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COPE® FOR CONTRACEPTIVE SECURITY: AN ASSESSMENT GUIDE

An Adaptation of the COPE® Quality Improvement Approach

EngenderHealth's Quality Improvement Series

www.engenderhealth.org/cope

COPE® for Contraceptive Security: An Assessment Guide

An Adaptation of the COPE® Quality Improvement Approach

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Contents

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This volume, which represents a further adaptation of the COPE® process and tools, is part of that evolutionary process. EngenderHealth is thankful for the support from a range of individuals and organizations that have made the development of this assessment guide possible. In particular, EngenderHealth is grateful for the support of the American People, through USAID, which funded the development of this set of guides by means of The RESPOND Project (under the terms of cooperative agreement GPO-A-00-08-00007-00).

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Acronyms and Abbreviations

FP	family planning
FEFO	first-expired, first out
HMIS	health management information system
ILS	integrated logistics system
IUD	intrauterine device
LMIS	logistics management information system
MIS	management information system
NSV	no-scalpel vasectomy
QI	quality improvement
SMS	short message service
USAID	U.S. Agency for International Development

About COPE®

COPE (which stands for client-oriented, provider-efficient) is a process and a set of tools in an ongoing quality improvement (QI) process used by health care staff to assess and improve the quality of the care that they provide. COPE empowers staff to proactively and continuously assess and improve the quality of their services. Two assumptions inform the COPE process:

- Recipients of health care services are not passive patients waiting to be seen by experts, but rather are autonomous health care consumers, or clients, who are responsible for making decisions about their own health care and who deserve—indeed, have the right to—high-quality health care.
- Health care staff desire to perform their duties well, but without support and critical resources, they cannot deliver the high-quality services to which clients are entitled.

The standard COPE process uses a series of 10 self-assessment guides that are based on a framework of seven ***clients' rights*** and three ***staff needs*** that are implicit in the two assumptions above (see Figure 1, page 2). The rationale is that the more clients' rights are honored and that staff needs are met, the higher the quality of care will be.

COPE recognizes that staff are the experts who can identify obstacles to high-quality care and when given support, will efficiently use existing resources to overcome those obstacles. COPE focuses on aiding staff in identifying challenges in systems and processes, rather than finding fault with individual staff members. When staff work with COPE, they develop a sense of ownership of the assessment findings, become invested in implementing the recommendations they derive from the process, and feel good about the quality of services they deliver and about their contributions to the facility and to the health of their community.

About This Assessment Guide

COPE for Contraceptive Security: An Assessment Guide encourages staff to think through every dimension of contraceptive security, to ensure high-quality family planning (FP) services. The COPE process enables staff to discuss the quality of their services, identify problems that interfere with the delivery of quality services, identify the root causes of those problems, recommend ways to solve the problems, implement the recommendations, and follow up to ensure resolution of the problems. To do this, *COPE for Contraceptive Security* uses 10 self-assessment guides based on different aspects of contraceptive security.

Figure 1. The Rights of Clients and the Needs of Staff

The Rights of Clients

Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to health and health care services. Information and educational materials for clients need to be available in all parts of the health care facility.

Access to services: Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Informed choice: Clients have a right to make voluntary, well-considered decisions that are based on options, information, and understanding. The informed choice process is a continuum that begins in the community, where people get information even before they come to a facility for services. It is the service provider's responsibility either to confirm that a client has made an informed choice or to help the client reach an informed choice.

Safe services: Clients have a right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Providing safe services also means proper use of service delivery guidelines, quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during the delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff's handling of clients' medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services, supplies, referrals, and follow-up necessary to maintaining their health.

The Needs of Health Care Staff

Facilitative supervision and management: Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients.

Information, training, and development: Health care staff need knowledge, skills, and ongoing training and professional development opportunities to remain up to date in their field and to continuously improve the quality of services they deliver.

Supplies, equipment, and infrastructure: Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

Adapted from: Huezo & Diaz, 1993.

Note: This listing represents a generic description of clients' rights and staff needs. In this publication, the 10 self-assessment guides are structured according to aspects of contraceptive security, but where relevant, they still reflect the influence of clients' rights and staff needs.

EngenderHealth's first COPE® handbook, which was published in 1995, focused on FP. The COPE® process and set of tools have since been adapted for use in other health services, such as HIV and AIDS, cervical cancer, and community engagement (see Figure 2, for the full listing of all COPE products).

