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Including the
Private Sector
in the
SPARHCS Process



A Companion to
The SPARHCS
Process Guide

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Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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SPARHCS

**Including the Private
Sector in the
SPARHCS Process**

**A Companion to
The SPARHCS
Process Guide**

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Acronyms

CHAK	Christian Health Association of Kenya
CIDAIA	Contraceptive security committee
CPR	Contraceptive prevalence rate
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
FP/RH	Family planning/reproductive health
GIZ	Deutsche Gesellschaft Für Internationale Zusammenarbeit (German Society for International Cooperation)
GOPFP	General Office for Population and Family Planning
HENNET	Health NGOs Network
IPPF	International Planned Parenthood Federation
LMIS	Logistics management information system
MSI	Marie Stopes International
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Sanitation and Public Health
NGO	Non-governmental organization
Ob/gyn	Obstetrician/gynecologist
PPP	Public-private partnership
PPP-HK	Private Public Partnerships – Health Kenya
PRSP	Poverty reduction strategy paper
PSP- <i>One</i>	Private Sector Partnerships- <i>One</i>
RH	Reproductive health
RHCS	Reproductive health commodity security
SHOPS	Strengthening Health Outcomes through the Private Sector
SPARHCS	Strategic pathway to reproductive health commodity security
SUPKEM	Supreme Council of Kenya Muslims
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Including the Private Sector in the SPARHCS Process: A Companion to The SPARHCS Process Guide

Many countries are now facing resource and programmatic challenges created by growing populations of women of reproductive age, increasing use of contraceptives for family planning, still substantial unmet need, and growing response to the HIV/AIDS pandemic. Chief among these challenges is the need to maintain a consistent, accessible supply of high quality contraceptives and condoms and family planning/reproductive health services sufficient to satisfy the increasing demand. Meeting this challenge has been made more difficult in many countries by limited public resources available for reproductive health and by diminished or shifting international donor support.

SPARHCS – Strategic Pathway to Reproductive Health Commodity Security, is a tool created in 2004 to help country program planners and managers successfully meet the challenges of increased demand and limited resources through development and implementation of strategies for securing and maintaining the supplies essential to family planning and reproductive health services delivery. The SPARHCS process has been designed to bring together a wide range of stakeholders from within the public, private/nonprofit, and private/commercial sectors—each with its own set of capabilities and resources—to work together toward the goal of reproductive health commodity security (RHCS).

Country experience to date with the SPARHCS process has been largely successful. It has become clear, however, that it is sometimes difficult to effectively involve the anticipated wide range of stakeholders. In particular, it has sometimes proved difficult for public sector leaders in family planning and reproductive health to engage a variety of private sector stakeholders in the SPARHCS process. Without adequate inclusion of the financial and service delivery resources of the private/nonprofit and private/commercial sectors, strategies for creating and maintaining RHCS become more difficult to implement and may have diminished opportunities for success.

Public sector family planning and reproductive health program planners and managers cannot, therefore, afford to leave the considerable human and financial resources that the private/nonprofit and private/commercial sectors represent less than optimally involved in the RHCS process. This is a companion to *The SPARHCS Process Guide*, published in 2008 to aid RHCS planners in engaging public sector stakeholders. It seeks to provide guidance to RHCS planners in how best to involve a wide range of **private** sector stakeholders in the SPARHCS process and thus gain their partnership with the public sector in ensuring a consistent, accessible supply of high quality contraceptives and condoms and family planning/reproductive health services for all those who need and want them.

1

Reproductive Health Commodity Security

Reproductive health commodity security (RHCS) exists when women and men can choose, obtain, and use quality reproductive health (RH) commodities, especially contraceptives and condoms, when and where they need them. This definition emphasizes three areas of concern:

- **Clients** – There is no reproductive health commodity security unless the whole market of current and potential contraceptive clients is able to choose, obtain, and use the contraceptive methods and condoms they want. The “whole market” ranges from those clients who require free or subsidized products to those who are able and willing to pay for what they want and need. Consequently, the public, private/nonprofit, and private/commercial sectors all have an important role in ensuring contraceptive security. The whole market of clients cannot be appropriately served if any one of these delivery channels is either absent or unduly constrained.
- **Commodities** – Reproductive health commodity security exists only when clients can make an informed choice from among a full range of high quality contraceptive methods and services at a price they can afford. Ensuring access to permanent and long-term methods is as important to contraceptive security as ensuring access to resupply methods such as pills, injectables, and condoms.
- **Long-term assurance** – Reproductive health commodity security requires that the methods women and men want are consistently and reliably available. Long-term assurance of availability means that the public sector, the private sector (both nonprofit and commercial), and donors must make long-term commitments to the financing, procurement, and distribution of contraceptive products and services. Long-term assurance is facilitated by effective market segmentation where available resources are used efficiently and without unnecessary overlap as each sector serves that part of the whole market for which it is best suited or where it is most needed.¹

¹ *Contraceptive Security Ready Lessons, Overview, Contraceptive Security Defined, pages 1–2.*

2

The Whole Market Approach to RHCS

The whole market of current and potential contraceptive users is demographically, socially, economically, and politically diverse. Reaching all these consumers effectively requires an approach that responds to the varying contraceptive method and service needs of each individual—from those who cannot afford to pay to those who are able and willing to pay for whatever they need, from those who want short-term contraception to those who seek long-acting or permanent methods, and from those who are long-time contraceptive users to those who have not yet adopted contraceptive use.

Creating contraceptive security for all these differing consumers in ways that are most supportive of the needs of each requires the participation of a variety of product delivery channels and service providers. The resources and competitive advantages of the public, private/nonprofit, and private/commercial sectors can each effectively reach and serve some but not all of the whole market for contraceptive products and services. Conversely, the whole market cannot be efficiently or perhaps even fully served if one or more of these sectors are omitted from the RHCS process.

Reaching the whole market of consumers with a consistent supply of the full range of quality reproductive health products and services—in other words, creating reproductive health commodity security—is most efficiently achieved through the process of market segmentation. The concept of **market segmentation** recognizes that the diverse overall market can be divided into smaller groups of consumers who have certain characteristics in common. The consumer and potential consumer characteristics around which RHCS market segments are formed may include such things as income level, age, geographical location, parity, type of contraceptive method or service desired, and history of contraceptive use. Information, product prices, and services that are most appropriate for and acceptable to these smaller groups of similar consumers can then be delivered through the channel—public, nonprofit, or commercial—that is most appropriate and most accessible for each market segment.

An approach to RHCS that coordinates the efforts of the public, private/nonprofit, and private/commercial sectors not only ensures that the multiplicity of consumers' reproductive health needs are effectively met and that the strengths and advantages of each sector is used to its best advantage but also helps avoid inefficient use of resources, unnecessarily overlapping efforts, and conflicting goals. Such a coordinated approach is based on a clearly stated role for each sector and on a clearly defined segment of the reproductive health supply market for each to serve and is often referred to as “the **whole market approach**.”² Without this coordination, RHCS stakeholders may find themselves competing to serve the same limited portion of the overall market while other market segments remain underserved or even unserved.³

Key benefits of the whole market approach include:

- **Creating RHCS for each consumer** through the most personally acceptable service delivery channel supportive of her/his use of contraceptive products and services;
- **Enhancing equity** by targeting public sector subsidies and free products and services to those consumers who truly need them;
- **Increasing access** to contraceptives and condoms for underserved clients through more efficient use of available resources; and
- **Harnessing multi-sectoral support** for RHCS.⁴

² *Contraceptive Security Ready Lessons*, Lesson 3, page 1.

³ *Contraceptive Security Ready Lessons*, Lesson 11, page 4.

⁴ *The SPARHCS Process Guide*, page 10.

3

The Private Sector as Part of the SPARHCS Process

A recent assessment (USAID | DELIVER, 2008) of more than fifty country reports—produced as part of the SPARHCS process in each country—explored the degree to which the role of the private (non-public) sector and issues affecting the private sector had been addressed. A random sample of twelve country reports was reviewed.

In general, this assessment of selected SPARHCS country reports found varying degrees of success from country to country in incorporating private sector input, issues, and stakeholders. Findings of particular importance include the following:

- A wide range of **private sector stakeholders** was not always included in the information-gathering process in country assessments;
- The place of the **private sector in the country context** – including national policies and regulations that affect reproductive health commodity security (RHCS) and in the general social, economic, cultural, and political environment – was often not fully addressed;
- The **capacity of the private sector** to contribute to RHCS was not evaluated in depth;
- Very few assessments examined **policy issues relating to the private sector**;
- While the reports broadly addressed sources of reproductive health commodities, information sufficient to understand fully the **role of the private sector in the total picture of commodity procurement and sources** was not often provided; and
- Donor resources channeled through social marketing programs and NGOs were better addressed than **resources available for RHCS through other private sector channels**.⁵

While many challenges to full inclusion of the private sector in SPARHCS country assessments—including the varied backgrounds and experiences brought by consultants and other participants to the process, the priority interests of the various donor agencies that fund the process, availability of relevant data, initial level of interest of the private sector in RHCS, and the widely varying country contexts in which the process is applied—will always exist, they may be minimized with clear guidance and a more standardized approach to including the private sector in the SPARHCS process. This companion to *The SPARHCS Process Guide* seeks to provide that guidance.

⁵ *Engaging the Non-Public Sectors in the SPARHCS Process*, Draft, USAID | DELIVER Project, 2008.

4

Who Is the Private, or Non-Public, Sector?

In broadest terms, the private sector includes any entity or individual that is not owned, managed, controlled, or salaried by the public, or governmental, sector. The private sector may operate not-for-profit (nonprofit) or for-profit (commercial). The table below illustrates the wide range of private sector entities that may be encountered in the RHCS process.

Table 1. Private Sector Entities in Family Planning/Reproductive Health

Nonprofit	Commercial
NGO service delivery organizations	Pharmaceutical, condom, and device manufacturers: domestic and international
NGO/civil society advocate organizations	Pharmaceutical, condom, and device importers
Faith-based service delivery organizations	Product distribution companies, including warehousing and transportation companies Waste processing companies
Social marketing organizations	Private practice doctors, nurses, midwives
Universities: training for medical and health care providers; clinics and hospitals; faculty as trainers and advocates	Retail pharmacists
Associations of doctors, nurses, mid-wives, pharmacists	Traditional medicine and health care providers
Manufacturers' associations	Commercial shops, markets, vendors, and boutiques Employers offering health care benefits Health insurance companies HMOs Hospitals and clinics Media, advertising, and market research companies Workplace clinics

Engaging the private sector in the SPARHCS process is essential for a number of reasons:

- The private sector already makes a significant contribution to family planning/ reproductive health service delivery. Table 2 illustrates the degree to which the private sector provides methods and services to current contraceptive users in a range of country settings.
- Consumers often value private sector services over services available through other channels because they perceive them to be higher quality, more reliable, or more accessible.
- Resources, skilled providers, and infrastructure from all sectors will be required to help governments, now falling short of meeting Millennium Development Goals, provide greater access to family planning and reproductive health care.
- Many NGOs serve vulnerable populations in hard-to-reach areas that otherwise might have limited or no access to the public sector health system.⁶
- In a number of countries the private sector provides methods, such as permanent or long-acting methods, that the public sector is either not allowed or unable to provide.

Table 2. Current Role of the Private Sector in Contraceptive Services Delivery⁷

Country	CPR	Source of Modern Method — Private (%)
Indonesia 2007	57.4	76.7
DRC 2007	6.7	74.3
Nigeria 2008	10.5	73.5
Uganda 2006	15.4	61.7
Paraguay 2008	52.4	57.7
Jordan 2007	41.9	57.6
Ghana 2008	13.5	54.1
Philippines 2008	21.8	53.6
Bolivia 2008	24	50.1
Honduras 2005-06	37.7	49.8
Bangladesh 2007	47.5	49.5
India 2005-06	48.4	42.9
Kenya 2008-09	28.0	41.7
Colombia 2010	56.9	41.4
Liberia 2007	11.7	40.1
Sudan 1989-90	5.1	39.3
Mexico 1987	28.9	36.1
Guatemala (RHS) 2008	29.3	38.0
Egypt 2008	57.6	33.4
Mozambique 2003	14.2	29.5
Tanzania 2010	23.6	26.4
Malawi 2010	32.6	25.7
Ethiopia 2005	9.7	19.9
Rwanda 2007-08	16.3	10.4

⁶ Policy Brief: *The Vital Role of the Private Sector in Reproductive Health*, B. O'Hanlon, Private Sector Partnerships-One Project, no date, page 4.

⁷ Table prepared by USAID/SHOPs, based on data from Demographic and Health Surveys completed between 1987 and 2011.

5

Including the Private Sector in the SPARHCS Process

The size and importance of the private sector's current share of the family planning/reproductive health care market and the likelihood of its future growth demand that the private sector be an integral part of every SPARHCS assessment. While the role of the private sector no doubt varies from country to country, no assessment can be considered complete without including comprehensive data that describe its role as well as the impact of the regulatory and service delivery environment on its present and future operations. Additionally, no SPARHCS process effort should be considered complete without including representatives of both the private/nonprofit and private/commercial sectors as stakeholders.

Review of existing SPARHCS country assessments indicates varying degrees of success in incorporating private sector input, issues, and stakeholders. Public sector unfamiliarity with the private sector's perspective, discomfort with the concept of profit in health care, inexperience with public-private sector collaboration, and the private sector's lack of understanding of its role in addressing national public health concerns and of the potential for growth in the contraceptive market may be some of the factors that have contributed to these results.⁸

There are, however, techniques and approaches for more effective communication and collaboration between the public and private sectors that can be used to improve the level of success in more fully incorporating the private sector in the SPARHCS process.

