# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>6</td>
</tr>
<tr>
<td>Acronyms</td>
<td>7</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>8</td>
</tr>
<tr>
<td><strong>1.0 INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.0 SITUATION ANALYSIS AND ISSUES</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 CONTEXT</td>
<td>14</td>
</tr>
<tr>
<td>2.2 CLIENT UTILIZATION &amp; DEMAND</td>
<td>20</td>
</tr>
<tr>
<td>2.2.1 SERVICES AVAILABILITY &amp; UTILISATION</td>
<td>20</td>
</tr>
<tr>
<td>2.2.2 CONTRACEPTIVE USE &amp; TREND</td>
<td>21</td>
</tr>
<tr>
<td>2.2.3 UNMET NEED FOR CONTRACEPTION</td>
<td>22</td>
</tr>
<tr>
<td>2.3 COMMODITIES</td>
<td>26</td>
</tr>
<tr>
<td>2.4 COMMITMENT</td>
<td>30</td>
</tr>
<tr>
<td>2.5 CAPITAL</td>
<td>34</td>
</tr>
<tr>
<td>2.6 CAPACITY</td>
<td>38</td>
</tr>
<tr>
<td>2.6.1 SERVICE PROVIDER SKILLS</td>
<td>38</td>
</tr>
<tr>
<td>2.6.2 LOGISTICS MANAGEMENT</td>
<td>38</td>
</tr>
<tr>
<td>2.6.3 FORECASTING</td>
<td>43</td>
</tr>
<tr>
<td>2.6.4 PROCUREMENT</td>
<td>44</td>
</tr>
<tr>
<td>2.6.6 MONITORING and EVALUATION</td>
<td>46</td>
</tr>
<tr>
<td>2.7 COORDINATION</td>
<td>49</td>
</tr>
<tr>
<td><strong>3.0 CONCLUSION</strong></td>
<td>51</td>
</tr>
</tbody>
</table>
LIST OF ANNEXES

ANNEX I  Vanuatu Next Steps for RHCS 2006  53
ANNEX II  Forecasted Contraceptive Requirements for 2009 - 2014  54
ANNEX III  List of references  55
ANNEX IV  List of people met during consultancy  56
ANNEX V  Terms of Reference for Vanuatu Consultancy  57
ANNEX VI  Literature Desk review of other UN work In Vanuatu  62
ANNEX VII  IMPLICATIONS OF other HEALTH PLANS for the planning of RH and RHCS in Vanuatu  65
ANNEX VIII  Stock card  68
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 Vanuatu. The Pacific RHCS Plan of Action (PoA) was developed in 2003 and signed by the Minister of Health of Vanuatu. 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 Vanuatu Director General, Ms Myriam Abel, for her support during this consultancy and to the Director of Public Health, Len Tarivonda for his kind assistance. Gratitude is also extended to all who have contributed to this report, including the Head of the Central Medical Stores, Steven Hosea; RH Co-ordinator, Apisai Tokon; the RHCS Officer, Marie Jean Baptiste; the IT Officers from the six Provinces; the Pharmacy Officers; the RH Supervisors and the Central Medical Stores staff of the Ministry of Health. 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 acknowledgements are extended to the RHCS Manager, Mr Peter Zinck, who undertook this review and wrote this report and to the Technical Advisor for Health Systems and RHCS, Dr. Annette Sachs Robertson, who provided technical assistance. Without the support and contribution of the aforementioned persons, departments and organizations this report would not have been possible.

Mr Najib Assifi
Director, Pacific Sub-Regional Office & UNFPA Representative
ACRONYMS

AMC  Average Monthly Consumption
AMI  Average Monthly Issues
AQI  Annual Quantity Issued
AUS AID  Australian Agency Aid
CBOs  Community Based Organisations
CCM  Country Commodity Manager (software)
COC  Combined Oral Contraceptive
CMS  Central Medical Stores
CPR  Contraceptive Prevalence Rate
CST  Country Services and Support Team
CYP  Couple Years of Protection
DHS  Demographic Health Survey
ECPs  Emergency Contraceptive Pills
FC  Female Condom
FP  Family Planning
GDP  Gross Domestic Product per capita
HIV/AIDs  Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome
ICPD  International Conference on Population and Development
IPPF  International Planned Parenthood Federation
IUCD  Intrauterine contraceptive device
LMIS  Logistics Management Information System
MDG  Millennium Development Goal
MM  Method Mix
MoH  Ministry of Health
MOS  Months of Stock
MoU  Memorandum of Understanding
NMTC  National Medicines & Therapeutic Committee
NSA  Non State Actors
O&G  Obstetrics and Gynaecology
PI Cs  Pacific Island Countries
QTO  Quantity To Order
RH  Reproductive Health
RHCS  Reproductive Health Commodity Security
SCF  Save the Children’s Fund
SDPs  Service Delivery Points
SPARHCS  Strategic Pathway to Reproductive Health Commodity Security
SOh  Stock on Hand
STGs  Standard Treatment Guidelines
STI  Sexually Transmitted Infection
SWAp  Sector Wide Approach
TOR  Terms of Reference
UNFPA  United Nations Population Fund
WHO  World Health Organisation
This Reproductive Health Commodity Security (RHCS) Situational Analysis Report is an update of the 2007 Report. The Report has been prepared to provide an assessment of the RHCS situation in Vanuatu’s Ministry of Health (MoH). In addition, this Report is to provide a better understanding of policy and operational constraints that affect RHCS. This Report will also contribute to Vanuatu’s RH policy and RHCS strategic plan.

The RHCS Situation Analysis was undertaken through a workshop conducted for RH Supervisors from the Provinces, their IT counterparts and Pharmacy personnel. Senior Staff at the CMS were interviewed and Staff (nurses/midwives) at the Vila Central Hospital’s Pharmacy Department, the Family Planning Unit and selected health centres were visited.

Findings and recommendations have been categorised and discussed using the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework. The following key findings and recommendations have been made:

1. **Context**

   A number of long term planning policy documents have been developed by the MOH and are very supportive of RH and RHCS programs including the RH Policy and Strategy; the National FP Service Guidelines, the National STI Guidelines and the National HIV and PMTCT Plans and Guidelines. A notable absence is a National Medicines Policy that would outline the framework for the development of a Pharmaceutical Services divisions to provide a proper surveillance program for medicines imported into the country for both public, NGO’s and private sector. These medicines regulatory programs are imperative to ensure safety, quality and efficacious RH medicines and RH commodities. These programs include pre-marketing (either through a basic medicine registration process or a pre-qualification process of suppliers) and post marketing surveillance (adverse drug reaction or medication incident reporting).

2. **Client Utilization and Demand**

   Client utilisation of a wide range of services is evident at the national, provincial and sub-provincial levels.

   Consideration should be given to the conduct of a Demographic Health Survey (DHS) or a Reproductive Health (RH) survey to ascertain contraceptive prevalence by age, income and province and to determine the effectiveness of current RH and RHCS programs through the analysis of service utilisation patterns, unmet need and perceived barriers to care. Further strengthening the Health Information System to provide timely and accurate health service statistics on RH service utilisation for national, provincial and sub-provincial use should also be considered.
3. **Commodities**

A broad range of contraceptives are available in Vanuatu. Future expansion for inclusion of implants may be worth considering. Whilst an inclusive approach is the most preferred way in extending the RH influence outside the medical fraternity, the ceiling on pricing margins on RH/RHCS commodities in the private sector needs a closer review. In addition, the charging of RH services in the public sector makes economic access to quality and comprehensive RH services a barrier also.

4. **Commitment**

The political commitments and support for RH and RHCS programs has been commendable over the years. The MoH may wish to consider in the longer term for sustainability purposes translating this level of commitment into an administrative will to commit a small allocation of funds for RH commodities including contraceptives and RH medicines from the government vote.

5. **Capital**

It is estimated that Vanuatu needs close to $80 000 (USD) for its annual contraceptive requirements annually. This figure will increase when other RH equipment and medicines are included and when an increase in uptake of male and female condoms occurs in future.

6. **Capacity**

Ongoing refresher training for health workers need to continue on a more on site training basis. For logistics management (LM) a key area focus should be on forecasting, procurement and LMIS (Logistics Management Information system). These training activities should be competence based. Consideration should also be given to an IT roll out plan “Channel software” 6 provinces and at Central Medical Stores.

7. **Coordination**

Whilst the RHCS Committee has been established and is meeting with formalised terms of reference, its formation should be extended to the provinces also to ensure proper implementation and monitoring of RHCS at National and Provincial level. The Ministry of Health take a leadership role nationally and in the provinces to ensure that all RHCS issues from the provinces filters through nationally. The deployment of an RHCS focal point should facilitate this process.

The membership should be extended to the include NGOS, CBO’s, private sector, a legal expert, Malvatumauri, and the Women & Youth representatives.
1. INTRODUCTION

1.1 Demography

Vanuatu comprises 88 islands of which 66 are inhabited. The country is divided into six provinces, namely Shefa, Sanma, Malampa, Tafea, Penama and Torba and almost 80% of its population are rural dwellers.

The geographical dispersion of these islands, the rugged mountainous terrain and the various population densities across the islands make access to reproductive health services and the delivery of RHCS commodities by sea and land a logistic challenge for health management.

1.2 Socio-economic Status

Vanuatu is a growing country with a young population, where most of the population is under the age of 30 years. While Vanuatu’s population has increased rapidly over the past decade, average annual growth in gross domestic product per capita has been primarily negative, turning positive only since 2003. With a human poverty index of 27.4, Vanuatu is ranked 52nd in the world and third poorest in the Pacific.

A looming issue is the large proportion of the population comprising youth, with 43% of the population 14 years and younger. In addition to this is the increasing trend of teenage pregnancies. These youths are about to enter the workforce with jobs being created far more slowly than the current and future inflow of young workers. In addition, Government is not fully-funding education and other public services for children. On a positive side, Vanuatu has substantial long term prospects for growth and development.

There has also been progressive improvement in key health indicators over the past 40 years with crude birth rate decreasing from 45 in 1967 to 33 in 1999. The fertility rates and infant mortality rates have seen decreases from 6.7 births per woman in 1967 to 4.5 and 123 infant deaths per 1000 live births to 25 respectively in 1999.

1.3 Health Services Delivery

Health Services are largely government funded and are provided through a decentralized health system through 5 referral hospitals, 26 health centres, 104 dispensaries and 188 First Aid Stations. A private hospital was recently opened in Port Vila. The type and quality of health services often depends on the knowledge and skill of individual health providers, working in these health facilities.
1.4 Health Budget

The major source of funding for the Ministry of Health (MoH) is the recurrent government budget, although donors provide additional funds for specific purposes. The recurrent budget of the MoH increased between 0.2% and 2.2% per annum from 1998 to 2004 except for 2000 when it increased by 7.6%. For 2004, the budget ceiling was cut by 5% from 2003 levels (after the inclusion of the Health Cabinet in the MoH budget).

Table 1: Education and Health Expenditure in Vanuatu, 1990-2005

<table>
<thead>
<tr>
<th>Health Expenditure (Mn Vatu)</th>
<th>1990</th>
<th>1995</th>
<th>2000</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>887</td>
<td>1330</td>
<td>1848</td>
<td>1972</td>
</tr>
<tr>
<td>Health</td>
<td>457</td>
<td>598</td>
<td>904</td>
<td>810</td>
</tr>
</tbody>
</table>

Source: ADB fact sheet: Vanuatu

The Government of Vanuatu’s expenditure on health per capita basis is less than half of those of the governments in Fiji, Samoa or Tonga. Public expenditure as a percentage of GDP was 2.3% in 2001, compared to 4.7% in Samoa and 2.7% in both the Solomon Islands and Fiji.

These fiscal realities require a balance to be found between expensive tertiary health care and more affordable primary health care, and demands greater efficiency in management and delivery of services. Owing to these economic challenges of a shrinking health budget and increasing demand for health services, the Ministry will be inclined to rationalise services to priority areas in great need through a disciplined workforce.

1.5 Workforce

There is a high concentration of health workers in hospitals and urban areas, with only one-third of staff working in community health services. There are staff vacancies that cannot be filled because of budget shortfalls. Vanuatu has fewer health workers per population than most other countries in the Pacific region. It is recognized that there is a gap between the health services and the health workforce that the people of Vanuatu need and what the MoH can afford to provide. The MoH has developed a Master Health Services Plan (2004 – 2009) that will identify health services to be provided at each level of the health system, including minimum staffing standards. This new Master Plan is a continuation of a previous Master Plan which covered the period 1997 – 2001. The updated Master Plan is aimed at improving the quality, coverage and relevance of Health Services in Vanuatu and provides the policy framework for preparing and implementing annual Corporate Plans for the Ministry.

Since 1999, the outcome of various reform initiatives under the 2000 and 2001 Corporate Plans have resulted in improved quality of life indicators, wider access to medical care in rural communities following the opening of dispensaries, better planning and distributions systems in place through an incremental devolution process, improved worker knowledge and skills in family health issues, an improved information system and an improved drug system.
The MoH has also developed a Workforce Plan for the period 2004 – 2013. This Workforce Plan is based on current and expected services and staffing norms, and includes assumptions about growth in demand as the population increases, workforce attrition, and improvements in the efficiency of the workforce.

1.6 Workforce Management

Vanuatu relies heavily on expatriate medical specialists and general practitioners outside of Port Vila and Luganville to provide services and supervision in a variety of specialty disciplines. It is likely that this will continue to be the case for the foreseeable future.

1.7 Maternal Mortality

Measuring maternal mortality has been a difficult exercise in Vanuatu, except where there is comprehensive registration of deaths and causes of death. For this reason, a process indicator like the proportion of births attended by a skilled health personnel attendant was reported at 88% in 1999. This is a considerable increase when compared to 1990 when it was 79%. This reveals considerable progress in Vanuatu’s health status and a general improvement in the quality and availability of health care facilities. Similarly, the contraceptive prevalence rate has increased from 15% in 1991 to 28% in 1999. The recent Multi-Indicator Cluster Study by UNICEF reported a national contraceptive prevalence rate of 37%, 83% of women attended antenatal care and 74% were delivered by a skilled birth attendant.

The 1999 National census estimated a maternal mortality ratio of around 33 maternal deaths per 100,000 live births. In 2005, there were 4 confirmed maternal deaths from all facilities, resulting in maternal mortality ratio of approximately 84 per 100,000 live births.