Figure 2. COPE Publications: Addressing a Range of Health Services

The following COPE publications are currently available:

COPE® for Contraceptive Security: An Assessment Guide (2013)

COPE® for Male Circumcision Services: A Toolbook to Accompany the COPE® Handbook (2010)

COPE® for Comprehensive Abortion Care Services: A Toolbook to Accompany the COPE® Handbook (2009)

COPE® for HIV Counseling and Testing Services: A Toolbook to Accompany the COPE® Handbook (2008)

COPE® for HIV Care and Treatment Services: A Toolbook to Accompany the COPE® Handbook (2008)

COPE® for Services to Prevent Mother-to-Child Transmission of HIV: A Toolbook to Accompany the COPE® Handbook (2004)

COPE® for Cervical Cancer Prevention Services: A Toolbook to Accompany the COPE® Handbook (2004)

COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook (2003)

COPE® Handbook: A Process for Improving Quality in Health Services, Revised Edition (2003)

COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services (2001)

COPE® for Child Health: A Process and Tools for Improving the Quality of Child Health Services (draft, 1999)

COPE®: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services (1995)

Community COPE®: Building Partnerships with the Community to Improve Health Services (2002) (*Note:* This toolbook presents a variation on the COPE process.)

In addition, COPE tools have been adapted for use in *Quality Improvement for Emergency Obstetric Care: Leadership Manual and Toolbook* (2003).

With this new publication, EngenderHealth provides tools and processes that can be used to improve contraceptive security. This assessment guide includes an overview of contraceptive security issues, an orientation to the COPE process, and 10 contraceptive security–related self-assessment guides to aid district and facility health and logistics management personnel with the process.

COPE for Contraceptive Security represents a variation on the standard COPE® process: It does not include interviews with clients, a record review, or a client-flow analysis. Its focus instead is on gathering the perceptions of a broad range of facility staff and managers on the details of how the commodities, supplies, equipment, and systems (e.g., training, supervision, counseling, and infection prevention) necessary for the continuous provision of contraceptive services are managed and secured (see What Is Contraceptive Security? on page 6).

Principles Underlying COPE

Quality in health care is often defined as providing client-centered services and meeting clients' needs. The QI process is an effort to continuously do things better until they are done right every time. There are several reasons to improve the quality of the health care services provided in any health care setting. Improving quality safeguards the health of both clients and staff, ensures more effective treatment, adds features to attract clients, maintains the organization's strengths, and fosters efficiency and cost savings.

The COPE process and tools draw on management theories and principles widely used in a range of fields, including health care. The most important QI principles on which COPE is based are the following:

- Meeting the needs and expectations of customers, both external (such as clients, donors, headquarters, and the Ministry of Health) and internal (such as other staff and other departments within the health care setting)
- Having all levels of staff become involved in and feel ownership of quality and of the process for improving quality
- Focusing on processes and systems, and recognizing that poor quality is often a function of weak systems, weak processes, inadequate organization of work, or implementation problems, rather than the fault of individuals
- Promoting efficiency and cost-consciousness by eliminating the costs of poor quality (e.g., repeat work and waste of time, effort, recourses, etc.)
- Enabling continuous staff learning, development, and capacity building, since staff need skills to carry out the QI process and provide quality services, and supervisors and team leaders need to be able to facilitate the work of staff and the development of those skills (i.e., the COPE process helps to identify learning needs and provides participants with an opportunity to learn about international standards for contraceptive security)
- Making QI work in an ongoing and continuous process

COPE enables staff to apply these principles in a range of service settings through the following four steps of the continuous QI process:

1. Information gathering and analysis
2. Action Plan development and prioritization
3. Implementation of the Action Plan
4. Follow-up and evaluation

Why Use COPE to Improve Quality?