The SPARHCS Process Guide, a planning resource for the SPARHCS tool,⁹ published in 2008, was designed as a companion to the SPARHCS tool and is meant to assist program managers and their technical assistance support in carrying out the SPARHCS process. The guide underscores that the SPARHCS process is based on the program cycle of planning-implementation-monitoring-evaluation. It describes how stakeholders use the SPARHCS tool as a framework for identifying and prioritizing key RHCS issues, use and adapt the tool to country- or region-specific conditions and needs, and can undertake the process of designing and implementing RHCS strategic plans in response to SPARHCS assessment findings.¹⁰

⁸ *Engaging the Non-Public Sectors in the SPARHCS Process*, Draft, USAID | DELIVER PROJECT, no date.

⁹ *The SPARHCS Process Guide*, R. Rao and N. Olson, USAID | DELIVER PROJECT, 2008.

¹⁰ *The SPARHCS Process Guide*, page vi.

For the most effective results from use of the SPARHCS process, the guide recommends that each element of the program cycle be addressed in the following order:

- **Pre-process planning** – determining the rationale for use of the SPARHCS process, setting the process parameters;
- **Awareness raising** – using and sharing information to raise support for RHCS issues and solutions;
- **Joint diagnosis** – gathering information and analyzing data to understand and document the RHCS status regionally, nationally, or locally;
- **Strategic planning** – using information gathered to develop a multi-sectoral strategy for improving RHCS;
- **Implementation** – putting the RHCS strategic plan into action; and
- **Monitoring and evaluation** – measuring achievements and change, making mid-course corrections for enhanced success.¹¹

In the following sections, we will consider each step in the SPARHCS process—pre-process planning, awareness raising, joint diagnosis, strategic planning, implementation, and monitoring and evaluation—and discuss how best to include the private sector in each.

A. Pre-process Planning

What is pre-process planning?

The purpose of pre-SPARHCS process planning is to ascertain the rationale for its use before beginning to build support for the task.¹² A small planning group led by the Ministry of Health/Family Planning and Reproductive Health (MOH FP/RH) first meets to discuss process parameters and then calls together a group of stakeholders in RHCS to gain consensus in four key areas:

- **Rationale, or impetus, for SPARHCS:** For example, are there perceived problems in service delivery or logistics, high unmet need, low CPR, donor scale-back, etc.?
- **Product focus:** For which category of products or services do stakeholders wish to increase RHCS?
- **Short- and long-term expectations and results:** What are the expected outcomes from use of the SPARHCS process in the next two years? In the next ten years?
- **Available resources:** What are the likely costs in money and time of implementing the SPARHCS process? From which sources will funding for these costs come?

¹¹ *The SPARHCS Process Guide*, pages 3–4.

¹² *The SPARHCS Process Guide*, page 5.

Is there a role for the private sector in pre-process planning?

There are two primary reasons for involving the private sector in the pre-process planning phase:

- The earlier any stakeholder is involved in the planning and implementation process, the more likely that stakeholder is to feel “ownership” in the process and to be committed to participation throughout. This is as true for private sector stakeholders as it is for public sector stakeholders.
- The perspectives and concerns of the private sector are important to include in the pre-process planning phase. Both the nonprofit and commercial segments of the private sector have a vested interest in each of the four areas of consideration previously described. Possible rationales for undertaking the SPARHCS process may already have impact on the size of the FP/RH market. How do private sector concerns affect its commitment to the FP/RH market? Product focus is also likely to have a direct impact on the future work of both nonprofit and for-profit organizations. Are these products or services already available through private sector channels? Are they in the corporate “pipeline”? Finally, the status of the market in both the short- and long-term is the basis for private sector strategic planning. How will private sector entities need to be prepared to continue to participate successfully in the marketplace?

Involving the private sector in pre-process planning

Even when front-line planners understand the importance of involving the private sector in the pre-planning process and other phases of SPARHCS, they may be unfamiliar with potential private sector stakeholders or feel uncomfortable approaching them. While private sector stakeholders in some countries may be excited to participate, private sector entities in other countries may be resistant or disinterested in participating.

How can RHCS front-line planners successfully include the private sector in pre-process planning and the stakeholders group?

- **Identifying potential private sector stakeholders**

Using Table 1, “Private Sector Entities in FP/RH,” as a guide, make a list by category (e.g. NGO service delivery organizations, private practice midwives, social marketing organizations, pharmaceutical distribution companies, etc.) of all private sector representatives who are known by the front-line planners. Ask the help of the known private sector representatives to identify other leading or influential individuals or entities in their own and other categories. In populous categories like shop and boutique owners or retail pharmacists and private medical practitioners, look for recognized leaders or seek out professional associations who can represent the category as a whole. Try to identify every entity that manufactures, imports, or distributes contraceptive products in the country. Be sure that representative(s) in every private sector category are identified. Collect and record contact information for each. (This list will prove very useful when the SPARHCS joint diagnosis information gathering process begins. See “Joint Diagnosis” section.)

When PATH began to work with the Ministry of Health in Vietnam to create a Total Market Initiative, there was interest in involving the commercial sector in the government-led technical advisory group at the beginning of the project but little clear idea of how to facilitate meaningful commercial sector participation. There were no professional associations of private health care providers, and the government's General Office for Population and Family Planning (GOPFP) had little experience in collaboration with the private commercial sector.

Two key activities helped PATH and GOPFP identify key commercial sector stakeholders for the Total Marketing Initiative effort: a family planning stakeholder analysis and a review of contraceptive sales data purchased from IMS Health, a research company that provides health care information in more than 100 countries worldwide.

1. **Stakeholder analysis.** Based on interviews with 38 stakeholders in which they were asked to identify key influencers, PATH used a network mapping tool to visually display Vietnam's family planning network. Analysis of this map not only confirmed which stakeholders were well represented in the technical advisory group but also identified opportunities for improved coordination among the governmental, non-governmental, and commercial sectors.
2. **IMS data.** PATH purchased IMS data on current contraceptive sales in Vietnam. These data identified all contraceptive brands currently being sold in the country along with the names of their distributors and/or manufacturers. Several of these identified commercial sector players had been previously unknown to public sector family planning program managers.

- **Inviting the private sector to participate**

Some categories of the private sector (for example, NGO service delivery organizations, social marketing organizations, NGO/civil society advocacy groups, university ob/gyn faculty) may already have established relationships with counterparts or program managers in the public sector. This existing relationship makes it easy for front-line planners to regard them as stakeholders and thus to invite them to participate in the SPARHCS process. This existing relationship may also predispose these private sector representatives to agree to participate.

While these previously known private sector representatives are important to RHCS and to the SPARHCS process and are perhaps comfortable for front-line planners to include, they should not be the only private sector entities and individuals involved. It is essential to include representatives from a wide variety of private sector categories—including those from the commercial sector and private practice—in the stakeholders group in order to enrich the SPARHCS assessment process with a complete picture of the RHCS environment and to bring all the expertise and infrastructure resources available to the RHCS task.

- **Convincing the private sector to participate**

Members of the private sector who have not had reason previously to collaborate with the public sector in RH/FP program activities may not understand the concept of RHCS, its importance to the overall public health, or its possible benefits to/impact on their businesses. Consequently, potential private sector stakeholders may

need to be one of the first audiences targeted for SPARHCS process awareness raising activities. (See “Awareness Raising” section.)

Choosing the right office or individual to invite a private sector representative to participate as a stakeholder in the SPARHCS process can be important in getting a positive response. A representative of a contraceptive manufacturer, for example, might agree to participate if asked by an influential ob/gyn specialist whom the company already knows and whose goodwill could be important to product acceptance in the marketplace. An endorsement by the head of his/her professional association might influence a busy private practitioner or retail pharmacist to agree to join the stakeholders’ group. An invitation to participate issued by the Minister of Health in which s/he states that RHCS is an important concern for his/her office is also likely to generate participation by private sector representatives whose businesses want the goodwill of the Minister.

Total Market Initiative project planners in Vietnam found it very helpful to contact the managers of international contraceptive manufacturing companies through their participation in the Global Reproductive Health Supply Coalition. These higher level managers, who supported their company’s collaboration with the public sector in a total market initiative, then contacted their country-level managers and urged them to participate in the Vietnam project.

- **Making participation private sector friendly**

Getting a private sector representative to agree to participate as a stakeholder in the SPARHCS process is only the first step. Creating an environment where s/he is willing to continue to participate is equally important. Front-line planners of the SPARHCS process should make it easy for the private sector to participate as stakeholders.

Carefully plan stakeholder meetings. Ensure that they are focused, time efficient, and results oriented. Time is money in the private sector world.

Be sure that everyone understands before leaving what has been accomplished in each stakeholders’ meeting and what are the next steps. Give everyone some new insight or piece of useful information to take away so that the meeting has remembered value for the participants.

Try to schedule important meetings at times when the private sector is easily able to attend. Perhaps evening meetings or meetings centered around a meal can occasionally be an option. Ask private sector stakeholders what meeting dates and times or meeting schedule will most easily work for them.

Don’t expect private sector representatives to be able to attend frequent meetings. Find some way to keep them involved in the process even when they cannot attend. For example, send meeting summaries, focused on decisions and actions, by email. Solicit their feedback by email. Follow-up with a phone call if it is necessary.

Try to limit any outside-the-meeting tasks for private sector stakeholders. Assign a stakeholder “secretary” to do any necessary writing or compiling of the ideas, issues, and information contributed by the stakeholder group.

Make private sector stakeholders feel that their input is valued and that their issues are important. Though the private sector perspective/approach may differ from that of the public sector, listen carefully to what these stakeholders have to say. If there are regulatory issues that need to be resolved so that the private sector can effectively contribute to RHCS, ensure that these concerns can be brought forward and discussed collegially.

Country Example: Honduras

In Honduras, Abt Associates launched a Total Market Initiative in order to address unmet need for contraceptive products. Using 2005/6 Demographic and Health Survey data along with IMS retail pharmacy data from 2005-2010, Abt and JSI conducted a health sector market segmentation analysis. Along with the market segmentation analysis, Abt conducted in-depth stakeholder interviews and facilitated a stakeholders' workshop to present the segmentation analysis findings and create a platform for discussion about how to engage various stakeholders in addressing the issue of unmet need for contraceptive products.

In March 2010, the activity concluded with a large stakeholders' workshop in Tegucigalpa, Honduras. More than 30 organizations from the public sector, the NGO sector, the international donor community and the commercial sector met to analyze the Honduran family planning market and identify segmentation strategies to better reach unmet need. Companies from the commercial sector included Pfizer, Durex Distributor Solis, CPL Condom Manufacturer, Medical Center of San Miguel, Vijosa Injectables Manufacturer, and Aarsal Laboratories. The one-and-a-half day workshop resulted in the development of 15 possible sector-specific strategies for market segmentation and/or market expansion. The workshop reinvigorated the local Contraceptive Security Committee (CIDAIA), which had not met since the June 2009 coup d'état. The Vice Minister of Health closed the workshop by officially reconvening the CIDAIA and invited all workshop participants to continue the momentum of the Total Market Initiative. Since then, the CIDAIA has expanded its membership. The group last met in July 2013.

Tips

- When you approach potential private sector stakeholders, make it clear that you are first and foremost seeking their expertise and perspective—not their money—as inputs into the SPARHCS assessment process. Establish trust through successful collaboration before asking for financial partnership.
- Don't rely solely on social marketing organizations to represent the commercial sector in pre-process planning and stakeholder groups. Social marketing efforts are sometimes regarded as competition, even unfair competition, by commercial sector pharmaceutical and condom manufacturers, importers, and distributors. Be sure that both perspectives are represented within the stakeholders group.

B. Awareness Raising

What is awareness raising?

The purpose of awareness raising in the SPARHCS process is to build support for the concept of reproductive health commodity security generally and for the joint diagnosis/SPARHCS country assessment process specifically.¹³

Information sharing is the primary tool for awareness raising. Already available information, such as Demographic and Health Survey (DHS) data, as well as new information gathered during the SPARHCS process joint diagnosis can be used to educate target audiences to the impact of RHCS across many sectors in the national environment, to motivate advocates for RHCS, to gain support for solutions to improve RHCS, and to elicit support among potential stakeholders for participation in the SPARHCS process.

Development of carefully targeted messages delivered by relevant influentials to specific audiences is critically important to the success of any awareness raising effort and is generally discussed in *The SPARHCS Process Guide* section on awareness raising.

Is there a role for the private sector in awareness raising?

There are two important roles for the private sector in SPARHCS process awareness raising:

- As a **target audience** for RHCS awareness raising activities and
- As **influential spokespersons**, or advocates, for RHCS.

Reaching the private sector with the RHCS/SPARHCS message

Awareness raising activities can be an important tool in convincing private sector representatives of the importance of RHCS in the national context as well as of the importance of their participation and input into the SPARHCS process.

Understanding the perspective and motivations of the private sector is the first step in developing compelling messages that will effectively influence private sector decision makers to support RHCS and to participate in the SPARHCS process. For-profit health care providers base their decisions primarily on the potential for-profit. They may also be influenced, however, by a real desire to improve the public health and the general well-being of their clients, a desire to gain respect or standing in their communities, or a desire to represent the interests of their colleagues and profession on the public or political stage. NGO service providers may base their decisions both on their need to generate revenue as well on their need to meet self- or donor-established service delivery expectations. NGO managers may also seek through some decisions to strengthen their relationships with government or donor partners. In private industry, virtually every decision to invest time or resources must yield a profit. In many countries, however, the desire to be recognized as “socially responsible” now drives some corporate decision-making. In regulated industries like the pharmaceutical industry, some corporate decisions may be made on the basis of gaining the goodwill of the regulating entity.¹⁴

¹³ *The SPARHCS Process Guide*, page 8.

¹⁴ *The Vital Role of the Private Sector in Reproductive Health*, B. O'Hanlon, Private Sector Partnerships-One Project, February 2009, page 5.