1.8 HIV and STI

Owing to the lack of available data, the extent and HIV and STIs in Vanuatu is quite difficult to estimate. The MoH’s HIV Coordinator reports that there are 3 cases of those infected with HIV and they are all female, while there were only 2 cases of AIDS-related deaths. STI prevalence is high according to information obtained from RH Supervisors from the provinces. A survey of the ante-natal women at Vila Central Hospital revealed the following incidence rates:

- Trichomonas vaginalis: 27.5%
- Chlamydia trachomatis: 21.5%

The Second Generation Surveillance Surveys of antenatal mothers suggests a high prevalence of STIs in women of less than 25 years of age. Furthermore, results of recent sexual behaviour studies reveal high unprotected sex rates, especially in less than 25 year age group. Knowledge of HIV transmission and protection is high but to date, translation of that knowledge to safe sexual behaviour has not occurred on a large scale. Sexual violence is reaching unprecedented high levels.

---

6 UNDP: Republic of Vanuatu, Millennium Development Goals Report 2005
7 UNICEF, A situation analysis of Children, Women & Youth: 2005
1.9  Health Surveillance and Reporting

Despite donor assistance in this area, in the past there appears to be a characteristic lack of a robust Health Information System for management and planning purposes. Quality and accurate data is critical to facilitate the most efficient use of scarce resources.¹⁸
2. SITUATION ANALYSIS AND ISSUES

2.1 CONTEXT

As part of its ongoing commitment under its Comprehensive Reform Program, the MoH developed a 5-year Health Services Master Plan in 2004, which is a continuation of the 1999 – 2002 Master Plan. The 2004 Master Plan and sets out five priority areas. Priority two is “to improve the health status of the people of Vanuatu.” Recommendation three of this priority is to “promote child spacing and reduce teenage pregnancy:

- Strengthen family planning with men and women and improve the adolescent reproductive health and sexual health for all
- Strengthen primary health care to deal with reproductive and sexual health issues
- Strengthen community ownership of these social issues.

This high level commitment has led the Public Health Unit in the MoH to develop a RH Policy and a RH Strategy and to place emphasis on RH programs.

Reproductive Health / RH Programs

A good RH program is one where people are able to have a satisfying and safe sex life. These people should also have the capability and the freedom to make informed choices about reproduction.

On the contrary, poor reproductive health accounts for a significant part of the burden of disease amongst adolescents and women in Vanuatu. RH is not simply the absence of disease - it covers a range of conditions that includes safe motherhood, prevention of STI and HIV, family planning and healthy sexual development for adolescents.9

Whilst there are no current data available in Vanuatu to account for the burden of poor reproductive health, WHO estimates that poor reproductive health accounts for up to 18% of the global burden of disease and 32 % of the total disease burden of women of reproductive age. Poor reproductive health is responsible for more than one third of all disability-adjusted life years.

Whilst the government is committed to ensuring universal access to comprehensive RH services, it is difficult to determine the current level of accessibility given the lack of a demographic health survey and the widespread nature of habitation throughout the provinces. The percentage of deliveries by skilled attendants is relatively high but contraceptive use at the national and provincial levels remains low. Information on unmet need is not available.

A recent facility assessment on Emergency Obstetrics/Family Planning conducted in Vanuatu in 2006 revealed that services provided at all levels are in need of improvement in terms of outreach and coverage. Upgrading of facilities is needed to ensure that comprehensive and basic emergency obstetrics care is accessible to all pregnant women in a timely fashion.

An RHCS review on logistics management in 2007 and 2005 cited the need for more training and focused national attention at all levels, for improved information systems for logistics and service statistics.

Several socio-cultural, economic and political factors affect sexual and reproductive health of all ages. There is need for increased male involvement in reproductive health, particularly in reproductive health decision making and care.

**Legislation**

Vanuatu has significant private sector that warrants the need for regulation of the profession, the practice and therapeutic goods. It does this through several Acts which governs the registration of pharmacies and pharmacists, the practice of pharmacy and the distribution of medicines, including dangerous drugs. These Acts include Chapter 12 Dangerous Drugs Act, Chapter 23 the Control of Pharmacists and Chapter 48 Sale of Medicines Control.

Chapter 23 governs the registration of pharmacists and the practice of pharmacies in Vanuatu. Currently, there are six registered pharmacists, with one, an expatriate, working in the CMS. The remaining five own their own pharmacies based in Port Vila and Sanma Province.

The Sale of Medicines Control Act encompasses the following three schedules:

- **Schedule 1:** any person can sell medicines listed in this Schedule.
- **Schedule 2:** only a Pharmacist or a druggist can sell medicines listed in this Schedule.
- **Schedule 3:** medicines that can only be sold with a prescription.

A review of these Schedules reveals that there are no RH commodities listed in Schedules 2 and 3 which is encouraging for RHCS access. However, Schedules 2 and 3 includes other RHCS commodities such as antibiotics, anti-hypertensive, sedatives and other medicines, which is an issue for RHCS access in that rural health care workers will not be able to dispense these medicines which will restrict access for rural dwellers.

In remote health centres, dispensaries and aid post kits. Apart from these regulations, Vanuatu does not have a Medicines Regulatory Authority to ensure a pre-marketing and post marketing surveillance program for medicines entering the market. As such medicines coming into Vanuatu cannot be assessed in terms of safety, efficacy and quality. Although the Sale of Medicines Control Act ensures that no sub-standard medicines from dubious sources are imported into the country and to date, there have been no reported cases of these in Vanuatu, the establishment of such a Medicines Regulatory Authority would ensure that this does not occur. This would ensure that RH commodities and RH medicines are safe, of good quality and efficacious.
Currently, Vanuatu does not have an authority that polices the prices of essential goods like RH medicines and RH commodities. An equivalent body like the Prices and Incomes Board which ensures the private sector does not charge exorbitant prices for RH commodities, making it difficult for people to access RH commodities.

**Health Policies**

The MoH has 15 Policies which were developed in 2002 and includes a Drugs Usage Policy. This Policy recognises that medical supplies are key to the operations of the Ministry and the Ministry is committed to rationalise the number, type and the way it supplies its medical items.

The Ministry has an Essential Medicines List and all contraceptives and RH medicines are on this List.

However, this policy does not address the broader aspects of medicinal use that includes:

- Legislation and regulation
- Selection of Essential Medicines
- Registration, Quality Assurance and licensing for sale of medicines
- Procurement of Medicines and Medical Supplies
- Medicine Storage and Inventory Control
- Distribution of Medicines
- Rational Medicine Use
- Medicines Information
- Human Resources
- Advertising and promotion
- Monitoring and evaluation
- Traditional Medicine
- Technical Cooperation with other countries and International Agencies

All these are essential components in ensuring RH commodities and reproductive medicines imported into a country are safe, of good quality, affordable and are efficacious.

**Medicines and Therapeutics Committee**

There is a Medicines and Therapeutics Committee which only meets at a hospital-level. This Committee is chaired by the Principal Pharmacist from CMS and addresses clinical and therapeutics issues.

There is no Committee at a national level. In Fiji, Solomon Islands and Tonga for example, this Committee deliberates on clinical, pharmaceutical, economical and logistical merits in choosing which medicines should be provided by government free of charge or publicly subsidised by Government.
Analysis:

Encouraging Findings (Strengths):

- RH has been part of the MOH CRP in the past 2 decades (1990’s to 2000) and Government has developed a MHSP (2004 – 2008) that includes RH as an output in one of the five main priority areas.
- An RH policy is currently being developed which will include RHCS and RH medicines also.
- There are no RH commodities on schedule 2 and 3 of the “Sale of Medicines Control Act”. This places an unrestricted access of RHCS commodities in the public sector making a wider access of RH commodities to remote and rural health facilities.
- All RH commodities and RH medicines are listed on the Vanuatu Essential Medicines list.

Areas of Concern (Weaknesses):

- The geographical dispersion of islands in Vanuatu and the variation in population density poses logistical challenges in terms of access to comprehensive quality RH and in the establishment of a reliable LMIS for RHCS.
- With 42% of the population being 14 years and younger and government not fully-funding education and public services for children, this generation will have difficulty in securing employment, as jobs are being created far more slowly than the current and future inflow of young workers.
- RH commodities are on the Essential Medicines list but are not government funded.

Risks (Threats):

- The current economic challenges may see some rationing and prioritisation of the national health services to a basic essential package.
- The increasing teenage pregnancies and increasing STI’s trend that is currently under-reported

Recommendations (Opportunities):

LEGISLATION:

Consider a licensing mechanism for RHCS and RH medicines that falls within the schedule 2 and 3 regulations

A revision of Schedules 2 and 3 needs to be undertaken to establish a licensing mechanism that would only enable trained RH workers to store and dispense these medicines.
Strengthen the National Medicines and Therapeutics Committee:

A National Medicines and Therapeutics Committee should be established at the national level and given the authority, support and the expertise to develop policies that decide on the selection of medicines and RH commodities to be included in the Essential Medicines List.

The current Hospital Drugs and Therapeutics currently chaired by the Principal Pharmacist could be strengthened at the National Level with the expansion of Committee members that would have the expertise on therapeutics, public health and policy making. Other members or specialists can be co-opted on a when required basis.

Develop a National Medicines Policy:

A National Medicines Policy should be developed to ensure safe, good quality and affordable RH commodities, including contraceptives, and RH medicines.

The formulation of a National Medicines Policy will set the broad priorities for development of pharmaceuticals over the next 5 years. The policy will ensure that RHCS and Essential Medicines supplied through the CMS are given the appropriate logistical and clinical support to ensure its ongoing availability. The existing LMIS for Essential Medicines can be further strengthened with the integration of contraceptives and other RH commodities. The policy must also ensure that all essential medicines imported into the country are reviewed by a medicines registration process to ensure safety, quality and efficacy.

Establish a Policy on the Selection of Essential Medicines:

Under the proposed National Medicines Policy the MOH should consider a policy position on the selection of Medicines in accordance with the Essential Medicines concept as defined by the World Health Organisation (WHO). Essential Medicines are those that are of most utmost important, and necessary to satisfy the priority health needs of the majority of the population.

Consider a Five Year financing mechanism to mainstream the funding of RH commodities, including contraceptives, into the MOH annual drug budget:

Poor reproductive health constitutes a disease burden to Vanuatu families. RH commodities and RH medicines are therefore considered priority Essential Medicines. They are on the Vanuatu Essential Medicines list and should be provided free of charge. The Ministry of Health therefore should start considering a phased funding program over five years to mainstream the funding of RHCS and RH medicines into the Governments yearly operating budget under the drugs budget.
Integrate RHCS in all relevant National Health Policies:

Integrate comprehensive RHCS explicitly in all relevant national health policies, Essential Medicines Program and the forthcoming RH Policy/Strategy documents.

Develop an integrating policy that links the work of Pharmacists that is accountable for logistics management of Essential Medicines and the RH Supervisor who are accountable for logistics management of RH commodities. The current work programs and activities of Pharmacists and RH Supervisors in the provinces could be integrated where Pharmacy officers are accountable for overall logistics management of RH medicines and RH commodities. The RH Supervisors to be accountable for the provision of RH Services and programs. The forecasting can be done by the Pharmacy personnel in consultation with the RH Supervisors. This encourages a team approach in sharing and reducing the duplication of work in an area where there is already a heavy work load.

Consideration should be given towards linking the Essential Drugs Program and the Reproductive Health programs as far as possible. A best place to start is to have RH representatives on the Hospital Drugs and Therapeutics Committee and a Pharmacist on the RHCS coordinating committee.
2.2 CLIENT UTILIZATION AND DEMAND

2.2.1 Service Availability and Utilization

With its rough island terrain, travel and communication between islands is expensive and often very difficult. Many islands are linked by air but some can only be reached by boat, and travel within some islands is still by foot or canoe as roads do not exist. The isolation of many villages particularly those in the outer provinces, hampers access to health services.

Vanuatu has five hospitals located in five provinces. Each hospital provides obstetric, surgical, medical and paediatric services. There are also 27 health centres which provide outpatient and inpatient services, including birth delivery care, health promotion and preventative health services such as immunisation. Each health centre is staffed by a nurse practitioner. Vanuatu also has 74 dispensaries located in the rural areas and they provide outpatient services, focusing on health promotion and preventative services. These dispensaries are staffed by a General Nurse. The lowest level of a health facility is an Aid Post of which there are 180 in Vanuatu. These are usually established and funded by the communities themselves and they provide first aid, some basic medicines and community education.

During the RHCS workshop, the RH Supervisors presented key RH activities that they provide in the provinces. In addition, they highlighted the following staffing and operational constraints which challenges their daily work:

- Delay in deliveries of medical supplies from the CMS
- Supply of near expired stocks from CMS and also from UNFPA
- Shortage of necessary supplies and materials
- Lack of biomedical equipment and maintenance skills to operate and maintain them
- Not enough Reproductive Health awareness in communities
- Staff workload is too heavy
- Shortage of nursing staff
- Staff appointments are for too short a period or are based at one workplace for too long
- Inadequate supervision by managers and supervisors
- More nurses are working past retirement age with renewable contracts
- Refusal of nurses to be posted to remote clinics

Discussions with public health staff revealed the need for improved health facilities to enable user friendly services that is equitable, transparent selection of staff for capacity building, timely distribution of RH commodities and improved storage conditions.
Table 2: Barriers to Access and Utilization of FP Services

<table>
<thead>
<tr>
<th>Access</th>
<th>Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Geographical location of clients dwelling from SDPs</td>
<td>• Cost of services including transportation to SDPs</td>
</tr>
<tr>
<td>• Financial constraints related to infrastructure including roads</td>
<td>• Lack of information/knowledge of FP options</td>
</tr>
<tr>
<td>• Readily available male and female condoms to high risk groups</td>
<td>• Socio/cultural perceptions influencing choice</td>
</tr>
<tr>
<td>• Over-reliance on certain methods of contraception and limited choice of contraceptive</td>
<td>• Service provider’s attitude and skills</td>
</tr>
<tr>
<td>• Shortage of trained personnel</td>
<td></td>
</tr>
</tbody>
</table>

2.2.2 Contraceptive Use and Trend

Total number of women of child bearing age in the 1999 census was 105,529. The demand for contraceptives is increasing and so is the CPR. Since 1991, the CPR has been increasing steadily from 15% to 37% in 2007, as reported in the UNICEF MICS. Reports from the five provinces were collected and tabled for 2006 trends. An estimated CPR of 21.6% was calculated. This rate underestimates the actual CPR as data is incomplete. The private sector figures from private doctors and retail pharmacies have not been included in MoH figures.