- COPE promotes teamwork and cooperation among all levels of staff. By using the self-assessment tools together, supervisors and all staff, including support staff, become accustomed to working as a team.
- Self-assessment promotes a sense of ownership among staff. When all levels of staff assess their own services, rather than having the services evaluated by outsiders, they feel that the problems they identify are theirs and they feel responsible for implementing the solutions they develop. This creates a sense of *ownership* and *commitment* to the solutions developed.
- COPE relies on the wisdom of the experts. The experts on the services in a particular setting are the *staff* who provide them and the *clients* who use them. COPE gives both staff and clients a chance to apply their expertise and insights toward improving services.
- The tools are practical and relatively simple to use. The COPE tools are directly related to what staff do in their daily work.
- COPE boosts morale and provides a forum for staff and supervisors to exchange ideas. By providing all staff with an opportunity to become involved in problem solving and decision making, COPE leads to increased staff morale.
- COPE helps to communicate service standards to staff and thereby improves performance. The COPE Self-Assessment Guides are based on international and national service standards. Using the guides raises awareness of the importance of quality, what quality services are, and what is important to clients and staff.
- COPE is cost-effective. COPE is inexpensive to conduct. All that is needed are a few hours of a facilitator's time, time for staff to participate during regular working hours, flipchart paper, markers, and photocopies of the Self-Assessment Guides needed for the exercises.
- COPE is transferable and adaptable. COPE has been used in a range of health care settings, from national referral hospitals to small clinics, in both private- and public-sector institutions, and in both very low-resource and very high-resource settings. COPE has also been applied to many different health services, from FP to maternal and child health services, to infection prevention practices, and to HIV prevention, care, and treatment services for all staff in a health care setting.
- COPE helps facility managers work more effectively. Although service managers may initially find introducing COPE and QI to be time-consuming, once staff become involved in solving day-to-day problems on their own, managers generally find that they have more time to focus on major problems.
- COPE helps reduce costs associated with poor quality. If something is not done correctly the first time, it must be fixed, often repeatedly. Moreover, the consequences may be serious, in terms of both cost and the health of individuals and the community. COPE helps reduce the cost of poor quality by assisting staff to identify and solve problems, focusing on processes and systems to prevent problems from occurring in the future.

How to Use This Guide

COPE for Contraceptive Security should be used in conjunction with the *COPE Handbook* (EngenderHealth, 2003). Facilitators should refer to the *COPE Handbook*, which describes in detail the COPE process, how to use the COPE tools, and who should participate in the COPE exercises.

Who Should Participate in the COPE for Contraceptive Security Exercises?

Improving quality is the responsibility of all staff at a facility. Therefore, as many staff as possible should participate in COPE exercises. Because contraceptive security requires coordination from many levels of staff, it is important that each department and each cadre of staff is represented, including clinical service providers, administrative staff, medical stores staff, housekeeping and cleaning staff, guards, drivers, etc. The COPE facilitator will orient staff and help selected on-site COPE facilitators organize subsequent COPE exercises, to establish a continuous QI process at the facility.

What Is Contraceptive Security?

Contraceptive security exists when people are able to choose, obtain, and use the contraceptive methods and services they want, so as to achieve their reproductive intentions throughout their reproductive life cycle (Wickstrom & Jacobstein, 2009; USAID | DELIVER PROJECT, Task Order 1, & The RESPOND Project, 2010). Contraceptive security therefore includes ensuring that a full range of methods is available to clients when they want them. There are three important elements to contraceptive security (adapted from USAID, [no date]):

- ***Clients.*** Programs that ensure contraceptive security serve the entire market of current and potential clients, from those who require free supplies to those who can and will pay for commercial products.
- ***Contraceptive methods.*** Contraceptive security means that clients can make voluntary and informed choices from a full range of high-quality methods and services at affordable prices. Ensuring access to permanent methods (i.e., female and male sterilization), long-acting reversible methods (e.g., hormonal implants and intrauterine devices [IUDs]), short-acting methods (e.g., injectables and oral contraceptives, emergency contraceptive pills, and condoms), and natural methods (e.g., cycle beads)—as well as ensuring the availability of necessary medical equipment, instruments, and expendable supplies—are all essential aspects of contraceptive security.
- ***Continuity.*** Contraceptive security means that the methods and services that people want are available when they want them. This requires long-term commitment and leadership from all stakeholders—the public sector, the private sector, donors, and communities.aspects of contraceptive security.

In this guide, we use the term “contraceptive security” to refer to all contraceptives, medical equipment, instruments, and expendable supplies necessary for the continuous provision of contraceptive methods and services. Contraceptive security therefore includes ensuring the

availability of contraceptives and related supplies, as well as the systems (e.g., training, supervision, counseling, and infection prevention) needed to provide contraception.