General themes for messages that may be persuasive to private sector decision-makers include:

- RHCS is important to the overall public health;
- RHCS and contraceptive prevalence, through their impact on the population growth rate, affect all sectors of the national economy;
- RHCS can also have an impact on health care-related business;
- There is increasing need/room for the private sector in the RHCS “whole market approach”; and
- An FP/RH market expanded by the RHCS process may create expanded business opportunities.

Messages should often be crafted specifically for each subgroup of the private health sector—private practitioners, pharmaceutical business people and pharmacists, NGO service delivery managers, insurance companies, HMO managers, and the like. The benefits of participation in the SPARHCS process must be clearly and effectively communicated to each. Possible benefits to the private sector of participation in the SPARHCS process may, for example, include:

- Establishing name/brand recognition among health sector influentials;
- Having input into RHCS strategic planning for market development;
- Having input into developing strategies for market segmentation;
- Improving knowledge of market opportunities and potential;
- Gaining ready access to results of government and donor-funded market research such as the DHS for use in consumer profiling;
- Gaining a forum for addressing legal and regulatory constraints that negatively impact business;
- Building relationships with public and donor sector agencies that could lead to future profitable public-private partnerships; and
- Building relationships with the public sector as a basis for possible future product sales or service delivery contracts.

Awareness raising messages should be clear, concise, and correct. Each message should be tailored specifically for its target audience and delivered in an attractive, attention-compelling way. Unsubstantiated or inaccurate claims are not persuasive and may lead to distrust.¹⁵

Who delivers the message to a target audience may be as important to the message’s persuasiveness as the message itself. Private sector audiences for RHCS and SPARHCS awareness raising messages are most likely to listen to and believe those messages if they come from spokespersons who have particular credibility with the audience group. For example, a leading ob/gyn physician or well-regarded medical school faculty member may be especially influential with private practice physicians or other health care providers. Pharmaceutical industry representatives may be especially influenced by those who know the dynamics of the marketplace such as international consultants, market research specialists, and DHS data analysts. In any event, the message should be delivered in the “language” of the target audience by a credible advocate.

¹⁵ *The SPARHCS Process Guide*, page 9.

One-on-one conversations, small group meetings, or large workshops and conferences are channels through which awareness raising messages to the private sector can be delivered. Venues for awareness raising should be chosen according to the message(s) to be delivered. For example, messages that convey the meaning of RHCS and the importance of RHCS to the public health and ultimately to the national economy may be effectively delivered in large workshops or conferences that have a wide range of participants. Messages conveying to a company or organization the particular or business benefits of participation in the SPARHCS process, however, should most likely be conveyed in one-on-one conversations or in a small group of similar companies and organizations.

Using the private sector as an advocate for RHCS

Once convinced of the importance of RHCS, private sector leaders can become effective public advocates both on the national stage and also within their industries or organizational groups. Heads of NGO service delivery organizations and NGO/civil society advocacy groups are often spokespersons for RHCS and related services/client rights. Advocacy, aligned as it can be with fund- and general support-raising, is frequently considered to be “part of the job” for NGO leaders. Influential private providers and professors of medicine also sometimes advocate for RHCS in general and the safety or health benefits of contraceptive use/selected methods in particular.

Less frequently realized, perhaps, is the potential for RHCS advocacy that private sector business leaders represent. When business leaders present the same messages that are delivered by health care providers and program managers, public sector policy makers may be more likely to be receptive. The messages are seen as important to a broad-based constituency with considerable resources for political support.

Facilitating an advocacy role for the private sector

During the pre-planning and awareness raising phases of the SPARHCS process, members of the RHCS coordinating committee will likely be able to identify several representatives of the private sector who have particularly good public speaking skills or who are charismatic leaders. If the SPARHCS process awareness raising activities succeed in convincing these individuals of the importance of RHCS, they may be successfully invited to become spokespersons or advocates for RHCS themselves.

Obtaining agreement from these “self-inclined” individuals in the private sector to speak to various audiences in support of RHCS is, of course, a first step. The second, and equally important, step is to provide potential advocates with the support they need to be effective spokespersons:

- Private sector representatives, including members of the commercial sector, should be included in any training sessions or workshops that are provided for potential RHCS advocates;
- Explicit messages, message points, or even scripts should be prepared and provided to private sector as well as public sector advocates;
- All advocates should have practice in delivering their RHCS messages prior to presenting to an audience;
- Opportunities/fora for private sector RHCS advocates should be organized and scheduled well in advance, so that the private sector advocates can accommodate each event; and
- Advocates should be selected for each audience according to their likely credibility with and influence on that audience.

Country Example: Kenya

Advocating for engagement of the private sector requires one unified voice representing its multi-faceted nature. In September 2009, USAID funding through the PSP-*One* project launched the Private Public Partnerships – Health Kenya (PPP-HK) entity that replaced the Interim PPP Steering Committee. The initiative is comprised of public, commercial, faith-based, and nonprofit actors strongly committed to forging PPPs to attain Kenya's health goals. PPP-HK partners include the Ministry of Medical Services (MOMS), Ministry of Sanitation and Public Health (MOPHS), Kenya Private Sector Alliance, Health NGOs Network (HENNET), Kenya Episcopal Conference, Christian Health Association of Kenya (CHAK), and Supreme Council of Kenya Muslims (SUPKEM).

PPP-HK's main priority has been to influence the policy review process to ensure private sector perspective in the proposed reforms. PPP-HK members have met together, as a group and with each of their constituencies, to review the initial background analysis and provide input. PPP-HK has also written and presented a position paper to the Legal Committee that outlines how to acknowledge private sector contribution to the overall Kenyan health sector and how to align the private sector to public health objectives. Operating under a mutually agreed-upon mandate, PPP-HK continues to foster a common vision among the different health stakeholders on national health priorities, and advocate for PPPs that leverage each sector's comparative advantage and use resources efficiently to improve access to health care.

C. Joint Diagnosis

What is the joint diagnosis?

The purpose of a SPARHCS joint diagnosis is to understand and document the RHCS status nationally, locally, or regionally. It forms the basis for the development of an RHCS strategic plan. The SPARHCS tool presents a framework for the joint diagnosis in the form of a series of questionnaires designed to gain the information necessary to assess each of the SPARHCS process components—capital, coordination, client utilization, capacity, commitment, context, and commodities—that must be considered in future RHCS strategic planning.¹⁶

There are five essential steps in the joint diagnosis process:

- **Formation of an RHCS coordinating committee**, a multi-sectoral group of technical and policy-level stakeholders who will support and participate in the assessment and strategic planning;
- **Desk-based research**, the collection and analysis of existing RHCS data and review of existing technical reports;
- **Presentation of joint diagnosis methodology to stakeholders**, in which the objectives, expected out-puts, and methods of the diagnosis are presented to stakeholders and their feedback is obtained;

¹⁶ *The SPARHCS Process Guide*, page 11.

- **Key informant interviews and workshops**, in which in-depth information and data are gained from individuals with policy and program experience and cross-cutting issues are identified; and
- **Presentation of findings/building consensus for the RHCS strategic plan**, where findings are validated and commitment is obtained to proceed with development of the strategic plan.¹⁷

Is there a role for the private sector in the joint diagnosis?

There are three primary ways in which the private sector can actively participate in the joint diagnosis process:

- As members of the RHCS **coordinating committee**;
- As members of the RHCS **stakeholders group**; and
- As **key informants** in the information gathering process.

The involvement of private sector representatives in the RHCS coordinating committee and in the RHCS stakeholders group has been discussed in the “Pre-Process Planning” section. Consequently, we will focus in this section on the role of private sector representatives as key informants in the joint diagnosis as well as on the diagnostic guide used to gather information from them.

Identifying private sector key informants

A simple process for identifying key private sector representatives and inviting them to participate in the SPARHCS process has been described in the “Pre-Process Planning” section. It is very important that representatives from the wide range of private sector entities working in areas related to RHCS are included as key informants. (See Table 1.) Without fullest possible information from the private sector, a distorted or inaccurate picture of the RHCS environment, its strengths and its weaknesses, may be portrayed in the joint diagnosis report. An RHCS strategic plan based on an inaccurate or incomplete picture of the overall environment is not likely to succeed in solving RHCS gaps effectively.

Persuading the private sector to share its information

Private sector representatives who understand the importance of RHCS and understand the purpose of the SPARHCS process are more likely to agree to provide information during the joint diagnosis process than those who have heard of neither. The inclusion of a range of private sector representatives as target audiences in the SPARHCS awareness raising process (See “Awareness Raising” section.) may, therefore, greatly facilitate information gathering for the joint diagnosis. In any case, every information-gathering interview should begin with a brief explanation of RHCS, the SPARHCS process, the donor or governmental agencies supporting the process, how the information gained will be used to develop a strategic plan for implementing an RHCS “whole market” approach, and the importance of including the interviewee’s perspective and knowledge in the overall picture. Assurances of confidentiality or non-attribution of statements and opinions should also be given by the interviewer.

NGO informants and private practitioners who have participated previously in donor-supported projects are more likely, through familiarity, to be immediately willing to share information in the joint diagnosis process. One-on-one interviews are likely to be most successful in gathering information from for-profit private sector entities and representatives.

¹⁷ *The SPARHCS Process Guide*, page 12.

Establishing rapport with the interviewee is important in establishing the level of trust required to share information—especially when some of the information may be considered proprietary or competition sensitive. If a contraceptive manufacturer’s representative, for example, is reluctant or unwilling to share brand-specific sales data, ask if there are more general or method-specific data that can be shared comfortably. Often international consultants can obtain fairly full information from for-profit entities and practitioners because they are viewed as “neutral” in the local competitive or regulatory context.

Tip

Where private sector commodity sales/distribution data are not readily available or where the private sector is reluctant to share that information in a meaningful way, always check—by asking a local market research firm or the local office of a pharmaceutical company—to see if the pharmaceutical contraceptive and condom market is monitored by an IMS-type subscription research firm or by a local market research agency. In Ukraine in 2010, a local research company freely shared its contraceptive market data and analysis with a donor team assessing the environment for contraceptive security there.¹⁸

Using the SPARHCS process diagnostic guide to gain information from and about the private sector

The SPARHCS tool presents a comprehensive diagnostic guide for use in assessing the various components of the RHCS environment: client utilization and demand, commodities, commitment, capital, capacity, coordination, and context. The guide is designed to facilitate diagnosis and can be modified by its users to reflect country-specific concerns and needs.¹⁹ Information gained through use of the diagnostic guide forms the regional, national, or local RHCS assessment and provides the basis of future strategic planning for improved RHCS.

Appendix A contains the SPARHCS diagnostic guide. To make it easier for diagnostic guide users to identify the issues or areas where private sector input is especially important, each question within the guide that pertains to the private sector is highlighted in blue. Possible sources of information are listed in parentheses following each private sector-related question in the diagnostic guide.

Self-monitoring the inclusion of private sector information in the joint diagnosis

Prior to final analysis and presentation of joint diagnosis findings to the stakeholders group, the RHCS coordinating committee should review the data collected to be sure that private sector issues, information, and key informants have been adequately included. If weaknesses in private sector data collection are found, they can be remedied before the assessment report is finalized and presented.

A guide to help the RHCS coordinating committee review the preliminary joint diagnosis for appropriate inclusion of private sector data and issues is included in Appendix B.

¹⁸ Bowers and Ravenholt, *Contraceptive Security in Ukraine*, GH Tech, 2010.

¹⁹ *SPARHCS Process Tool*, page 13.

D. Strategic Planning

What is an RHCS strategic plan?

The RHCS strategic plan is based on the findings of the joint diagnosis. It provides an opportunity to address weaknesses identified in the country assessment, better utilize existing strengths, improve on-going programs, and adopt new directions where necessary—all for the purpose of improving reproductive health commodity security. The strategic plan is not an end in itself but rather a tool for achieving improved RHCS.

A successful RHCS strategy identifies and prioritizes problems and challenges, identifies solutions and implementers of solutions, estimates the costs of desired change and the sources of necessary funds, unifies stakeholders around an agreed upon set of objectives, and catalyzes stakeholders to commit to and support the actions necessary to improve RHCS.²⁰

The RHCS strategic planning process includes the following elements: goal statement, priority issues, strategic objectives, actions, sub-actions, coordinating or managing agencies, implementing agencies, estimated budget, output indicators, and outcomes.

²⁰ *The SPARHCS Process Guide*, page 21.

Country Example: Kenya

Inclusion of the private sector requires a platform through which public and private sector actors can share resources and coordinate efforts. Recognizing the need and political will for such a platform in Kenya, Abt Associates collaborated with the Ministry of Medical Services (MOMS), Ministry of Sanitation and Public Health (MOPHS), the Kenya Private Sector Alliance, and the World Bank to organize a series of collaborative workshops. The workshops commenced in April 2009 in Naivasha, bringing together a diverse crowd representing the Government of Kenya, donors, private commercial and not-for profit health providers, regulatory boards and professional associations, pharmaceutical sector, and government and private health insurance. Workshop participants achieved many significant results that laid the groundwork for a productive dialogue and inclusive participation in future collaborations between the public and private sectors in the strategic planning process. The achievements included:

- Dispelled myths and built trust
- Reached common ground on the importance of partnering
- Demonstrated political commitment
- Established consensus on and commitment for priority recommendations

Demonstrating their firm commitment to public-private dialogue, all participants signed a pledged entitled the Naivasha Declaration. Shortly after Naivasha, organizers developed a smaller workshop aimed at further defining public-private collaboration. Once again, participants representing the diversity of the Kenyan health sector achieved results such as:

- Developing a roadmap to implementing public-private partnerships (PPPs)
- Defining a PPP Council and actions to institutionalize it
- Recommending activities to sustain a dialogue process between the key stakeholders

The momentum generated at Naivasha continues today. In the spirit of the new constitution, which encourages greater participation of Kenyan civil society, USAID, through the SHOPS project, and other international donors (GIZ, DANIDA, WHO) will support the Ministry to convene 10 stakeholder workshops around the country. These meetings are expected to build consensus and encourage public-private dialogue on harmonizing and consolidating 47 disparate Health Acts.

