moving upwards, will continue do so only quite slowly. The major short-term determinants increasing the demand for family planning services, and commodities, would appear to be the economic ones.

Access to services, or rather the difficulties of access to health services, appears to be suppressing demand, and leaving unmet need. It must always be borne in mind that health services are a Supplier-led market, and access to most of the free commodities is still contingent on a formal consultation with health care staff. That in itself is a big barrier (even though it may be a needful one for some products) and it hinders the free flow of un-priced health goods. In the rural areas particularly, access to FP and other RH services is occasional, and frequently opportunistic through attendance at an SDP for reasons other than seeking FP (eg child vaccination, illness, antenatal care). Health Centre staff willingness for activities to address FP issues with visiting women seems consistent and widespread. Some of the options that women reportedly would like to choose, however, are not delivered at that level of care - especially implant insertion and loop insertion/removal. The extra cost of access to the authorised centres is a real barrier, and is leading to loss of contact, and failure to deliver what the client actually wants/needs. One health centre informally estimated that up to 10 clients a month in the catchment would be failing to obtain what they needed, due to this phenomenon.

Brainstorming is very urgently needed to create more and fresh options for better accessibility to RH goods and services, and particularly for lowering or softening the impact of the “Agency” character of a health system, where law correctly limits the supply of medicines under the supervision of various health professionals.
Current data on unmet need for family planning is not available. A DHS is planned for 2009 which will facilitate collection of this data as well as information on patterns of utilisation. Unmet need is arising from physical access problems, as indicated, but there are also administrative and supply problems that are leaving demand (expressed need) unmet. Supply and administrative problems will be addressed elsewhere. The matter of unmet need that is also unexpressed – no formal requests are received – is problematic, but health staff commonly feel that some new-refreshed primary health service outreach Teams would turn up considerable extra demand in the target communities.

Overall national uptake rates (as opposed to the public sector rates) are quite hard to determine given that the majority of population is now urban, and being so gives them much greater direct access to commodities through the private channels. These sales and supplies do not appear to be monitored regularly or comprehensively. With many more points of condom distribution being mooted through anti-HIV programs, etc, there is probably a much higher usage overall than is indicated by the official Ministry of Health figures.

There is an obvious need for better national networking and proper coordination in the data collection on all RH commodities supplied from through different kinds of outlets. The coordination matters are addressed below, but it should be emphasised here that monitoring issues and outreach are high priority items for a new strategic plan.

2.1.2 Health Services Information: trends and demand assessment

The Fiji health information system is built up on the consolidated monthly returns (CMR) that are required from the service delivery points (SDPs). According to our conversations, this data is processed into the central system well and rapidly, but the informational feedback is rarely seen back at the service points, where it is most needed for situational planning. There is also a lag in the output, which may be due to delays in reports received – timely quality output depends on having the vast majority of reports received on time, and processed rapidly. Some delays seem to be due to time for mailing, which in turn is transport dependent, with remote areas having less frequent, and not always reliable, transport services.

The contraceptives listed on the CMR do not quite match the actual current products eg Norplant® has been replaced by Jadelle®, and Multiload® by Copper-T®. This does not impair reporting much, because data is transformed into generic terms (Pills, IUCD, Implants, etc) and there are sufficient reporting slots on the form. However it takes extra care in these circumstances to ensure that the right data is being entered.

There are also local IUCD insertion records, and Implant insertion records. These are original data sources for the consolidated monthly reports.

The inputs to health information are coherent but outputs are not always available to Health Managers on demand. The staff of the Family Health Unit, for example, do not have direct access to current data; they cannot pull down reports from the central health computing system on demand. Management monitoring depends on periodic outputs, the most coherent of which appears to be the Annual Report. This is not regarded as being frequent enough to allow for effective early intervention by the health program managers. More regular, automated outputs are desired, and local staff indicated real desire to see comparative statistics so that they can all see “how they are doing”.

In summary: the health information system, although gathering relevant data in a mostly timely fashion, is not generating sufficient information rapidly, nor is there automatic dissemination to local health staff to self-monitor their progress. Managers cannot routinely judge demand levels, or monitor the services, and cannot readily or regularly adjust the response. The opportunity for a sense of intervention effectiveness is only occasional, and the health system is consequently slow to adapt to demands.

Recommendations from the above sections are given in Box 1

### 2.1.3 Uptake and utilisation trends to 2007 – and their interpretation.

In 2005, there was a wide reported disparity in contraceptive usage across geographic regions with the Central Division reporting the highest contraceptive prevalence and the Eastern Division reporting the lowest. This seems to be largely unchanged. One explanation is the relative rurality of the Eastern Division, but figures have not been seen which analyses the difference, if any, in contraceptive uptake between urban and rural populations. In any case such a bare analysis is likely to be problematical, being liable to confounding factors such as diversities that are known to affect health care and personal health choices: educational status, wealth, etc. It is also not clear if any or all Private sector RH services and supply were reflected in the earlier figures. If they were, it might help to provide some explanation – since access to private health services and the degree of urbanity are closely connected. The latest views seem to be that the private sector remains unmonitored. Since private health care is primarily concentrated in the urban areas, and since they may be expected to monitor their own stocks and usages closely (for financial motives, if nothing else), it should not, in principle, be difficult to collect and include their data.
**Box 1 - Recommended Action Items on the Demographic and Data areas of RH Services**

- **Update the national quantification formulae for Reproductive Health Commodity forecasting with the 2007 Census data and trends.** Note: in an integrated system of supply, such as Fiji has, this may also strengthen forecasting for a wide range of health goods.

- **Institute a regular feedback Bulletin of national summary health information to all Service Delivery Points, with comparative statistics by Division and Sub-Division, so that each SDP can see how they are doing relative to their local area and the national situation.** Note: This could possibly be a specific RH bulletin (parallel to the EPI one), but SDPs really need a Bulletin with all-services information, not just ‘family planning services’.

- **Senior Health Managers should be given a direct electronic access to the health service Information System, including RH services monthly statistics and trends.**

- **Update the monthly consolidated health information report with current RH Products.**

- **Ensure the Fiji curricula in Health (Human Studies) have content and aims consistent with national health goals, especially in the RH area.** That is: ensure the right ‘health messages’ are reaching children and young people, in appropriate ways at the appropriate early stages in life.

- **Plan for multi-skilled Teams, perhaps on a Sub-divisional basis, to extend an integrated package of primary care items through outreach, by: a) scheduled visits to Health Centres & Nursing Stations, and/or b) by visits to remote islands/communities.**

- **Make monthly or quarterly RH item reporting (numbers issued, total costs) mandatory for Private Hospitals, Pharmacies, NGOs and dispensing/supplying GPs.** Note: this can be readily done via a simple IT system report that flags RH items as a formal subset of their inventory.
In fact there are observed instabilities in supply. According to the uptake figures, and taking into account the central stock trends, and the present staff opinions on matters of local stock-out (that they happen more frequently and for longer periods at a time, than they did, say, two years ago), there appear to be real shifts in demand for RH commodities. Some methods are more in demand, but those demands are not fully met, in part due to due to lacks in supply. Some RC commodities show more demand than current supply capacity will meet, leading to stock-outs. Other items are overstocked, which does not necessarily mean there is a reduced or zero demand. On the contrary, it may mean that a real (ie felt) demand is not being met due to barriers in access - as discussed above. The fact of unstable stock levels is an alert - both over's and under's. Monitoring of stock reports tells us the fact that there is a problem (or more than one), but tells us nothing of the nature of the problem - the “problems that underlies the problems” – ie the real causative factors.

In a situation where the data on fundamental needs and demands is weak, successful supply cannot be designed and performed. That is what is being seen. That there may also be difficulties in the distribution side may also be true. The immediate current focus seems to be that “training to manage stock better”, will resolve much of the out of stock problems. But unless the analysis is taken back to fundamental interpretation of the needs and demands the rest of the operating supply cycle will never work, and no amount of “tinkering with supply side factors” will resolve the problems. See below for more discussion of these points under the Section on “Commodities”.

It also has to be pointed out that there are difficulties of definition particularly when using data relating to condoms in the trends of contraceptive uptake, and then using that data to forecast requirements. Condoms were (and still are?) generally perceived as family planning requisites - contraceptives. They are certainly still listed that way on the health reports. The “% acceptors [of FP services] using condoms”, is used as a performance measure in national health statistics and KPIs. Figures are described and presented on the assumption that condoms are sought and used as contraceptives per se. This may only be partly true, particularly in some segments of the population. Additionally the statistics are apparently public sector-based figures, where the trend seems to be steady. This is not a truly national picture. The general view amongst private sector informants says that demand is markedly increasing.

Condoms are heavily promoted as an item of infection control (IC), besides their being a contraceptive method. Contraceptive prevalence figures are based in part on condom usage – it seems a large factor in calculating “contraceptive prevalence”. In this equation are placed issues figures for all condoms, not the quantities required by clients for a particular purpose of family planning. A distinction is not made between family planning use, contraceptive use in a non-family context, and the purely STI-HIV prevention use, so the national measure of “contraceptive prevalence” may be misleading, and a false idea may be gained that more interest is being expressed in “family planning” than is really true, though the interest in contraception may still be very great. In other words, the figures for contraceptive prevalence do not reliably indicate the interest in family planning, as such, and are likely to be confounded also by utilisation for infection control as a primary motive. One cannot at present really tell the trend of uptake of condoms for “contraception”.

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Couple-years Protection achieved (CYP) – does not appear to be used as a national indicator and probably needs to become one. However, its calculation as a measure of family planning ‘protection’ gained may be as compromised as the contraceptive prevalence, if all condom use is going to be artificially classified as use of ‘family planning’ requisites.

Thus: the trend data are not exact, and data collection not yet comprehensive. The use of KPIs, and the manner of reporting needs much further study. The national RHCS coordination body must be empowered to receive all the appropriate usage data (or at least be given the proper information that is generated from them), and to compile appropriate RHC usage reports which are fed back to the managers and the service delivery points. See also the section on Coordination.

**Recommended Action Items on Uptake/Utilisation Trends, and related data**

- A fresh needs assessment for contraceptives should be designed – with real care and attention given to the various modes of condom demand (FP, CP and IC).
- The Health Information System (or the RHCS body) should collect and include private sector data on contraceptives and other RH commodities. If not given voluntarily, such data should be compelled – see further on under Context.
- All offices and bodies with any functions or interests allied to or affecting RHCS – senior managers, clinical and health program managers, service delivery points, etc, should receive regular adequate reports on trends of RHC utilisation. A list of these recipients needs to be made and a report designed and provide within the integrated health information system.
- Adopt Couple-Years Protected (CYP) as a national health KPI - but care must be given to its definition and its calculation.

**2.1.4 Possible limitations on demand** *(see also Quantification under 2.2)*

Demography and its indications of unmet need have been discussed. Health Services based projections on how to determine unmet need must also be considered, and the effect that health services and their organisation may be having on RH clients and the expression of demand for goods and services.

Mention has already been made of access barriers in Health services where these are limited to certain types of practitioner, and those kinds of practitioners are not readily available. The well known Agency feature of health care is also important in as a determinant of expressed demand: where a client has limited knowledge of health and the options to choose for care and action, the ‘agent’ – the health staff – is a key for making choices. Recognised / authorised health staff provide all the information on which a client choice depends, and seems also to be their sole channel for change.
Field observations in this review lead to a strong suspicion of unexpressed demand, as well as some locally expressed demand which is not accounted for further up the chain in health planning, and thus remains unprovided. Both of these are affected by the ability or capacity which health staff have to exercise Agency on behalf of clients to have demand expressed in the right way, at the right level, so as to be heard by the right health planning staff who can influence the health service organisation (or its re-organisation, where needed) to help meet the needs. This applies even within the Sub-Divisional level, let alone trying to reach the Divisional or National levels.

By observation, local health staff do not feel routinely empowered to advocate in this way, or at least feel they have very limited opportunity to do so. And of course actual clients have even less chance. There is no deliberate and proper consumer inclusion in local health services review, and there appears to be no formal network of RH and FP medical and nursing staff with information feedback, as there is say, for immunisation services (EPI program). As a result there is little data gathering on Client views of RH and no recorded self-assessments by the relevant health staff (either for themselves as service providers, or as acting as the clients’ Agents). Little formal review of local RH services occurs, so little happens by way of revision of services, or of adjustment to any plans to accommodate fresh views and useful, local, client-focused data.