This guide encompasses both short-acting methods (which mainly depend on the availability of the contraceptives themselves) and long-acting and permanent methods (which depend on the availability of methods and skilled providers and service supports).

What Is the "Last Mile/Last Kilometer"?

Using input from experts in the field of contraceptive security and results of field-testing in two districts of Tanzania (Newala and Meru districts), EngenderHealth adapted the COPE approach to include questions specifically related to contraceptive security at the "last mile" of service delivery—i.e., between districts and health facilities and between service providers and clients.

The phrase "last mile" (or "last kilometer") is used frequently in the telecommunications industry, where it describes a network's ability to get information into a client's hands. Similarly, the "last mile" of contraceptive security refers to ensuring that the contraception that clients want is available when requested. Often for clients, the actual distance to a health facility is considerably more than a mile/kilometer, especially in rural areas. When motivated clients reach a facility, it is their right to be served, and when the system breaks down, clients are at risk of unintended pregnancy. Helping clients meet their fertility intentions is the ultimate goal of all contraceptive security efforts—and continues to be a challenge for many health systems in developing countries.

Securing the supply chain that brings the necessary requirements for contraception from the district to the health facilities, pharmacies, and community distributors is also a "last mile" in contraceptive security and is a major focus of this publication. The COPE process and tools facilitate and support district- and facility-level participants in identifying challenges or threats to contraceptive security and in developing novel ideas and innovative solutions to remedy or obviate those challenges. Thus, the goal of this assessment guide is to help logistics management personnel, service providers, support staff, and policymakers come up with local solutions for local problems affecting FP access.

Implementing COPE

When health care management decides to introduce COPE for contraceptive security at a facility or in some other service setting for the first time, they should seek help from an experienced COPE facilitator. This is usually an external facilitator (from the Ministry of Health, a nongovernmental organization, or a technical assistance agency) who has been trained in COPE and has experience with implementing it. During the initial exercise and the first follow-up exercise, a staff member from the site receives on-the-job training to become a site facilitator.

With the assistance of the external facilitator (if needed), the site facilitator will be responsible for organizing all subsequent COPE exercises at the site, together with the QI committee. (Such a committee plays a key role in making QI an ongoing responsibility and the focus of the daily work of staff at all levels.)

Before conducting COPE for contraceptive security, facilitators should read through the *COPE Handbook* in its entirety and become familiar with the process for using the self-assessment guides and for conducting action plan meetings.

The Introductory Meeting

Each COPE contraceptive security exercise begins with an Introductory Meeting, during which the COPE facilitator explains the overall COPE process to all of the participants and how it can be applied to contraceptive security. The facilitator and the participants then organize teams to work with each of the self-assessment guides on contraceptive security.

Facility teams should be prepared to set aside meeting time for several hours a day over a period of two to three days. Once established, teams will work to follow up on issues identified during the introductory COPE meeting—preferably as part of their regular internal staff meetings and/or meetings with supervisory teams from the district. As needed, additional in-depth COPE exercises can be conducted to tackle new issues as they arise, to continuously monitor quality and address district and facility concerns about quality services. Ideally, the facility will work with not only *COPE for Contraceptive Security*, but with other tools relevant to the services they provide.

The COPE Tools

This publication includes 10 self-assessment guides. These tools are practical and easy-to-use data collection and analysis forms that are designed to be *flexible*, so that each site can adapt them to meet its particular needs. All 10 guides do not need to be completed at one time; the facility can prioritize which guides to use at what point in the process. COPE facilitators should present all of the guides as potential topics of work during the orientation meeting, but the teams can decide how to set their own priorities.

The self-assessment guides included here cover the following topics: Organization and Staffing; Organizational Support for Logistics System; Logistics Management Information System; Procurement/Requisition; Inventory Control Procedures; Warehousing and Storage; Transport and Distribution; Finance/Budgeting; Planning/Donor Coordination; and Medical Equipment, Instruments and Expendable Supplies. Each guide consists of a series of questions related to the quality of services, systems, and procedures; these questions are based on international standards and guidelines. Each of these self-assessment guides contains a series of questions specific to the details of contraceptive security, logistics, and supply management, as well as financing.