Why is the private sector important to RHCS strategic planning?

Inclusion of the private sector in the RHCS strategic planning process is important for a number of reasons:

- The **whole market of current and potential contraceptive users** can be effectively and efficiently served only when all sectors—public, private/nonprofit, and private/commercial—are coordinated and engaged.
- Private sector representatives are likely to have **previous experience in the development of strategic plans** and in the process of strategic thinking. They may thus be useful partners in the planning process.
- Private sector involvement in the strategic planning process will likely **ensure that the private sector's agenda, resources, and capacities are included** in the overall plan.
- Involvement of the private sector in the strategic planning process increases the likelihood that the private sector will feel “ownership” in the plan and will thus **commit its resources and efforts to support and implement the actions necessary to improve RHCS.**

Including the private sector in RHCS strategic planning

There are several steps that can be taken to include the private sector effectively in the RHCS strategic plan and in the strategic planning process. Many of these approaches are the same as those taken to encourage private sector participation in the SPARHCS process overall.

- **Gathering full information.** The first step in including the private sector in the RHCS strategic planning process is gathering full information about the private sector during the joint diagnosis assessment. (See “Joint Diagnosis” section.) With complete information in hand, the RHCS strategic planning committee can ensure that private sector issues, capacities, and resources are included in the strategic plan wherever appropriate.
- **Persuading the private sector to participate in strategy development.** Private sector representatives should be directly invited to participate in development of the RHCS strategic plan. As discussed more fully in the “Awareness Raising” section, there are a number of reasons or benefits that may influence private sector representatives to invest their time and effort in this process. These benefits may include:
 - Having input into RHCS strategic planning for market development;
 - Having input into developing strategies for market segmentation;
 - Improving knowledge of market opportunities and potential; and
 - Building relationships with public and donor sector agencies that could lead to future profitable public-private partnerships.

- Maintaining private sector participation in strategy development. The strategic planning process should be private sector friendly so that private sector stakeholders will participate to the fullest extent possible. Making the overall SPARHCS process “private sector friendly” is discussed in some detail in the “Pre-Process Planning,” section, and includes, among others, the following important steps applicable to the strategic planning process:
 - Have realistic expectations for the time private sector representatives can devote to this process;
 - Facilitate well organized, result-focused work meetings;
 - Use flexibility in ways of obtaining input and feedback from private sector representatives such as one-on-one conversations, email, etc.; and
 - Make it clear that private sector input is both important to the RHCS process and valued by RHCS planners as well as valuable to the private sector participants themselves.

Tip

While program-focused, donor-funded NGOs and commercial sector entities or private practitioners and HMO/clinic managers, for example, may have different amounts of time available to participate in RHCS strategic planning, don't let differences in time invested create a strategy that is biased toward one segment of the private sector or the other.

- **Addressing private sector issues in the strategic plan.** Analysis of the data collected during the joint diagnosis process should identify any unnecessary constraints on the private sector's ability to contribute to improved RHCS as well as any as-yet-unused or underused private sector capacities to improve RHCS. The strategic planning committee should ensure that strategies for resolution of these constraints as well as strategies for optimum use of private sector capacities to improve RHCS are included in the overall plan.

Examples of constraints on the private sector's role in improving RHCS that may be found to exist and can be addressed in the strategic plan include:

- Unnecessary or inefficient competition with other stakeholder products and services due to an unsegmented RH/FP market;
- Limitations on RH/FP services that can be delivered by private providers;
- Limitations on where RH/FP services can be delivered;
- Inadequate product distribution systems and practices (in both the nonprofit and commercial sectors);
- Import tariffs, price controls, price structure controls on pharmaceutical contraceptive products, condoms, and contraceptive devices;
- Unnecessary difficulties or delays in new contraceptive product registration;
- Limitations on the advertising and promotion of RH/FP products and private provider services;

- Outdated or inaccurate protocols governing RH/FP service delivery; and
- Outdated or inaccurate teaching in medical, nursing, midwifery, and pharmacy schools.

Examples of opportunities for expanding the private sector's role in improving RHCS that may be found to exist and can be addressed in the strategic plan include:

- Inclusion of private providers in public sector RH/FP training programs;
 - Establishment of continuing education requirements for private providers and pharmacists that include RH/FP topics;
 - Creation of sufficient consumer demand for RH/FP products and services (through IEC, advertising, counseling, etc.) to make private sector service delivery sustainable;
 - Development of insurance, voucher, HMO, and other service delivery financing schemes that expand the number of consumers able to access RH/FP products and services in the private sector; and
 - Adoption of out-sourcing or other public sector-private sector partnerships in RH/FP services delivery.
- **Gaining private sector commitment to the strategy.** Once key issues—problems, gaps, or opportunities—in the RHCS context are identified in the strategic planning process, submit to private sector representatives what opportunities may exist for them as a result of the strategic effort to improve RHCS. Look for potential contributions and actions from the private sector that serve its business or programmatic purposes as well as the public health goal of improved RHCS. Ask the following questions:
 - Where do corporate and NGO program strategies parallel or overlap RHCS strategies and thus create opportunities for private sector resource and capacity commitment to the strategy?
 - How may synergies be created in these common areas?
 - In what areas does a critical mass of demand for RH/FP services exist that can be profitably or sustainably served by the private sector?
 - How can the competitive advantages of the nonprofit and for-profit sectors best be used in improving RHCS for all consumers?
 - What investments by donors or the public sector—such as in provider training or in IEC materials and advertising—may “leverage” or make possible further private sector investment?
 - What changes in government policies or regulations may create further opportunities for private sector resource and capacity commitment to RHCS?
 - What, if any, are the possibilities of public-private partnerships that may improve RHCS within the region/country/local context?
 - Where are the win-win opportunities for public sector-private sector collaboration for improved RHCS?

If business value is generated as a result of these identified opportunities, then the private sector will continue to invest its resources—commensurate with the value generated—in the RHCS strategy.

Tip

Avoid the temptation to “assign” to the private sector RHCS strategic tasks that are not compatible with their corporate or programmatic goals. For example, it is not likely that the commercial pharmaceutical sector will consistently or reliably deliver contraceptive products to sparse rural populations with low incomes because serving that market segment is not likely to be profitable.

Country Example: Honduras

In March 2010, Abt Associates concluded a market segmentation analysis with a large stakeholders’ workshop in Tegucigalpa. Organizations from the public sector, the NGO sector, the international donor community and the commercial sector met to analyze the Honduran family planning market and identify segmentation strategies to address unmet need. Companies from the commercial sector included Pfizer, Durex Distributor Solis, CPL Condom Manufacturer, Medical Center of San Miguel, Pharmaceutical Distributor Drogueria Mandofer, Vijosa Injectables Manufacturer, and Arsal Laboratories Injectables Manufacturer. The one-and-a-half day workshop resulted in the development of 15 possible sector-specific strategies for market segmentation and/or market expansion.

Commercial sector participants were very enthusiastic about being involved in the Total Market Initiative and appreciative of the opportunity to be engaged in discussions. Manufacturers and distributors alike actively brainstormed commercial sector strategies with their government and nonprofit counterparts. Some of the strategies developed include creating PPPs which leverage their commercial sales forces to distribute national IEC materials on family planning, establishing institutional sales staff and institutional pricing strategies, and establishing a PPP for joint development of an electronic contraceptives information portal.

Because commercial sector participants had not been involved before in the contraceptive security committee, they found the workshop to be very beneficial both in terms of information exchange and networking. Mr. Oscar Delgado from the Salvadoran drug manufacturer, Vijosa (which sells three brands of injectables in Honduras), stated that the workshop helped them identify market niches which they are currently not reaching. Dr. Karen Chincilla from Pfizer said the workshop opened her eyes to the fact that there are consumers within their target group who are sourcing from the public sector, which presents a missed opportunity for the brand.

- **Creating a detailed work plan and identifying expected outcomes.** Every institutional participant in the SPARHCS process must understand not only the overall strategy being developed to improve RHCS status but also the actions necessary to put the strategy in motion toward achieving stated objectives. For which action(s) is each private sector participant responsible, and how will each coordinate its efforts to reach the objectives set forth in the strategic plan?²¹ Members of the RHCS strategic planning committee should meet with representatives of all involved private sector entities to identify and agree upon:
 - The specific actions by each private sector participant that are necessary to achieve RHCS strategic objectives;
 - The timeline for each private sector action or series of actions;
 - The person within each private sector association, organization, or company responsible for seeing that the actions are implemented;
 - The person, organization, or committee through whom private sector actions will be coordinated with the actions of other participants; and
 - The expected outcomes of the respective participants' actions.

This “agreement” with private sector participants will likely be as strong as the perceived business value that it brings to them.

²¹ *The SPARHCS Process Guide*, page 27.

E. Implementation

What is implementation in the context of the SPARHCS process?

Implementation is the process of turning an RHCS strategic plan into action. The transition from plan to action can be challenging. RHCS coordinating committees in many countries have reported that a primary obstacle to moving successfully from plan to action has been the lack of leadership necessary to obtain the human resource and financial commitments required.²² Where the transition from plan to action has occurred successfully, three key elements have consistently been found: political will, detailed work planning, and program integration.²³

What is the role of the private sector in implementation?

The primary role of the private sector in implementing an RHCS strategic plan is to serve with high quality RH/FP products and services those consumers who are able and willing to use private sector sources for what they need. (This role is more fully discussed in the section, “The Whole Market Approach to RHCS.”) More specifically, the role of the private sector in implementation is to fulfill its commitment as laid out in the detailed work plan supporting the strategy for improved RHCS within the regional, national, or local context. (See “Strategic Planning” section.)

Additionally, the private sector can play a role in developing and sustaining the political will required to support successful RHCS implementation. When private sector industry and civil society leaders join public sector RH/FP spokespersons in advocating for the importance of RHCS, policy makers and political leaders are more likely to respond with continuing necessary support. Advocacy messages delivered from multiple sources are seen as important to a broad-based constituency with considerable resources for political support and may, therefore, lead to the necessary political commitment for successful implementation. (The ability of the private sector to advocate for RHCS is discussed more fully in the section, “Awareness Raising.”)

²² *The SPARHCS Process Guide*, page 25.

²³ *The SPARHCS Process Guide*, page 25.

Maintaining the private sector's commitment to implementation

Maintaining the private sector's commitment to its role in implementing the RHCS strategy requires an understanding of what makes the private sector tick. As time passes and the pressures of everyday business accumulate, NGO and for-profit providers and business managers may begin to lose interest and may be diverted from RHCS priorities to other tasks and problems—unless there is value gained for their businesses from continuing participation. There are, however, several important steps that can be taken to increase the likelihood that private sector participants remain committed and active in the implementation process.

- Establish regular contact between the RHCS implementation coordinating committee and private sector implementers. Gather feedback and plan or initiate appropriate responses to newly identified problems and opportunities.
- Work to ensure that donors and the public sector fulfill any commitments they have made to the implementation process—especially those that have impact on the private sector's ability to provide RH/FP goods and services. The private sector is not likely to remain committed to implementation actions that have not been facilitated, for example, by promised policy/regulatory changes, promised training, or promised investments in demand generation.
- Maintain a level playing field. Offer equal opportunities for participation and the advantages of participation to all relevant companies and organizations—even though some will choose not to participate. Even-handedness and transparency can increase trust and lead to further commitment.
- Never share data and information given in confidence by one private sector entity with others.
- Try to keep the implementation process working on “private sector time.” Long delays in receiving donor and public sector approvals or responses to work plan actions discourage private sector participants who are often held to tight timetables for performance results by corporate and program bosses. Respond promptly and nimbly to changes that may occur in the RHCS marketplace.
- Ensure that the public sector and the RHCS implementation coordinating committee share the credit for successes achieved with private sector implementers. Share opportunities for publicity and public recognition, wherever appropriate, with private sector implementers and stakeholders.

F. Monitoring and Evaluation

What is the purpose of monitoring and evaluation in the RHCS implementation process?

Timely collection and analysis of reliable data are essential for evaluating progress toward RHCS objectives,²⁴ for making necessary adjustments in strategies and work plans while activities are being implemented, and for ensuring accountability.²⁵ Regular feedback on the status of the RHCS “marketplace” will provide managers in both the public and private sectors with the information they need to make sound decisions on how best to continue to invest their available resources in reaching RHCS objectives. Without reliable feedback on the effectiveness of actions taken, scarce resources and valuable time may be lost in continuing unproductive or underproductive activities; and ultimately the goal of reproductive health commodity security may not be reached.

Data necessary for monitoring and evaluating the RHCS implementation process may be obtained through a variety of sources such as population-based surveys like the DHS; public sector LMIS; public and private sector service delivery records; NGO, social marketing, and commercial sector product sales data; consumer research; provider surveys; IMS-type pharmaceutical distribution reports; commercial pharmaceutical distribution and warehousing records; and national household income and expenditure surveys.

How do you measure private sector success in the RHCS implementation process?

Success is measured against the achievement of expected outcomes, such as those identified as part of the strategic planning process. It is important, therefore, that expected outcomes—or measures of success—be appropriately correlated to RHCS strategic objectives.

What may seem to be an obvious measure of success is sometimes not a correct measure of achievement of a strategic objective. For example, growth in the number of contraceptives sold or distributed through public or NGO sector outlets might seem to indicate success. If, however, a strategic objective is better segmentation of the contraceptive market to ensure more efficient use of available resources, then increased public and NGO contraceptive distribution represents success only if the contraceptives were distributed to consumers who could not afford to pay the price of a commercial sector brand.

Appendix C illustrates some possible RHCS strategic objectives related to the private sector and expected outcomes, or measures of success, that may be used to evaluate their achievement.