Table 3: Family Planning Acceptor by method, 2006

<table>
<thead>
<tr>
<th></th>
<th>Oral Pills</th>
<th>IUCD</th>
<th>Condoms</th>
<th>Depo Provera</th>
<th>Tubal ligation</th>
<th>Vasectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panama</td>
<td>83</td>
<td>1,374</td>
<td>56</td>
<td>1,857</td>
<td>204</td>
<td>72</td>
</tr>
<tr>
<td>Sanma</td>
<td>91</td>
<td>2,248</td>
<td>252</td>
<td>2,086</td>
<td>557</td>
<td>61</td>
</tr>
<tr>
<td>Malampa</td>
<td>83</td>
<td>637</td>
<td>44</td>
<td>667</td>
<td>198</td>
<td>0</td>
</tr>
<tr>
<td>Shefa</td>
<td>64</td>
<td>317</td>
<td>825</td>
<td>1,960</td>
<td>655</td>
<td>14</td>
</tr>
<tr>
<td>Tafea</td>
<td>92</td>
<td>530</td>
<td>16</td>
<td>400</td>
<td>584</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>5,106</td>
<td>1,193</td>
<td>5,573</td>
<td>7,154</td>
<td>1,623</td>
<td>147</td>
</tr>
<tr>
<td>CPR</td>
<td>21.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Statistician, Ministry of Health Vanuatu, 2006

Table 4: Method Mix: 2005 – 2006

<table>
<thead>
<tr>
<th></th>
<th>Number of Users</th>
<th>% Mix</th>
<th>Number of Users</th>
<th>% Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Oral Users</td>
<td>6,332</td>
<td>39%</td>
<td>5,106</td>
<td>24%</td>
</tr>
<tr>
<td>Number of Injectable Users</td>
<td>5,394</td>
<td>33%</td>
<td>7,175</td>
<td>35%</td>
</tr>
<tr>
<td>Number of Condoms Users</td>
<td>2,472</td>
<td>15%</td>
<td>5,573</td>
<td>27%</td>
</tr>
<tr>
<td>Number of IUD Users</td>
<td>803</td>
<td>5%</td>
<td>1,193</td>
<td>6%</td>
</tr>
<tr>
<td>Female Sterilization (tubal ligation)</td>
<td>992</td>
<td>6%</td>
<td>1,623</td>
<td>8%</td>
</tr>
<tr>
<td>Male Sterilization (vasectomy)</td>
<td>213</td>
<td>1%</td>
<td>47</td>
<td>0.2%</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>16,206</td>
<td>100%</td>
<td>20,717</td>
<td>100%</td>
</tr>
<tr>
<td>Total WCBA: 105,529</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPR:</td>
<td>15.4%</td>
<td></td>
<td>21.6%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Statistician, Ministry of Health Vanuatu, 2006
Vanuatu offers a wide range of contraceptive methods that ranges from the natural method to the modern contraception methods. From this data, in 2006, the most preferred method of contraception was the injection at 35% followed by condoms at 27%. This could be largely attributed to the convenience it offers and the minimal apparent side effects. The oral contraceptive is the third most preferred method of contraception and there has been a decrease in usage from 39% to 24% mix. Condoms on other hand increased from 15% in 2005 to 27% in 2006. The least used method is male sterilization at 0.2% followed by IUCD users at 8%.

Although there is an increase in the use of condoms, a review should be undertaken through a DHS to determine patterns of utilisation of RH services, including Family Planning. The survey should also include female condoms which are hardly used based on data from the Provinces.

### 2.2.3 Unmet Need for Contraception

There are indications of considerable unmet need for family planning in Vanuatu. High levels of teenage pregnancy suggest a significant unmet need for contraception in this age group (Figure 1).

**Figure 1: Percentage of all births to teenage mothers by age, 1994-2007**

![Figure 1: Percentage of all births to teenage mothers by age, 1994-2007](source: Statistics, Ministry of Health, 2008)

The timely reporting and completeness of the HIS in general has been a cause for some concern. At the time of the RHCS visit the writer noted the difficulty in getting accurate data and complete data in a timely fashion especially from the provinces.

Whilst these are figures only collected from the government sector, a proper DHS would provide better trends for each method of contraception as well as unmet need for contraception.
Analysis:

Encouraging Findings (Strengths):
- Committed, dedicated provincial team that are well trained and very experienced health workers (Doctors, RH Supervisors, Pharmacy officers, Nurses, laboratory, statistics, midwifery, village health worker and peer educators) in general RH programs, midwifery and basic maternal obstetric & gynaecological skills
- Communications system is in place.
- The health care teams are mobile in that they can move around the islands by boat and plane for coastal health facilities provided funding for logistics arrangements is provided.
- Availability of Standard Treatment Guidelines on Obstetrics & Gynaecology, STI and RH.
- An increasing uptake trend for male condoms from 2005 (15%) to 2006 (27%)

Areas of Concern (Weaknesses):
- In addition to the shortage of staff, most health workers are overwhelmed with work in the provision of RH programs and other public health programs (e.g.: MCH, IMCI, EPI, Health Promotion and nutrition). In addition to their day to day work they are to have administrative and reporting responsibilities of documenting HIS requirements for every PH program.
- Proper forecasting is not currently done for contraceptives and RH medicines
- Most provinces are now staffed with older nurses who may have slowed down a bit.
- Very limited IEC materials
- Some buildings, equipments and appliances require renovation works, maintenance and replacement.
- There are no qualified biomedical engineers available nationally that could assist in the purchase and maintenance of clinical equipment used in RH programs.
- While a Health Information system is being used, data from the provinces are not uploaded in a timely fashion and hence recent data is not readily available.

Risks (Threats):
- Remote geographical settings of rural villages make health facilities inaccessible.
- The continuous movement and transfer of staff.
- Poor community support and an increasing trend of social problems
- Zealous religious beliefs on RH, contraceptive methods and RHCS
- Donors are phasing out funding long term

Recommendations (Opportunities):

Link RH and STI Programs:
RH and STI programs should be reviewed and linkages explored in detail for integration of services.
Consider more integrated mobile visits to the Provinces:
Through proper planning the MOH should consider the coordination of provincial visits as a bigger mobile team where the whole medical team visits the provinces as a whole rather than separate teams.

Busy Clinics with large population densities should have good roads:
Consider lobbying to government for improved infrastructure especially roads or regular boating schedules to remote areas.

Strengthen the Management of Bio-Medical Equipment in all provinces:
In line with findings from the EmOC Facility assessment, a number of health facilities need renovations. This should be done in conjunction with renovations works for the storage of RH/RHCS supplies and equipment.

MoH should consider the establishment of a Biomedical Unit whose core business will be the servicing, maintenance and the replacement of medical equipment used in RH programs. This unit should be staffed with a qualified Biomedical Engineer initially on an expatriate basis and who should train a local person at the national level, preferably at the CMS. This can then be extended to the Provinces.

Develop an Asset Maintenance Policy and an Asset Master Plan for the Ministries buildings, equipment and appliances
MoH should consider the development an Asset Maintenance Policy and a long term Master Maintenance Plan for building, equipment and appliances that are used for RH programs. Whilst UNFPA does not provide funding or assistance for infrastructure such as renovations works and buildings, it is raised here for the purposes of achieving appropriate storage requirements for RHCS commodities.

Consider the development of a 5 year Equipment Maintenance and an Equipment Replacement Plan. This Plan must document the date of purchase of each equipment to assess the remaining useful life and the estimated date of replacing the machines. For recently purchased machines, a list of spare parts should be prepared that is required for each machine.

Consider the formation of an Essential Equipment and Appliances list for all RH programs.

Collect better accurate, complete and comprehensive data from public, private and NGO’s to better understand contraceptive use and trends in order to streamline RH supplies in changing demand and method preferences:
Encourage better collection of data (HIS and LMIS) from CMS and the 6 provinces. Include the private sector and the NGO in the collection of data (HIS and LMIS) through appropriate policies.

Consider a Demographic Health Survey or a Knowledge Attitude and Practices Survey on sociocultural perceptions and level of knowledge about FP methods.
Such surveys would enable the Ministry to regularly to monitor its programmes and determine if they are having a change in knowledge and use of family planning and reproductive health services.
Consider investing in social marketing of both female and male condoms;

Promote availability of a broadened contraceptive choice in all provinces especially long term methods such as vasectomy, IUCDs and implants as well as female condoms and ECPs

Ensure a policy environment to support broadened choice, through training of relevant health care providers in all provinces

Undertake follow up of women who have defaulted for family planning clinics through improved outreach services
2.3 COMMODITIES

Vanuatu has three main sources of RH and RHCS commodities that include UNFPA, NGOs and the Private Sector:

a. Public Sector: UNFPA supplies

Since 2000, the Ministry of Health has been receiving contraceptives and other reproductive health commodities from UNFPA. Contraceptives have been on the Essential Drug List for Vanuatu for several years.

Table 5: Ministry of Health Contraceptives, 2008

<table>
<thead>
<tr>
<th>Commodity</th>
<th>Unit</th>
<th>Unit Cost (USD)</th>
<th>Current Stock CMS 02/10/08 (units)</th>
<th>Average Monthly Consumption</th>
<th>Months of Stock (Months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microgynon</td>
<td>Cycles</td>
<td>0.25</td>
<td>54,446</td>
<td>8,513 cycles/month</td>
<td>6.4</td>
</tr>
<tr>
<td>Micolut Tablets</td>
<td>Cycles</td>
<td>0.35</td>
<td>24</td>
<td>509 cycles/month</td>
<td>0.04</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>Vials</td>
<td>0.77</td>
<td>11,150</td>
<td>1,767 vials/month</td>
<td>6</td>
</tr>
<tr>
<td>Condoms Male</td>
<td>Pieces</td>
<td>.03</td>
<td>108,576</td>
<td>20,129 pieces/month</td>
<td>5.4</td>
</tr>
<tr>
<td>Condoms Female</td>
<td>Pieces</td>
<td>0.42</td>
<td>5,000</td>
<td>304/month</td>
<td>16</td>
</tr>
<tr>
<td>IUCD</td>
<td>Unit</td>
<td>0.31</td>
<td>140</td>
<td>14/month</td>
<td>10</td>
</tr>
<tr>
<td>Levonorgesterel</td>
<td>Cycles</td>
<td>1,448</td>
<td></td>
<td>3/month</td>
<td>482</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, Vanuatu, 2008

Whilst UNFPA has been the main provider of contraceptives to the Government over the past three decades, when the Family Program started with the Ministry, it has also been the provider of RH commodities and other RH products.

b. Non-Government Organisations (NGOs)

NGOs have evolved as strong partners in promoting Sexual and Reproductive Health in Vanuatu and the Government has forged strong partnerships with these organizations, particularly as they attempt to provide preventive and treatment services to young people and other marginalized groups.

The Vanuatu Family Health Association is the main NGO which supplies contraceptives and other RH commodities in Vanuatu. They get their stock from their parent body, The International Program on Planned Parenthood. A summary of the contraceptives received is tabled below.
### Table 6: Contraceptives VFHA 2008

<table>
<thead>
<tr>
<th>Contraceptives</th>
<th>Quantity (1 Jan)</th>
<th>IPPF</th>
<th>Other Agencies</th>
<th>Total</th>
<th>Branches/Clinics</th>
<th>Other Agencies</th>
<th>Loss/Damaged/ Promotional samples</th>
<th>Written off</th>
<th>Total</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUCD Copper T 380</td>
<td>330</td>
<td></td>
<td></td>
<td>330</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>230</td>
</tr>
<tr>
<td>Neogynon Pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microval Pills</td>
<td>4,290</td>
<td></td>
<td></td>
<td>4,290</td>
<td>120</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,170</td>
</tr>
<tr>
<td>Nordette Pills</td>
<td>60</td>
<td>600</td>
<td></td>
<td>660</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>630</td>
</tr>
<tr>
<td>Microgynon Pills</td>
<td>4,200</td>
<td></td>
<td></td>
<td>4,200</td>
<td>2,730</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,470</td>
</tr>
<tr>
<td>Nordiol Pills</td>
<td>930</td>
<td></td>
<td></td>
<td>930</td>
<td>210</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>720</td>
</tr>
<tr>
<td>Lo Femenal Pills</td>
<td>4,600</td>
<td>1,200</td>
<td></td>
<td>5,800</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,600</td>
</tr>
<tr>
<td>Male Condoms</td>
<td>22,176</td>
<td>532</td>
<td></td>
<td>22,708</td>
<td>3,456</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19,252</td>
</tr>
<tr>
<td>Female Condoms</td>
<td>0</td>
<td>1000</td>
<td></td>
<td>1,000</td>
<td>110</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>890</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>5,000</td>
<td></td>
<td></td>
<td>5,000</td>
<td>700</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,300</td>
</tr>
<tr>
<td>Marvelon 28</td>
<td>1,900</td>
<td>500</td>
<td></td>
<td>2,400</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,200</td>
</tr>
<tr>
<td>Prostinor 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: VFHA, 2008

### Table 7: A summary of non-contraceptives received and issued, January – December 2006

<table>
<thead>
<tr>
<th>Contraceptives</th>
<th>Quantity (1 Jan)</th>
<th>IPPF</th>
<th>Other Agencies</th>
<th>Total</th>
<th>Branches/Clinics</th>
<th>Other Agencies</th>
<th>Loss/Damaged/ Promotional samples</th>
<th>Written off</th>
<th>Total</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy test kits</td>
<td>20</td>
<td>25</td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Jelly</td>
<td>811</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>811</td>
</tr>
<tr>
<td>Pap smear brush</td>
<td>90</td>
<td>2,000</td>
<td></td>
<td>2,090</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>Gloves unsterile</td>
<td>1,000</td>
<td>1,000</td>
<td></td>
<td>2,000</td>
<td>1,200</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>800</td>
</tr>
<tr>
<td>Syringes</td>
<td>1,200</td>
<td>5,000</td>
<td></td>
<td>6,200</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,700</td>
</tr>
<tr>
<td>Gloves sterile</td>
<td>800</td>
<td>800</td>
<td></td>
<td>1,600</td>
<td>350</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,250</td>
</tr>
</tbody>
</table>

Source: VFHA, 2008
c. Private Sector

A notable player in the provision of RHCS commodities is the Private Sector which includes private General Practitioners and Retail Pharmacies. There are a total of five Pharmacies in Vanuatu - three in Port Vila and two in Santo Espiritu. The following information was provided by Health Wise Pharmacy in Port Vila:

Table 8: Contraceptives at Health Wise Pharmacy

<table>
<thead>
<tr>
<th>Commodity</th>
<th>Price (VVU)</th>
<th>Price (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microgynon 20 ED</td>
<td>2,000</td>
<td>17.86</td>
</tr>
<tr>
<td>Microgynon 30 ED</td>
<td>1,000</td>
<td>8.93</td>
</tr>
<tr>
<td>Microgynon 50 ED</td>
<td>600</td>
<td>5.36</td>
</tr>
<tr>
<td>Microlut (Shering brand)</td>
<td>600</td>
<td>5.36</td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rough Rider (Fiji brand): 12 pieces/pack</td>
<td>1,200</td>
<td>10.71</td>
</tr>
<tr>
<td>Durex (Australian brand)</td>
<td>1,500</td>
<td>13.39</td>
</tr>
</tbody>
</table>

Most of the RH commodities are sourced from Australia and Fiji. There are currently no price ceilings for medicines and RH commodities in the private sector. There is also no Prices and Incomes Board to monitor the pricing of items sold in the retail or wholesale sector.