Team members review the question guides during their normal workday and decide which questions reveal an issue that they have observed or experienced at their site. The tools are flexible; team members do not have to answer every question, and they can write in issues that are not raised directly in the self-assessment guides.

After going through the self-assessment questions individually and/or as a team, the team members meet to discuss the problems they identified, determine their root causes, and recommend solutions, including who will implement the recommendations and when. They record their findings in a Team Action Plan, for discussion at the Action Plan Meeting.

Developing Solutions: The Action Plan

When COPE participants have completed their selected self-assessment guides, they convene an Action Plan Meeting to discuss, consolidate, and prioritize the problems and recommendations in the Team Action Plans. Through this process, the team develops a Facility Action Plan that lists:

- Each problem identified
- The root causes of the problem
- The actions recommended to solve the problem
- The staff members responsible for organizing and implementing the recommended actions
- The completion date for each action

Self-Assessment Guides for Contraceptive Security

Organization and Staffing

The team working on this guide should include staff who manage logistics coordination and/or communication between the district and the facility; staff who provide supervision; and human resources personnel.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

Staffing and Training

1. Does the district/facility have a logistics officer or a designated staff member responsible for procurement and management of medical supplies?
   - Has this staff member been trained on the logistics management information system (LMIS)?
   - Does this staff member have a trained back-up in the event of his or her absence?
   - How are logistics responsibilities communicated when there are new staff or more staff?

2. Is there a logistics officer who is fully responsible for the following activities?
   - Managing and using the LMIS
   - Filling out requisition/request forms
   - Calculating quantities needed
   - Signing for contraceptives and other medical supplies when they are delivered
   - Handling inventory management, storage, and distribution
   - Organizing inventory storage
   - Supervising district/facility stocks and inventory levels
   - Communicating regularly with the district/facility

3. Are there dedicated LMIS staff whose sole or main responsibility is the procurement, requisition, storage, and stocking of contraceptive methods, medical equipment, instruments, and expendable supplies?

4. How many different staff positions are responsible for logistics tasks? Is the number of staff sufficient to meet the full range of logistics management needs and responsibilities?

5. Are all of the positions with key logistics tasks currently filled? Are all of those staff trained?

Feedback and Supervision

6. How are management and communication between the district and the facilities coordinated? Which of the following activities are used to coordinate supervision between the districts and the facilities?
   - Formal meetings/site visits
   - Joint work plans
   - Written communications
   - Telephone communications
   - Mobile technology communication (texts or short message service [SMS] messages)
   - Other_____

7. What is the role of the district in the procurement and/or requisition process?

8. Do districts provide supervision/technical assistance to facilities in developing their procurement and/or requisition plans?

9. Does the district use any of the following to provide feedback to the facility?
   a. Questions or comments about requisitions
   b. Dispensed to (family planning) user data
   c. Variance between the quantity requested and the quantity received

10. How often do the district and facility logistics staff communicate concerning the following?
    - Planning and logistics management
    - Stock levels
    - Requisitions
    - Deliveries

11. Do guidelines exist for information flow between health facility and the district for the following?
    - Submission of requisitions
    - Frequency of reporting
    - Who is responsible
    - How data are aggregated

Other Issues That You Think Are Important:

12. _____

13. _____

14. _____

Organizational Support for the Logistics Management System

The team working on this guide should include staff who are familiar with organizational policies, standard operating procedures, and job descriptions.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Are there written procedures and guidelines (e.g., manuals, policies, standards) to help staff carry out their logistics management responsibilities?

2. Do logistics staff have the tools and resources they need to do their jobs (e.g., job aids, forms, carbon paper, calculators, shelving, vehicles, funds for transport, etc.)? If not, which tools or resources are needed?

3. Do the facility staff who are end users of health care supplies know that they have requisition responsibilities? (Include staff who need to request contraceptives and related supplies to do their job.) Are these responsibilities included in written job descriptions?

4. Are supervisory responsibilities specified in written job descriptions?

5. What is the system for supervision between districts and facilities? What is the supervisory structure, by job position/title and by level?
   - How do district-level staff manage the supervision of facilities' logistics activities?
   - How often is supervision conducted at the facility?
   - What is done during district staff meetings with facility-level logistics staff?
   - Are guidelines available for how the supervisor is to conduct the supervisory visit?
   - Are supervisory visits conducted according to an established schedule? If not, why not?
   - Are there any constraints to conducting supervisory visits?
   - Are tools available that describe what to cover when conducting a supervisory visit (e.g., guidelines, a checklist)?
   - Do supervisors use these guidelines and tools?