²⁴ *Contraceptive Security Ready Lessons*, Lesson 5, page 1.

²⁵ *The SPARHCS Process Guide*, page 27.

Appendices

Appendix A: The SPARHCS Diagnostic Guide²⁶

The following questionnaire/guide is taken directly from *SPARHCS – Strategic Pathway to Reproductive Health Commodity Security*. Questions that require information from or about the private sector, both for-profit and nonprofit, are highlighted in blue in this appendix for easy reference. A few questions that may shed further light on the role of the private sector in RHCS have been added in this appendix to the original Diagnostic Guide. These additional questions, also highlighted in blue, are marked with an asterisk. Possible sources of information can be found in parentheses at the end of each highlighted question.

A. Client Utilization and Demand

This section develops profiles of clients (current and potential) for reproductive health products. It examines distributions of use and unmet need by age, residence, education, standard of living, etc. It also asks questions about how efficiently providers are serving the whole market of clients, as well as about access, discontinuation, and the impact of activities to increase demand for products. This information will help determine strategies to, for example, expand method mix, address unmet need, and better target financial resources to ensure maximum reach.

The tables and questions focus on contraceptives, but can be modified for other RH supplies. They are meant to give users overviews of use and unmet need. Data about past trends and the present may be available from national surveys, like the Demographic and Health Surveys or Reproductive Health Surveys, though perhaps with secondary analysis. Future estimates provide important information for planning commodity requirements. They can be more difficult to obtain and require new analytical work specifically for the assessment.

²⁶ Taken and adapted from *SPARHCS – Strategic Pathway to Reproductive Health Commodity Security*, 2004, pages 15–30.

A.1. Use of Contraceptives

Contraceptive Prevalence ¹	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
All methods					
By Method					
Traditional methods					
Modern methods					
Pill					
IUD					
Injectables					
Implants					
Male condom					
Female condom					
Vaginal method					
Emergency contraception					
Female sterilization					
Male sterilization					
By Age					
< 15					
15–19					
20–49					
By Parity					
By Residence					
Urban					
Rural					

¹ Percentage of married women, or women of reproductive age, using contraception. Where data is available, users of the guide can examine contraceptive use by sex and marital status, adding rows to the table. Access to and use of condoms by men can be a special concern for HIV prevention programs.

Contraceptive Prevalence ¹	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
By Geographic Area (e.g., Province, State)					
By Education					
No education					
Primary					
Secondary					
By Wealth Quintile					
1					
2					
3					
4					
5					
Percent of Users of Modern Methods who Obtain their Method From:					
Public sector					
NGO provider					
Social marketing program					
Commercial sector					

¹ Percentage of married women, or women of reproductive age, using contraception. Where data is available, users of the guide can examine contraceptive use by sex and marital status, adding rows to the table. Access to and use of condoms by men can be a special concern for HIV prevention programs.

A.1.1. Is method use tilted towards short-term, resupply methods? Or, long-term and permanent methods? What are the implications of the method mix for RHCS? For example, short-term methods require more frequent and reliable systems of forecasting, financing, procurement, and distribution to supply programs.

*A.1.1.a. **Is there a difference in method use between the public and private sectors? Between the commercial and free or subsidized (NGO) sectors?** (Sources: DHS data, existing NGO and/or social marketing project market research, public sector service delivery data, provider interviews, commercial sector market research, commercial and social marketing product sales data)

*A.1.1.b. **What accounts for any difference found in method use between the sectors?** (Sources: provider interviews, pharmaceutical industry marketing manager interviews, public and NGO sector service delivery manager interviews, DHS consumer data, project consumer/user research data, commercial market research data)

A.1.2. **What is the profile of users in each sector (public, NGO, social marketing, commercial) according to their age, income/standard of living, residence, and education?** (Sources: DHS data, NGO and social marketing project consumer research data, public sector service delivery data, provider interviews, pharmaceutical industry marketing manager interviews, and pharmaceutical industry consumer research)

A.1.3. **How well and how efficiently do service providers collectively cover the whole market in terms of clients' income, their location, the methods they want, and where they prefer to obtain them? Is each provider type serving the client groups and supplying the RH products that fit best with the provider's comparative advantage and objectives?** (Sources: DHS data, NGO and social marketing project consumer research data, public sector service delivery data, provider interviews, pharmaceutical industry marketing manager interviews, and pharmaceutical industry consumer research)

- **Is the public sector concentrating its resources on serving the poor, or where there are no private sector alternatives?** (Sources: DHS consumer profile/source of service data, public sector program manager interviews, public sector service delivery data, private provider interviews, pharmaceutical industry marketing manager interviews, NGO and social marketing project consumer/user research, NGO and social marketing program manager interviews)
- **Is the widespread availability of free or subsidized products interfering with expansion of commercial markets?** (Sources: NGO and social marketing sales data, commercial sector sales data, NGO and social marketing manager interviews, pharmaceutical industry marketing manager interviews, DHS consumer profile/source of service data)
- **Is there access to affordable, quality services for clients who are able and willing to pay for RH supplies?** (Sources: public sector and private sector outlet data/outlet mapping, private provider interviews, public sector service manager interviews, NGO and social marketing program manager interviews, pharmaceutical industry marketing manager interviews, pharmaceutical distribution company manager interviews, DHS consumer profile/source of supply data, NGO and social marketing project consumer research)

A.1.4. **Are there differences in coverage by public and private sector programs that may limit client choice?** For example, are clients in rural areas limited to public sector sources? (Sources: DHS consumer profile/source of supply data, public sector and private sector outlet data/outlet mapping, provider interviews, public sector program manager interviews, NGO and social marketing manager interviews, pharmaceutical industry marketing manager interviews, pharmaceutical distribution company managers, commercial sector sales data by geographic area, NGO and social marketing project sales/service delivery data by geographic area, public sector service delivery data by geographic area)

A.2. Unmet Need for Contraception

Unmet Need For Family Planning ¹	10 Years Ago	5 Years Ago	Current
For spacing			
For limiting			
Total			
Total Unmet Need²			
By Age			
< 15			
15–19			
20–49			
By Parity			
By Residence			
Urban			
Rural			
By Geographic Area (e.g., Province, State)			
By Education			
No education			
Primary			
Secondary			

¹ Definitions of unmet need for family planning vary. In the Demographic and Health Surveys, “unmet need” refers to fecund women who either wish to wait two or more years before having another child (spacers) or wish to stop childbearing altogether (limiters), but are not using a contraceptive method. Broader definitions can include, for example, women who are using a method of family planning, but are in need of a more effective or preferred method.

² This table examines the distribution of total unmet need. The distribution of unmet need for spacing versus limiting can be of interest as well. Need for spacing versus limiting can shift significantly according to certain client characteristics, such as age and parity, with implications for method availability.

Unmet Need For Family Planning ¹	10 Years Ago	5 Years Ago	Current
By Wealth Quintile			
1			
2			
3			
4			
5			

A.2.1. What is the percentage of current non-users of contraception who intend to use a contraceptive method in the future?

A.2.2. Of the total demand for contraception (current use plus unmet need), what percentage is being satisfied?

A.2.3. What are the main reasons for unmet need (e.g., fear of side effects, perceived spousal objections, religious reasons, lack of access, etc.)? Do gender and ethnic norms create barriers to women’s and men’s use of contraceptives and other RH commodities? And, if so, how?

*A.2.3.a. **Do the reasons for unmet need vary from sector to sector? If so, why?** (Sources: private provider interviews, pharmacist interviews, NGO program manager interviews, public sector program manager interviews, NGO/social marketing program consumer research, commercial market research)

A.2.4. **What are the key activities (current and planned) to address unmet need? What are their results to date? What future results are expected? How are they expected to affect use of public versus private sources?** (Sources: public sector FP/RH policy maker interviews, public sector service delivery manager interviews, private provider interviews, HMO manager interviews, public and private sector insurance policy maker/manager interviews, NGO and social marketing project manager interviews, pharmaceutical industry marketing manager interviews, pharmaceutical industry manufacturing manager interviews)

A.3. Service Access and Utilization

A.3.1. **Do all clients who want contraceptives and other RH supplies have physical access to them? If not, what and where are the main shortcomings in the public sector, in the private sector, in urban vs. rural areas, in different geographic regions?** (Sources: public sector and private sector outlet data/outlet mapping, private provider interviews, public sector service manager interviews, NGO and social marketing program manager interviews, pharmaceutical industry marketing manager interviews, pharmaceutical distribution company manager interviews, DHS consumer profile/source of supply data, NGO and social marketing project consumer research)

A.3.2. **How often are clients turned away or referred to other facilities because basic services or products (as expected according to norms and standards) are not available at their preferred source? Or, because a provider of the preferred gender is not available?** (Sources: private provider interviews, pharmaceutical distribution company manager interviews, NGO manager and provider interviews, HMO manager interviews, hospital/clinic manager interviews, pharmacist interviews, NGO/social marketing program consumer research)

A.3.3. What are contraceptive discontinuation rates among different groups (e.g., by age, socioeconomic or education status)? What are the reasons for discontinuing use of contraceptives (e.g., lack of satisfaction, side effects, spousal objections, lack of physical access to a facility or other resupply source, lack of product, financial constraints, did not get preferred method)?

*A.3.3.a. **What are the contraceptive discontinuation rates by source of supply? What are the likely causes of any differences in discontinuation rates from one source to another?** (Sources: DHS data, NGO/social marketing program consumer research, private provider interviews, public sector provider interviews, public sector service delivery data, pharmacist interviews)

A.3.4. Where total demand for family planning (met need plus unmet need) remains low, will securing sufficient supplies to satisfy this level of demand fully realize stakeholders' vision for RHCS? **How will activities to increase use of family planning affect the demand-supply relationship? Is supply keeping up with new demand? Will future supply keep pace?** (Sources: pharmaceutical industry marketing manager interviews, pharmaceutical industry manufacturing manager interviews, pharmaceutical importation and distribution company manager interviews, pharmacist interviews, public sector policy maker and FP/RH program manager interviews)

B. Commodities

This part examines the sources of RH commodities in a country and the relative contributions of different public and private sector channels. The table considers past trends and asks about future expectations; it may need to be duplicated for each of the different commodities under consideration in the assessment (contraceptives, STI drugs, etc.). Such an analysis can help determine each sector's role in the provision of RH commodities. Questions are also asked about how stockouts are prevented, how product quality is ensured, and how products are registered.

B.1. Sources of RH Commodities

Quantities of Commodities Procured By:	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
Government ¹					
UNFPA					
USAID					
Modern methods					
DFID					
KfW					
IPPF					
Implants					
PSI or DKT					
Other					
Other					
Percent of Distribution or Sales Provided By:					
Provided By:					
Public sector					
NGO provider					
Social marketing program					
Commercial sector					
Other					

¹ "Government" can refer to national, state, provincial, or another local authority.

B.1.1. Which family planning methods does each program—public, NGO, social marketing, commercial—offer? (Sources: NGO/social marketing service delivery and sales data, pharmaceutical distribution company manager interviews, commercial pharmaceutical market sales data, public sector drug registration manager interviews, HMO/clinic/hospital manager interviews, public and private sector insurance plan manager interviews)

- **Are some sectors largely oriented towards resupply methods (e.g., pills, condoms, injectables) and hence more dependent on frequent and reliable financing, procurement, and distribution to keep programs in full supply?** (Sources: NGO/social marketing sales and service delivery data, commercial sector sales data, DHS data, public sector service delivery data)
- **How many different brands for a given method are being subsidized—whether by government or donors—through public, NGO, and social marketing programs?** (Sources: NGO and social marketing program manager interviews, donor agency RH/FP staff interviews, public sector RH/FP program manager interviews)
- **How are they differentiated? Are they all actively considered necessary by some constituency and by what criteria?** (Sources: NGO/social marketing program manager interviews, NGO/social marketing consumer profile and brand research, pharmaceutical industry marketing manager interviews, public sector RH/FP manager interviews, NGO/social marketing product sales data, commercial sector contraceptive sales data, public sector contraceptive distribution/sales data)

B.1.2. Are products that should be maintained at full supply? Or, does rationing occur? (Sources: pharmaceutical industry distribution company manager interviews, commercial contraceptive sales data, NGO/social marketing program manager interviews, NGO/social marketing sales data, public sector RH/FP program manager interviews, public sector RH/FP commodity and logistics manager interviews, public sector service delivery data)

- **Have stockouts of products occurred within the last year in any of the programs?** (Sources: pharmaceutical distribution company manager interviews, pharmaceutical industry marketing manager interviews, commercial sector sales data, NGO/social marketing program manager interviews, NGO/social marketing sales/service delivery data, private provider interviews, public sector RH/FP program manager interviews, public sector RH/FP commodity and logistics manager interviews, public sector RH/FP service providers)
- **If so, which products, what programs, at what level(s) in the supply chain, for how long, and why?** (Sources: pharmaceutical distribution company manager interviews, pharmaceutical industry marketing manager interviews, NGO/social marketing program manager interviews, public sector RH/FP program manager interviews, public sector RH/FP commodity and logistics manager interviews)

B.1.3. How reliable are supplies in each program? Is supply reliability limiting program expansion? Sources: pharmaceutical distribution company manager interviews, pharmaceutical industry marketing manager interviews, NGO/social marketing manager interviews, private provider interviews, public sector provider interviews, public sector commodity logistics manager interviews, public sector RH/FP program manager interviews, public sector service/product distribution data, NGO/social marketing service/product distribution and sales data, commercial sector sales data)

B.1.4. Have significant amounts of any products in any program expired within the last year? Which products, what programs? Where in the supply chain? And, why? (Sources: pharmaceutical distribution company manager interviews, pharmaceutical industry marketing manager interviews, public sector commodity logistics manager interviews, NGO/social marketing program manager interviews, public sector RH/FP program manager interviews, public sector pharmaceutical oversight manager interviews, pharmacist interviews)

B.1.5. What policies and quality control procedures and capacities are in place to ensure product quality for each product, in each program, and throughout each supply chain? (Sources: public sector RH/FP program manager interviews, public sector RH/FP commodity logistics manager interviews, public sector pharmaceutical regulator interviews, pharmacist interviews, pharmaceutical manufacturer interviews, pharmaceutical distribution manager interviews)

- **How are complaints about product quality handled and investigated?** (Sources: public sector RH/FP program manager interviews, public sector RH/FP commodity logistics manager interviews, public sector pharmaceutical regulator interviews, pharmacist interviews, pharmaceutical manufacturer interviews, pharmaceutical distribution manager interviews)

B.1.6. What are the policies that affect importation of contraceptives and other RH supplies? Are tariffs applied to imported RH supplies? (Sources: public sector pharmaceutical regulator interviews, ministry of finance interviews, pharmaceutical importer interviews, international pharmaceutical manufacturer interviews)

B.1.7. What are the procedures for product registration/licensing? (Sources: pharmaceutical importer interviews, public sector pharmaceutical regulator interviews, pharmaceutical manufacturer interviews)

- **Are they well understood, transparent, and efficient?** (Sources: pharmaceutical importer interviews, public sector pharmaceutical regulator interviews, pharmaceutical manufacturer interviews)
- **Are the time and costs required for registration perceived by the private sector as “normal” or unduly burdensome? Could they be streamlined?** (Sources: pharmaceutical importer interviews, public sector pharmaceutical regulator interviews, pharmaceutical manufacturer interviews)

B.1.8. Are there local manufacturers of any RH products? Which ones? (Sources: public sector pharmaceutical regulator interviews, pharmaceutical manufacturer interviews)

B.1.9. Which donors have been or are involved in supplying RH commodities? What products have each provided last year, this year, and next year? Are there any long-term donor commitments or plans for supplying RH commodities? By whom and for what products?