Flowing the other way – towards the clients – the national policy on creating greater and appropriate demand for RH goods and services appears also to be limited, with a limitation on access. In a supplier-led market like health, clients are not empowered to make demands except as they are deliberately given the opportunity and the capacity to do so. It is the principal agent in Health – the Ministry of Health – that has the key influence in this arena. If it regards itself as limited, say by cash budgets, or political problems in competing for extra resources, it may unwittingly neglect to investigate any extension in services, or allow much by way of advocacy for improvements, on the pre-supposition that such extensions will automatically demand extra resources, which in turn will be denied or very difficult obtain; or at least so uncertain as to be not worth the bother of trying to plan. In a milieu of negative expectation, it is clear that one may expect to see little invitation to either staff or clients to review services.

This is what appears to be seen. It will therefore be vital for RH services staff to ensure that part of their advocacy is towards the health management for the empowerment and opportunity to be given them to see how service improvements might be obtained by managing existing resources better (efficiency gains), and not merely by making extra resource demands. Exploring client need/demand does not automatically mean increasing the service delivery costs – it may lead to reassessing how services are delivered. Process reengineering and other quality improvement methods can be employed by local health staff to carry out effective reviews of client demands and how to meet them. Even the training need that this exposes does not have to pose an “extra budget” demand: it can be delivered via existing annual commitments to Nurse refresher courses.

What is needed is a recognition that local health staff, together with their clients, can and should be the most natural and proper forum where service review is empowered, and where plans can be first laid to meets the needs effectively and efficiently. The unrecognised limitation is in a failure to empower staff to plan and develop services.
Further limitations are placed on demand, that depend on the policy about health messages, and the formal and informal signals that are being sent about the RH products, for instance, with condoms. If the message is being sent that these are for “infection control”, rather than as contraceptives, and if this is being responded to, what is the impact on demand, and what are the implications for usage, and what will be the required modifications for monitoring of that use? Conversely, if the condom message is still that these are “family planning items” – what limitations does this induce in those who hear this message but are in conflict with it: they are not planning a family, but require STI-HIV protection (eg, spouse of HIV+ partners)?

Finally, there are nursing practice limitations that limit the ability to deliver services locally, and thus are suppressing demand expression, both from lack of service availability, and via the non-operation of the Agency mechanism. An example:

- Implants are not done by Nurses or Midwives – which has not been approved by the official nursing body. Certain issues relating to this matter have remained unresolved (and possibly unaddressed):
  - Skills and training (defined competency and accreditation)
  - It is “not on the job description” (nursing policy and practice)
  - It may require legal updates
  - It implies not only practice, but supervisory issues

### Recommended Action Items on Improving Needs/Demand Assessment

- Consider the creation of a national Network of health staff involved in RH, for information exchange, peer review, peer education, experience sharing, benchmarking, and as a channel and facilitator of RH services review and planning.

- Empowerment of local health staff to share experiences, data, and ideas for the local review of services, and to act more effectively as the Agents for client demand.

- Quality improvement to be considered as a refresher topic, to enable local service and performance review, and improvement planning, within existing budget, or funded out of the benefits/savings which may appear in any improvement exercise (shared gains).

- A study of the cost-benefit of a proposal to enable nurse practitioners to insert hormonal implants and or IUCDs.

- The classification and terminology surrounding condoms needs to be clarified, both in the national inventory, and in national and local health promotion strategies.
2.1.5 Accessibility

In theory this is universal in the public health facilities. All the basic items are on the standard health care facility stock lists (imprests, order forms), and are supplied without discrimination subject to availability of national imported stocks. There is no local manufacturing. Local staff views are that stock outs seem to have been more frequent and of greater duration across the last two years. Further discussion on Stock outs – see under 2.2 Commodity: Supply

Community pharmacy and private medical services are still patchy, and confined to populous areas, following the standard market model for prescription medicines – which is dominated by the underlying access (or otherwise) to prescribers, and by retail location. The retail Prices of items remain much as they were in the 2005 report, allowing for inflation.

Inclusion of the items in the Fiji Bulk Supply scheme as essential medicines required by the public and able to be provided through private pharmacies, should be reviewed.

2.1.6 Access as affected by Affordability

Affordability of RH commodities is not an issue for RH services in the public sector because they remain free-at-point-of-use. Explorations and discussions of patient co-payments and cost recovery measures, as recommended in the 2005 RH planning framework, do not appear to have progressed very far, and have not resulted in concrete decisions.

Costs of physical access do not appear to have changed greatly since the 2005 report, nor has the usual range of personal, social, or popular KAP factors that usually affect utilisation of the public health services. Retail pharmacies remain a good source of contraceptives, and prescription items, for those convenient to the townships, and who can afford them, and the prices of those services and items appear still to be high relative to general incomes, as reported before. If the Fiji economy has slow growth then incomes will not generally change far within any reasonable short to medium term planning timeframe. They may on a very-long term trend, but that is beyond the ordinary planning scope covered by this review. For practical purposes the general affordability of RH products is either the same or slightly worse than before.

Some reports were made about price adjustment in times of public stock out. At least at one location, when a public facility ran out of stock of Microgynon®, clients were referred to the local pharmacy where the unit price had doubled by the end of the day.
**Box 4**

**Recommended Action Items on Accessibility - Other**

- Monitor retail prices, and strengthen public choice by publishing a comparison of contraceptive prices from all sources - data to be compelled if necessary.
- Review status of contraceptive items in the Fiji Bulk Supply Scheme, and consider price controls on key items.
- Consider how the national controls of Pharmacy affect equity of access by ensuring the appropriate location of Pharmacy, and other medicines outlets such as dispensing Doctors.

### 2.2 COMMODITIES

Figure 2 shows the broad concepts in managing “essential medicines”. It shows the interlinks of need (demand) with supply, and the dependency of both on effective prior work being done in selection and quantification. It also indicates core systems, as a hub, upon which the whole operation depends for effective management and efficient delivery. The following subsections should be read keeping this framework clearly in mind.

**Figure 2 – key concepts in managing essential medicines and supplies**

![An Essential Medicines Framework Diagram](image)
2.2.1 Inventory Selection & Listing; Classification; Reporting

The current inventory of RH commodities is tailored in Fiji to meet priority demands, and is felt to be up to date. However, the published listing that expresses the intentions for availability and use are not so up to date. The information sources used by health workers (stock forms, treatment guides) do not match the current inventory reality. It is inappropriate to wait for two years or more to print revisions of Essential Medicines List, when the real underlying catalogue is changing much more often. The manner and timing of publication need to be reviewed, perhaps using a publishing format (eg a folder) that more readily allows frequent updates to be circulated to all service delivery points.

The mechanism of inventory review (medicines list review) is more often being driven by clinician demand than by national Committee decision. The list of Class C items (in the ABC volume classification) includes items procured that were requested for individual patients (patient-named basis), or as tertiary specialist items. Some of these relate to reproductive health. Much of the national concern about stock-outs is wrapped around these low-volume items, and it produces a false picture in the KPIs on stock-outs at the national level (ie in the FPS Centre, Suva). Since many of the items are not, in a proper sense, “stock” items, the concept of a stock-out may not be at all appropriate. False results are being generated through mis-classifications.

In the process of selection and listing, the status of any item used that affects RH is a matter to be considered under RHCS. Poor classification will mislead monitoring, and either raise concerns that are unreal, or misdirect resources to non-priority areas. The points to be classified include the stock status, and the user allocations. Stock status is where the item is going to be guaranteed by the FPS to be held as “stock” – ie to be continuously available. That includes all the kinds of health facility at which it will be stocked. User allocations are similar: it is the level or type of health worker who will be permitted to access, utilise, issue, or dispense the item. These two classes may overlap: for instance, designating an item as stock at a Nursing Station implies that generalist Nurses at that level are entitled to utilise the item, and further implies they are to provide the service which delivers the item (eg pills and family planning).

In a hospital setting this changes; the right to ‘prescribe’ medicines is not given as a right to Nurses, and in Hospitals they don’t do it; nor is a Nurse given the right to run a private FP clinic. The contextual nature of these classifications and usages of legally limited pharmaceutical items in the course of public sector health care duty must be carefully covered from a medico-legal viewpoint: as independently legitimate (which implies that Nurses in themselves do have the right to prescribe), or as medically ordered and/or supervised, in which case Nurses will are ‘administering’ the item only in accordance with appropriate written or verbal prescribing instructions.

Product, or item, designations need to be reviewed for all products affecting RH in:

- the Fiji essential medicines list, and
- the FPS inventory management system, and
- the lists of items used to order ‘stock’ for each level of health facility (the stock report/ order forms).
It was noted above that items that had been phased out were still listed on the monthly health information report form (eg Norplant®, superseded by Jadelle®), so those, too, need review.

It was also noted that usage reports on RH items are hard to obtain from the inventory system.

All these above issues indicate a need to properly classify and flag (tag) appropriate sub-sets in the national inventory of health supplies. With items appropriately tagged for their RH purpose (or as of interest in RHCS), as well as for their stock status and the user allocation, it will then be possible more regularly to pull down better reports on deliveries, usages, trends, stock outs, etc, and to construct management reports with useful comparisons by Division, locality, health facility type, and by user.

UNFPA and others whose health interests are primarily in RHCS should not hesitate to support work which will generally strengthen health systems, especially where the aim is to integrate, to simplify, and to avoid expensive duplication of vertical supply systems for multiple health programs.

A review and classification of items for RH will involve many that are not merely for RH purposes. Some general health goods service both RH needs and other health needs eg, antibiotics, gloves, anaesthetics, or dressings. The manner of classification and the method of tagging in the IRT system must be appropriate. Some goods will be exclusively family planning (FP), these are, by basic definition, Reproductive Health commodities, but are not the whole RH picture; there are RH-specific commodities that are not FP requisites. Reporting of FP items is needed, so a tag is required, that is either replaces, or is in addition to, their RH identity. As usual with IT, clear outputs must be specified before the input items and data reporting tags can be defined.

A scheme for national stock monitoring is, in essence, another reporting requirement from the inventory management systems (or LMIS in the RHCS parlance), and should be promoted and allowed for in that way. Where health facility stock reports are being provided at regular intervals and used for supply, as they are in Fiji, the data already exists for effective stock monitoring (including stock out rates). What it requires is analysis and reporting. Note: the current manner of stock reporting and the use of that data in the supply system does not allow for assessing the stock out duration, because the date at which the stock reached zero in the local facility, is not currently recorded on the stock report form. That can usually be got from the local facility’s bin card, or other stock record (eg local computer system, but only if it has been set up to do so).
2.2.2 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 as consumable stocks are, though there is no reason in principle why they should not be (though at a different interval – say twice a year). They are not capital items, and some are not routine stock items either.

There appears to be a gap in the management of these items. Goods that are recurrent supply (drugs, consumables) are well considered by the FPS and the national drug committee; as are capital bio-medical goods with the National Medical Equipment Committee. But it seems likely that the “minor” equipment is getting 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. What appears to be missing is proper representation and advocacy for basic health care equipment in the primary care centres.
The replacement need of small clinical equipment is a regular need. Strictly speaking these are “recurrent” items, but they are not consumables. These items are expected to have a certain life, and there are genuine limitations on that life. That life may not fall within a 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 2-3 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 counting, and submission to the FPS (or any other appropriate Agency/supplier as may be appointed). The question of whether the FPS carries an ongoing stock, or buys them periodically in batches as reports accumulate, requires further thought and detailed study. From the RCHS viewpoint it is unacceptable to have no regular system for assessing the state of the items, reporting the requirements, and of meeting the need.

In any facility there will also be normal deterioration, or wear and tear, of fixtures, fittings, and furniture. Some general poor conditions were noted; of fixtures (eg drug storage, or lack of it), clinical furniture, and general furniture (eg office needs). 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.

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**Recommended Action Items on non-drug supplies**

- Regular budget amounts should be earmarked each year, for defined categories of clinical equipment purchase. Single point accountability needs to be identified in the Health system for managing small clinical equipment.

- A rolling program of equipment replacement should be considered, with a regular method of equipment status reporting, parallel to that used for reporting stock status of ordinary medical supplies.

- The national standard for clinical equipment at the different levels of care should be regularly reviewed, and must include appropriate sets for the various RH services.
2.2.3 Quantification & Procurement

2.2.3.1 a) Ordinary Quantification Considerations

Quantifications of RHCS supply in Fiji seem to be shaky. The data for a demographic epidemiological model are somewhat fragile and sparse as discussed in Section 2.1. Some of this will improve with publication of the 2007 Census. The method can be readily used to set some top and bottom limits. In a form of base-budgeting for service requirements, there can be a minimum forecast defined for a particular health services plan for a given population. A maximum can be defined by the requirements of the largest predicted population to be provided that specific health service profile. Where 100% targeting is used this is easy, but assumptions are made about utilisation and uptake rates that are less than 100%. Unfortunately, the historical health service and epidemiological data used to justify the expected rates (or trends) are confounded by prior unmet need, and the Agency and access barriers that were discussed above.