6. If a staff member's performance in logistics management is not satisfactory, is the person provided with any of the following?
   - In-service training

- On-the-job training
- Written instructions on how to improve
- A coach or mentor
- Other (describe) _____

7. What types of activities take place during visits from district logistics and/or supervisory staff?
   - Review of procedures for forecasting needs
   - Review of procedures for ordering products
   - Review of procedures for completing and submitting requisition forms in a timely way
   - Observation of product storage
   - Conduct of a physical inventory
   - Review of logistics records and reports
   - Discussion of budgeting for logistics activities
   - Review of changes made since last supervisory visit
   - Conduct of on-the-job training to improve job performance
   - Discussion of what is working and what is not working
   - Discussion of what help is needed (staff, training, equipment, forms, etc.)

8. Has training been given to current staff at all appropriate levels in the following areas?
   - Completion and submission of requisition forms
   - Completion and submission of logistics management information system (LMIS) reports
   - Proper storage of health products
   - Maintenance of proper stock levels
   - Determination of quantities to be ordered
   - Determination of quantities to be issued
   - Estimation of annual needs
   - Review of reports and records
   - Other

9. Is there a process in place for improving any gaps in the knowledge and skills of logistics personnel at the district level? At the facility level?

10. Does the program conduct periodic staff development activities (e.g., classroom training, coaching, on-the-job training, etc.)?

Other Issues That You Think Are Important:

11. _____

12. _____

13. _____

Logistics Management Information System

The team working on this guide should include staff who are responsible for logistics, staff who are familiar with reporting, and/or staff who track and log deliveries and stock levels.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Is there a logistics management information system (LMIS)?

2. Are contraceptive logistics data collected through another information system (e.g., health management information system [HMIS], integrated logistics system [ILS], vertical family planning management information system [MIS])?

3. Is the logistics system paper-based or automated (i.e., tracked via a computer database, web site, or mobile technology)?

4. How are logistics data used? How are the data calculated or analyzed?

5. Does the logistics system include the following?
   - Stock-keeping records
   - Shipping records
   - Requisition/request forms
   - Inventory record books/control cards
   - Bin cards
   - Issue vouchers

6. What reports are generated using facility logistics data?
   - What information is included in the reports?
   - How often are reports sent to the district?

7. How do (facility and/or district) managers monitor reporting rates and follow up to obtain missing reports?

8. How does the district use the reports received from the facilities? Does the district use the reports to provide feedback to the facilities?

9. What decisions are based upon reports?
   - Procurement/requisition
   - Transport/delivery
   - Scheduling of supervisory visits
   - Resupply quantities
   - Other: _____

10. Does the district log and track deliveries that are received at the facility level, according to the following measures?
    - Amount received
    - Date received
    - Wastage due to expiry date or poor quality

11. How does the district follow up on delayed/missing stocks requested?

12. Does the ordering facility receive follow-up on the following aspects of expected deliveries?
    - Expected delivery date
    - Expected delivery quantity
    - Expected delivery of missing/incomplete stock requested

13. How are situations in which supplies are stocked out/overstocked reported to the district?
    - Does the district have accurate, updated information on which facilities are stocked out, understocked, adequately stocked, or overstocked?
    - Do districts report national stock-outs to the facilities?

14. What data on the following aspects of product availability are tracked? Who tracks these data? How often?
    - Percentage of facilities reporting
    - Stock-outs (i.e., number of facilities reporting no stock for each method or related equipment, instruments, or expendable supplies)
    - Inventory balance (stock on hand)
    - Quantities requested
    - Quantities received
    - Variance between quantity requested and quantity received
    - Supplemental contraceptives/supplies purchased
    - Supplemental contraceptives/supplies received
    - Losses and adjustments
    - Dispensed to user
    - Dispensed for community-based distribution

15. Are there documented guidelines at the facility and/or the district level for the following?
    - Management and use of the LMIS
    - Calculation/forecasting of the quantities needed
    - Handling of requisition/request forms (completion, timely submission, follow-up)
    - Organization and filing (request forms, shipping records, dispensed-to-user data)
    - Inventory management, storage, and distribution
    - First-expired, first out (FEFO)
    - Product selection
    - Budgeting, and collection and submission of user fees
    - Supervision and staff development