B.1.10. For the commercial sector, what is the percentage of total revenue from family planning and other RH commodities? What is the investment in them (marketing, innovations)? What are local manufacturers’ plans for expanding their production capacity or distribution base? Does the commercial market have the willingness and potential to expand? What are the barriers to expansion? (Sources: pharmacist interviews, pharmaceutical industry marketing manager interviews, pharmaceutical manufacturer interviews, pharmaceutical distribution company manager interviews)

*B.1.10.a. **How do commercial pharmaceutical companies perceive the market for each RH/FP method or product? What is their product strategy/target market for each brand/method?** (Sources: interviews with local and international pharmaceutical marketing managers and general managers of local and international pharmaceutical manufacturers)

B.1.11. **For NGO and social marketing programs, what is the percentage of total revenue from family planning and other RH commodities? What cost recovery systems (e.g., pricing, fees, cross-subsidies) do they have in place or intend to implement? Are there waiver systems for the poor? What are their plans to expand family planning and other reproductive health services and associated products in their programs?** (Sources: NGO and social marketing program manager interviews, NGO and social marketing program marketing manager interviews, NGO and social marketing program financial manager interviews)

B.1.12. **Who is the intended market for each private sector provider, both current and planned?** (Sources: pharmaceutical industry marketing manager interviews, pharmaceutical manufacturer interviews, pharmaceutical distribution company manager interviews, NGO and social marketing program manager interviews, NGO and social marketing program marketing manager interviews, public sector RH/FP program manager interviews)

C. Commitment

Of all the elements in the SPARHCS framework, commitment is perhaps the most difficult to assess by itself. Rather, the best evidence may be when other elements are in place, such as when there is a supportive policy and regulatory environment, sufficient capital to meet client needs, and the necessary human and systems capacities. Still, there are some questions that can be asked about political commitment, commitment from within the private sector, and capacity for advocacy for RHCS. It is important to keep in mind that commitment to RHCS is not the same as commitment to family planning/reproductive health. Rather, it is about the policy level embracing the need to make and keep supplies available to clients, both women and men.

This section also looks at the extent to which there is commitment to RHCS under health sector reforms and development assistance for poverty reduction and sector wide approaches.

C.1. Commitment in the Public and Private Sectors

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

- Who are key leaders/champions for reproductive health commodity security within government? At what levels?
- How does leadership initiate and support efforts to achieve reproductive health commodity security?
- Why are leaders motivated to support RHCS? How deep is their commitment to meeting women's and men's RH needs?
- Are leaders committed or opposed to using government funds to support reproductive health commodity security? Is there a budget line item for contraceptives and/or other reproductive health supplies? Has government funding for them and related services increased or decreased over time?

*C.1.2. **Are there leaders/champions for RHCS from within the private sector, for example among major employers or labor organizations? Among private providers and pharmaceutical business leaders?** (Sources: personal interviews with private providers and business leaders; newspaper or other media reports; interviews with industrial association leaders; interviews with union leaders; interviews with NGO/civil society leaders)

C.2. Advocacy

C.2.1. **Are civil society organizations mobilized and do they have the capacity to advocate for reproductive health commodity security?** (Sources: interviews with NGO/civil society leadership; interviews with leaders in the Ministry or government office responsible for NGO oversight; interviews with known FP/RH advocates)

- **Are they able to act as sources of information for decision making? Do they act as “watchdogs” for improvements in RHCS?**
- **Are all segments of society, particularly the disenfranchised, represented by civil society organizations that are advocating for RHCS?**
- **Are RH commodity issues regularly included in broader health advocacy efforts and civil society dialogues?**

*C.2.1.a. **Do pharmaceutical manufacturers, importers, and distributors speak out on regulatory constraints to their businesses? Do trade and health/medical professional associations?** (Sources: interviews with representatives of pharmaceutical manufacturers, distributors, and importers; interviews with representatives of trade and professional associations)

C.2.2. **How often and how well do the media cover family planning/reproductive health issues? Is reproductive health commodity security covered?** (Sources: interviews with NGO/civil society leadership; interviews with known FP/RH advocates; interviews with leadership in Ministry of Health/FP/RH; interviews with representatives of the media; interviews with research firms that track media content)

C.3. Health Sector Reform and Development Assistance

C.3.1. Are family planning/reproductive health services and supplies included in a Poverty Reduction Strategy Paper (PRSP)?

C.3.2. Are family planning/reproductive health services explicitly addressed in a sector-wide approach? Is financing for contraceptives, condoms, and other supplies included?

C.3.3. **What is the impact of health sector reform on provision of reproductive health and family planning services and supplies, including decentralization, health systems integration, and private sector involvement?** (Sources: interviews with public sector RH/FP policy makers and program managers; interviews with private sector service providers; interviews with private sector hospital/clinic managers; interviews with insurance and HMO managers; analysis of public and private sector service delivery and product sales data; analysis of household expenditure data)

- **What are the effects of shifting decision-making responsibilities from central to local levels?**
- **Is the burden of public sector financing also shifting?**
- **What kinds of partnerships is the public sector building with the private sector for provision of health services (e.g., contracting)?**
- **Is the provision of reproductive health and family planning services and supplies explicitly addressed under these reforms? Or, are they are being “orphaned”?**

D. Capital

This section examines the full range of current and potential financing for RH commodities: government, household, donor, and third party. It looks at recent financing trends as well as future expectations. Importantly, it asks whether future financing will be adequate to ensure products are available to clients who want them. If, for example, donor support is declining, stakeholders should investigate what other sources of financing are able to keep pace with demand. A strategy can then be developed to ensure adequate funding is available to meet client demand. As for the table in the commodities section, the table may need to be duplicated for different commodities.

D.1. Government, Donor Funding

Source	Amount of Funding For Commodities					
	5 Years Ago	Last Year	This Year	Next Year	5 Years from Now	10 Years from Now
Government Budget¹						
Using internally generated funds						
Using loan credits						
Using other donor funds (e.g., grants)						
Donor²						
UNFPA						
USAID						
DFID						
KfW						
Other						
Other						
Other International Funding Sources						
IPPF						
Other						
Total Funding						

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

² "Donor" refers to direct donor financing of commodities, generally through donor procurement mechanisms

D.1.1. What is the current amount of public funding available for RH commodities? What are the expenditures?

- What is the share of family planning/reproductive health as a percentage of the total government health budget?
- Family planning as a percentage of the reproductive health budget?
- RH commodities as a percentage of the family planning budget?

D.1.2. What are the public sources of financing for contraceptives and other RH commodities, and what percentage of the total expenditure do each represent?

- How much is spent by the central government? Local government? Social security?
- How are the funds used?
- Are public resources being targeted to the poorest of the poor?

D.1.3. Are there cost recovery systems in place for public sector services and supplies? How do these systems function and how are the funds used? Is there a waiver system or other safety net for the poor?

D.1.4. **Are public funds used to provide supplies or subsidize services through private providers (e.g., NGOs, social marketing programs)?** (Sources: interviews with MOH FP/RH managers responsible for procurement; interviews with MOH FP/RH managers responsible for service delivery and contraceptive distribution; interviews with social marketing managers; interviews with NGO service delivery managers)

*D.1.4.a. **What impact, if any, do these subsidies and free supplies have on private sector service provision and sales?** (Sources: interviews with representatives of pharmaceutical manufacturers and distributors; interviews with retail pharmacists; interviews with private providers; interviews with HMO/hospital/clinic managers; analysis of consumer research data)

D.1.5. What contraceptive/commodity financial data do key decision makers have? How do they use it?

D.2. Household Funding

D.2.1. **What are out-of-pocket expenditures on contraceptives, other RH commodities, and family planning/reproductive health services? How much are users paying for services and supplies, and what are they charged for?** (Sources: national household income and expenditure data; interviews with HMO and insurance providers; interviews with private providers; consumer research data; pharmacy survey data; interviews with public sector service delivery managers; interviews with NGO service delivery managers; consumer survey and focus group research)

- **By standard of living or income?**
- **By rural-urban?**
- **By method?**
- **By source (public, NGO, social marketing, commercial)?**
- **By geographic area?**
- **Do women and men pay differentially for services?**

D.2.2. **Do women and men have equal access to household funds? If there are inequalities, what are the impacts for household funding of FP/RH services and supplies?** Sources: analysis of consumer surveys; consumer intercept interviews; analysis of household income/expenditure surveys; consumer focus group research)

D.2.3. **What is the ability and willingness to pay among current users, as well as among clients with unmet need, for family planning/reproductive health supplies? By provider (public sector, NGO, social marketing, commercial)? By client characteristics (income/standard of living, rural-urban, education, etc.)?** (Sources: analysis of household income/expenditure surveys; analysis of DHS data; consumer and potential consumer survey research)

D.3. Alternative Financing Mechanisms

D.3.1. **What are the third party/health insurance schemes including social/national insurance, private insurance, and employer coverage?** (Sources: interviews with private sector insurance and HMO managers; interviews with public sector health care policy makers; interviews with employers; interviews with social/national insurance managers)

- **Who are the main third party payers? What kinds of individuals are covered by each? Who is eligible? How many people do they cover? How much do they spend?**
- **What is the coverage for family planning and other reproductive health services and commodities?**

D.3.2. What alternative financing mechanisms are available to finance commodities (e.g., community-based financing)?

D.4. Current and Future Funding

D.4.1. How adequate is current funding for contraceptives and other reproductive health supplies?

- What is the current funding gap?
- **How dependent are social marketing organizations, NGOs, and others on government and donor subsidies?** (Sources: interviews with RH/FP staff of donor agencies; interviews with social marketing organization managers; interviews with public sector RH/FP program managers; analysis of social marketing business plans and income/revenue reports)

D.4.2. How adequate will future funding be?

- What are the expected significant changes in funding—sources and type?
- What are the expected/most reliable sources of funding over the next five to ten years, and what amount will each contribute?
- What will be the financing requirements for contraceptives, other supplies, operations, and capacity improvements to meet future demand?
- What is the expected gap?

E. Capacity

This section focuses on the service provider, logistics, forecasting, procurement, and monitoring and evaluation capacities that are necessary for RHCS. All of these are necessary, whether for the public sector, an NGO, a social marketing program, or the commercial sector. Unless otherwise indicated, the questions should be asked separately for any program of national importance.

Other capacities that are critical for RHCS are addressed elsewhere in the guide. Advocacy is addressed under “C. Commitment,” capacity to develop supportive policies is addressed under “G. Context,” while coordination is its own section (F).