Analysis:

Encouraging findings (Strengths):

- All RH commodities are supplied free of charge in the public sector. In NGOs RH commodities are provided free of charge with a small service fee that is charged as dispensing fee for the service rendered.
- The VHFA have a good documentation procedure for its contraceptives and other RH medicines
- In the past there has been an increasing trend for natural methods of contraception. This trend is slowly decreasing with a general increase in the contraceptive prevalence rates in the urban and rural areas
- There were no reported losses or oversupply in the VHFA which reveals a good logistics management system in place.
- There is a very cordial relationship between public and NGO’s which is encouraging for information collecting and is critical in sharing the workload for different clients (in particular teenagers) in different income and age related groups.
- To date there has been no quality complaints on RH commodities and RH medicines from any of the three sources (public, private and NGO)
Areas of Concern (Weaknesses):

- A hospital fee is charged for patients seen at any health facility which is an issue in accessing RH services and RH commodities. The economically and disadvantaged poor patients may not be able to access RH services.
- There is an increasing trend for STI’s and teenage pregnancies. During the time of the visit there were stock outs of Azithromycin for Chlamydia treatment in the Public Hospitals. This reveals inaccurate forecast estimations and coordination issues between service providers and CMS.

Risks (Threats):

- The MOH does not have a Medicine Regulatory Authority, this presents quality, safety, and efficacy risks of all medicines imported into Vanuatu for both Public, Private and NGO supplies.
- There are no quality procedures in place to ensure quality RH commodities and RH medicines throughout the supply chain.

Recommendations (Opportunities):

Expanding RH programs through an inclusive policy approach:
The Ministry of Health should work closely with the private sector and NGO’s so that the policies and strategies that are formulated are inclusive and capture their contribution also. This is important as the high number of teenage pregnancies is indirectly related to young people purchasing condoms from the private sector because it has anonymity and more user-friendly than government facilities.

Review/reconsider the policy position of charging patients for public health programs.
The MOH should consider reviewing the policy of charging patients for public health programs, in the absence of a means test or a safety net for the poor and majority of Ni-Vanuatuans who live in rural areas, where the rural population is high (80%), per capita is very low and poverty is high. This scenario makes access to RH services a concern.

Pricing of RH commodities, including contraceptives and RH Medicines in the private sector:
The MoH should pursue a policy position on affordability of essential medicines with Government and a policy on pricing of RH commodities.
2.4 COMMITMENT

There is no doubt that Vanuatu is heavily committed to the promotion of a quality and comprehensive RH program through a secure RHCS program. Over the past decade, many studies, agreements, policies and plans have been agreed to by successive Vanuatu Governments. Those that form a global, regional and national perspective in Reproductive Health and on the direct well-being and women include:

1. The Convention for the Elimination of Discrimination against women (CEDAW)
2. International Conference on Population and Development (ICPD)
3. The Millennium Development Goals (MDG)
4. Pacific Ministers of Health RHCS Meeting: Auckland

In 2004, WHO adopted its first strategy on Reproductive Health. This Strategy targets five priority areas in reproductive health and sexual health:

1. Improving ante-natal, delivery, post partum and new born care.
2. Providing high quality services for family planning including fertility services
3. Eliminating unsafe abortions.
4. Combating STIs (including HIV), RTIs, cervical cancers and other gynaecological morbidities.
5. Promoting sexual health.

On a national level, the Government and Ministry of Health have embarked on the following programs and plans:

1. The National Comprehensive Reform program
2. The National Priorities and Action Agenda

While Government is committed to ensuring universal access to comprehensive RH services, it is difficult to determine the current level of accessibility, given the lack of a demographic health survey and the widespread nature of habitation throughout the provinces. The percentage of deliveries by skilled attendants is relatively high but contraceptive use at the national and provincial levels remains relatively low. Information on unmet needs was not available.

Commitment in the country is demonstrated by the level of Civil Society participation and the visibility of the level of participation. In addressing the trend of high levels of teenage pregnancies, a number of Youth Groups have evolved, with the commitment to educate more youth on safe and responsible sexual behaviour.

Since 1994, a number of Community-Based Organisations (CBOs) and NGOs have provided some of RH programs. These are classified in two groups - one for those that are involved in Peer Education and two, for those that are involved in the broader RH programs which include Peer Education and the provision of RH commodities.
Community Based Organisations are heavily involved in peer education and act as an entry point amongst youth and adolescents, to promote the concept of responsible youth and safe sex, mainly through the use of condoms. These CBOs include the following:

1. Youth Challenge International (YCI), Port Vila.
2. Foundation of the Peoples of the South Pacific (FSP), Port Vila.
4. WanSmol Bag (WSB), Port Vila.
5. Haulua Youth Drop in Centre, Pentecost.
6. Youth Drop In Centre, Luganville, Santo.

Only the two NGOs that provide RHCS commodities were able to be met:

1. **Vanuatu Family Health Association (VFHA)**

   The VFHA, which is located in Port Vila and is governed by an Executive Director who is supported by an Executive Council, is a subsidiary body of the International Planned Parenthood Federation (IPPF). The NGO’s Constitution identifies the areas of activities it works in and these include:

   a) Organise campaigns to promote awareness;
   b) Provide information and education;
   c) Promote and provide quality family planning, reproductive and sexual health;
   d) Plan and implement family planning initiatives in support of national family planning programmes, collaborate with government and other agencies in promoting and providing family planning related services;
   e) Promote and sustain productive and quality services to continue to enhance the image of VFHA and IPPF;
   f) Strengthen the capacity and competence of VFHA;
   g) Uphold the principle that real sexual equality is to empower women to regulate their own fertility;
   h) Work towards eliminating unsafe abortions;
   i) Measure the quality, coverage and effectiveness of VFHA programs.

In 2006, VFHA provided Family Planning services and through clinics.
### Table 9: Family Planning Users by method, VFHA, 2008

<table>
<thead>
<tr>
<th>Method</th>
<th>New Acceptors</th>
<th>Continuing Users</th>
<th>Total Acceptors</th>
<th>% Mix</th>
<th>Total Visits</th>
<th>Total Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Contraceptives</td>
<td>119</td>
<td>438</td>
<td>557</td>
<td>55%</td>
<td>1,523</td>
<td>4,786</td>
</tr>
<tr>
<td>IUD</td>
<td>36</td>
<td>47</td>
<td>83</td>
<td>8%</td>
<td>92</td>
<td>45</td>
</tr>
<tr>
<td>Condom</td>
<td>43</td>
<td>32</td>
<td>75</td>
<td>8%</td>
<td>92</td>
<td>3,311</td>
</tr>
<tr>
<td>Injectable (3 month dose)</td>
<td>118</td>
<td>157</td>
<td>275</td>
<td>27%</td>
<td>586</td>
<td>586</td>
</tr>
<tr>
<td>NFP 5 (Natural Family Planning)</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>1%</td>
<td>22</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>323</td>
<td>681</td>
<td>1,004</td>
<td>100%</td>
<td>2,315</td>
<td>8,728</td>
</tr>
</tbody>
</table>

Apart from counselling services, the VFHA also provides maternal and child health services including immunisation, ante-natal, postnatal and other preventative and curative health services. It also provides Pap smear and pregnancy tests as well as infertility and sterility counselling.

2. **Northern Care Youth Clinic (NCYC):**

CYC is a program of WanSmol Bag with the Northern District Health Services and was established in 2005, through funding from AusAid. The clinic formed part of the Louganville Youth Centre before it closed. It is staffed by a nurse, a clinical manager, six full time peer educators and a security/grounds man. The NCYC’s main goals are:

1. To help in the development of young people to become responsible adults.
2. To support information and education in sexual and reproductive health.
3. To provide services in reproductive health for young people, including counselling.

Its primary role is to provide a youth-friendly clinic where young people can access sexual and reproductive health services. So the NCYC works to prevent STIs and HIV, unplanned teenage pregnancies and helps young people grow into responsible adults. It does these by providing the following services:

1. STIs - treatment and prevention
2. Family planning and contraceptives
3. Counselling
4. Voluntary Confidential Counselling and Testing (VCCT)
5. Referral of cases – to the Family Health Clinic and to Hospitals
6. General consultation
Analysis:

Encouraging Findings (Strengths):

- Vanuatu has ratified a number of International and regional conventions that support RH programs
- The MOH has a National HIV Strategic Plan and is currently developing an RH/RHCS policy that will create a very supportive environment for RHCS.
- In 2004 the Vanuatu Minister of Health signed the Pacific Plan of Action re-affirming its political commitment at the highest level of Government.
- RHCS commodities and RH medicines are listed on the Vanuatu Essential Medicines list.
- The MOH has recently appointed a RHCS officer and convened its first RHCS coordinating committee.
- There is support within the MOH to translate this level of commitment into a funding commitment of a dedicated RHCS vote using government funds.
- There are a growing number of peer educator’s organisations that are expanding the distribution outlets for male condoms.

Areas of Concern (Weaknesses):

- There are no identified key leaders from outside the health fraternity like the Church, the villages, private sector or Parliament that can become champions and strong vocal advocates of RH including RHCS in Vanuatu.

Risks (Threats):

- Health management reform programs can either centralise or decentralise authority and may make RH and RHCS programs lesser of a priority or less visible.

Recommendations (Opportunities):

Peer Educators
In light of the high teenage pregnancy trends and the increasing prevalence of STI’s, the MOH needs to formally recognise peer educators as key providers in the mobilisation of resources to combat HIV and STI.

Budgetary Commitment for RH
Support MoH to advocate for budgetary allocation for procurement of RH commodities, including contraceptives, by 2012.

Identify an RHCS champion and conduct advocacy workshops for parliament (health committee) on the importance of RH and RHCS.
Health in Vanuatu is funded by a combination of government at 80% (which includes both inpatients) and private at approximately at 20% (limited to outpatients only).

Table 10: Expenditure on Essential Services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>887</td>
<td>1330</td>
<td>1848</td>
<td>2065</td>
<td>2074</td>
<td>1957</td>
<td>1972</td>
<td>-</td>
</tr>
<tr>
<td>Health</td>
<td>457</td>
<td>598</td>
<td>904</td>
<td>926</td>
<td>925</td>
<td>790</td>
<td>810</td>
<td>-</td>
</tr>
<tr>
<td>Exchange Rate (Vatu per US Dollar)</td>
<td>117.06</td>
<td>112.11</td>
<td>137.64</td>
<td>111.81</td>
<td>122.19</td>
<td>111.79</td>
<td>109.25</td>
<td>111.22</td>
</tr>
<tr>
<td>$ USD</td>
<td>3,903,980</td>
<td>5,334,047</td>
<td>6,567,858</td>
<td>8,281,906</td>
<td>7,570,178</td>
<td>7,066,821</td>
<td>7,414,187</td>
<td></td>
</tr>
<tr>
<td>Total Population (000) As of 1 July</td>
<td>147.3</td>
<td>168.4</td>
<td>191.7</td>
<td>202.2</td>
<td>207.7</td>
<td>213.3</td>
<td>218.0</td>
<td>221.5</td>
</tr>
<tr>
<td>GNI Mn Vatu</td>
<td>19004</td>
<td>22733</td>
<td>33164</td>
<td>30353</td>
<td>32331</td>
<td>34777</td>
<td>37486</td>
<td></td>
</tr>
<tr>
<td>Health Expenditure as a % of GDP</td>
<td>2.4%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>3.1%</td>
<td>2.9%</td>
<td>2.3%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Health Expenditure Per Capita</td>
<td>$27</td>
<td>$32</td>
<td>$34</td>
<td>$41</td>
<td>$36</td>
<td>$33</td>
<td>$34</td>
<td></td>
</tr>
</tbody>
</table>

Source: Key Indicators of developing Asian and Pacific Countries: ADB 2007

As shown, Health Expenditure as a percentage of GDP stays around 2%, which is the same as in Fiji but low compared to Samoa’s 4.7%. Health Expenditure on a per capita basis which was $34 in 2005 is low compared to other Pacific Island Countries. In 2004, the budgetary ceiling was cut by 5% from its 2003 levels and it is expected that there maybe further reductions in the recurrent budget available to the health sector in future

As such, reliance on donor funding may continue indefinitely, until the economic situation improves significantly. In addition, it is incumbent on the Ministry of Health to ensure proper forecasting of RHCS requirements before committing to funding them in the Government Budget.
In doing so, two forecast estimates were made for comparative purposes which amount to (in USD):

- 2008 Logistics-based estimates: $52,834
- 2008 Health services-based estimates: $65,980
- 2008 CCM software estimates: $66,212
- 2007 RHCS Annual Contraceptive estimates: $80,730.

Current estimations for RHCS requirements are approximately US$80,000.00 per annum. It is proposed that this be considered as phased-funding over five years.