Other Issues That You Think Are Important:

16. _____

17. _____

18. _____

Procurement/Requisition

The team working on this guide should include staff who provide support for procurement, who fill out requisition/request forms, who submit forms, and who handle procurement orders.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Describe the process for procurement/requisition:
   - Generally, who initiates the request?
   - Who is responsible for completing request paperwork?
   - When does this take place?
   - Is there a standard or a formula for calculating quantities?
   - Who compiles the data that go into the calculation?
   - How long does the process take?
   - Is there a standard timeline for requisition?
   - How are late requisitions/receivables handled?
   - How are emergency/supplemental procurements and/or requisitions managed?

2. At the district level, do supervisors review request forms after facility submission?

3. Is there a posted schedule/timeline for submission request forms?

4. How does the district follow up when request forms are submitted late?
   - How does the district follow up when request forms received are incomplete?
   - What information is considered "required" information when completing request forms?
   - How does the district follow up when a facility does not submit request forms?

5. Which of the following information is considered/required when filling out request forms?
   - Consumption data/dispensed-to-user data
   - Stock-on-hand data
   - Losses and adjustments
   - Required order lead times of suppliers
   - Shipment and handling schedules

- Regional/national stock levels
- Stock-out periods
- Demographic data (e.g., community size, catchment area)
- Distribution problems (e.g., overspill from other areas, leakage)
- Incomplete/partial shipments/receivables in previous period
- Late/incomplete submission in the previous period

6. Are quantities requested compared against your facility's budgets? By whom? How often? What is the process for adjusting procurement/requisition plans in the case of a budget shortfall?

7. How does the district/facility supplement its stock when quantities received do not meet quantities requested?
   - Does the district provide contraceptives/supplies for facilities that do not receive the full amount requested?
   - Is there a policy that enables facilities to procure contraceptives or related supplies directly, if needed?
   - Are purchases limited to prequalified suppliers?
   - How are supplemental requisitions/purchases budgeted?

8. How are requisitions/purchases handled when stock-outs occur?

9. Are there established procedures for placing emergency orders? How often are emergency orders placed? Generally, are emergency orders filled?

10. How are orders that are received late handled? When are they filled? When are they delivered?

Other Issues That You Think Are Important:

11. _____

12. _____

13. _____

Inventory Control Procedures/Receiving Supplies

The team working on this guide should include staff who receive deliveries, staff who check the quality of contraceptives, equipment, and supplies, and staff who are familiar with stock levels, including supervisors and medical stores department staff.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. What type of inventory control system is used (e.g., push, pull, or combination[1])?

2. How many levels are included in the inventory system (e.g., district to facility to community-based distribution)?

3. Are there designated staff who are responsible for receiving deliveries at the district? At the facility?

4. Do the designated staff have the responsibility/authority to do the following?
   - Delegate staff to receive goods in their absence
   - Sign for the receipt of goods
   - Check for the quality of goods received
   - Check for the completeness of the order
   - Provide feedback if the order is incomplete/damaged

5. Do staff responsible for requesting supplies communicate/coordinate with staff responsible for purchases? How? How often?

6. How do facility staff communicate with purchasing staff when items are missing/deliveries are incomplete? Is this information shared with the district?

7. In general, are the correct amounts of all products procured and obtained at the appropriate time?

1 In a push system, the supplying level (national medical store/medical store department) determines the quantity of supply to be shipped. The quantities shipped are often based on forecast amounts. In a pull system, districts/facilities request quantities to replenishment their stock levels. Often, the quantities requested are based upon consumption data (e.g., amounts distributed to clients in the previous period). Many systems may use a combination of these systems. For example, regional warehouses may pull from the National Medical Store, then push supply to district health centers.

8. What are the procedures for quality assurance? Who is responsible for quality assurance? How often are quality assurance activities done?
   - Do districts have the responsibility/authority to check completeness or quality of deliveries to the facilities?
   - Is there a procedure for recording and reporting complaints about product quality to suppliers?

9. At the moment, what products are considered by the program to be in full supply (i.e., sufficient quantities in stock to provide continuous service for the quarter)? What items are likely to run out before the end of the quarter or before restocking?