E.1. Service Provider Skills

***E.1.1. What percent of clients, with what profile, use different kinds of providers (ob/gyns, general practitioners, midwives, nurses, community-based deliverers, pharmacists, drug store clerks)? How does this profile vary between the public and private/nonprofit and private/commercial sectors?** (Sources: analysis of DHS data; consumer intercept surveys; interviews with private providers and retail pharmacists; interviews with public sector RH/FP program managers and providers; interviews with NGO providers)

- **For which supplies and services?**
- **How medicalized is the provision of contraceptives? What are the implications for access to contraceptives and program costs?**
- **Do the characteristics of providers, (e.g., the mix of female and male providers) match with clients’ needs and preferences?**

E.1.2. What is the level of provider skill by service provider? (Sources: interviews with private providers; interviews with representatives of medical, nursing, midwifery, and pharmacy schools; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations; interviews with HMO/hospital/clinic managers; interviews with NGO service providers and managers; interviews with MOH FP/RH policy makers; interviews with public sector program managers and service providers)

- **Does provider training include counseling for informed choice, taking into account gender norms, logistics/reordering, and appropriate technical skills (e.g., IUD or implant insertion and removal)?**
- **Are facilities stocked with the appropriate contraceptives and other supplies given the skill level of health personnel to provide services according to standards of care?**
- **Is there provider bias against particular client groups or methods? If so, what are the implications for client access to contraceptives or other products?**

***E.1.3. Do supervisors check the quality of the providers' work and provide on-the-job training to improve their skills in counseling including attention to gender issues, storage, ordering, record-keeping, etc.? Are there mechanisms for quality of care monitoring and enforcement in the private/nonprofit and private/commercial sectors?** (Sources: interviews with private providers and retail pharmacists; interviews with public sector service delivery managers; interviews with NGO service managers; interviews with HMO/hospital/clinic managers; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations)

E.2. Logistics

***E.2.1. For each program and for the private/nonprofit and private/commercial sectors, how does the distribution system work and what capacities exist?** (Sources: interviews with representatives of pharmaceutical manufacturers; interviews with commercial sector pharmaceutical distribution company managers; interviews with pharmaceutical warehouse managers; interviews with retail pharmacists; interviews with HMO/hospital/clinic supply managers; interviews with NGO program and clinic managers; interviews with public sector RH/FP program managers; interviews with public sector RH/FP commodity logistics managers; interviews with public sector RH/FP warehouse managers)

- **Is the logistics system “push” or “pull”? How many levels are there in the supply chain? Can they be reduced?**
- **Is a maximum/minimum inventory control system in place? How much stock is held at each level?**
- **Are the storage conditions throughout the system adequate to manage the product load and prevent loss through damage and theft?**
- **Is transportation adequate at all levels?**
- **Is the distribution schedule appropriate?**
- **Is there a system where timely and accurate data on stock on hand and consumption are collected and used for reporting on use, for ordering resupply, and for making shipments at all levels?**
- **Are there guidelines/systems in place for inventory management and for handling expired or defective products?**

***E.2.1.a. How do private practice physicians and midwives obtain IUDs and other RH/FP products? Are they regularly “detailed” by medical representatives? Do salesmen regularly call on them?** (Sources: interviews with representatives of pharmaceutical manufacturers and distributors; interviews with private providers; interviews with retail pharmacists)

E.2.2. For the public sector, is the contraceptive logistics system stand alone or integrated with other products? If donor resources diminish, can it be sustained?

*E.2.3. **What is the future capacity of public sector and private sector distribution systems?** (Sources: interviews with representatives of pharmaceutical manufacturers; interviews with commercial sector pharmaceutical distribution company managers; interviews with pharmaceutical warehouse managers; interviews with retail pharmacists; interviews with HMO/hospital/clinic supply managers; interviews with NGO program and clinic managers; interviews with public sector RH/FP program managers; interviews with public sector RH/FP commodity logistics managers; interviews with public sector RH/FP warehouse managers)

- **Is the distribution infrastructure improving or deteriorating?**
- **Are the demands on the system likely to increase? Can the system expand to accommodate the increase?**
- **Do weaknesses in infrastructure (e.g., bad roads or too few wholesalers) limit the availability of supplies?**

E.3. Forecasting

E.3.1. Are program commodity needs forecast two to five years in advance?

E.3.2. What data are used for forecasting need? (e.g., consumption, losses/adjustments, stock on hand, sales data, demographic data, service statistics)? How reliable are the data?

E.3.3. How often are forecasts updated?

E.3.4. Who is responsible for forecasting and what skills and training do they have? Do they require donor assistance for completing their forecasts?

E.3.5. Are forecast data used to advocate for resources to ensure full supply (for those products that require it)?

*E.3.6. **How good are retail pharmacists at forecasting need, ordering, and inventory control? Are there stock outages in the commercial sector?** (Sources: interviews with retail pharmacists; interviews with representatives of pharmaceutical manufacturers and distributors)

E.4. Procurement

E.4.1. Who is responsible for procurement of contraceptives and other RH supplies? What kind of procurement training do they receive, if any? Is there coordination between logistics and procurement staff?

E.4.2. What data are used for procurement plans? Are appropriate products procured to address forecast need? Prevent stockouts?

E.4.3. How effective is donor coordination for procurement? Are there obstacles? Are donor lead times for procurements reasonable for programs to work with effectively?

E.4.4. **Have there been donor-related disruptions in supply to programs? For what reasons? What is being done to avoid them in the future?** (Sources: interviews with NGO program managers; interviews with social marketing managers; interviews with representatives of donor agencies; interviews with MOH FP/RH program managers; interviews with MOH commodity managers)

E.4.5. **What are the procedures for government procurements (e.g., issuing tenders, evaluating bids, monitoring supplier performance)? How transparent, timely, and efficient are they? Do they comply with the international competitive bidding procedures of fenders? Where do government procurements typically source contraceptives and other RH supplies? What prices are they paying? Do they have access to hard currency? What are lead times for government procurements? Are they reasonable for programs to work with effectively?** (Sources: interviews with MOH FP/RH program managers; interviews with MOH commodity managers; interviews with representatives of pharmaceutical manufacturers)

E.4.6. Have there been disruptions, or the threat of disruptions, in supply to programs due to delays or other difficulties in government procurements? For what reasons? What is being done in the future to avoid them?

*E.4.6.a. **Do pharmaceutical importers have any difficulty in obtaining delivery of products from their manufacturers in a timely way?** (Sources: interviews with representatives of pharmaceutical manufactures, importers, and distributors)

*E.4.7. **What procedures are in place to assure product quality in both the public and private sectors?** (Sources: interviews with MOH drug and pharmacy regulators; interviews with representatives of pharmaceutical manufacturers)

E.4.8. Is there scope for efficiencies and cost savings by reforming or centralizing procurements across programs? For example, is one financing source paying more than another for the same product?

E.5. Monitoring and Evaluation

E.5.1. Do programs routinely collect appropriate data and information for management decision making, monitoring, and planning for RHCS? Is the data appropriately disaggregated by client characteristics (e.g., age, sex, location, etc.)? Is there a management culture that supports evidence-based decision making?

*E.5.1.a. **What data for RHCS, if any, are available from the private/nonprofit and private/for-profit sectors?** (Sources: interviews with MOH FP/RH program managers and policy makers; interviews with NGO and private practice providers)

E.5.2. Is there a functional MIS for each program? Does it receive policy level attention and support? Do higher levels provide feedback to lower levels about performance based on MIS data?

E.5.3. Does the policy level receive appropriate information? How? Does the policy level use it for analysis and decision making?

*E.5.3.a. **Are private sector RHCS data included in information received by the policy level? Are private sector RHCS data incorporated into the analysis and decision making process?** (Sources: interviews with MOH FP/RH program managers and policy makers)

E.5.4. Is population-level data collected at an appropriate frequency, reported, and used to measure overall program performance and to make adjustments? Is it disaggregated by respondent characteristics (e.g., age, sex, location, socioeconomic status, etc.) and used to monitor inequalities in reproductive health, and in access to and use of FP/RH services and supplies?

F. Coordination

This section addresses the need for coordination among a wide range of stakeholders and at multiple levels to achieve reproductive health commodity security. It asks questions about who should coordinate, how they coordinate, and what have been the results.

F.1. Who Coordinates, How, and Why

F.1.1. Who are the stakeholders that need to coordinate their activities (donors; government agencies; public, NGO, social marketing, and commercial sector providers; technical agencies; etc.)? (Sources: analysis of stakeholder assessment; interviews with private providers; interviews with NGO managers and providers; interviews with social marketing managers; interviews with representatives of pharmaceutical manufacturers; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations; interviews with public sector providers; interviews with MOH FP/RH program managers and policy makers; interviews with representatives of donor agencies; interviews with representatives of medical, nursing, midwifery, and pharmacy schools; interviews with representatives of technical agencies)

F.1.2. What formal and informal coordination mechanisms exist? What is the willingness to foster coordination? (Sources: interviews with private providers; interviews with NGO managers and providers; interviews with social marketing managers; interviews with representatives of pharmaceutical manufacturers; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations; interviews with public sector providers; interviews with MOH FP/RH program managers and policy makers; interviews with representatives of donor agencies; interviews with representatives of medical, nursing, midwifery, and pharmacy schools; interviews with representatives of technical agencies)

- **Among donors?**
- **Within government?**
- **Between donors and government?**
- **Among service providers in different sectors?**
- **Between government and service providers?**
- ***Between government and pharmaceutical manufacturers and distributors?**
- **Between government and civil society organizations?**
- **Among technical agencies?**

F.1.3. Is there a committee or task force for RHCS? How influential is it? Who is it comprised of? Is there representation of disenfranchised groups?

F.1.4. Does the government, particularly the Ministry of Health, play a leadership role in coordinating key stakeholders? In particular, how well do different parts of the government coordinate for RHCS (e.g., Ministries of Health and Finance)?

F.1.5. **What are the information flows that facilitate coordination?** (Sources: interviews with private providers; interviews with NGO managers and providers; interviews with social marketing managers; interviews with representatives of pharmaceutical manufacturers; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations; interviews with public sector providers; interviews with MOH FP/RH program managers and policy makers; interviews with representatives of medical, nursing, midwifery, and pharmacy schools)

F.1.6. **What are the existing coordinated activities and their expected outcomes, such as better coordination of donor procurements or more rational and sustainable segmentation of the contraceptive market?** (Sources: interviews with private providers; interviews with NGO managers and providers; interviews with social marketing managers; interviews with representatives of pharmaceutical manufacturers; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations; interviews with public sector providers; interviews with MOH FP/RH program managers and policy makers; interviews with representatives of medical, nursing, midwifery, and pharmacy schools)

F.1.7. **To what extent and how are stakeholders involved in policy development? In advocacy and work with the media? Which stakeholders?** (Sources: interviews with private providers; interviews with NGO managers and providers; interviews with social marketing managers; interviews with representatives of pharmaceutical manufacturers; interviews with representatives of medical, nursing, midwifery, and pharmacist professional associations; interviews with public sector providers; interviews with MOH FP/RH program managers and policy makers; interviews with representatives of medical, nursing, midwifery, and pharmacy schools)

F.1.8. Have key stakeholders come together to develop a joint strategy for RHCS?

- Is the strategy generally known and supported in the government and among key stakeholders?
- Is it included in a broader strategy (e.g., a health sector program) or does it stand alone?
- Who led its development and who was involved?
- Who has responsibility for coordination and oversight of the implementation of the strategy?
- If there is no strategy, do stakeholders have the capacity to develop one? To monitor progress on RHCS and make adjustments?

G. Context

The success of a RHCS strategy depends on a range of contextual factors affecting individuals' ability to choose, obtain and use RH supplies. To define the broader health, political, and economic environment as it affects RHCS, this section considers:

- Policies and regulations that bear on the ability of public and private sector programs to secure and deliver reproductive health supplies; and
- Basic demographic, health, and other development indicators.

G.1. Policies and Regulations

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

- Are these supportive of securing reproductive health supplies? And if so, how?
- Are they supported by adequate programs and funding?
- How are the policies and programs implemented? What are/have been the implications for supplies?

G.1.2. Does the HIV/AIDS policy formally link to the population/family planning policy? Does it explicitly mention securing adequate supplies of condoms or other commodities?

***G.1.3. For family planning/reproductive health and HIV/AIDS commodity issues, how are decisions made and who is involved? Are civil society groups, for example, women's health advocates, included? Private providers and suppliers?** (Sources: interviews with MOH policy makers and commodity managers; interviews with NGO/civil society leaders; interviews with leading private providers; interviews with representatives of pharmaceutical manufacturers; interviews with representatives of medical professional associations)

G.1.4. **Are contraceptives and other reproductive health supplies on the national essential drugs or medicines list (EDL or EML)? Which ones? Does being on the list bring any special status, such as waiver of duties, priority in budgeting or resource allocation decisions, waiver from procurement restrictions (e.g., "buy local")?** (Sources: interviews with MOH drug regulators; interviews with public sector RH/FP policy makers and commodity managers; interviews with representatives of pharmaceutical manufacturers, importers, and distributors)

G.1.5. **Are there age- or parity-related restrictions, requirements for parental or spousal consent, prescription requirements, or other policies or other restrictions that limit access and choice of contraceptives?** (Sources: MOH FP/RH policy and regulatory statements; interviews with private providers; interviews with HMO/hospital/clinic managers; interviews with public sector providers; interviews with public sector RH/FP policy makers and program managers)

G.1.6. **What policies affect, positively or negatively the private sector's ability to provide contraceptives? Other reproductive health supplies?** (Sources: public sector RH/FP policy and regulatory statements; interviews with representatives of pharmaceutical manufacturers, distributors, and importers; interviews with MOH drug regulators; interviews with private providers and retail pharmacists; interviews with Ministry of Finance taxation and tariff policy makers; interviews with representatives of media and advertising companies)

- **Are there price controls?**
- **Are there limitations on distribution?**
- **Are there taxes and duties (excise, import, value-added tax) or exemptions that affect the private sector?**
- **Is there a ban or other restrictions on advertising?**
- **Are there other operational policies or regulations that adversely or positively affect the private sector?**

G.1.7. **What other regulations or operational policies affect delivery of supplies and services?** (Sources: public sector RH/FP policy and regulatory statements; interviews with representatives of pharmaceutical manufacturers, distributors, and importers; interviews with MOH drug regulators; interviews with private providers and retail pharmacists)

- **Are there restrictive licensing requirements?**
- **Are there any restrictive dispensing regulations?**
- **Are there limitations by specific cadres of health professionals?**

G.1.8. **Do policies assure the capacity of service providers to provide contraceptives and other supplies?** (Sources: interviews with public sector RH/FP policy makers; interviews with medical, nursing, pharmaceutical, and midwifery professional associations; interviews with medical, nursing, pharmaceutical, and midwifery curriculum managers; interviews with private providers and retail pharmacists; analysis of provider KAP survey data)

- **Do service delivery guidelines, protocols, norms, and standards specify appropriate products? Do they include quality assurance procedures and basic logistics principles such as ordering, recording, storage, handling, etc.?**
- **What are the training and certification requirements (pre- and in-service) specific to methods? Are they enforced?**

G.1.9. What are the policies and regulations regarding distribution of public funds for family planning and reproductive health? What is the process for determining annual funding, levels and allocations?