Table 11: Vanuatu Forecasted Contraceptive Quantities for 2008 – 2012

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>225,507</td>
<td>231,370</td>
<td>237,386</td>
<td>243,558</td>
<td>249,891</td>
<td>256,388</td>
</tr>
<tr>
<td>WRA using modern FP</td>
<td>72,162*</td>
<td>74,038</td>
<td>75,963</td>
<td>77,938</td>
<td>79,964</td>
<td>82,043</td>
</tr>
<tr>
<td>1. Microgynon – 5382 (33% in method-mix)</td>
<td>80,730</td>
<td>82,829</td>
<td>84,982</td>
<td>87,191</td>
<td>89,458</td>
<td>91,784</td>
</tr>
<tr>
<td>2. Microlut – 950 (6%)</td>
<td>14,250</td>
<td>14,621</td>
<td>15,001</td>
<td>15,391</td>
<td>15,791</td>
<td>16,202</td>
</tr>
<tr>
<td>3. Depo – 5394 (33%)</td>
<td>21,576</td>
<td>22,137</td>
<td>22,713</td>
<td>23,304</td>
<td>23,910</td>
<td>24,532</td>
</tr>
<tr>
<td>4. Male condom – 2472 (15%)</td>
<td>370,800</td>
<td>380,441</td>
<td>390,332</td>
<td>400,481</td>
<td>410,894</td>
<td>421,577</td>
</tr>
<tr>
<td>5. Female condom**</td>
<td>11,124</td>
<td>11,413</td>
<td>11,710</td>
<td>12,014</td>
<td>12,327</td>
<td>12,647</td>
</tr>
<tr>
<td>6. IUCD – 803 (5%)</td>
<td>230</td>
<td>236</td>
<td>242</td>
<td>248</td>
<td>254</td>
<td>261</td>
</tr>
</tbody>
</table>

* : based on 2005 CPR of 32%
** : FC qty is estimated as between 2-5% of male condom use

Note: Units for pills is cycles, depo is vials, MCs, FCs and IUCD are in individual pieces
During the RHCS visit, it was noted that there were stocks of Microlut which were lost from between the Vanuatu Port and the CMS. This came to light when figures on the shipping manifest, the invoice, packing list and the actual goods collected did not match. The CMS needs to investigate this incident further. While this does not occur often, it was considered important that UNFPA review the Ministry of Health’s current freight forwarding terms and conditions and to consider delegating the shipping responsibility of RH commodities to the CMS.

**Analysis:**

**Encouraging Findings (Strengths):**
- Funding assistance may continue from both technical and donor agencies
- Government is considering Health reform program to promote transparency, accountability and a results oriented based culture of work ethic

**Areas of Concern (Weaknesses):**
- The government budget on health from 1998 to 2007 has increased from 3.7% to 3.8%. In real terms this is fairly negligible when you consider inflation and cost of fuel and goods also increasing.
- With the increased advocacy on the integration on STI and RH, the uptake of condoms (male and female) is likely to increase four fold. CMS and the provinces would need to be closely involved with outreach programs to anticipate such increases.

**Risks (Threats):**
- Economic growth has been stagnant for the last 4 -5 years. This would mean rationalisation of resources to priority areas which may put some public health programs at risk

### Table 12: Estimated Costs of Contraceptives for Vanuatu with Cartage Cost for 2008 - 2012 (US$)

<table>
<thead>
<tr>
<th>Contraceptives</th>
<th>Unit Cost</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microgynon</td>
<td>0.25</td>
<td>20,707</td>
<td>21,246</td>
<td>21,798</td>
<td>22,365</td>
<td>22,946</td>
<td>109,062</td>
</tr>
<tr>
<td>Microlut</td>
<td>0.35</td>
<td>5,117</td>
<td>5,250</td>
<td>5,387</td>
<td>5,527</td>
<td>5,671</td>
<td>26,952</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>0.77</td>
<td>17,046</td>
<td>17,489</td>
<td>17,944</td>
<td>18,411</td>
<td>18,890</td>
<td>89,780</td>
</tr>
<tr>
<td>Male Condom</td>
<td>0.03</td>
<td>11,413</td>
<td>11,710</td>
<td>12,014</td>
<td>12,327</td>
<td>12,647</td>
<td>60,111</td>
</tr>
<tr>
<td>Female Condom</td>
<td>0.42</td>
<td>4,793</td>
<td>4,918</td>
<td>5,046</td>
<td>5,177</td>
<td>5,312</td>
<td>25,246</td>
</tr>
<tr>
<td>IUCD</td>
<td>0.31</td>
<td>73</td>
<td>75</td>
<td>77</td>
<td>79</td>
<td>81</td>
<td>385</td>
</tr>
<tr>
<td>Sub - Total</td>
<td></td>
<td>59,149</td>
<td>60,688</td>
<td>62,266</td>
<td>63,886</td>
<td>65,547</td>
<td>385</td>
</tr>
<tr>
<td>Cartage @ 15%</td>
<td>8,872</td>
<td>9,103</td>
<td>9,340</td>
<td>9,583</td>
<td>9,832</td>
<td>46,730</td>
<td></td>
</tr>
<tr>
<td>Unit Costs</td>
<td></td>
<td>$68,021</td>
<td>$69,791</td>
<td>$71,606</td>
<td>$73,469</td>
<td>$75,379</td>
<td>$358,266</td>
</tr>
</tbody>
</table>

**Analysis:**

**Encouraging Findings (Strengths):**
- Funding assistance may continue from both technical and donor agencies
- Government is considering Health reform program to promote transparency, accountability and a results oriented based culture of work ethic

**Areas of Concern (Weaknesses):**
- The government budget on health from 1998 to 2007 has increased from 3.7% to 3.8%. In real terms this is fairly negligible when you consider inflation and cost of fuel and goods also increasing.
- With the increased advocacy on the integration on STI and RH, the uptake of condoms (male and female) is likely to increase four fold. CMS and the provinces would need to be closely involved with outreach programs to anticipate such increases.

**Risks (Threats):**
- Economic growth has been stagnant for the last 4 -5 years. This would mean rationalisation of resources to priority areas which may put some public health programs at risk
Recommendations (Opportunities):

UNFPA may have to continue with funding assistance of around (USD) $80 000 a year with the MOH for the next few years given the current economic situation.

A Phased funding (2008 – 2012) should be considered carefully so that other equally important public health programs do not suffer.

Reduce unnecessary wastage through prudent and diligent use of existing government resources.

Strengthen forecasting skills with the RH Supervisors and Pharmacy personnel at CMS and the provinces to ensure there is no short fall in estimation of Annual Contraceptive and RH requirements.
2.6 CAPACITY

2.6.1 Service Provider Skills and premises

A recent survey of facility assessment in 2006 for Emergency Obstetrics and family planning revealed that services provided at all levels are in need of improvement in terms of outreach and coverage. The report added that although there is a good technical competence of providers providing antenatal, intrapartum, and postnatal care as well as family planning care, some urgency in upgrading of facilities is needed to ensure that comprehensive and basic emergency obstetrics care is accessible to all pregnant women in a timely fashion.

Further training is needed to increase the coverage and types of contraceptive methods and to strengthen referral systems.

2.6.2 Logistics Management (LM):

(The term LM is used here to refer to supply system or sometimes known as pipeline system in the US)

Logistics Management (LM) forms the core of this RHCS assessment and as such the approach used here is to assess three components of LM with additional probing questions to get a closer understanding of which knowledge and skills area is lacking. The three components are:

- design of the LM
- operations of the LM
- use of the LM

DESIGN of the current LM structure

UNFPA Copenhagen sources globally annually and supplies contraceptives and RH commodities to the UNFPA Sub-Regional Office in Suva, Fiji. UNFPA Pacific sources from UNFPA Copenhagen with a lead time of 6 - 8 months. This is conducted once a year and the annual orders for the preceding years for the 14 PICs including Vanuatu is placed in March every year.
The Central Medical Stores is a warehouse of the Ministry of Health in Port Vila that sources from the UNFPA regional warehouse in Suva, Fiji annually. This year a special order (sea freight and air freight) had to be made in September owing to anticipated stockouts of contraceptives.

The Central Medical Stores then distributes under a decentralised logistics system to Provincial Hospitals. The Provincial Hospitals then supplies to the provinces every two months to the Area Health Centres, Dispensaries and Aid Post kits.

The CMS has the following main core responsibilities:

- procurement
- port clearing
- receipt and inspection
- inventory control storage
The distribution from CMS to provinces is through the provincial LM order forms and is delivered every two months. The area health centres, dispensaries and aid post kits order from the provincial hospitals using their LM forms for health centres (a blue copy), dispensaries (a yellow copy) and aid post kits (a white copy). From these SDP it is dispensed directly to patients. The SDP can measure the consumption or the dispensed data of contraceptives and other RH commodities to patients.

**Staffing:**
**Pharmacy**
There are currently 6 staff working in the logistics system of the Ministry of Health under the Central Medical Stores. Two of them are stationed at the Central Medical Stores and the remaining four work in the provinces.

**RH Supervisors in the Provinces**
The same applies for nurses working in the Provinces. In the past specific training programs have been developed for training nurses managing health centres and dispensaries. These training programs are for Pharmacy and Medicines knowledge but there has been very little on logistic management.

Most Pacific Island Countries, like Fiji, use the mixed system but with a fixed maximum allocation system. On the positive side, the Provincial Hospitals, Health Centres, dispensaries and aid post kits conduct ongoing stocktake before requesting commodities from the higher level.

**OPERATIONS of the LM system:**
Vanuatu and the Solomon Islands are the only PICs that use the topping up of commodities a floating allocation system. A comprehensive reform program under the MHSP (1999 – 2002) conducted in 2002 with a number of AusAid projects helped establish this drug supply system for the CMS to the provincial hospitals, health centres, dispensaries and aid post kits.

This drug supply system is the logistics management system that is used by CMS to replenish medicines, vaccines, RH medicines and RHCS commodities in the provinces. This system has been in existence for a while and appears to be working well with the CMS to ALL the respective health facilities.

The advantage is that it is a simple process that encourages an assessment of stock commodities, its status and the usage. For logistics management this is critical as it is simplicity and user friendly procedures on replenishment that ensures accuracy and above all promotes flexibility.

**LM replenishment forms:**
In LM the essential data include current stock levels, the current status (losses, stock out, expiry) and the amount used. There are four forms that are used to replenish stocks and the following data’s are captured on the forms:

The amount of the last stock check + amount received – current stock check = amount used
Quantity to order = Amount used x 2 - current stock on hand

The following questions were asked to assess the logistics management system:

1. Are the forms and reports that are used easy to understand and use?

The forms used include a blue form for hospitals and health centres, yellow forms for dispensaries and white form for First Aid post kits. It should be noted that a similar system of ordering is also in place in the Solomon Islands Pharmaceutical Supply system.

The forms are quite easy to use and have been translated into “bislama” for the benefit of nurses, nurses aides and any health worker working in the remote health facilities that is responsible for replenishing supplies for each health facility.

2. Is there dispensed data at the Provincial levels and SDP points

At the provincial levels the dispensed data are kept either in a family planning register or a pills register. Most RH Supervisors were documenting entries at the end of the month. This delay increases the likelihood of errors and hence the integrity of the data collected.

This current practice of documentation makes forecasting using dispensed data from SDP at provincial levels also unreliable and hence estimations for national and provincial annual RHCS and RH requirements not reliable also.

For this reason more time needs to be spent on reviewing the inventory levels of each contraceptive and RH commodities and need to have store cards as a basis of documenting the movement of contraceptives received and dispensed to clients.

3. What is the level of knowledge and use of LM system standards and reporting procedures?

The knowledge on their LM ordering system is good.

The entries that are made on the differing units of issues of each contraceptive are a source of errors. These data from the provinces are not fed to the CMS for procurement purposes also.

The concept of reducing the time between when the transaction of the commodity is completed to the time the clerical entries are made in the stock cards and the daily activity registers is critically important in reducing documentation errors.

USE OF THE LM SYSTEM:

4. What is the level of completeness of data recording and reporting?

A visit to the CMS and Vila Hospital noted that there were no stock cards kept for any of the RH commodities including contraceptives. In addition, the records kept on the IT MYOB software and the actual physical stock differed on most of the contraceptives that were counted.
Whilst the system of ordering is working, the only concern is the absence of the use of stock cards. In the absence of stock cards being used at central and at provincial level the only data that can be accessed is the MYOB data which in most cases was different from the actual physical stock levels. If stock cards were used we could assess the data a bit more in detail regarding the shipped data or the issued data from CMS to the provinces, issued data from the provinces to another and issued data from the provinces to the lower levels. The usefulness of these data becomes more relevant in the forecasting. This makes forecasting using issued data from CMS unreliable and hence estimations for national and provincial annual contraceptives and RH requirements less reliable also.

5. What is the timeliness of data recording and reporting?

Vila Central Hospital Family Planning and Ante-natal clinic

The Ante-natal and Family Planning Clinic was also visited. Whilst records were entered in a family planning register and a pills register, these were entered after each month. The data that were kept ranged number of ante-natal clinics to number of counselling given on RH. There needs to be some form of standard documentation that is kept daily. A daily activity and a monthly register are recommended in this regard and is attached below.

6. What is the quality and accuracy of reported data?

During this visit it was noted that Azithromycin tabs for the treatment of Chlamydia was out of stock at CMS. The Hospital Pharmacy did have some stock but nurses and doctors at the clinic were not kept informed of this availability in stocks.
7. **Is data used for determining and validating order quantities?**

At the time of this visit, Microlut tabs were running very low in stock. A small supply had to be air freighted in from UNFPA Suva warehouse. Closer investigations on this revealed that 7 pallets were delivered from Fiji, only six pallets were received at the CMS. The RHCS Manager should explore the current freight arrangements from Fiji UNFPA warehouse to be delivered to the CMS warehouse and not the port of Vanuatu.

The CMS currently uses the issued data from the MYOB to make orders to the UNFPA regional warehouse in Fiji. Previous RHCS situational analysis reports have recommended that CMS consider the use data at the Service Delivery Points from the Provinces and use the dispensed data. It is recommended that CMS uses the forecast estimates from the six provinces in estimating their annual contraceptive requirements.

8. **Is data used for managing and trouble shooting the LMIS?**

A number of process, structural and impact indicators would need to be developed to assess the level of effectiveness, efficiency and reliability of the LMIS (refer to RHCS Strategy).

### 2.6.3 Forecasting

RHCS involves forecasting contraceptives using three methods and they include:
- Logistics based estimates
- Health Services based estimates
- Demography based estimates

During the RHCS workshop the writer attempted to have a session with the participants on forecasting. Whilst these were mainly to do with contraceptives, forecasting can also be conducted for other RH commodities also. A few training sessions of the three types of forecasting for annual contraceptive requirements was conducted but most participants felt that these training needed a lot more time to understand the basis and rationale of these forecasting methods. What was worth noting is the basic mathematic skill in estimating and calculating minimum and maximum requirements based on the estimated lead time between the delivery between CMS and the respective provinces.
2.6.4 Procurement

The current CMS purchasing process relies heavily on UNFPA for the purchase of all its contraceptives. For other RH medicines, CMS sources these on its own tendering process. Procurement is a specialised skill and is usually acquired working on site. Supplies are best managed only when the principle of six “Rights” are applied in logistics management. The Six “Rights” are:

- **The Right commodities**
- of the **Right** quality
- in the **Right** quantity
- procured at the **Right** cost
- delivered ...
- to the **Right** place
- at the **Right** time
- ...for...
- the **Right** person ("final kilometre")

Logistics management often fails when the programme is not able to fulfil one or more of the six “Rights” for the “final kilometre.” Capacity (both human and infrastructure) to properly handle these six “Rights” relate to different elements of supply chain management – user friendly service provider skills; sustainable financing; forecasting; intelligent procurement of right type, quality of commodities; good warehousing practices (inventory management) and timely distribution of credible commodities.