The logistical/historic model is constantly used in Fiji, at the FPS Centre, based on consumption, with consumption having “issues” as a proxy. It is assumed that apart from any adjustments of actual known wastage or expiry, all stocks issued are used. This type of consumption figure is affected by suppressed demand via irregularity of supply - the negative spiral aspect of a supplier-led market. The cash limitations on the Fiji health supply budgets in the last few years are a further cause of insufficient procurement. Rationing or allocations then have to occur, forcing local stock outs as the overall supply cannot meet the overall historic demand (let alone future demand). This is actual reported staff experience all through the supply chain.

In such a scenario, the issues data at FPS cannot be taken as a proxy for consumption, but would have to be very carefully and radically transformed with an appropriate knowledge of the stock out durations (how many places, for how many days per year). This type of data is not collected or reported, so therefore it is quite unknown by what factor of “shortage of supply” any future requirements must be adjusted upwards.

Additionally, reported views suggest that lack of local supply is already suppressing the demand for services, as it begins to impair public confidence. Demand that was previously expressed (and may have been met) becomes suppressed, and is effectually converted back into unmet need. This is, as said, the negative spiral of a Supplier-led market where the Supplier (ie Health) fails to keep its supply up far enough to lead to all proper demands being adequately expressed - which it only can be through the Supplier. Not only is the health-agency phenomenon in operation, but there is, for the majority of people, a virtual public monopoly on health services: for most people, and in particular the poor and the remote, there are no practical, reachable alternatives.

In this event, historic consumption has to be adjusted not only for stock out but for suppressed prior demand. That is, an apparent trend of downward usage does not reflect a real trend of lowered demand. This leaves us to conclude that population-based forecasting using targeted success rates is the more robust method, taking a “good” year historic consumption as a minimum guide – a year in which stock outs were few, and services kept up reasonably well with the then rate of demand. In the event of failure to reach the service targets, the assessed
stocks will have moved more slowly, but that should show in monitoring. Out-performance of local targets could in theory lead to demand outstripping supply, and to supplementary orders, but that is actually unlikely. The population forecast method all too often leads to supply methods based on allocations (for service forecasts), and very quickly this can end up in the negative spiral unless allocations are closely monitored and adjusted – a very tricky and potentially costly effort.

2.2.3.1 b) Special Quantification Considerations in the Pacific

The Pacific is peculiarly isolated! An important phenomenon that is often not given due weight in quantifications for procurement to Pacific Island Countries (PIC) is the effect of long shipping times. It is by no means uncommon for goods supplied by overseas manufacturers or wholesalers (even ex-stock), to take 4-6 months to arrive by sea. Total order lead time being often much longer, where that includes tendering, tender evaluation, manufacturing of larger lots, and total trucking/shipping times into final receipt. It is quite usual for the process to take around 8 months.

In such a scenario it can be shown by basic logistical principles that forecasting and ordering on an annual basis will never deliver sufficient goods to make a Pacific Country central medical store operate effectively. It will never keep in-stock. To maintain effective supply in this peculiar situation the required stock target (forecast period) is 15-18 months. This is in stark contrast to a continental or a compact island situation (eg Caribbean) in which typical mainland lead times are measured in days, or perhaps weeks. In those situations order forecasts are for weeks or months only, and 2 or more order cycles are achieved in a year. Annual forecasting works well.

It cannot be too strongly over-emphasised that the total order cycle, and the stock forecasting for the independent Pacific Islands Countries cannot be done on an annual basis, but has to be on a basis indicated by the real logistics: normally 18 months.

We repeat this, in another form: where donor programs, bilateral 3rd party payers, or Third Party Suppliers insist on dealing with quantifications on an annual basis, the medical system will not succeed in the typical PIC.

Quantifications of future health services, the RH service performance rates, and so on, will continue to be planned and budgeted year by year. This is right and proper. It works within the normal budget cycle and the ordinary accounting periods. When one has obtained the demographic data, utilised the epidemiological pattern, forecast the fresh health services, and combined in the past consumption and current stock data, with allowances for stock-outs and hidden demands, then one may come up with an annual RH commodity forecast. That also is good and right. It is only when one is forecasting for those goods to be supplied by sea that the peculiarity arises. If one then orders, to be delivered by sea, an amount only that will top up to the calculated annual requirements, the supply system in a PIC will inevitably fail.
Attempts to overcome the problem of the long lead are varied. Some of them are very costly alternatives:

a) Order bulk by sea up to an 18 months target, not 12 months.
   
a. This involves ordering and shipping large quantities. It results in a large amount delivered at one time, and a large capital tie up of stock on shelf.
   
b. There is also a nasty effect on cash flow, with a very large lump sum to pay on delivery - sometimes even more than a complete 12-month budget vote - just because more than 12 months’ worth may have had to be ordered. Commitment made in one financial year (eg ordered/committed in mid 2008) would not be paid till the next financial year! The usual accounting systems do not cope with such large rollovers, and fiscal systems (as in most PIC - they do not do accrual accounting), do not carry forward current “unspent” budget to a following financial year.

b) Order smaller, and more frequently, and airfreight the goods.
   
a. a natively very costly way to move the total amount required
   
b. also requires multiple drops due to small local freight capacity

b) Purchase the goods at a more local market where leads are shorter.
   
a. the only viable nearby quality markets are Australia and NZ, both of which themselves suffer the price of isolation. Paying goods at their rates is worse than buying at a distance. It also, for RHCS, automatically cuts out preferred 3rd Party suppliers like UNFPA.

d) Contract and commit further ahead (18-24 months) and have several partial deliveries by sea, paying-as-you-go for each landed delivery.
   
a. This smooths the stock and cash flows, with less tie-up
   
b. It requires good forecasting up to 2 years ahead
   
c. Stock movements must be closely monitored, and later tranches adjusted either up or down as demand/usage indicates.

The latter option above is the one now being targeted by the most competent systems in the PIC. As a pre-requisite it requires the senior officers of Health, Treasury, and donors/partners to understand accrual accounting very clearly. They must recognise why there has to be a large forward stock commitment (contracted amounts), and to recognise that the total contract commitment and the tranche payments will be very different! They must also provide the medical supply staff with high quality inventory management and accounting tools for monitoring and adjustments.
Recommended Action Items on Quantification of RH Commodities

- Quantification for RHC should be done in the PIC logistical context, balancing convenience and value. If best prices are to be obtained, and freight costs are not to be excessive, then convenient regional sources (e.g., NZ) may not be used, nor may bulk supply routinely be airfreighted.

- If reliable forecasting is to be done, in a context of past supply instability, and future health and economic uncertainty, then multiple modes of quantifications should be done and compared. Special attention must be paid in the light of hidden demand, and recent stock-outs.

- The 2007 Census data should be combined with the most reliable demand indicators - going back if necessary to usage figures based not on 2007/8 but on those that reflect a more regular stock flow situation in the “best recent previous year”, and carrying these forward, with additional allowances for the current priorities for the improvement of Reproductive Health services.

2.2.3.2 Procurement

We now ask what is the Fiji procurement status for RH commodities, and what are the appropriate local recommendations for the future? We have shown a number of traps in the pre-purchasing stages of procurement. There are difficulties in quantifications, which inevitably knock-on to become budgeting problems, as funds are limited, and closely targeted to anticipated quantities of goods to be bought. Budgets have been historically low, and are not improving.

Fiji has procured its FP items via the UNFPA on a 3rd Party Procurement basis using FPS national medical supply budgets. Fiji is thus funding its own RHC buying, using a preferred Supplier on pricing and quality grounds. These goods are not subject to the ordinary Tender process. The client-supplier relationship appears good. Placing the orders reportedly takes some time, and deliveries under the arrangement appear to have been sound though, inevitably, on long lead times. The quality of goods was acceptable and quantities delivered were in accordance with estimations and orders. As far as is known, the payment record is also reasonable.

However, for reasons that are not fully clear, national stocks were not successfully maintained at levels sufficient to meet the service demands, though service statistics do not indicate any great increases in demand. On more than one occasion interim orders were placed via other Agents. Partly this may have been timing, but partly – it is suspected – there is a link to the lead-time phenomenon, and quantifications may have been performed in the trap of “annual thinking”. We have shown the highly problematic nature of performing International procurement in the Pacific, and what methods are usually utilised for delivery in the PIC context. The principles discussed do not appear to have been applied thoroughly in recent national RHC procurement.
With deliveries having been slightly erratic, the supply to SDPs has been volatile and consequently some clients have failed to be served adequately. As mentioned above, confidence may be affected and demands may have already become suppressed.

Some of the RH commodities are Class A bulk purchases, and these are generally well managed in Fiji. Many FP and RH items are relative small quantity, like IUCD and hormonal implants. Using ABC classifications to determine procurement methods and order intervals may not be the best lead method. If RH and FP items were classified as recommended, above, in a fresh sub-set, they could be defined as a new Tender Lot.

**Recommended Action Items on Procurement of RH Commodities**

- Options for forward contracting should be reviewed with the 3rd Party supplier, and forecasts updated in the logistical context to improve the amounts being delivered in the contracted tranches.
- FP items, so tagged in the Inventory, should be procured together as a new Tender Lot, even if the ‘Tender’ is restricted by a given MoU to a single preferred Supplier.
- Items that are general medical supply items, but critical to reproductive health, should be so tagged in the inventory system, to enable more frequent particular reports to be more easily drawn out, to monitor more closely their stock status and usage.
- The ABC classification may not express RH or other specialised health priority, and should be used with caution as the leading procurement indicator.
- Parameters for machine-generated predictions of order quantities must be set to fit with the logistical realities, and not based on assumptions of “annual” ordering.

### 2.2.4 Supply to Health Service Delivery Points

Stock outs and monitoring have already been mentioned. It is only pertinent here to repeat the remark that stock outs, while they often involve supply problems, are more frequently caused by procurement limitations than by supply side factors. However, in Fiji, as formerly in Kiribati, it is true that the use of the wrong kind of imprest system is causing great and unnecessary difficulties on the supply side. These are being addressed in detail under the national pharmaceutical strategic planning.

Fiji, in fact, has at least three different medical supply systems - for FP requisites, for general health goods, and for cold-chain items. This impairs the coherence of RHC security, and better integration is required to service the needs.

The cold chain system must stand on its own merits, and although the lead is given with
EPI there are other thermo-sensitive products, that are not vaccines, that require the cold chain supply system. Care must be taken that cold chain policy is not too overshadowed by immunisation policy, and that cold chain management for health is not subsumed only under immunisation.

There are lessons to be learned from the monthly FP supply systems that can be transferred into a review of the general quarterly health supply system. For one thing the stock reporting and ordering is not based on a fixed maximum imprest, but the amounts to order are calculated on recent usage. The usage is projected forward over a target period (in this case two months), and the amount to be ordered (ie requested to be supplied) is the top up of current stock to the calculated target figure.

This method is very close to that used in other PIC, called the “floating point” system, which is much more suitable for use than the fixed maximum imprest system that is used in the quarterly general supply.

Wrongly applied methods of supply may be a significant cause of stock out, and it must be noted that a fixed-maximum imprest method is not appropriate where order interval is long >about 2 weeks. Fiji, which has traditionally had a quarterly supply to most of its health facilities for most of its goods, has already found this system overstocks slow moving lines, and undersupplies the fast ones. Although it is a simple issues calculation (subtract stock from max, and supply the difference) it is in fact an unwieldy system for distance supply, as it requires a lot of costly professional input to keep it adjusted to the right stock levels. It cannot adjust itself to trends, and it does react to sudden surges in demand: it keeps on plodding away!

In a situation of quick turnaround, and easy communication, fixed maximum imprests work extremely well. Thus with facilities that are nearby, have short order intervals, and with whom it is easy to discuss adjustments, fixed maximum is the technique of choice. Examples are hospital wards supplied by pharmacy or local medical store, or nearby health centres accessible by road, and with good phone links.

The floating point supply option has been most strongly developed in Solomon Islands. It is, in effect, a simplified version of the method in the Pocket Guide to Managing Contraceptive Supplies. Instead of the health centre staff doing the calculation of usage, projecting it, and estimating an order, all they really need to do is report their stock – accurately, and regularly. On arrival at the supply point the latest stock data is added to the system, and the easiest way to calculate the required order is to allow the computer system to do it – which is considerably labour-saving! An expert pharmacy or medical stores technician can review a 100-item order in a few minutes, but the computer will do it in micro-seconds.