***G.1.10. Are there policies that restrict or regulate fees for family planning and other reproductive health services (levels, exemptions) in either the public or private sector? For contraceptives and other supplies in either the public or private sector?** (Sources: MOH policy statements and regulations; interviews with public sector RH/FP policy makers; interviews with MOH drug regulators; interviews with public sector regulators or NGOs; interviews with private providers; interviews with NGO service delivery managers; interviews with hospital/clinic managers; interviews with representatives of pharmaceutical manufacturers and distributors; interviews with retail pharmacists)

- **What financial management policies and guidelines exist for retention of fees, management of funds, facility budgeting, local procurement?**

G.2. Demographic, Health, and Development Indicators

Indicator	10 Years Ago	5 Years Ago	Current	5 Years from Now	10 Years from Now
Total population					
Percent of population that is urban					
Percent of population that is rural					
Population growth rate					
Per capita income					
Adult literacy rate					
Number of women of reproductive age					
Total fertility rate (TFR)					
HIV prevalence					
Infant mortality					
Maternal mortality					
Average age at marriage for women and men					
Average age at delivery of first child					
Other					
Other					

Appendix B: The RHCS Coordinating Committee's Private Sector Review Guide²⁷

Section 1: Process

1.1 Which, if any, private stakeholders have been interviewed or included as key informants as part of the assessment? How many in each category? Does the selection provide a comprehensive and balanced view of the private sector?

- Social marketing organizations
- Manufacturers – domestic and international
- Pharmaceutical importers and distributors
- Retail pharmacists
- Hospital and clinic owners/managers
- Industry associations
- Private practice providers: physicians, nurses, midwives
- Traditional medicine/health care providers
- Provider associations
- NGO service delivery organizations
- NGO/civil society RHCS advocacy organization
- HMOs
- Health insurance companies
- Employers offering health care services through own clinics or contracts for service

1.2 Are data (production, sales, services provided, geographic distribution, number of providers, types of providers, etc.) on the private sector collected? Are sales data from both the social marketing and commercial sectors used in the assessment?

1.3 Does the assessment describe the current role (manufacturing, distributing, counseling, prescribing, delivering LAPM, financing, advocating, educating, market researching, etc.) of the private sector in RHCS?

1.4 Do the recommendations consider both the current and potential role (manufacturing, distributing, counseling, prescribing, delivering LAPM, financing, advocating, educating, market researching, etc.) of the private sector?

²⁷Adapted from "Annex A: Reviewer's Guide, Engaging the Non-Public Sectors in the SPARHCS Process: A Review," USAID | DELIVER PROJECT, no date.

Section 2: Context

2.1 If the assessment includes an inventory and role of key stakeholders, is the private sector included?

- Social marketing organizations
- Manufacturers – domestic and international
- Pharmaceutical importers and distributors
- Retail pharmacists
- Hospital and clinic owners/managers
- Industry associations
- Private practice providers: physicians, nurses, midwives
- Traditional medicine/health care providers
- Provider associations
- NGO service delivery organizations
- NGO/civil society RHCS advocacy organization
- HMOs
- Health insurance companies
- Employers offering health care services through own clinics or contracts for service

2.2 Does the assessment take a “whole market” perspective? Does the assessment look at how the public, NGO, and commercial sectors either complement or compete with each other? Are there unnecessary overlaps in service delivery? Are there gaps in service delivery?

Section 3: Capacity

3.1 Is the institutional capacity and mandate of the public sector considered in terms of its:

- Regulation/oversight of private sector services;
- Regulation/oversight of private sector product and supply;
- Recognition of the private sector's role in achieving national strategies and goals; and
- Use of outsourcing to the private sector?

3.2 Is the public sector's ability and effectiveness in coordinating with the private sector considered? How does the public sector perform in regard to:

- Including the private sector in coordinating committees;
- Including private sector providers in national training programs;
- Including private sector needs and resources in national workplans (training, IEC, demand generation, service delivery, etc.)?

3.3 Does the assessment look at the capacity of the private sector in regard to:

- Service providers (number, location, cadre);
- Percentage of contraceptive users served by the private sector (urban/rural, SES status); training;
- Contraceptive method delivery (by type);
- Maintenance of adequate contraceptive supplies (logistics/supply chain management)?

3.4 Does the assessment look at the NGO and commercial sectors' distribution capacity (by method)?

3.5 Does the assessment look at the commercial sector's manufacturing capacity (by method)?

Section 4: Policy

4.1 Are public sector regulations and policies considered in terms of whether or not they provide an enabling environment for private sector service/product delivery/sale?

4.2 Have data been collected on policies that affect the role/operation of the private sector, especially in regard to:

- Service delivery restrictions (types of providers allowed to prescribe, counsel, or provide each method);
- Procurement;
- Price controls;
- Advertising restrictions;
- Taxes and duties; and
- Any others?

Section 5: Commodities

5.1 Does the assessment present information on source/procurement (domestic or international manufacturers, importers, distributors) of commodities? Who (donor, IPPF, MSI, UNFPA) has paid for commodity procurement? Are trend data presented?

Section 6: Financing

6.1 Does the assessment include the percentage of funding for contraceptive products and services that comes from households (out of pocket)?

6.2 Does the assessment indicate the source of supply for contraceptive products and services?

6.3 Does the assessment quantify the donor resources for contraceptives/RH that are channeled through social marketing programs, through NGOs, and through private providers/commercial sector?

6.4 Does the assessment include information and/or recommendations on consumers' ability and willingness to pay for RH/contraceptive products and services?

6.5 Does the assessment describe segmentation in the RH/contraceptive market, i.e. which consumer groups are served by which providers or through which channels?

Appendix C: Illustrative Strategic Objectives and Expected Outcomes: Measures of Success for Inclusion of the Private Sector in RHCS

The whole market approach to reproductive health commodity security involves the active participation of both the public and private (nonprofit and commercial) sectors. The strategic objectives for private sector involvement in the RHCS process—from the reproductive health/family planning program planner’s point of view—include positive change in each of four primary areas: market size, equity, accessibility, and sustainability. Tools for measuring change in each area are described in the table on the following pages.

Total Market Indicators²⁸

- **Market Size:** The market “potential” as measured by the units of contraceptive products sold or distributed, the rate of use or the numbers of users.
- **Market Equity:** The ability of consumers in the market from all income quintiles to find products/services at prices they are willing to pay.
- **Market Accessibility:** The ease of access to a contraceptive product in different geographical regions of a country/market.
- **Market Sustainability:** The ability of the market to serve a critical mass of consumers with well established demand and willingness to pay with minimal government or donor support. When the market achieves this degree of viability, the number of market entrants will go up and market shares will be divided among a wider number of suppliers. The level of competition in the market from various sources of supply with unsubsidized sources of supply having a market share in excess of 50% substantial share and no one source having dominant share.

The table on the following pages gives more precise examples of the indicators and summarizes the various issues with each one.

²⁸Total market indicators and the table that follows were developed and written by Jeff Barnes, Abt Associates, 2008, as part of the work of Workstream 2, Market Development Approaches Working Group for the Reproductive Health Supplies Coalition.

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
1. Market size		
1.1 Units of product sold or distributed	When the data can be obtained, sales or distribution are reliable in that they can be verified against stock movements or revenues. However, because sales can leak out of the market one is trying to measure and because significant percentages of units sold or distributed may be wasted, they are not a reliable proxy for use. Sales can be difficult to compare since they may be collected at various points in the supply chain—units imported, units sold to a national distributor or units sold to retail level. The closer the level of sale to the consumer, the better the indicator of use.	Typically, sales from social marketing programs can be obtained easily and verified. Units distributed through public sector programs may be difficult to obtain. Sales from commercial suppliers are very difficult to come by, unless the country has market reading services such as Neilsen or IMS. The cost of obtaining sales data is comparatively low, except for IMS or Neilsen reading services that charge significant fees.
1.2 Number of users	To obtain this indicator, one would typically have to project from nationally representative surveys on reported use and model the number of users from population data. In terms of assessing profit potential, the number of users in the market is as important as understanding average rate of user and the segments of heavy, medium and light users of products. Estimates of number of users are only as reliable as the survey data and census on which the estimates are based.	Ascertaining this requires nationally representative surveys and relatively recent census information. In most markets of interest, this data would be available without needing further investment. Where national surveys have not been done or where the specific product information is lacking, obtaining it would be very costly.
1.3 Consumption of product per capita	This indicator would have to be obtained by dividing units of product sold or distributed by the total population. This indicator is another way of weighing the overall potential of the market since profitability depends not only on the total consumption but also on how concentrated that consumption is in geographic areas and how many heavy users there are. This indicator provides a rough proxy for those factors.	If total units sold or distributed is available then this indicator is easily available at no cost.
1.4 Number of products/ brands in the market, and number of product/ brand launches in the last year	On the principle that supply increases as market potential increases, tracking the number of market entrants and market offerings is another proxy. Conversely, if commercial products drop out of the market, it could be a sign that market potential is being hurt by subsidized or free competition. These are not perfect indicators since many economic and regulatory factors drive market entrants. However, all other factors being equal, supply will follow demand and market potential. If the number of products or brands is dominated by free or subsidized brands, that still represents a market potential, albeit one that is dependent on increasing willingness to pay over time.	This information is readily available from retail audits at minimal cost. Even small samples of retail outlets will usually capture all the brands in a market.

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
2. Market Equity		
2.1. Number of brands in the market determined to be affordable to lowest wealth group	Most affordability measures rely on arbitrary rules of thumb (e.g. 1% of GNP per capita should buy 1 CYP). More sensitive measures of affordability need to be developed.	Establishing the number of brands and prices is easy. Determining their “objective” affordability may require new methods.
2.2 Percentage of consumers (current users and non-users) in each wealth group who report that the product is affordable or that the price is not a barrier to use	Willingness to pay indicators are more reliable indicators of equity than ability to pay indicators which involve arbitrary rules set by outsiders to decide in the place of the consumer what the consumer “should” be able to pay. Perceptions of affordability or willingness to pay are obtainable through surveys. The higher the percentage and the more even the percentages are across income quintiles, the more equitable the market.	<p>Nationally representative surveys that include significant numbers of people from all income categories are long and costly to do. However, it may be possible to add willingness to pay questions to an existing household survey. Or, it may be possible to collect this information from a targeted population (e.g. low and middle-income) on a smaller scale.</p> <p>Respondents must know and understand the product or service and its costs and benefits to be able to reliably answer questions on willingness to pay.</p>
3. Market Accessibility		
3.1 Percentage of consumers in a defined geographic area of the market who report knowing where to obtain the product or who report that distance to a delivery point is not a barrier to use	Markets that may show strong growth and may be equitable in terms of pricing, may still have gaps for consumers in selected regions or in rural areas. The higher this percentage for an area, the less effort and investment should be made in opening delivery points, managing distribution channels, etc. Low percentage areas require more attention to stockouts, opening of delivery points and communication to consumers about where to find the product.	This information can be collected through surveys, provided the survey sample includes sufficiently large samples in the areas of interest. The smaller the analytical unit of area, the more expensive it will be to provide statistically significant samples for all areas of the market. The larger the analytical area, the less guidance the data provides on improving accessibility.
3.2 Percentage of product delivery points reporting a stockout in the last 3-6 months	When appropriate systems are established to collect this data (including retail outlet surveys) the indicator is a highly reliable predictor of accessibility. Knowing what to do about the indicator is more problematic since stockouts may reflect poor resupply systems, a sudden increase in demand, poor forecasting by the retailer, cashflow constraints by the retailer, etc.	Within a closed system such as the public sector, there may be reliable MIS systems producing data on rates and duration of stockouts. In commercial retail outlets, this may be available from Nielsen or IMS readings or through retail outlet surveys.

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
3. Market Accessibility		
3.3 Number of delivery points in a given area or for a given population	Some product or service delivery points may be registered with government authorities such that it is possible to analyze the number of service delivery points in specific districts with known populations. The higher the ratio of delivery points to consumers, the higher the accessibility. Some social marketing programs also track numbers of outlets and where they are located. There is a large margin of error, however since the indicator represents a “point in time” image of accessibility, and the data are often out of date and difficult to keep up to date. Outlets that closed are typically not taken off the registration lists in a timely manner and even in a social marketing database, outlets that may still exist, may have chosen to stop carrying the product.	If in-country references sources exist (provider registration lists, SM databases), this indicator can be obtained at low cost. If not, conducting a census of commercial retail outlets can be expensive. Typically, however, pharmacies and clinics are limited enough in number that registration lists combined with some on the ground verification, can provide a fairly accurate picture.
4. Market Sustainability		
4.1 Market leader’s market share	Dominance of market by one provider is typically a sign of a weak, unsustainable market. When the government or a social marketing program provides 80-90% of a product type it means that the market is dependent on a single source of supply and the subsidy that finances the source of supply. In a healthy, sustainable market, there are multiple sources of supply, many of which are unsubsidized and no one provider has more than 30-40% of the market share.	As long as number of units can be estimated and the source of each seller/distributor of product units can be identified, then market share can be calculated through a percentage of each provider’s units over the total units distributed or sold.
4.2 Number of unsubsidized brands in the market and market share of unsubsidized brands	Although the overall number of brands/products in the market is representative of market potential, market sustainability should only take account of the unsubsidized brands—these may be commercial or sold at full cost recovery from government or NGO providers.	Number of brands in the market is easily available through small retail audits. Knowing the source of supply and the retail price should be sufficient to determine which of the brands are unsubsidized.
4.3 Number of sources of supply serving the market	A market that has all its supply “eggs” in one basket is less sustainable than one which is supplied from several sources. A market may have several brands supplied by a single NGO in which case it is less sustainable than a market that has the same number of brands, but supplied by several sources (commercial, government and NGO).	Retail audits and background research on the suppliers of each brand will be sufficient to establish this indicator.