*The following points are tabled for consideration in evaluating the procurement process.*

The procurement process contributes to providing clients with a continuous stream of the right commodities/products, in the quantities needed, always seeking to avoid costly errors of over supply and shortages. As such, the main purpose of the RHCS procurement process are to contribute to provide the right quantity, of right commodities, with the right quality according to international prices standards, in the right place, at the right time, and at the right place.

- Procuring the **right goods/service**
  For RHCS CMS delegates this responsibility to UNFPA.
  For RH Medicines this involves CMS getting the all information that enables one to make the right purchase decision by:
  - Knowing the specifications (model, size, colour, performance, tensile, strength, formulation etc)
  - Availability (different types)
  - History (bad reports, failure rates, legal issues)
  - Consumer preferences
  - The availability of local support and back up (trained personnel to handle implementation and maintenance service, availability of spare parts)
• Getting the **right quality**
  CMS does not conduct a medicines registration process nor does it conduct a pre-qualification of its suppliers. Such a scenario places a risk on quality of non-contraceptive RH medicines imported into Vanuatu. For contraceptives, UNFPA purchases from WHO approved pre-qualified suppliers.
  - CMS would need to conduct a thorough evaluation of suppliers before contracts are awarded, based on documentary evidence, factory inspections and samples of commodity.
  - Conduct sampling and testing before shipment by independent inspection company and laboratory to a pre-determined protocol known by the supplier at the time of contract award.
  - Ensure that all commodities conform to international standards

• Getting the **right price**
  - This involves a competitive research (International/local competitive bidding (ICB/LIB), request for proposal (RFQ), quotation or negotiation
  - It involves identifying the right source
  - Ensuring the right specification (according to WHO essential drug list/ UNICEF catalog, UNFPA/TSD contraceptive list) and economic quantities

• Getting the **right quantity**
  This involves
  - reviewing the usage rates (past consumption trends, patterns and levels e.g.: preferences between IUDs and female condoms and overall volume)
  - assessing Storage capacity and distribution capacity (shelf life of product) Cross reference to warehousing
  - Reviewing Mode of transportation (split shipment)
  - Considering the economies of scale (discount for larger orders)
  - Calculating budget availability

• Achieving the **right time**
  The lead time is the time between the issuance of a request and receipt of goods. This includes:
  - Time for order processing
  - Time for manufacturing process
  - Time for shipment to destination (air/sea freight)
  - Time for inspection/custom clearance
  This involves calculating the correct lead time for each level from UNFPA Copenhagen, to UNFPA regional Warehouse, from UNFPA warehouse to CMS, from CMS to provincial hospital levels, from provincial levels to Health Centres, dispensaries and aid post kits.
• Arriving at right place

This involves getting the
• correct consignee address and details (indicate special port if applicable)
• correct documentation (AWB, B/L, invoice, packing list, inspection, labeling, keep cool items etc)
• Import licenses and exemptions.

Whilst this list is exhaustive it is imperative to cover these areas of competence as there is no such formal training program available for purchasing suited for PICs. It is recommended that the RHCS manager considers developing one for PICs.

2.6.5 Monitoring and Evaluation (LMIS):

Given the resource constraints in terms of staffing and level of IT infrastructure available, the strategy has to be developing a simple, flexible and easy to use system that does not require a high level of IT sophistication or IT support. The current manual system of ordering is working well and as the EmOC survey showed, very little of the other reproductive health commodities did run out of stock during the time of the survey. In addition, the provinces reported very little stock outs of RH commodities, including contraceptives. This reveals that the manual system of replenishment is working to some extent. The concern is the over stocking or the over supply of a number of RH and contraceptive commodities and the supply of near expired items from CMS and UNFPA regional warehouse. This can be achieved by streamlining the current work through the use of stock cards, the daily activity register and a monthly report to be sent up the higher supply locations for management purposes (refer to supply manual on VII). The emphasis should be placed on the documentation and reducing the interval between the actual work and the clerical entries of documenting the work or the transaction completed.

Consideration should also be given a simple, flexible and easy to use system of replenishment and software to support the manual system already in place.

The use of the Channel software should be considered for the CMS and the five main provinces. Given that the CMS has already got IT software (MYOB) in place, there were still concerns that the software lacks the ability to track the expiry dates and batch numbers of items stored. The CMS Manager recommended that Pharmacy personnel from CMS or the provinces be sent for on site training on this software.

The strategy in rolling out IT software would be to start small with a number of sites and add more. Thereafter, start small with a number of RH commodities and add more. Later, start small with a number of reports for monitoring an evaluation purposes and add more.

It should be noted the Channel has the ability to track and manage inventory for not only RH commodities but also vaccine and Essential Medicines. In other developing countries like Afghanistan, Bhutan, Sri Lanka and Mongolia, it is used to manage essential medicines, vaccines and other commodities successfully.
Analysis:

Encouraging Findings (Strengths):

- **Replenishment Process:**
  The reports received from the RH supervisors of the provinces indicated very little stock out, only reports of near expired stock and over supply of items. The facilities assessment conducted by a UNFPA Consultant in 2006 for FP and EmOC discovered the same observation. The report went on to say that there were very little stock outs of essential medicines also for Obstetrics commodities and antibiotics. The only concern was the oversupply of some RH commodities.

- **CMS: Dispensed data**
  The LM replenishment process from CMS and the provinces using the current LM form is working well.

Areas of Concern (Weaknesses):

- **Are the essential LM data collected?**
  LM Manual system:
  There are no stock cards available at the CMS or the provinces to keep record of any of the above critical information. All this information is kept on the computer software (MYOB) electronically.

- **LM forms:**
  The only data that are not collected are the losses, and the adjustments that are removed from the pipeline for any reason other than consumption by clients (due to expiration, theft and damage). These adjustments that either increase or decrease stock need to be accounted for.

- **Physical stock versus IT System stock:**
  A brief stock take of all RHCS commodities conducted by the RH Officer and the Senior Pharmacist at CMS, revealed large stock discrepancies between system stock and actual physical stock.

- **Ongoing Stock take**
  In addition there are very little frequent stock takes conducted at the CMS. This same scenario of no stock cards applies also for the Provinces Hospitals, Health Centres and Dispensaries.

- **IT LM System: MYOB**
  The IT MYOB software used at CMS and the provincial hospitals cannot track expiry dates or the batch numbers and is also a concern.

- **Central Medical Stores and Pharmacies in the Provinces**
  The main issues encountered at CMS are losses due to:
  - Damage from incorrect storage or transport conditions
  - Theft of stock whether by health worker or outside
  - Misdirection of stock
  - Unnecessary supplies in stock
  - Supplies that expire before they can be used

---

Vanuatu, Ministry of Health, CMS Presentation to WHO workshop Nadi, Steven Hosea 2008
- **LM Training**
  To date none of the Pharmacy personnel working in the Ministry has received any formal training on LM. Most of the training that is provided in the past has been through past expatriate Pharmacists teaching CMS Senior staff on site, Pharmacy and medicines knowledge. Whilst these has been commendable, there has been very little training on the different LM supply systems actual LM training to strengthen LM competence at CMS and the provinces. There is very little by way of policies and strategies employed to ensure that all CMS and Pharmacy personnel competence in the provinces is improved.

**Risks (Threats):**
- Wrong entries, poor documentation will lead to inaccurate forecasts and hence unreliable estimates for it annual contraceptive and RH requirements.

**Recommendations (Opportunities):**
*The following strategies are to be encouraged for good inventory practice:*
- Ensure that stock cards are used at the CMS and the six main provinces.
- Ensure that the daily activity registers and the monthly reports are used in all the RH clinics.
- Provide hands on and on site training on forecasting at CMS and the six main provinces.
- Explore the use of Channel with the CMS and the two main urban provinces at the hospitals (Villa Hospital and Northern Hospital).
- Start with contraceptives only and when working well, add other RH Commodities, bearing in mind the strategy “think big but start small and acting now”. Once stock outs and reduction of over supply has been achieved, slowly add other items on to the system.
- Develop relevant indicators (process, structural and impact) to assess the effectiveness of the LMIS.
- The RHCS Manager should consider developing a training program for procurement that applies the concepts of the six rights in procurement.
2.7 COORDINATION

The success of RHCS programs is dependent on the level of cooperation between and amongst the key stakeholders. In addition there needs to be clarity of expectations on their respective roles within the RHCS plan.

For this reason there needs to be a conduit through a Committee to coordinate the levels of activities at national level and provincial level. Given that RH is largely a Public Health issue, Government (the Ministry of Health) should take on a leadership role and a central coordinating role.

National Coordination:

A RHCS Committee has been established at the Ministry of Health this year and was convened by the Director of Public Health. This committee has since met twice with membership from the Health Information System unit, Wan Smol Bag a NGO and the National RH/FP coordinator of the Ministry of Health. The Principal Pharmacist and the CMS Manager who play a key role on the RHCS forecasting and logistics requirements were not able to attend its last meeting. The committee has since developed a Terms of Reference and have appointed an RHCS officer whose duties and responsibilities relate to supporting the RH coordinator and promoting RHCS.

The success of this committee will largely be determined by the appointment of the Chairman, the leadership he provides, the Secretary of the Committee, the recording of activities and the convening of the meetings. The RHCS officer will assist the RH coordinator in the secretarial duties of ensuring these meetings take place. The development of the RHCS policy and the RHCS Strategy will form the platform for the work.

A key responsibility of the position will be also will be to ensure the implementation of a sound monitoring and evaluation framework on the RHCS program and activities.

This committee needs to have a more expanded representation to ensure that there is a wider representation amongst other key stakeholders like Youth and Women's group. There is a notable absence of young people or peer age group in the committee.

Provincial Coordination:

The level of coordination at the provincial level for implementation purposes is to be considered also. This would ensure that the RH Policy is implemented nationwide. Whilst the membership could be the same also, the inclusion of a Pharmacist into the Provincial Committees will add more value with the logistics and forecasting contribution.

During the RHCS workshop the issue of a mobile team for Supervision of RH and RHCS programs was also brought up. The current practice is piece meal approach by the respective RH teams like AHD, EmOC, FP, RH and RHCS. The group felt that there would be more synergy in the visits if they were all coordinated together. This would ensure a
proper and smooth coordination of work within RH but also between the Ministry of Health and the NGO’s.

In Sanma province, this Provincial committee would report to the current HIV/AIDS Committee.

**Recommendations:**

- Ensure current RHCS committee meets frequently and includes key stakeholders including the private pharmacies and young people
- Develop the ME framework for the RHCS strategic action plan so that activities can be well planned and followed up
- Consider the activation of RH/RHCS committees in the provinces
- Consider comprehensive RH mobile teams to the provinces and districts for a more coordinated operation of provision of RH services for the underserved areas.
3. CONCLUSION

The SPARHCS framework has been useful in identifying policy and operational issues that will affect RHCS in Vanuatu. The results of the SPARHCS assessment in terms of findings and recommendations have been tabled above. These recommendations should form the basis of expansion of the RHCS Strategy for Vanuatu.

Whilst the contextual environment has been very supportive of RH programs and RHCS, there is a need to develop a National Medicines Policy in order to ensure that RH commodities, including contraceptives and RH medicines are safe, of good quality and is efficacious.

The main theme that requires urgent consideration is the strengthening of the Logistics Management Information System as it covers a holistic approach that includes selection, forecasting, financing, procurement, storage & inventory control, distribution and proper user of RH commodities.

A list of progress indicators like process, structural and impact indicators will be developed to assess the status of progress. A monitoring and evaluation framework should be established to ensure that the aspirations in achieving RHCS in Vanuatu is fully realised.

RHCS is only possible through a clear vision on the broader goals of where RH programs would like to be in Vanuatu for the future. A clear vision has been captured in the National RH Policy and RH Strategy Document 2008, which is currently being finalised by the MOH. An integrative approach and working with medical or non medical audience would broaden the arm of mobilising resources to collectively achieve this vision. With proper capacity competency building and a team of committed and sincere workforce, Vanuatu is well on the way to achieving RHCS for all its citizens.

The success from this RHCS program can be an entry point in strengthening logistics in other priority areas like vaccines, essential medicines and other inventory items stocked at the hospital that requires logistics accountability.
## LIST OF ANNEXES