Modules to cope with this type of issue stock system have already been started in mSupply®, and are being trialled in Solomon Islands. The inventory system used in the FPS, Suva, already bears a facility for entering client stock reports, and it could quite readily be re-programmed to alter its calculations from the fixed maximum method to the floating point. In the later logistics rules have to be attached to each client, to ensure the correct allowances for clients real lead time, and hence for a realistic forward stock projection to cover their forthcoming needs.
Another lesson to be learned from the FP supply system is the possible benefits of decentralised supply, and of having the supply point closer to the primary health facility. Western Division staff were clear: the monthly FP supply system from Health Centre to Nursing Stations, was working very well, subject only to the Health Centre receiving adequate stocks (which points once more back to the quantification and procurement problems). The client-supplier relationship was good, the order interval was short, the amount of stock moving was small, and stocks turned over nicely, and the supply point was easy to get to. This lies in contrast to the FPS which is distant, and not at all well known.

It also proves that effective medical supply functions can be done more locally. There needs to be more evaluation of this, and a proper study done of the benefits of creating a better hierarchy of supply: of decentralising. The clear implication is that medical stores in Lautoka and Labasa should be greatly developed and strengthened to supply their Divisional clients, instead of all Health Centre orders going up to Suva.

General supply could then be done on a monthly or 2-monthly basis (depending on the client locations), and the target stocks on shelf could be reduced. Together with the change in supply technique to floating point, the potential is considerable for a reduction of local stock outs, savings on capital tie-up, better flows of stocks to clients and much less potential for wastage.

Further discussions of IT in Supply – see under “Capacity – Technical”

**BOX 9**

**Recommendations on Supply Systems used for RHCS**

- The integrated central I.T. at the FPS, which also tracks stocks at Divisional level is good, but unlikely to be useful at other levels – it lacks a pharmacy service front-end for patient issues (ie dispensing). Exploration is required of a good value integrated suite for pharmacy/inventory to be provided at the Divisional and further levels of supply (Health Centres and Hospitals). One example, being used in other PICs, is mSupply®.

- Combine the FP items into one consistent stock list of Commodities for supply to the health facilities (SDPs), to strengthen a single, integrated supply system.

- Trial a reform of supply methods, and verify benefits of a decentralised supply activity with the aims of:
  - shortening the supply interval and having supply from a more local point, in place of all orders being serviced by the FPS at Suva adopting a ‘floating point’ technique from elsewhere [or simplify the method used for FP items, which has similar effect, but is more complex for the staff at SDPs].
  - using fixed maximum imprest only for very short-lead SDPs (eg supply to wards by a hospital pharmacy), and using floating point methods more appropriate to any site with a longer lead time.
2.2.5 Quality Assurance (Products)

Fiji has a scheme for the pre-qualification of Suppliers which is felt by those involved with procurement to have been working well. However, its needs some review, as its exclusion criteria may be too strong. Some international generic medicines suppliers are excluded on certain medico-legal grounds (concerning product registration), but their quality assurance passes the most stringent assessment. One example is IDA, based in Amsterdam, who do not register any products in their country of origin (Netherlands), because Europe is not their target market. Their QA systems have been assessed by the Food & Drug Administration (FDA, Washington, USA) for goods to be supplied to USAID programs. In terms of quality of goods this standard is regarded by many PICs as sufficient, and it may so for Fiji, too.

At the procurement level both in relation to products supplied by UNFPA, and in relation to products from other sources no dissatisfaction was expressed as to the quality of products received.

However, in the field, health staff in various units reported some quality problems, and it is unclear if the prequalification scheme has worked as well as it might. It must be emphasised that batch data are unknown, and that official reports were apparently not filed, and thus investigation into the problems does not seem to have occurred.

Two particular problems are detailed in Annex E, concerning Copper-T, and gloves.

After the phasing out of MultiLoad the selected IUCD was Copper-T 380. There have been some reported quality queries with the latter product. This was reported by Staff at more than one place, and in more than one Division. The removal threads of the device apparently detach on removal, or even sometimes before the scheduled removal. In some cases this has meant referral for surgical removal of an IUCD.

In consequence, health staff report a rise in reservations among clients about use of IUCDs in general, and of the newer product in particular. Some individuals demand the older product, it being seen as more reliable. Quality concerns voiced among the FP-seeking consumers seems to travel rapidly and widely (bad news travels fast) and if not followed up could threaten the credibility and acceptance of goods, may harm the reputation of RH services, and affect public confidence in the health supply chain.

Another problem concerned examination gloves. Details are given in Annex E. Staff reported some of the gloves were found to be holed when taken from the box. Being abstemious, they laid aside only damaged gloves, and used what was left. However, this may not be the best or safest response: if it is the formed quality of the gloves that is in question, then gloves which appear to be whole might still be below standard. It depends on the precise nature of the production problem.

There appears to be little awareness of the appropriate way to report quality problems with medical supplies.
Recommended Action Items on Quality Assurance of RH Commodities

- Review the Fiji Pre-Qualification Standard to allow for inclusion of Suppliers of international “unregistered” generics (eg IDA, et al) whose quality assurance system has passed assessment by acceptable benchmark Agencies (eg FDA, USA).
- QA reporting and investigation. Check that these product queries were received, investigated and answered, including implications for the implementation of the Fiji pre-qualification standard.
- Review the process for QA problem reporting, and check recall procedures.

2.2.6 Private Sector availability

The private sector medical and pharmacy services include some aspects of RH. As was reported in 2005, a wider range of oral contraceptives is provided by the retail pharmacies, but at relatively high prices. The situation is little changed.

2.2.7 Quality Use of Medicines in STIs, etc

No data has been found either on the quality of prescribing for STIs, or on the rate of availability of medicines, or for the rate of successfully completed treatments of STIs.

The lack of data on quality prescribing for STIs, on the rate of availability of the relevant medicines, or for the rate of successfully completed treatments of STIs, is a cause of some concern. As is well known, the likelihood of HIV transmission is increased where an STI is present, and untreated STIs increase national vulnerability. There is, therefore, a peculiar priority required on the early diagnosis and treatment of them, besides their importance to the individual, the sexual partners, etc.

These types of indicators are important, but no plans were mentioned by any respondents in terms of future study and RHCS monitoring. The judicious selection and use of these kinds of health system quality markers can help to focus attention, and set priorities for planning and resource allocation, to ensure better success in finding and combating HIV, communicable diseases of the reproductive tract, and certain consequential RH-related risks (eg raised risks of cervical cancer).
2.3 COMMITMENT

2.3.1 Policy Priorities

There is no national population policy for Fiji, as such, and one is neither known nor planned at the Ministry of National Planning. National approaches to issues relating to population and health are dealt with in the 2006 National Strategic Development Plan, which is discussed at Section 2.7, below.

2.3.2 Practical Commitments

Although it was mooted in the 2005 Action plan for RHCS, there is, as yet, no inter-sectoral multi-professional RH steering committee. There are several possible leading Clinical Service bodies that could host this: the National Maternal Health Committee, or the National Child Health Committee.

Strategic planning for RH Services, if it is to be done as a distinct strand, needs a fresh mandate from the Ministry of Health, one which will be practical. Since RH is a cross cutting issues for several clinical areas, it might not function very well as a subcommittee to existing Clinical Services, and perhaps could be “repackaged” and put up as a National Action Group, different from, but linked to existing Committees. With HIV-AIDs as a growing national need, a strong case could perhaps be made for HIV prevention to become a lead focus in reproductive health, but this will not cover, for example, all the maternal and child health aspects, though it will considerably help with adolescent reproductive health.

The plain fact is there are many interests in RH, and almost all of them already have specific commitments to their part of the RH spectrum. Clinicians usually pass off commodities matters to Pharmacy/ Medical Stores. But FPS is not a sufficient leader in RHCS because of the varied clinical implications, and areas of RHCS that are beyond its own remit (eg Nursing standards).

Recommended Action Items on Quality Use of Medicines

- Consider the benefits of monitoring the medicines situation using the WHO set of Indicators (Level 1, 2, 3) – indicators Structure, Process, and Outcomes in access and quality use of medicines (QUM).
- Consider how to apply QUM to plan improved outcomes in STI, and other RH related conditions, both as a means to disease control, and reduction of HIV vulnerability.
If RHCS coordination is to be real and productive there must be a distinct operational commitment. A champion is needed within the MoH, to help the Ministry itself gain a true sense of the priority. It may be that an agenda of “commodities security” alone is insufficient as a motivator – it may be that improving RH (in which RHCS is seen as one of the important factors) will be more attractive to the MoH.

### 2.3.3 Political and Financial Commitments

Fiji Government procures its own contraceptives and RH commodities showing high level commitment to sustainable RHCS. However, there is uncertainty in the long term as to health budgets, operational structures, and status of health strategic plans. Unless these issues are resolved, the commitment to, and planning of a comprehensive approach to RHCS is unlikely.

Gaining more commitment across the nation appears to be something of a chicken-and-egg situation. It will depend largely on the Ministry of Health recognising the priority for improving RHCS. It is, however, itself a commitment for MoH to do so, and it is unclear exactly who is best placed to help the MoH achieve that. From the operational viewpoint, the Family Health Unit is most suitable, and strong support for this Unit to take up the challenge and organise the first meetings may be the first step.

This may be tantamount to saying that RHCS must be injected quite forcibly into the Unit’s remit, as they may not currently feel empowered to host it. One might raise the motivation by offering RHCS as a support framework for improving RH outcomes, rather than RHCS being an end in itself.

### 2.3.4 NGO’s and Development Partners

Various people seen during the field visits expressed their warm appreciation of the continued support for RH matters from interested Bodies in MCH, Cancer, Family Planning, STIs and HIV-AIDS. Here seems to be a good background of assistance and support, but coordination needs strengthening. The underlines the necessity of having some sort of group to lead, and the above discussion refers.

#### Recommended Action Items on Commitment

- Verify the status of national plans and policies affecting population health and RH.
- Identify the best organisational point of accountability within Health to lead a Group which can plan and implement improvements in RHCS – NB: commodities security may not be a sufficient agenda, whereas improving RH service outcomes might be.
- UNFPA to advocate for coherence in monitoring various RH outcomes, and suggest a fresh approach to be taken with a RH coordinating group.
- Apply external support to the initial formation of an RH improvement group.
2.4 CAPITAL

2.4.1 Overall Government Budget

The current economic climate in Fiji and the present Government reform approach is seeing expenditure cuts imposed. The Ministry of Health has been restructured at the very senior level, and there are Government budget limitations. Without direct intervention via appropriate planning the trend of decline in real values of the medical supply budgets may continue. They already appear to be lagging behind service and population demands on a steady long-term basis. A larger gap between supply and demand is thus developing through time.

As mentioned above it is more likely that the effects and problems in procurement are the prime causes of national stock outs, the impact of which work its way down the chain in a wave, or domino effect. Supply system effects are also known, but having less budget, without some radical way to address better value in procurement, will only make things worse. It is hard to see where purchase prices can be affected in any case, where the items are being obtained on benchmark with preferred suppliers such as UNFPA (acting in a 3rd party role).

More realistically, means must be sought to preserve or increase the capital being denoted for medical supply, which can help to maintain RHC security. There appear to be no definite plans in the MoH to address this issue. Most strategic health plans are simply expressing more and better services to be more widely available, both in the primary/secondary clinical services, and in the specialist programs. These tend to be based on the assumption of continued Government budgets, or an almost automatic pick-up of needs by external Agencies. Both assumptions seem to be false, and the operational plans (corporate plans, business plans) year by year will see less resource and thus, at best, a slow down in achievements.

One way to address this is to try and ensure that all the necessary health components are well expressed and supported in any Medium Term Expenditure Framework in public sector planning. It is not known if this method of national cost/cash forecasting is currently used in Fiji. If so, Health must play a vigorous part in shaping it. If not, then non-government and external organisations might wish to consider suggesting it as a helpful tool to preserve forward commitments on the key areas of expenditure, like Health. Another way to help address the long-term situation is to improve the high-level policy commitment for a target % part of the GDP to be committed to Health, and, specifically within that, to good health supply. Other tactics include strong negotiation for agreement on “absolute” elements of increase, such as an inflation hedge, or a population index, which might at least preserve the real terms value, even if actual increases in capital commitment are not possible.

2.4.2 Re-structuring the Medical Supply budgets

There will be extraordinary pressure on medical supply budgets in coming years. With STI rates increasing, and other indicators apparently adverse for the trend in HIV-AIDS, the budget for treatments and preventions in this area alone will be significant. Experience with the treatment costs of HIV-AIDS elsewhere suggest that if no special action is taken to restructure the Government health supply budget there will be a catastrophic effect on primary care services if the tertiary and specialist claims on the funds are met through a single medical supply budget.
Distinctions are urgently needed in the Fiji health supply budgets to prevent the costs of specialist needs, such as HIV-AIDs, oncology, etc, eating an overlarge share. It will be essential in future to protect the supply budget for “core stock” items, the list of items required for primary care, including many RH commodities: contraceptives, antibiotics for STI and other RH-critical perinatal infections, and items (both drug and non-drug) that are vital to infection control and to the provision of quality maternity services. Detailed suggestions for this approach are given in the separate report (prepared for WHO) on Pharmaceutical Strategic Planning. In essence it is proposed that there be a budget (accounting line) for core health care supplies - items that are needed in general primary and secondary care. Various means are used to calculate the required core funds, and in that process it also will become clear what must be funded on another line: one to be created to fund specialist and high-cost drugs (such as ARVs, cancer treatments, etc). By this means core funding for most items affecting RHCS can be preserved in the public sector.

This type of reservation strategy is not new. Even the advanced economies are finding health costs to be a challenge, and, in Australia for instance, in their public scheme for Pharmaceutical Benefits, there are several ways in which access costly drug entities is limited: such as Section 100 (the list of Highly Specialised Drugs), and the class of “Authority-prescription”. The individual Clinician cannot, unfortunately, be the last word in this matter. Of course, proper clinical judgement as to appropriate therapy must be incorporated into the EM selection, to make the final essential medicines lists credible and authoritative for practitioners who are guided by it.

Re-classifying Fiji’s essential medicines list, and redefining the supply budgeting may perhaps mean some hard choices in therapeutic selection, the better to ensure the most cost-effective use of goods. There may even have to be a distinct retrenchment in the essential list for both “core” and “specialist” medicines. Some difficult risk-benefit-cost choices will have to be made about what is, in fact, affordable treatment.

The possible threats to the viability of screening and diagnostics must also be taken into account, not merely the therapeutic. This is particularly true for preventive and promotive health programs. These must take their fair share with Acute care.
Recommended Action Items on Capital

- MoH should investigate the existence and terms of any MTEF for the next 5 years, and ensure a proper negotiating place to help develop one, in terms of gaining a robust future for health funding.

- The FPS should examine its inventory, and all proposed therapeutic approaches, to identify and budget for the high cost and Specialist items.

- Acute care and preventive care programs should receive equitable proportions of core supply budgets, and, where possible a Health Program should ensure that the FPS is well informed of its advance requirements.

- Primary care services (incorporating all ordinary RH services), and secondary care services should be allocated appropriate levels of funding for “core supply”. This can be benchmarked at, say, a minimum USD10 per capita, per annum (referenced to a given year to allow for inflation and currency shift).

- Funding for specialist goods required by tertiary care (specialist health services) should be budgeted separately from core supply. Program funding by clinical services could be considered (eg Directorate funding for HIV-AIDS program, oncology services).

2.5  CAPACITY

2.5.1 Workforce Issues

An examination of the 2007 MoH Annual Report (page 65-67) shows a significant rate of vacancy for medical officers. There are 78 vacancies listed in an establishment of 396; a vacancy rate of 19.7%. The area that appears to be in greatest lack is Public Health where 28 of the 78 vacancies are listed. Given that much of the RH activity is covered by general practice and public health, this is a serious figure. Other categories with higher rates of vacancy are also of concern to RH are paediatrics, anaesthetics, along with O&G.

It has not been found if there are benchmarks or targets for staff-patient ratios or staff-population ratios? The general picture for nursing seems good, but retention matters were expressed as a concern in several conversations. Conditions and incentives for rural and remote service were seen as possible ways to address local priorities to attract staff into service with poor/remote segments of the population.

The distribution of workforce may possibly be unbalanced if reports of workload in health centres are correct, and if it is true that in more than place outreach and zone nursing services are often interrupted to ensure that local primary and acute care continues safely. A study of this appears to be needed, and priorities set that will ensure a fair and continuous commitment to public and primary health.
Taken along with the shortage of PH medical staff, this may indicate that Fiji is not providing itself with sufficient workforce capacity to deal with primary care.

Pharmaceutical and Medical Stores operational HR capacity appears to be reasonable, but would need to be reviewed in any plan to restructure medical supply services. The same cannot be said of pharmaceutical management or for national medicines policy and control. A number of function are not adequately covered, and a definitive study appears to be needed, to ensure these areas are properly covered for the future. The medicines and medical technology regulatory area has a direct effect on RCHS in terms of availability, access, and affordability.

2.5.2 Statistics, and Information Technology

Technical Capacity / Skills, Facilities, IT

Health services data collection is coherent and reliable. The need for a greater dissemination of appropriate health information has been noted above. There is little local IT, with perhaps one computer for a Health Centre, but wireless and wired telephonic services cover a very substantial portion of the population. There is a real and urgent need to explore ways of using technological interfaces to communicate information both to and from the health information service, and the central supply.

These developments do not presuppose large amounts of money spent on desktop IT and other large footprint hardware. Creative approaches need to be explored, and the forums in which to brainstorm the possibilities need to be facilitated.

Technological advances can empower much greater access to health service data and information, and provide quite new ways to respond much faster and more flexibly to changing supply needs.

Supply management software does not have to be expensive – mention of good value integrated suites, for dispensing and stores, has already been made (e.g., mSupply®). This type of software can easily operate on quite small entry-level hardware, the price of which is also dropping rapidly on the world market. The cost-benefits of upscaling IT across health is an urgently required study.

2.5.3 Medical Laboratory Capacity

Local access to medical laboratory services, for smear examination, seems to have regressed in the last few years. Basic haematology (blood counts and haemoglobin) is also not always available at the district hospital level. It is unclear if this is one of core of the factors of laboratory workforce, laboratory services management (including the acquisition of equipment and the maintenance of facilities), supplies, and biomedical equipment maintenance. All of these were suggested as locally possible. A primary RH service requires a certain amount of laboratory support, without which diagnostics and therapeutics are sometimes less informed than they should be.
### 2.5.4 Training Needs

Training outputs overall appear to be good, going by the MoH Annual report. Basic skills for medical, nursing, pharmacy, and medical technology all appear to be good, varying from year to year in the FSM and FSN outputs, which presumably depends mainly on the state of funds and the academic staffing.

Reproductive Health Training Programme at the Fiji School of Medicine currently provides opportunities for RH programme managers to study programme management of which RHCS should be an integral component.

Few Nurses in responsible positions in Health Centres appear to have received formal management and administration training, other than a local government in-service (ie on public service procedures, etc). Other health professions also seem to lack in this area. Of particular interest is that very few have any awareness or training in service planning or in quality improvement, which is absolutely vital if one is to improve the health service outcomes (ie obtain Performance Improvement).

#### BOX 14

**Recommended Action Items on Capacity Building (IT, HR, Lab)**

- A think session leading to a new approach in IT for health is needed, on the creative use of modern IT (eg: smart-phones) for data collection and various kinds of health communication (referral, services advice, receipt of bulletins, stock reports/ordering, etc).
- The national oversight of RH must consider the lack of Public Heath specialists and the effects on RH outputs of zone services being drawn back into acute care.
- MoH should ensure effective liaisons between Laboratory services and the Biomedical program to minimise downtimes and ensure local continuity of basic diagnostic tests.
2.6 COORDINATION

2.6.1 National Coordinating Group

As has been mentioned above, there is as yet no national group or committee that is leading RHCS in Fiji. This was targeted in the 2005 report and plan, but it has not been adopted by MoH to be created as a separate entity, and as mentioned previously, the specific clinically-based Maternal Health, and Child Health, Committees - have not taken a lead to host such a group. The natural focal point within the MoH to facilitate a specific group that might lead RHCS improvement is the Family Health Unit, but as yet it has not formulated any specific RHCS plans.

It may be that a stronger title and racier approach might create a greater sense of importance and urgent. Labelling it as a “National Action Group” might enhance the expectation that this is an important and urgent matter. Whatever the particular tactics used, the improvement of “commodities security” itself may still not be of sufficient interest to attract the time and attention of busy clinicians and senior health staff. It is more likely that a smaller interim group (a champion with a few key supporters) may be better able to do some preliminary work, and suggest specific targets to be set for operational performance improvement. These will meet interest in the actual clinical and supporting Services. This may quicken a wider interest. At all stages, some motivators are needed: mostly positive in the first instance, to interest the bodies that do have RHCS interests but may not yet be addressing them (eg the national Maternal Health Committee). In the first phase, if no MoH champion can be found, external support may be necessary to ensure meet regularly, target RHCS matters. Some consideration might be given to modest meeting allowances, and to holding meetings at more attractive times together with other recognition (eg make them more like professional meetings at lunch times, or breakfast meetings with light refreshment and some educational content, such as “Assuring Quality in Care – the extended impact of a poor supply”). These types of meetings are often more attractive to Clinicians who may not be so readily available at other times.

Whatever type of group is facilitated it will need some initial funds and support – and that may imply a first phase Host organisation. If the MoH can be properly convinced, then operations should be subsumed as quickly as possible into the normal health organisational structures. A range of organisations have RH and all these may wish to help have some share in assisting with ‘round table’ meetings on RH improvements, that should include the improvement of RHCS. Initials sources therefore include MoH (use of Govt budget), bilateral donors, helper organisations: UNFPA,UNICEF, WHO, Marie Stopes, etc.

2.6.2 RHCS Action Plan and Responsibility for Implementation

The previous (2005) RHCS assessment bore a draft strategic/operational plan – see the Annex. Much of this is still valid, but depends on the first item – an Action Group or Steering Committee. The plan does not appear to have been published beyond the borders of the
group involved in the first RHCS assessment: many of whom are no longer in the places they then occupied. Present staff interviewed seemed to know little or nothing of it, and could not point to specific actions having been taken.

The author wishes to recommend that a fresh planning approach should be based on an overall objective to help fulfil national health goals. These are discussed further along in the report, under “Context”. To have an effective plan, and one that will arm an RHCS group to attract more attention, is to have one that will convincingly show how its own internal goals and targets will improve performance in the outcomes that are of interest to the Ministry and Cabinet. If one is evidently attempting to fulfil the desired goals in the National Health plan (a Ministry plan), and also in the National Strategic Development Plan (a Cabinet level plan), one may perhaps be more likely to achieve national agreement and obtain further national support.

In the past it would appear that the RHCS plan may have been seen to create further complexity of organisation: “...Oh no, not another Committee!...”, and as asking for further resources (“we do more functions, we need more budget”), and to be of such specific internal focus on ‘commodities’ that it has been presumed not to be a national health business matter, but one properly left to those operationally responsible for commodities: ie, dumped back into the lap of the Pharmacy/Stores service.

So much for the Plan’s goals. It will be further important to show that most resources already exist, and that supporting improvement in RHCS mainly consists in finding ways to empower local staff to solve current problems through managing resources better in their own professional environment, and releasing the power of their local knowledge and expertise to plan and do in the ways they know are better. A grass roots approach to improvement is always more productive in the long run than any imposed quality improvement system that is “added-in” from the top.

2.6.3 Public Health Service Organisation

Mention has already been made, under Capacity of changes in management in health, and public sector reform. There is a reduction in span of control for the PS (CEO) that may act negatively if the Directors feel more burdened, but conversely, if Directors have a wide span of interests they may be better able to cover a variety of areas, and RHCS (being a crosscutting issue), may find an easier home at the senior level.

Shifts in health planning priorities across time will occur, but only slowly. The current set of goals would seem likely to remain stable for a long while.
Recommended Action Items on RHCS planning and outcome improvement

- Use existing plan items updated with items from this 2008 Report, and refresh with views from a small stake-holder round table meeting (mini-workshop).

- Focus on showing how improving RH (which will over-arch RHCS) will help to fulfil existing national goals as stated in Government and Ministry documents. Particular emphasis should be given certain positive and negative aspects:
  
  a) methods for locally empowered service outcome improvement

  b) what would happen if nothing is done – the adverse impact of a “do nothing” scenario – impact of current adverse trends, further failure, etc.

2.6.4 Distribution Management – strengthening Health Systems

2.6.4.1 Achieving a high quality integrated Health Supply System

This report should be read in conjunction with the report on Strategic Planning for Fiji Pharmaceutical Services, in which there are detailed discussions about what manner of coordinated approach can be taken to the distribution of health commodities, which includes all RH goods.

In essence, because of the national aim to have an integrated health commodity supply system, any systemic improvements that would benefit the flows of RH goods would benefit the performance of health supply as a whole. That is to say, the Government, UNFPA, WHO, Donors, and any other person/Body interested in RH supply, should be happy that resources dedicated to the improvement of RH specific supplies have a simultaneous flow-on benefit to all health commodity supplies. Donor coordination is a key feature, and an approach that genuinely empowers local leadership is absolutely needful. Past tendencies merely to impose an external model of supply, and a tie-up of conditions that dis-empowers the local leadership, must be assiduously avoided.