<table>
<thead>
<tr>
<th>ANNEX</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Vanuatu Next Steps for RHCS 2006</td>
<td>53</td>
</tr>
<tr>
<td>II</td>
<td>Forecasted Contraceptive Requirements for 2009 – 2014</td>
<td>54</td>
</tr>
<tr>
<td>III</td>
<td>List of references</td>
<td>55</td>
</tr>
<tr>
<td>IV</td>
<td>List of people met during consultancy</td>
<td>56</td>
</tr>
<tr>
<td>V</td>
<td>Terms of Reference for Vanuatu Consultancy</td>
<td>57</td>
</tr>
<tr>
<td>VI</td>
<td>Literature Desk review of other UN work In Vanuatu</td>
<td>62</td>
</tr>
<tr>
<td>VII</td>
<td>IMPLICATIONS OF other HEALTH PLANS for the planning of RH and RHCS in Vanuatu</td>
<td>65</td>
</tr>
<tr>
<td>VIII</td>
<td>Stock card</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brief description of Next Steps</th>
<th>Who is responsible party/parties</th>
<th>Who will obtain Authorization (if needed)</th>
<th>Source &amp; Amount of resources needed (Financial/Technical)</th>
<th>What will be the impact</th>
<th>Compatible with existing plans and strategies</th>
<th>Estimated Completion date of this step</th>
<th>Expected completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steps#1: Set of National RHCS working committee</td>
<td>RCRHCS, CMSM, RHM AND FMC</td>
<td>MOH Executive</td>
<td>MOH and UNFPA</td>
<td>Improve on RHCS logistics</td>
<td>Yes</td>
<td>NOV - 04</td>
<td>FEB 2005</td>
</tr>
<tr>
<td>Steps#2: Lobby with HIS to develop a RHCS monthly form</td>
<td>National RHCS working group</td>
<td>National RHCS EOD Chairman</td>
<td>National RHCS</td>
<td>Have another avenue and have available data</td>
<td>Yes</td>
<td>DEC - 04</td>
<td>FEB 2005</td>
</tr>
<tr>
<td>Steps#3: NCRHCS to review MYOB of CMS ON RHCS</td>
<td>National RHCS working group, National RHCS, CMS and Principal Pharmacist</td>
<td>Computer from UNFPA to MOH to be transferred across to CMS</td>
<td>MOH and UNFPA</td>
<td>Be able to distribute RHCS according to consumption or dispensed data</td>
<td>Yes</td>
<td>DEC - 04</td>
<td>DEC 2004</td>
</tr>
<tr>
<td>Steps#4: Warehouse</td>
<td>NRHCS</td>
<td>NRHCS</td>
<td>WHO, MOH AND NGO</td>
<td>Prevent damage of vaccines</td>
<td>Yes</td>
<td>DEC - 04</td>
<td>DEC 2004</td>
</tr>
<tr>
<td>Steps#5: Logistics Management Monitoring visits</td>
<td>Participants of RHCS Nadi workshop</td>
<td>NRHCS</td>
<td>MOH and UNFPA</td>
<td>Better reporting on RHCS</td>
<td>Yes</td>
<td>DEC - 04</td>
<td>DEC 2004</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contraceptives</th>
<th>Unit Cost</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microgynon</td>
<td>0.25</td>
<td>20,707</td>
<td>21,246</td>
<td>21,798</td>
<td>22,365</td>
<td>22,946</td>
<td>109,062</td>
</tr>
<tr>
<td>Microlut</td>
<td>0.35</td>
<td>5,117</td>
<td>5,250</td>
<td>5,387</td>
<td>5,527</td>
<td>5,671</td>
<td>26,952</td>
</tr>
<tr>
<td>Depo provera</td>
<td>0.77</td>
<td>17,046</td>
<td>17,489</td>
<td>17,944</td>
<td>18,411</td>
<td>18,890</td>
<td>89,780</td>
</tr>
<tr>
<td>Male Condom</td>
<td>0.03</td>
<td>11,413</td>
<td>11,710</td>
<td>12,014</td>
<td>12,327</td>
<td>12,647</td>
<td>60,111</td>
</tr>
<tr>
<td>Female Condom</td>
<td>0.42</td>
<td>4,793</td>
<td>4,918</td>
<td>5,046</td>
<td>5,177</td>
<td>5,312</td>
<td>25,246</td>
</tr>
<tr>
<td>IUCD</td>
<td>0.31</td>
<td>73</td>
<td>75</td>
<td>77</td>
<td>79</td>
<td>81</td>
<td>385</td>
</tr>
<tr>
<td>Sub – Total</td>
<td></td>
<td>59,149</td>
<td>60,688</td>
<td>62,266</td>
<td>63,886</td>
<td>65,547</td>
<td></td>
</tr>
<tr>
<td>Cartage @ 15%</td>
<td></td>
<td>8,872</td>
<td>9,103</td>
<td>9,340</td>
<td>9,583</td>
<td>9,832</td>
<td>46,730</td>
</tr>
<tr>
<td>Unit Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$68,021</td>
<td>$69,791</td>
<td>$71,606</td>
<td>$73,469</td>
<td>$75,379</td>
<td>$358,266</td>
<td></td>
</tr>
</tbody>
</table>
Annex III: List of References

- Sample RHCS Mission Reports (PNG)
- SPARHCS Diagnostic Guide on RHCS - *A Tool for Assessment, Planning and Implementation*
- RHCS training package at national level
- Regional RHCS Workshop Report
- RNA Toolkit
- Pocket guide to managing contraceptive supplies
- RHCS training standard power point presentation
- RHCS: Pacific Plan of Action: Status of Recommendations
- Preliminary Report of the Solomon Islands Government (SIG) Demographic Health Survey
- National Sustainable Strategic Plan 2005-2025
- Fiji Essential Medicines Formulary 2006 Edition
Annex IV:  List of People Met

1. Mrs. Apisai Tokon – RH focal point
2. Dr. Len Tarivonda– Director Public Health Services
3. Dr. – Consultant O&G
4. Steven Hosea – Head of CMS
5. Ms. Lucy Norman – Senior Pharmacy Officer CMS
6. Sr. Marie Jean Bابتiste – RHCS Officier
7. Sr. Emily Bovu– VFHA
8. Marcel Braun – Principal Pharmacist
9. Regina Reihana – Pharmacist Northern Hospital
10. RH Supervisors, Pharmacists, IT counterparts in the provinces that were at the RHCS workshop.
Annex V: Terms of Reference for Consultancy

UNFPA Pacific Sub-Regional Office

Terms of Reference

For Reproductive Health Commodity Security (RHCS)
Status Assessment in Vanuatu

1. Background

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\(^{12}\). The global strategy for RHCS underpins a huge proportion of UNFPA efforts to improve Sexual and Reproductive Health. However, for the Pacific, RHCS faces greater challenges for the nearly 8.5 million population lives in about 24 Pacific islands countries and territories (PICTs) covering one-third of the earth's surface\(^{13}\). Access is a key factor in meeting RH needs of PICTs. In most countries, RHCS issues include logistics systems, infrastructure, procurement, warehousing, distribution, quality assurance, stock monitoring and management and unusually long lead times. Central to this is the capacity of PICTs to correctly forecast their needs so as to minimize the issue of overstocking as noted in the RHCS Report and Pacific Plan of Action.

For adequate forecasting of RH Commodities it is necessary for countries to have valid and timely logistics management information systems. Some Pacific Island Countries continue to struggle with maintaining valid logistics management information data at all levels of the pipelines. It was thus deemed necessary that a holistic RHCS Situational Analysis be undertaken in selected countries for identification of major gaps and the formulation of priorities through the development of an RHCS strategic Action Plan which should be able address these gaps.

While Regional RHCS trainings have been conducted in the Pacific, further training in country is necessary to ensure RHCS becomes a reality for all citizens. In-country training and a needs assessment is required for Vanuatu.

2. Objectives

In the context of RHCS, the overall objective is to ensure a secure supply and choice of quality contraceptives and other reproductive health commodities to meet every person’s needs at the right time and in the right place.

---

\(^{12}\) For details of recommended steps to promote RHCS at the national level see to the Annex to the Terms of Reference of the RHCS Thematic Trust Fund which can be accessed at the UNFPA intranet at: http://docs.unfpa.org/docushare/dsweb/Get/UNFPA_Publication-2215/TORs+for+RHCS+Trust+Fund++2004-FINAL.doc

Results
The following results are expected:
- Situational Analysis Report - Knowledge and understanding of the status of RHCS at the country level (for Vanuatu).
- RHCS Strategic Action Plan (for Vanuatu) - details of how to towards enhanced coordination and sustainability identified.
- Training of reproductive health and pharmaceutical personnel.

3. Assumptions and Risks

Assumption: In undertaking this initiative it is assumed that, the Sub-regional office for the Pacific will be proactive in following up the recommendations of the above activities.

Risks: If these recommended RHCS strategies are not incorporated in the national Reproductive Health Policy/ Strategy, they are much less likely to succeed.

4. In-house RHCS taskforce

A Task Force comprising the RHCS Advisor, the RHCS Manager a.i, the Vanuatu RH Coordinator and a representative from management met to develop the Terms of Reference for this review and training, selected the consultant, manage the consultancy, provide feedback throughout the process to UNFPA management and evaluate the consultancy output. Noting the urgent needs to carry out a RHCS Needs assessment for Vanuatu, it was agreed that the same consultant could visit Vanuatu (pending Government clearance) and then undertake 1 week consultancy in Vanuatu during the consecutive weeks.

5. Scope of work

Under the overall supervision of the in-house RHCS task force, the consultant will, for Vanuatu:
- Conduct a diagnosis of RHCS status;
- Identify factors that limit or enhance RHCS prospects ;
- Process those findings to reach consensus on priorities for improving RHCS;
- Make specific recommendations on how to move forward;
- Develop RHCS strategic action plan;
- Undertake training of RHCS with relevant personnel in Vanuatu

6. Specific aspects to be addressed

RHCS status assessment

The Strategic Pathway to RHCS (SPARHCS) encapsulates and defines the various aspects of RHCS and provides a detailed tool for assessment and planning with specific questions to address the complex set of issues involved. The RHCS status assessment should cover all the elements as specified in the SPARHCS. SPARHCS is available in http://www.maqweb.org/sparhcs/index.shtml
Below is an outline of the key areas that should be addressed in the assessment:
1) Assess, assemble data and identify data gaps pertaining to commodity utilization, method mix, demand, donor contributions and distribution on commodity utilization, method mix, demand, unmet need, donor contributions and access to services
2) Assess receptivity and feasibility of contraceptive use especially with Female Condoms in the countries.
3) Estimate short and long term (next 3 years) RH commodity needs and costs.
4) Describe and assess support to RHCS and RH commodities by government, donors, social marketing organizations, private sector and NGOs, etc.
5) Describe and assess the RHCS situation regarding supply management and LMIS, training, storage, transportation, distribution system and forecasting.
6) Assess current training needs within LMIS and for service providers (this is same as in training above)
7) Describe and analyze the current monitoring and evaluation mechanisms in place including data collection and reporting techniques
8) Describe and analyze the roles of RHCS stakeholders including public sector (health sector, police, military etc.), NGOs, Social Marketing organizations etc.
9) Discuss feasibility or strength of RHCS Coordinating Committee
10) Develop National RHCS Strategic Action Plan
11) Undertake training in RHCS with national focal points (both countries)

7. Methodology

The following methodologies will be used for Nauru and Solomon Islands:

- Initial briefing with the Task Force to specify the scope of work, expectations, and requirements of the consultancy.
- Desk based review to analyse documents, additional resources provided.
- Interactions (including observations of meetings, training workshops and visits to RH clinics) with RHCS focal point, Ministry of Health officials and field visits to selected health facilities (health centre and pharmacy).
- Interviews and focus group discussions with in-country RHCS focal point, RH coordinators, pharmacy staff and other relevant Ministry of Health officials and other relevant stakeholders.
- Review of relevant in-country data files and documents
- Use and adapt tools used in past RHCS reviews to gather information for the review
- Facilitate the in-country RHCS Training

8. Materials and Documents to be reviewed

The Sub regional Office for the Pacific will provide the following papers and reports for the RHCS review:


14 Can get secondary information from government through key informant MOH
15 If there is an existing one.
9. Deliverables

The following deliverables is required from Vanuatu:

1. RHCS status assessment
2. RHCS Strategic Action Plan
3. RHCS Mission report which will contain training component

Based upon the information obtained in the in-country assessment, the consultant will deliver a coherent Draft and three separate reports that address all aspects outlined above and will be divided into three components: assessment, action plan and training report.

The Draft Report will include recommendations on how to enhance the different components of RHCS and they will be discussed with and approved by key in-country stakeholders at the end of the mission. The recommendations should be made with a focus on the process of updating or developing a national Reproductive Health Commodity Security Strategy for developing country capacity, sustainability and coordination. Three specific issues that need to be particularly stressed are the enhancement of a national coordination mechanism, the existence of a budget line for RHCS and the inclusion of contraceptives into the essential drugs list.

10. Location and Timeframe

RHCS Review and Training: Total of 28 working days within the period from the end of July to early September 2008 (excluding travel time to and from Vanuatu) as follows:

- Three working days preparatory time (home-based) before mission
- Five working days in Vanuatu for review and training
- Eleven working days in Vanuatu for review and training
- Five working days to draft the reports (home based) and
- Four working days (home-based) to finalise the report based on comments received from UNFPA.

We will set deliverable of receiving both the final reports by 9 September 2008.
[Ref to Annex 1 for detailed consultancy work schedule]
11. Knowledge, Skills and Experiences Required

The consultant should have working experience in the area of RHCS and have been involved in development of RHCS strategic plans and situational analysis. He/she should have had some experience in conducting trainings on RHCS. A Masters level or the equivalent qualification in the area of public health, pharmacy, health management and/or other related social science field is desirable. Fluency in oral and written English. At least 5 years professional experience preferably in Programme and commodity management in the public or private sectors. Working experiences in the Pacific and knowledge of Pacific islands development issues are desirable. The consultant should be computer literate.
## Annex VI

### Literature Desk review of other UN work In Vanuatu:

<table>
<thead>
<tr>
<th>Source Document</th>
<th>Stated Element</th>
<th>Stated Aim or Action in Plan (or Policy Goal) With relevance to RHCS or RH</th>
<th>Comments/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Situational Analysis of Children, Women &amp; Youth: UNICEF 2005</td>
<td>Executive Summary Child and Maternity Health</td>
<td>United Nations statistics for Maternal Health are very serious. Fertility rates are very high and most women give birth without access to adequate obstetric care. Traditional Gender roles that restrict women’s input into decision-making limit their control over their own bodies and reproductive health</td>
<td>Although the fertility rates quite high the trend over the last 5 years has been decreasing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vanuatu spends less on its national health system per capita than most Pacific Neighbours. Limited resources impact negatively on the reach and quality of primary health care services. The Ministry of Health is working towards improving, planning, and management and training systems with support from donors. Accurate data and stronger reporting mechanisms urgently needed to be developed to inform national policy making</td>
<td>The actual budget trend both in terms of budget and expenditure on health needs more analysis in terms of %GDP spent on health and on per capita basis spent on health.</td>
</tr>
<tr>
<td></td>
<td>Executive Summary Vulnerable Children and Women</td>
<td>Vanuatu has ratified the Convention on the rights of the child and the Convention on the Elimination from all forms of discrimination against women (CEDAW). However significant efforts need to be made to bring legislation and development policy in line with both conventions. NGOs, community groups and donors have been the driving forces behind improvements in child centered development.</td>
<td>Women and Children population policies have been developed (name them), Including population policies.</td>
</tr>
<tr>
<td></td>
<td>Executive Summary Emergencies</td>
<td>Vanuatu is rated as the highest disaster prone country in the South Pacific. The countries geographical location is vulnerable to cyclones, earthquakes, Tsunamis and volcanic eruptions. Emergencies occur on annual basis, causing significant distress to communities, particularly those in isolated areas. Even so, disaster mitigation does not appear to priority for the government and occurs only on an ad hoc basis. Disaster preparedness needs to be mainstreamed into regular development programming.</td>
<td>Last cyclones Cyclone Ivy and cyclones Kerry. It passed over Penama Province in the North and destroyed over 95% of affected islands. Health Centres and Medical Supplies were damaged in half of affected localities</td>
</tr>
<tr>
<td></td>
<td>Executive Summary Broader Courses of Action</td>
<td>Responsibility of sustainable development and progress towards the fulfilment of children’s and women’s rights ultimately belongs to the people of Vanuatu. Elected leaders, public administrators and community groups mobilize and prioritise the use of resources. Development is influenced by key stake holders: Parliamentary Executive and members of Parliament; the Malvatumauri National Council of Chiefs, public administration; donors; NGOs and communities.</td>
<td>These will be the key people in mobilizing advocacy RHCS at a very high level.</td>
</tr>
</tbody>
</table>
## OVERVIEW

### Demographic trends

Vanuatu has a young population. In 1999, 43 percent of the population aged 0 -14 years with 54 percent aged between 15 - 64. Life expectancy as 70 years for females and 67 years for males. The annual population growth rate is estimated to be about 2.7%, which high by international standards and in comparison to most Pacific Island Countries. Sixty five of Vanuatu’s 82 Islands are inhabited. Almost 80% of Vanuatu’s population lives in rural areas. Over the past ten years urban population growth has been 2 - 3 times higher than that of rural areas, suggesting a pattern of rural - urban migration. The two most urban centres are Vanuatu’s capital, Port Vila (population 27,929) on Efate and Luganville (population 10,650) on Espiritu Santo. Both town have large communities and informal urban settlements just outside the town boundaries.