2.6.4.2 Responsibility for RH and General Health Product distribution

The operational responsibility for coordination of health supply distribution services is clear, being delegated to Fiji Pharmaceutical & Biomedical Services (FPBS). But the line of accountability seems to be changing as top-level health services structures are altered in line with economic and public service reform targets. A Directorship which was established for the FPBS Service seems to be threatened, and whereas the FPBS has responsibilities for goods that affect activities in both health care and health promotion, it is not yet clear to which of
those Directorships the FPBS will report in future, nor how coordination of accountability and reporting for health supplies will be achieved.

It is possible that internal reporting lines may become multiple, and existing demands of multiple donors and helpers must be considered in the FPBS responsibility matrix. In principle, FPBS ought only to have to provide a single simple set of reports (e.g., on usage trends, forecasts, and stock outs) out of which any helper should obtain all the information they need as a subset. However, the various programs provide different inputs and have varied demands for reporting. Examples include: JPIPS and regional cold chain management; vaccine support with UNICEF; UNFPA as RH commodities supplier; and aid from donors with HIV drugs, etc. Each additional demand places an extra pressure on FPBS to cope with different modes of procurement and reporting.

### BOX 15

**Recommended Action Items on Coordinating Distribution Improvements**

- FPS should have a clear reporting line, and be empowered to create a single set of composite output reports to satisfy stock monitoring information requirements of the multiple Donors and Helpers. Helpers must agree the content and format, and be prepared to assist with any necessary software adjustments/developments.

## 2.7 CONTEXT

### 2.7.1 National Health & Population Policy

There appears to be no specific separate national policy document on Population and Development. All matters relating to this are included in the 2006 national Strategic Development Plan (SDP, 2006), currently under review by the Interim Government as it develops its ‘SEEDS’ document – the Sustainable Economic & Empowerment Development Strategy. In Chapter 7.3, Social Services, of the 2006 SDP population-related measures do not appear, but the leadership for national health policy is quite clearly stated. The goals are, from the health services viewpoint, somewhat limited, and seem to be principally governed by, and selectively directed at, achievement of the Millennium Development Goals.

There are significant key performance indicators for Health in Section 7.3.2 of the SDP (KPI table, page 192). These are all reflected in some form in the National Health Strategic Plan 2007-2011. Seven out of the eleven health KPI’s in the SDP strongly bear on RH Commodity Security. These are:

- Child mortality rates
- Immunisation rates
- Maternal mortality rates
HIV/AIDS prevalence in 15-24 year-old pregnant women

- Note: this appears to mitigate targeted reduction of two separate things: teenage pregnancy and HIV prevalence. The pursuit of HIV reduction in a specific age-pregnancy group might seem good, but it is less effective. Better results to the nation (and to the KPI’s real target groups) would accrue from greater attention paid to the reduction of teenage pregnancy, and, simultaneously, to obtaining large increases in HIV prevention.

- Contraceptive prevalence rate

- Increased participation of private sector health care providers

- Elimination of drug stock-outs

  - (Note: this target relates to a central Fiji Pharmaceutical Services figure, not to a local health facility stock measure. The measure is problematic and highly technical, and has been discussed by this Author in some detail as part of a recent WHO Consultancy Report on Pharmaceutical Strategic Planning for Fiji\(^{10}\))

2.7.2 Legislation

2.7.2.1 Medicines legislation - licensed sellers

Updated legislation exists in draft for the control and classification of medicines and other therapeutic goods. Classifications are vital, as limitations to prescription or to Pharmacy sale may limit access to RH commodities. For some goods, however, the quality assurance concerns, and the public safety issues, demand appropriate controls on who may sell/supply, and the conditions under which they are allowed to do so. Three categories of therapeutic products are recognised in Fiji medicines laws:

- Medicines that can be sold in any retail store: "general sale’;

- Medicines that can be sold through registered Pharmacies (and under the supervision of the registered Pharmacist) without prescription;

- Medicines that are limited to supply on prescription only (the valid written order of a registered medical, dental or veterinary practitioner)

A fourth category exists in nearby Jurisdictions (eg Australia, Solomon Islands) with rurality problems of access to essential medicines similar to those in Fiji. It is that of Licensed sellers - persons who, from the registered premises specified in the licence, may sell any and all products for which the license is granted. This does not usually apply to prescription medicines, but does allow an extended range of items to be sold or supplied under controlled conditions where there is no immediate supply available via a registered pharmacy per se, or where there is no Doctor.

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\(^{10}\) R F Skinner, WHO/WPRO, 2008 (draft). Strategic Planning for Pharmaceutical Services in Fiji.
It is unclear if Licences to sell or supply medicines and other RH goods are expected to be allowed in Fiji, under the revised laws and rules, to suitable people working from suitable premises. It may be reflected in the existence of prior “Community Pharmacies” – which may be misleading, conflicting with the community services of a registered Pharmacy. This category of “licensed seller” is essential to have if a ruralised nation, with limited professional qualified staff, is to avoid over-limitation of supply, and where access to essential medicines and other health goods needs to be quickly improved (while maintaining the appropriate quality-protective conditions for acquisition, storage, supply and sale). A range of RH commodities already fall into the Pharmacy-only category, but that may not be reaching very far. Having more of the Licensed Seller category can help.

2.7.2.2 Emergency Supply by Pharmacists

Rules exist on the supply of prescription medicines by pharmacists in circumstances of emergency. This is different from the supply of “emergency contraception”, which is a standard Pharmacy-only type item.

Supply by pharmacists of prescription-only medicines is permitted in certain urgent circumstances, particularly where medicines have been lost or stolen, and treatment has been already legitimately prescribed, and must be carried on, but it is not practicable to obtain a prescription immediately. These conditions are not conducive to the increased supply by pharmacist of important urgent treatments such as one-dose STI packs. Some deregulation, or re-scheduling of such items would be needed if a faster private sector response to STI were to be available via Pharmacies.

2.7.2.3 Other laws relating to RH

This report does not consider other laws that might restrict access to RH commodities, but mention has been made of limitations of Nursing, and barriers to access through items that are limited by professional qualification. The eventual planning of action Items may turn up a number of areas where laws may require attention such as:

- Health professional laws and rules – particularly on Liability;
- Trade rules and Customs (eg duties and taxes on RH goods);
- Rights laws, and privacy (personal information about RH activity);
- Public Health – disease notification, etc;
- Family law, and conflicts of rights of parents/adolescents/children;
- Gender & Other anti-discrimination rules;
- Local law/custom/traditions, particularly on family and religion.
2.7.3 Society, Values and Culture

The multi-cultural aspect of Fiji demands attention to varied views on health, disease, family matters, and sexual mores. Observation indicates that health professionals have high levels of concern about the ongoing presence of stigma in FP and in wider RH issues such as HIV and its prevention. There are also varied attitudes to Conscience and the use of contraceptive products.

It would seem that considerable efforts will have to be maintained over a long period to achieve appropriate cultural changes, especially if unmet need for family planning are to be met (as was mentioned under Quantification, Section 2.2.3). The main agent of change is appropriate education, together with “personal encounter” - which opens up many possible local activities along the Public Relations line, involving such entities as iconic figures, celebrities, culturally important people, friendship-based strategies, and (perhaps most significantly for the religious context) ‘discipleship’ and cells, both of which are essentially forms of mentoring (one on one, or one-to-group).

A valid question is to be posed: **What are the entry points into people’s understanding and what will increase their motivation – which can assist to improve the uptake of RH services, and facilitate a fuller expression of demand?** This report recommends that this broad socio-medical issue become the subject of specific thought, perhaps as part of the sort of planning sessions mentioned in Section 2.6.1; the sort of sessions that are needed to be run by or for an early group leading the effort to refresh and enhance RH outcomes, including better reproductive health commodities security.
Recommended Action Items on Improving the Context

- Revise the Action Plan to adopt national goals and show how RHCS issues will contribute to their fulfilment, and how a do-nothing option will continue to adversely influence important health outcomes.

- Check the status of national policy documentation, such as the SEEDS and related types of over-arching national develop strategy, and align RHCS planning.

- Encourage RHCS planners to consider key aspects of each action-strategy:
  * information technology and management reporting
  * relevant indicators on outcomes (monitoring and evaluation of the item)
  * legislative and policy relating to the item
  * HR development – workforce/establishment, and training
  * operational management (item/activity, budget, responsibility, location, time)
  * capital: required facilities and equipment (new, or updated).

- Consider re-listing of RH pharmaceutical commodities where possible to enhance possibilities of improving access through more suppliers (eg licensed sellers).

- RHCS group to identify what social issues are barriers to access, and how these may be overcome, using educational and other approaches.

- “Empowering public understanding” can become a fresh banner for achieving more acceptance of RH services, and increasing uptake of commodities.
SUMMARY OF RECOMMENDATIONS

This is the consolidated list of recommended items for Strategic Planning (Action Items).

Demographic and Data areas of RH Services

1. Update the national quantification formulae for Reproductive Health Commodity forecasting with the 2007 Census data and trends. Note: in an integrated system of supply, such as Fiji has, this may also strengthen forecasting for a wide range of health goods.

2. Institute a regular feedback Bulletin of national summary health information to all Service Delivery Points, with comparative statistics by Division and Sub-Division, so that each SDP can see how they are doing relative to their local area and the national situation. Note: This could possibly be a specific RH bulletin (parallel to the EPI one), but SDPs really need a Bulletin with all-services information, not just ‘family planning services’.

3. Senior Health Managers to be given a direct electronic access to the health service data in the Information System, including RH services monthly statistics and trends.

4. Update the monthly consolidated health information report with current RH Products

5. Ensure the Fiji curricula in Health (Human Studies) has content and aims consistent with national health goals, especially in the RH area. That is: ensure the right ‘health messages’ are reaching children and young people, in appropriate ways at the appropriate early stages in life.

6. Plan for multi-skilled Teams, perhaps on a Sub-divisional basis, to extend an integrated package of primary care items through outreach, by: a) scheduled visits to Health Centres & Nursing Stations, and/or b) by visits to remote islands/communities.

7. Make monthly or quarterly RH item reporting (numbers issued, total costs) mandatory for Private Hospitals, Pharmacies, NGOs and dispensing/supplying GPs. Note: this can be readily done via a simple IT system report that flags RH items as a formal subset of their inventory.

Uptake/Utilisation Trends, and related data

8. A fresh needs assessment for contraceptives should be designed – with real care and attention given to the various modes of condom demand (FP, CP and IC).

9. The Health Information System (or the RCHS body) should collect and include private sector data on contraceptives and other RH commodities. If not given voluntarily, such data should be compelled – see further on under Context.
10. All offices and bodies with any functions or interests allied to or affecting RHCS – senior managers, clinical and health program managers, service delivery points, etc, should receive regular adequate reports on trends of RHC utilisation. A list of these recipients needs to be made and a report designed and provide within the integrated health information system.

11. Adopt Couple-Years Protected (CYP) as a national health KPI - but care must be given to its definition and is calculation.

**Improving Needs/Demand Assessment**

12. Consider the creation of a national Network of health staff involved in RH, for information exchange, peer review, peer education, experience sharing, benchmarking, and as a channel and facilitator of RH services review and planning.

13. Empowerment of local health staff to share experiences, data, and ideas for the local review of services, and to act more effectively as the Agents for client demand.

14. Quality improvement to be considered as a refresher topic, to enable local service and performance review, and improvement planning, within existing budget, or funded out of the benefits/savings which may appear in any improvement exercise (shared gains).

15. A study of the cost-benefit of a proposal to enable nurse practitioners to insert hormonal implants and or IUC Devices.

16. The classification and terminology surrounding condoms needs to be clarified, both in the national inventory, and in national and local health promotion strategies.

**Accessibility - Other**

17. Monitor retail prices, and strengthen public choice by publishing a comparison of contraceptive prices from all sources – data to be compelled if necessary.

18. Review status of contraceptive items in the Fiji Bulk Supply Scheme, and consider price controls on key items.

19. Consider how the national controls of Pharmacy affect equity of access by ensuring the appropriate location of Pharmacy, and other medicines outlets such as dispensing Doctors.

**Inventory, Listing, Reporting**

20. The useful concepts of the WHO-type essential medicines framework should be adopted for use a guide to the management of RH commodities: some of the commodities are in any case essential medicines; and the concepts can guide other commodity types (eg medical consumables and equipment); and coherent strengthening of a generic system (that can handle RHCS) will deliver wider benefits across the whole of health.
21. The Fiji EM lists need a fresh form to which updates can be readily added, and updates need to be published as and when required (not pulsed every few years).

22. The national health inventory system’s item classifications need to be revisited, and reworked in terms of the required reporting outputs. Item classifications in the inventory systems, for RH and FP, must be considered carefully, as many items have multiple uses (not merely for FP or RH).

23. Class C items (volume classification) should be carefully tagged to avoid distortion of the number of lines in “stock out” figures – what are the “non-stock” items?

24. Stock monitoring, including stock-out rates, should be automated in the LMIS from the data already being routinely captured off the periodic stock reports.

25. Monitoring of stock out durations will require particular sample studies.

**Non-drug supplies**

26. Regular budget amounts should be earmarked each year, for defined categories of clinical equipment purchase. Single point accountability needs to be identified in the Health system for managing small clinical equipment.

27. A rolling program of equipment replacement should be considered, with a regular method of equipment status reporting, parallel to that used for reporting stock status of ordinary medical supplies.

28. The national standard for clinical equipment at the different levels of care should be regularly reviewed, and must include appropriate sets for the various RH services.

**Quantification of RH Commodities**

29. Quantification for RHC should be done in the PIC logistical context, balancing convenience and value. If best prices are to be obtained, and freight costs are not to be excessive then convenient regional sources (e.g., NZ) may not be used, nor may bulk supply routinely be airfreighted.

30. If reliable forecasting is to be done, in a context of past supply instability, and future health and economic uncertainty, then multiple modes of quantifications should be done and compared. Special attention must be paid in the light of hidden demand, and recent stock-outs.

31. The 2007 Census data should be combined with the most reliable demand indicators – going back if necessary to usage figures based not on 2007/8 but on those that reflect a more regular stock flow situation in the “best recent previous year”, and carrying these forward, with additional allowances for the current priorities for the improvement of Reproductive Health services.
Procurement of RH Commodities

32. Options for forward contracting should be reviewed with the 3rd Party supplier, and forecasts updated in the logistical context to improve the amounts being delivered in the contracted tranches.

33. FP items, so tagged in the Inventory, should be procured together as a new Tender Lot, even if the ‘Tender’ is restricted by a given MoU to a single preferred Supplier.

34. Items that are general medical supply items, but critical to reproductive health, should be so tagged in the inventory system, to enable more frequent particular reports to be more easily drawn out, to monitor more closely their stock status and usage.

35. The ABC classification may not express RH or other specialised health priority, and should be used with caution as the leading procurement indicator.

36. Parameters for machine-generated predictions of order quantities must be set to fit with the logistical realities, and not based on assumptions of “annual” ordering.

Supply Systems used for RHCS

37. The integrated central I.T. at the FPS, which also tracks stocks at Divisional level is good, but unlikely to be useful at other levels – it lacks a pharmacy service front-end for patient issues (ie dispensing). Exploration is required of a good value integrated suite for pharmacy/inventory to be provided at the Divisional and further levels of supply (Health Centres and Hospitals). One example, being used in other PICs, is mSupply®.

38. Combine the FP items into one consistent stock list of Commodities for supply to the health facilities (SDPs), to strengthen a single, integrated supply system.

39. Trial a reform of supply methods, and verify benefits of a decentralised supply activity with the aims of:
   * shortening the supply interval and having supply from a more local point, in place of all orders being serviced by the FPS at Suva
   * adopting a ‘floating point’ technique from elsewhere [or simplify the method used for FP items, which has similar effect, but is more complex for the staff at SDPs].
   * using fixed maximum imprest only for very short-lead SDPs (eg supply to wards by a hospital pharmacy), and using floating point methods more appropriate to any site with a longer lead time.

Quality Assurance of RH Commodities

40. Review the Fiji Pre-Qualification Standard to allow for inclusion of Suppliers of international “unregistered” generics (eg IDA, et al) whose quality assurance system
has passed assessment by acceptable benchmark Agencies (eg FDA, USA).

41. QA reporting and investigation. Check that these product queries were received, investigated and answered, including implications for the implementation of the Fiji pre-qualification standard.

42. Review the process for QA problem reporting, and check recall procedures.

Quality Use of Medicines

43. Consider the benefits of monitoring the medicines situation using the WHO set of Indicators (Level 1, 2, 3) - indicators Structure, Process, and Outcomes in access and quality use of medicines (QUM).

44. Consider how to apply QUM to plan improved outcomes in STI, and other RH related conditions, both as a means to disease control, and reduction of HIV vulnerability.

Commitment

45. Verify the status of national plans and policies affecting population health and RH.

46. Identify the best organisational point of accountability within Health to lead a Group which can plan and implement improvements in RHCS - NB: commodities security may not be a sufficient agenda, whereas improving RH service outcomes might be.

47. UNFPA to advocate for coherence in monitoring various RH outcomes, and suggest a fresh approach to be taken with a RH coordinating group.

48. Apply external support to the initial formation of an RH improvement group.

Capital

49. MoH should investigate the existence and terms of any MTEF for the next 5 years, and ensure a proper negotiating place to help develop one, in terms of gaining a robust future for health funding.

50. The FPS should examine its inventory, and all proposed therapeutic approaches, to identify and budget for the high cost and Specialist items.

51. Acute care and preventive care programs should receive equitable proportions of core supply budgets, and, where possible a Health Program should ensure that the FPS is well informed of its advance requirements.

52. Primary care services (incorporating all ordinary RH services), and secondary care services should be allocated appropriate levels of funding for “core supply”. This can be benchmarked at, say, a minimum USD10 per capita, per annum (referenced to a
given year to allow for inflation and currency shift).

53. Funding for specialist goods required by tertiary care (specialist health services) should be budgeted separately from core supply. Program funding by clinical services could be considered (eg Directorate funding for HIV-AIDS program, oncology services).

Capacity Building (IT, HR, Lab)

54. A think session leading to a new approach in IT for health is needed, on the creative use of modern IT (eg: smart-phones) for data collection and various kinds of health communication (referral, services advice, receipt of bulletins, stock reports/ordering, etc).

55. The national oversight of RH must consider the lack of Public Heath specialists and the effects on RH outputs of zone services being drawn back into acute care.

56. MoH should ensure effective liaisons between Laboratory services and the Biomedical program to minimise downtimes and ensure local continuity of basic diagnostic tests.

RHCS planning and outcome improvement

57. Use existing plan items updated with items from this 2008 Report, and refresh with views from a small stake-holder round table meeting (mini-workshop).

58. Focus on showing how improving RH (which will over-arch RHCS) will help to fulfil existing national goals as stated in Government and Ministry documents. Particular emphasis should be given certain positive and negative aspects:
   a) methods for locally empowered service outcome improvement
   b) what would happen if nothing is done – the adverse impact of a “do nothing” scenario – impact of current adverse trends, further failure, etc.

Coordinating Distribution Improvements

59. FPS should have a clear reporting line, and be empowered to create a single set of composite output reports to satisfy stock monitoring information requirements of the multiple Donors and Helpers. Helpers must agree the content and format, and be prepared to assist with any necessary software adjustments/developments.

Improving the Context

60. Revise the Action Plan to adopt national goals and show how RCHS issues will contribute to their fulfilment, and how a do-nothing option will continue to adversely influence important health outcomes.
61. Check the status of national policy documentation, such as the SEEDS and related types of over-arching national develop strategy, and align RHCS planning.

62. Encourage RHCS planners to consider key aspects of each action-strategy:
   * information technology and management reporting
   * relevant indicators on outcomes (monitoring and evaluation of the item)
   * legislative and policy relating to the item
   * HR development – workforce/establishment, and training
   * operational management (item/activity, budget, responsibility, location, time)
   * capital: required facilities and equipment (new, or updated).

63. Consider re-listing of RH pharmaceutical commodities where possible to enhance possibilities of improving access through more suppliers (eg licensed sellers)

64. RHCS group to identify what social issues are barriers to access, and how these may be overcome, using educational and other approaches.

65. “Empowering public understanding” can become a fresh banner for achieving more acceptance of RH services, and increasing uptake of commodities.
ANNEXES

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ANNEX A
List of People Met and Interviewed

<table>
<thead>
<tr>
<th>Agency</th>
<th>Name of Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH Central Office:</td>
<td>Dr Josaia Samuela, National Adviser, Family Health Unit</td>
</tr>
<tr>
<td>Fiji Pharmaceutical and Biomedical Services Centre</td>
<td>Apolosi Vosanibola, Acting Chief Pharmacist</td>
</tr>
<tr>
<td>The ‘Oxfam’ Clinic for R/Health</td>
<td>Dr Mere Turagabaci, Sr Akeneta Matanitobua</td>
</tr>
<tr>
<td>Nausori Health Centre</td>
<td>Dr Susana Makalevu, Sub-Division Medical Officer</td>
</tr>
<tr>
<td>CWMH Pharmacy</td>
<td>No specific interview.</td>
</tr>
<tr>
<td>Private Pharmacy</td>
<td>No specific interview – some observations only.</td>
</tr>
<tr>
<td>Nadi District Hospital</td>
<td>Dr Tupo Raqona, O&amp;G/Maternity Services</td>
</tr>
<tr>
<td>Nadi Health Centre</td>
<td>Sr Amelia Railaka, Sister in Charge</td>
</tr>
<tr>
<td>Western Health Service</td>
<td>Dr Tharid Ali, General Manager, Community Health</td>
</tr>
<tr>
<td>Lautoka Health Centre</td>
<td>Sr Filo, Sister in Charge</td>
</tr>
<tr>
<td>Yanuya Nursing Station</td>
<td>S/Nurse Vani (seen on the visit to Lautoka Health Centre)</td>
</tr>
<tr>
<td>‘Healthchek’ Clinic, The Marie Stopes Intl clinic facility, Suva</td>
<td>Dr M Violet, Director</td>
</tr>
<tr>
<td>Ministry of Finance, National Planning Unit</td>
<td>Mr Mosese Qasenivalu, Principal Economic Planning Officer (Sectoral/Regional)</td>
</tr>
</tbody>
</table>
**ANNEX B**

Recommendations of the 2005 Fiji RHCS Assessment Report

**Country:** FIJI

**Reference:** 2005 Assessment Report

**Date of review:** 6-10 October 2008

<table>
<thead>
<tr>
<th>Recommendations from 2005 Report</th>
<th>Status of implementation</th>
<th>Remarks</th>
<th>Future Steps/ Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>A National Working Group (NWG)/Coordination Committee for RHCS should be established under the</td>
<td></td>
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<tr>
<td>chairmanship of the Chief Executive Officer of the MoH to provide the framework for</td>
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<tr>
<td>coordination, policy dialogue, advocacy as well as monitoring the implementation of RHCS in Fiji.</td>
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<tr>
<td>The National Working Group should form a NWG/Coordination subcommittee with Scope of Work/Terms</td>
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<tr>
<td>of Reference (TOR) clearly defined for development of the National RHCS Strategy.</td>
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<tr>
<td>Training on forecasting using appropriate forecasting software should be undertaken for</td>
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<tr>
<td>relevant personnel at Fiji Pharmaceutical Services (FPS) Centre. UNFPA could provide technical</td>
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<tr>
<td>assistance (TA) for the technical training in forecasting for FPS Centre staff, using</td>
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<tr>
<td>Spectrum, CCM etc.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations from 2005 Report</th>
<th>Status of implementation</th>
<th>Remarks</th>
<th>Future Steps/ Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training (formal workshop and on-the-job training) of government staff at different levels of</td>
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<tr>
<td>the pipeline on forecasting, quantity to order, procurement, inventory control, stock monitoring,</td>
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<tr>
<td>logistics management information system (LMIS) and storage should be undertaken.</td>
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<tr>
<td>Training in Family Planning should continue for upgrading technical skills of service providers</td>
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<tr>
<td>in all divisions at all levels. A widened contraceptive choice to include Emergency</td>
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<tr>
<td>Contraceptive Pills (ECP), Norplant and female condom as well as basics of RHCS should be</td>
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<tr>
<td>essential elements of the training.</td>
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<tr>
<td>A widened choice of contraceptives and RHCS issues should be included in updating of the</td>
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<tr>
<td>family planning (FP) manual and in the subsequent training of FP service providers.</td>
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</tr>
<tr>
<td>Recommendation from 2005 Report</td>
<td>Status of implementation</td>
<td>Remarks</td>
<td>Future Steps/ Modifications</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
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</tr>
<tr>
<td>Linkage between the current financial, inventory control and distribution software (Financial Management Information System - EpiCore) and the current warehouse management software in FPS Centre needs to be implemented to facilitate integrated and comprehensive commodity management. Support for procurement of this software is strongly recommended.</td>
<td></td>
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<tr>
<td>Mechanisms for quality assurance should be developed for ensuring viability of contraceptives and other reproductive health (RH) commodities at all levels of the pipeline management.</td>
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<tr>
<td>The existing essential drugs list should be reviewed and updated every 2 years to facilitate wider availability of RH commodities and contraceptives.</td>
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</tr>
<tr>
<td>MoH should continue to procure contraceptives and other RH commodities for its regular supply through UNFPA under a cost reimbursable memorandum of understanding (MoU). UNFPA should consider funding the shortfall for contraceptives as well as emergency supplies for contraceptives and other essential RH commodities.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation from 2005 Report</th>
<th>Status of implementation</th>
<th>Remarks</th>
<th>Future Steps/ Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve effective mechanisms for achieving sustainability of RHCS, consideration should be given to:</td>
<td></td>
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<tr>
<td>1. incorporating RHCS issues into relevant national level policy dialogue, health sector reform and other regional and national policy framework;</td>
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<tr>
<td>2. developing a multi-year RHCS resource mobilization plan; and</td>
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<tr>
<td>3. developing public-private partnerships for cost recovery schemes for contraceptives.</td>
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</tr>
<tr>
<td>MOH should consider supporting the implementation of a Demographic Health Survey (DHS), to provide the basis for evidence-based planning, forecasting and programming for RHCS as well as other aspects of RH especially FP.</td>
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</tr>
</tbody>
</table>
## ANNEX C