### Rural and remote communities

People living rural and remote communities have less access to quality social services, illustrated by generally poorer indicators in all areas of health and education. Given that 80 percent of Vanuatu’s population lives in rural areas, significant disparities in the well being or urban and rural communities are cause for serious concern. There are many small, isolated communities on the hundreds of Small Islands throughout the archipelago. Other villages are in a dense jungle or located on steep hillsides, only accessible by dirt tracks in dry weather. Walking or canoeing for several hours to get to medical facilities or markets is no unusual.

### Economic trends

Vanuatu experienced positive growth, the first time in several years. Although small estimated at 1.4 percent growth is forecast to continue and gain momentum in the coming years. Vanuatu has implemented a major reform programme since 1997 which has led to improvements in the management of public sector finances, with expenditure now more carefully controlled through an accountable and transparent process. However, a limited revenue base continues to constrain government efforts to deliver services and implement reforms. Revenue collection has fallen far short of projections in recent years, making budget management very difficult for individual departments and the government as a whole. It is expected that economic difficulties currently facing government will continue for the remainder of the decade, resulting in reduced resources for social services.

### Millennium Development Goals Report: UNDP

#### Socio-economic context: The People

Vanuatu’s population is increasing. The 1999 population census showed that the urban centres or Port Vila and Luganville are increasing rapidly, with 21% of the people of Vanuatu living in these urban centres. The remaining 79% live in the rural areas and mostly live off land and sea.

Fertility – the number of babies born to a woman is declining slightly (to note that birth cohorts are still increasing). The Ni-Vanuatu fertility rate decreased from 5.3 in 1989 to 4.8 in 1999. which is also reflected in the decrease in crude birth rate from 37 per 1000 to 33 per 1000?
The rate of infant mortality—babies aged less than a year dying—has also decreased. This means that while women are having slightly fewer babies, more of the babies are surviving.

The challenge is to provide the economic development and infrastructure to support the growing population—opportunities to generate income through things like access to land, jobs, and business activities, develop skills; markets for produce and so on are required.

The Economy
National economic growth has been uneven, and in recent years has declined, although the slight growth of the past two years is projected to continue. The economy of Vanuatu has a narrow income base, with over half of the economic activity being in the service sector (wholesale, and retail trade, government services, transport and communication), one quarter in the agriculture sector (mostly subsistence agriculture) and one tenth in manufacturing. The lack of training opportunities has resulted in shortages of skilled people in key parts of Government as well as the private sector. Vanuatu is ranked as a UN least developed country since 1995. With a per capita GDP of less than US $1,276, Vanuatu is the third poorest country in the Pacific with a national poverty incidence of 39% (1997, HIES). The human poverty index (HPI) ranks Vanuatu number 13 of 15 Pacific Island Countries and 128 on the UNDP Global Human Developmental Index (HDI) in 2003.

Government
In 1994 the 11 local Government councils established at Independence to form the link between Government and rural areas were restructured into six Provincial Governments to promote rural growth and devolve administration to the level where different needs and circumstances of rural districts would be better addressed and to ensure that rural areas receive an equitable share of Government Services. The long term goal is the devolution of financial and administrative decision making to the provincial government level.

Development goals and objectives
In an effort to address structural problems in the economy, Vanuatu began a Comprehensive Reform Program (CRP) in 1997, based on three areas of reform: public sector, economic and those promoting equity and social development (supported directly by the ADB) through a $25 Million loan, and integrated into assistance provided by other donors.

Evidence based decision making
The Vanuatu National Statistic system is working to address weaknesses in the quality, timeliness and coverage of a number of key outputs, while trying to meet existing and emerging demands for information. Government’s institutional capacity for analyzing statistical and other information for policy and decision making, and making necessary policy adjustments, is weak but improving through CRP initiatives.
## Annex VII

### IMPLICATIONS OF other HEALTH PLANS for the planning of RH and RHCS in Vanuatu

**Master Health Services Plan**

<table>
<thead>
<tr>
<th>Facility Needs Assessment for FP and EMoC in the RoV: UNFPA 2006</th>
<th>1.3 General Family Planning Information: General Family Planning Information Available Contraceptive Methods and Services the 5 Participating Hospitals</th>
<th>Although vasectomy (male sterilization) is still not popular in the country; the Obstetrician/Gynaecologist at VCH, who has been trained on the ‘non-scalpel procedure’, hoped to see a strengthening of the national promotional programme on vasectomy. Such a programme should take into consideration the custom and cultural beliefs and views associated with such FP method. Also bearing in mind that ‘female sterilization’ has no major obstacles in terms of culture and customs.</th>
<th>Expect and increase in Male Vasectomy in the future.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The wastage of FP supplies should be avoided through the close monitoring of stock in hand. For example: 199 doses of injectables (Depo-Provera) with 10/2006 expiry dates in stock in one of the hospitals, which was in excess of their requirements for the next two months; resulting in their possible wastage. This issue will be discussed again under sub-section 1.3.2. (a) (iii) as overstocking of FP commodities is also not uncommon in health centres and dispensaries.</td>
<td>Oversupply of Depo-provera is a consequence of poor forecasting and the lack of an inventory control system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Contraceptive Methods are recommended under the recently released Vanuatu Evidence Based Guidelines in Family Planning for Health Workers. As such, Postinor Pills (Emergency Contraceptive Pills) should be made available. This is preferable to the use of COCs and POPs.</td>
<td>Factor this into the logistics supply of Provincial Hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Although services on contraceptive norplants are not available in the country; proper insertion and removal sets should be provided at VCH especially to cater for the need of clients requesting removal of Norplants that were inserted in other countries. The obstetrician/Gynaecologist at VCH had successfully carried out a few Norplant removals in the past few months without proper insertion/removal sets.</td>
<td>Consider the use of Jadelle as a replacement for Norplants and the supporting training for its insertion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Assessment/Survey teams were informed that female condoms will soon be available in FP clinics, health centres and dispensaries</td>
<td>Factor this into the logistics supply of Provincial Hospitals</td>
</tr>
<tr>
<td></td>
<td>Available Contraceptive Methods and Services the 20 Health Centres and 11 dispensaries</td>
<td>A wider choice of FP methods will soon be possible with the expected introduction and distribution of female condoms and emergency contraceptive pills in the near future. In the meantime, nurse-practitioners, nurse midwives and registered nurses in H/Cs and dispensaries should familiarize themselves with the use of these two methods. This familiarization process could be channelled through formal and informal “hands on training” especially through supervisory visits.</td>
<td>Female and Emergency Contraception needs more awareness “hands on training” during supervisory visits.</td>
</tr>
</tbody>
</table>
The overstock of soon to be expired FP supplies could be avoided with better monitoring procedures. At the same time, surplus supplies should be returned to the National and Provincial Medical Supply Stores to be redistributed to other facilities where they could be used before the expiry dates. Moreover, supplies that are expiring within a six month period should only be distributed to facilities that could utilize them within that period. But again, this is only possible if each facility makes its requisition based on actual need (taking into account the available stock at hand) rather than ‘guessimates’ and/or ordering the same amount every quarter without any proper stock takes. Similarly, in order to avoid a ‘stock out’, as noted in a couple of facilities; it is highly recommended that at least a three month supply (based on calculated need) of each commodity is available in stock in at any given time.

Overstocking of near expired are a consequence of poor forecasting, lack of inventory control procedures and lack of monitoring from National levels.

Training of more staff on IUD insertion and removal supported by an ongoing programme to promote the use of this effective method should be considered.

Perhaps it is appropriate to again state here that FP was (and still is) one of the major ‘key factors’ in reducing maternal morbidity and mortality. As such, it should remain as an important component of the integrated national RH programme and not to be neglected.

### National FP Service Guidelines Technical Assistance provided by UNFPA

<table>
<thead>
<tr>
<th>Available FP Protocols and Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of the participating facilities have no specific reference materials on FP guidelines and protocols. However, most facilities used the “Vanuatu Manuals for Health workers” as a reference book for FP guidelines. A few copies of “Medical Eligibility Criteria for Contraceptive Use” (WHO) and the “Vanuatu National Family Planning Manual: ‘Essential Policies and Standard Practices for Family Planning” (South Pacific Alliance for Family Health (SPAFH) and Ministry of Health, 1993) were sighted in some facilities. The 2006 National FP Service Guidelines have been widely distributed and introduced at the provincial level and will need further updating in 2008.</td>
</tr>
</tbody>
</table>

### General Emergency Obstetrics Care (EmOC) Information

Observation and Findings:
(All thirty six participating facilities were assessed for EmOC utilizing the ‘signal functions’ (Note that the data for a period of 12 months (2005) were used rather than 3 months due to relatively small number of deliveries in most facilities).

- The available parenteral antibiotics at the dispensaries were ampicillin and metronidazole; at the H/Cs were ampicillin, gentamycin and metronidazole and in the hospital were ampicillin, gentamycin, metronidazole, cloxacillin and ceftriaxone were available in all hospitals.
- Administration of parenteral oxytocics was available and used in all participating facilities.
- Parenteral anticonvulsants and sedatives for pregnancy induced hypertension were available in all participating facilities with diazepam (valium) as the anticonvulsant drug of choice. Magnesium sulphate was also available in all hospitals and three H/Cs but has not been used in any of the facilities in the last two years.
- MgSO4 was available but not used.

Inventory Ordering System is working for Drugs.
### 3. General Data

**a. Hospital Beds**
- Recommended Four Year Phased Approach to Development of National Contraceptive Budget in MoH Annual Budget.
  - Year 1: $80 000
  - Year 2: $60 000
  - Year 3: $40 000
  - Year 4: $20 000
  - Year 5: 0

**c. Anaesthesia**
- Need to re-calculate this amount against the latest user data (dispensed data from the provinces) from 2006 and 2007
- LMIS forms to be reviewed and updated
- RH/RHCS policy to be developed
- Strengthen Standard Operating Procedures
- Develop and RHCS Manual for PICs.
  (Discuss with Annette)
- Emergency Contraceptive Pills
  - Capacity building
  - Forecasting
  - Need more on site training in the provinces.
- Alerts of contraceptive stock outs

### Female condom programming in the Pacific: UNFPA 2005

To better reflect the reality in Vanuatu, the FC initiative will address those who can and will negotiate FC use as well as those who cannot. Findings from key institutions and NGOs showed that there is political support for the FC initiative. As a first phase, criteria for selection for institutions for the reintroduction should target vulnerable groups including: Women in RH Services who want double protection Women outside of RH Services (menopausal, tubal ligations) CSW, MSM and women in gender-based violence relationships A taskforce representing these groups has been nominated (table 2). Specific training in the advocacy and use of the FC will be needed. The communication strategy needs to be culturally sensitive and target specific.

### RHCS Review 2003 UNFPA

Forecasting to be based on consumption data and not issue data which entails quite a number of other important processes needing improvement

- Using service statistics data alone for forecasting is not accurate and efforts need to be made to improve data management
- Regular stock-taking is required to maintain relevant status of SOH, MOS and QTO
- All clinics need to report on status of stock levels regularly to facilitate in-country pipeline planning and management

### Reproductive Health Policy 2008

- Reproductive Health Strategy 2008 – 2010
  - Technical assistance provided by UNFPA
- Drafted version includes key RH policy areas and RHCS Awaiting legislative clearance
Annex VIII: Stock Card

<table>
<thead>
<tr>
<th>Item Description:</th>
<th>Maximum Stock Level:</th>
<th>Maximum Quantity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warehouse Location:</td>
<td>Minimum Stock Level:</td>
<td>Minimum Quantity:</td>
</tr>
<tr>
<td>Stock Number:</td>
<td>Unit of Packing:</td>
<td>Average Monthly Consumption:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Transaction</th>
<th>Voucher Number</th>
<th>From/To</th>
<th>Requisition and Issue</th>
<th>Quantity</th>
<th>Balance on Hand</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: 1 copy for each item

The essential information that needs to be collected includes:

- **Item Description**: should include both contraceptive method and the brand.
- **Warehouse location**: describes where in the storage facility this product is kept (this is needed only if the storage area is large).
- **Stock number**: is the number assigned to the product by either the manufacturer or the central warehouse (this may not be necessary in some systems).
- **Maximum stock level and Minimum stock level**: refer to the highest and lowest levels that should be maintained for this product at this outlet, expressed as months of supply (the Maximum/Minimum inventory control system is explained in the next section).
- **Unit of packing**: is the number of individual pieces contained in the standard package for this product.
- **Maximum quantity and Minimum quantity**: are the highest and lowest quantities that should be on hand for this product at this outlet, at current rates of use. Always express quantities as individual pieces, not as larger units such as boxes and cartons.
- **Average Monthly Consumption**: is equivalent to one month’s supply. The calculation procedures are described in the next section.
- **Date of transaction**: refers to the date of transaction being recorded. The date is used to calculate average lead-time.
- **Requisition and Issue Voucher Number**: records the number on the voucher used for the transaction.
- **From/To**: indicates where the supplies are arriving from or to whom or to what facility they are being issued.
- **Quantity Requested, Received, and Issued**: are used whenever this contraceptive is ordered/requested, received from warehouse, or issued from the storage area. Record the amount and date (and voucher number if necessary).
- **Damage/Lost**: is used to record any non-standard changes to the inventory, such as damaged or expired contraceptives removed from stock, a correction after a physical count, or quantities removed to conduct quality testing.
- **Expiration Date**: records date of expiration of the product received or issued. This will help track the quantity of products due to expire.
- **Balance on Hand**: should be calculated whenever any stock is added or removed. Compare the new total with the maximum and minimum quantities at the top of the card. When a physical count is done, enter the number counted in this column.

**Remarks**: should be used to explain entries in Damage/Lost column and any other needed clarifications.