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Major Activities</th>
<th>Focal Point/ Responsible Unit</th>
<th>Timeline</th>
<th>Estimated Cost with Source(s)</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| 1. Functioning National RHCS Coordination Committee/ NWG established | a) Identify focal point in the MoH  
   b) Develop/finalize the TOR  
   c) Prepare/identify and invite the stakeholders as members including the allied govt. ministries and departments  
   d) Organize the first meeting  
   e) Organize 3 monthly meeting during the first year, and 6 monthly in the subsequent years. | CEO/MOH  
CEO/MOH  
CEO/MOH  
CEO/MOH  
Family Health National Adviser | Q3, 2005  
Q3, 2005  
Q4, 2005  
Q4, 2005  
Q 1,2,3,4 2006/2007 | MOH  
MOH  
MOH/UNFPA  
$500 (UNFPA)  
$3,000 (UNFPA) | MOH FH Adviser to be focal point and UNFPA to provide technical assistance, as needed. UNFPA could also act as a secretariat. |
| 2. National RHCS Strategy Developed | a) Form a NWG Subcommittee with Scope of Work/TOR clearly defined. MoH/CEO as the chair with representation from all relevant govt. sectors, donors and other counterparts.  
   b) Review the current RHCS assessment report and other reviews and reports  
   c) Prepare a draft RHCS strategy document and circulate for stakeholders' input.  
   d) Finalize and endorse from the highest government authority.  
   e) Disseminate | CEO, MoH  
NWG  
NWG Subcommittee  
CEO  
NWG | Q4, 2005  
Q1, 2006  
Q2, 2006  
Q3, 2006  
Q4, 2006 | MOH Resources  
MOH Resources  
MOH Resources  
MOH Resources  
$2,000/UNFPA | -MOH coordinate National RHCS strategy development  
-UNFPA provide TA |
<table>
<thead>
<tr>
<th>Outputs</th>
<th>Major Activities</th>
<th>Focal Point/Responsible Unit</th>
<th>Timeline</th>
<th>Estimated Cost with Source(s)</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| 3. National Capacity on RHCS enhanced                                  | a) Training/TA on forecasting personnel at FPS and introduce forecasting software  
   b) Training (formal workshop and on-the-job training) of govt. staff at different levels on forecasting, procurement, inventory and stock monitoring, recording/reporting  
   c) Include RHCS and widen contraceptive choice to include ECP, Norplant and Female condom in updated FP manual and in training of FP | National Adviser Family Health UNFPA | Q4, 2005 | $5,000                        | UNFPA provide TA |
|                                                                        |                                                                                                                                                                                                              |                                   | Q1 2006  | $30,000 (UNFPA/ AusAID)       | UNFPA provide TA |
|                                                                        |                                                                                                                                                                                                              |                                   | 2005/6   | MOH resources                | UNFPA provide TA |
| 4. A functioning integrated Comprehensive Warehouse Management System for FPS CENTRE | a) Review appropriate warehouse mgt. software that can be integrated with the present FMIS and warehouse management software  
   b) Allocate/mobilize required resources for procurement of software e.g. LMIS and technical assistance  
   c) Arrange training for the FPS CENTRE staff.  
   d) Introduce the comprehensive system. | FPS CENTRE                         | Q3, 2005 | MOH ($250,000)/ UNFPA to further explore with MOH ($5,000)/UNFPA | MOH and UNFPA undergoing further discussion |
<p>|                                                                        |                                                                                                                                                                                                              |                                   | Q1-2, 2006 | MOH                         | MOH and UNFPA undergoing further discussion |
|                                                                        |                                                                                                                                                                                                              |                                   | Q2, 2006  | MOH                         | MOH and UNFPA undergoing further discussion |
|                                                                        |                                                                                                                                                                                                              |                                   | Q3, 2006  | MOH                         | MOH and UNFPA undergoing further discussion |</p>
<table>
<thead>
<tr>
<th>Outputs</th>
<th>Major Activities</th>
<th>Focal Point/ Responsible Unit</th>
<th>Timeline</th>
<th>Estimated Cost with Source(s)</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| 5. An essential drug list with all RH commodities and contraceptives in place | a) Review the existing EDL in consultation with relevant UN and other organizations  
b) Develop a revised list to include all contraceptives and necessary RH commodities  
c) Circulate (wider) for experts opinion  
d) Finalize and disseminate | MOH, UNFPA, UNICEF, WHO NWG/MOH CEO/MOH MOH | 2006  
Q1-4, 2006  
Q1,2007  
Q2,2007 | MOH resources | TA from UNFPA  
Utilise existing EDL committee |
| 6. Effective mechanisms for sustainability on RHCS explored/developed and initiated | a) Incorporate RHCS issues into relevant national level policy dialogue, e.g. HSR, etc.  
b) Develop a multi-year RHCS resource mobilization plan  
c) Provide emergency/ buffer stock of contraceptives for next 2 years  
d) Explore social marketing with some cost recovery initiatives with NGOs | NWG/MOH NWG/MOH UNFPA NGO partners | 2006-2007  
Q1, 2007  
Q3, 2005, Q1, 2007  
Q1-2, 2007 | MOH resources  
MOH to incorporate with RHCS strategy  
$150,000/UNFPA  
75,000 for first 2 yrs | MOH, UNFPA technical assistance, if needed.  
Govt to explore diversified funding options after 2 yrs.  
MOH to network with NGO partners |
ANNEX D

Recent Quality Assurance Queries, RH Commodities, Fiji

1 Intra-Uterine Device: Copper-T 380

Public stock at FPS Product reportedly sourced/manufactured in India

Batch No: not reported. Multiple batches affected? Not clear

Problem: The IUD removal thread detaches in-vivo, within the normal product life.

Evidenced by:
1. Thread breaks off on attempted scheduled removal of the IUD at a Clinic; or
2. Concerned patients come in with a thread hat has detached; or
3. Patients come for scheduled or referred IUD removal, and no thread is found; but the IUD itself is still in place (observed by sonic scan).

Consequences:
1. some patients had to be referred for O&G surgical removal of IUD
2. bad publicity, and highly adverse word-of-mouth advertising
3. demand for older or alternative products to be kept and supplied
4. impaired public confidence and fear of possible contraceptive failure
5. damaged service credibility
6. lack of public confidence in QA, sourcing, and procurement

2 Gloves – unclear if Surgeons, or Examination

Batch – not reported. Suspected multiple. Clarification needed.

Problem: some gloves found holed or split on opening original packaging.

Risk: failure of two-way barrier product in infection control.

Note: Nurses lay aside the damaged gloves, and use the others apparently undamaged from the same pack. That might be a reasonable and thrifty response if the problem is merely one, say, of packing (eg machinery catches and tears an occasional glove) as in this case the gloves are being formed in proper fashion, and damaged afterwards. It is not a proper response if the observed problem means that glove production itself – when the glove is actually formed – is inconsistent. In that case some of the gloves may look OK, but actually may not be made to specification, and therefore they may fail to cover the IC risks even though apparently undamaged. In the latter case it is essential that the entire pack must be laid aside and reported/retuned.
ANNEX E
Suggested Strategic & Operational Planning Framework 2009 et seq

1 A Strategic Planning Frame

Strategic Plans take the longer term view. Not immediately bound by cost, but must be politically feasible in terms of being accepted into the MTEF or similar national financial or economic plan.

<table>
<thead>
<tr>
<th>Element or Current Issue of concern</th>
<th>Outcome measure (the Key Indicator)</th>
<th>Status at Sept 2008</th>
<th>Policy Goal or National Target</th>
<th>Activity (Strategy)</th>
<th>Person responsible</th>
<th>Activity Cost (estimated)</th>
<th>Proposed Funding source(s)</th>
<th>Target</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the matter?</td>
<td>How do we measure the matter?</td>
<td>Using that measure, where are we with in this matter?</td>
<td>Where should be with it?</td>
<td>How do we think we can get there?</td>
<td>Who will lead us there?</td>
<td>What (roughly) will it cost? Per year, per unit, or across the plan period.</td>
<td>From where, do we know or think those funds should or will come from?</td>
<td>Status to achieve on the way to the Goal in Column 3</td>
<td>Date by which the target must be achieved</td>
</tr>
</tbody>
</table>
2. An Operational Planning Frame

Such plans are short-term, and often may be capped within an annual budget allocation envelope, plus any available non-budget funds, such as those from projects, inter-country program support, direct donations, etc.

Routine activities, or core business items, must come first, followed by new initiatives and fresh mandates already planned under strategic allocations. It is rare to get $ allocations for new items on a operational plan that have not been previously been budgeted at the Strategic level. To do so they must have very clear priorities; they must be shown to be both urgent and of high importance. That may means specifying critical risks to be avoided or minimised, as well as stressing the benefits expected (eg improvement of performance under a key indicator).

<table>
<thead>
<tr>
<th>Activity (Strategy, from plan above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break these down into costed tasks where necessary</td>
</tr>
<tr>
<td>Input staff (main HR resources)</td>
</tr>
<tr>
<td>Other input resources</td>
</tr>
<tr>
<td>Activity Cost (closely estimated)</td>
</tr>
<tr>
<td>Proposed Funding source(s)</td>
</tr>
<tr>
<td>Target (from the Strategic Plan)</td>
</tr>
<tr>
<td>Actual Achievement (use Outcome measure, as defined in Strategic plan)</td>
</tr>
<tr>
<td>Date of measuring achievement</td>
</tr>
<tr>
<td>Performance on the year (see note below)</td>
</tr>
<tr>
<td>Cost (closely estimated)</td>
</tr>
<tr>
<td>Proposed Funding source(s)</td>
</tr>
<tr>
<td>Target (from the Strategic Plan)</td>
</tr>
<tr>
<td>Actual Achievement (use Outcome measure, as defined in Strategic plan)</td>
</tr>
<tr>
<td>Date of measuring achievement</td>
</tr>
<tr>
<td>Performance on the year (see note below)</td>
</tr>
<tr>
<td>Break these down into costed tasks where necessary</td>
</tr>
</tbody>
</table>

Specify currency and any conversion factors

Call this “A”

Call this “T”

> > becomes the ‘status’ when reviewing for the next planning round

% = A / T x100

100% = on target

<100% = not up to target

>100% = out-performed

Core roles

Agreed new items

Externally funded items

Priority new items not previously planned

Other items $ permitting

NOTE: if a performance improvement measure is required, then compare current achievement “A” with the previous status (from the Strategic Plan above)
ANNEX F

Other Documents Reviewed & End Notes

In addition to the references noted in the text, the following documents were reviewed and utilised:


Fiji Islands Government, Ministry of Finance and National Planning, 2006. *Strategic Development Plan 2007 – 2011; Parliamentary Paper No 92 of 2006*. NOTE: *This document was superseded by the Interim Government’s development (in 2007-8) of the Sustainable Economic and Empowerment Development Strategy (SEEDS), which as of the date of this report was in late draft and not yet published*. The SEEDS document reportedly retains the 2006 SD Plan goals and strategies that are relevant to general population health matters in principle (and thus to Reproductive Health by implication). In these matters it is therefore reasonable, as this report does, to utilise the 2006 document for help in looking to the likely future of RCHS in Fiji. RHCS issues may also be involved in the *People’s Charter* - another national document reportedly in draft as a working document in October 2008.