10. Have stock-outs for family planning products occurred in the last 12 months?
    - Which products are stocked out most frequently?
    - How long do the stock-outs normally last?
    - What causes these stock-outs?
    - Do stock-outs affect program services and performance (specifically, which products)?

11. How are in-stock data recorded? How does low-stock or stock-out information get communicated? To whom? How often?

12. Are there guidelines and established policies for maximum and minimum stock levels at which full-supply products should be maintained?
    - Are the inventory control guidelines for full-supply products respected so that stock levels generally fall between maximum and minimum?
    - Are stock levels (maximum and minimum) for full-supply products reviewed periodically?
    - Do reviews take into account changes in transport and information availability?

13. How are stock imbalances handled by logistics officers at the facility? How are stock imbalances communicated between the district and the facility?

14. Are there written provisions for the redistribution of overstocked supplies? Is there a process for harmonization of stock (distribution between overstocked/understocked facilities)?

15. Does the program have a system for tracking product losses and other adjustments?

Other Issues That You Think Are Important:

16. _____

17. _____

18. _____

Warehousing and Storage

The team working on this guide should include staff who are familiar with the warehouse and storeroom; staff who are familiar with the storage facilities; and/or staff who are familiar with storage guidelines.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Does the program have written guidelines for storage and handling of all products (e.g., manuals and posters)?

2. How is stock organized once it is in the warehouse/in storage?

3. Does the program have a policy/set of guidelines on storing and issuing stock according to first-expired, first-out (FEFO) inventory control procedures?

4. Generally, is stock stored in accordance with FEFO policies?

5. Are the storage facilities adequate to quickly identify stock levels?

6. Is the organizational system/infrastructure sufficient to meet storage needs?
   - Are products stacked at least 10 cm off the floor?
   - Are products stacked at least 30 cm away from the walls and other stacks?
   - Are products stacked no more than 2.5 meters high?

7. Does the storage system protect the contraceptive methods and related supplies from the following?
   - Humidity or water
   - Direct sunlight
   - Dust/debris
   - Harmful insects and rodents

8. Are all products arranged so that identification labels and expiry dates and/or manufacturing dates are visible?

9. Is the storage area secured with a lock and key?

10. Is the storeroom/storage system maintained in good condition (e.g., is it clean, is all trash removed, are shelves sturdy, are boxes organized)?

11. Does the storage system allow contraceptive methods and related supplies to be stored at the proper temperature during all seasons?

12. Is the existing storage capacity adequate to handle the current quantities of products? Consider the following aspects:
    - Warehouse
    - Shelving
    - Sufficient storage space
    - Labels

13. Is the current space and organization sufficient for existing products and for expansion (expected product deliveries in the foreseeable future)?

14. Are all hazardous waste, sharps, and biohazardous material disposed of properly? Are there written guidelines for their disposal?

15. Are all contraceptive methods, equipment, and supplies stored at one location? How and when are contraceptive methods, equipment, and supplies assessed at the different locations (e.g., the surgical ward, the family planning clinic, the pharmacy)?

16. How are contraceptive methods, equipment, and supplies distributed from the warehouse and storage areas to all potential family planning locations?

17. Can existing storage capacity handle all of the quantities needed to ensure that no stockouts occur?
    - How does the program cope with inadequate storage space?
    - Does the program have plans for meeting storage requirements for at least the next five years?
    - Are there any specific storage conditions that need improvement (e.g., cleanliness, organization, temperature, building structure, etc.)?

18. Does the program conduct at least one physical inventory of all products at storage facilities every six months?

19. How are quality assurance inspections of products at the storage facility conducted?

20. Are there written guidelines for disposal of sharps, biohazardous material, and other medical waste?

21. Are there guidelines for determining quality and handling losses?

22. Is there a procedure for recording complaints about product quality?

23. Are damaged/expired products physically separated from inventory and removed from stock records at the facility?

24. Are there written procedures or guidelines for destroying/removing damaged and expired products? How are expired/damaged inventory handled?

25. In practice, are damaged and expired products destroyed according to the program's disposal guidelines?

26. How are losses recorded?

Other Issues That You Think Are Important:

27. _____

28. _____

29. _____

Transport and Distribution

The team working on this guide should include staff familiar with deliveries, delivery routes, shipping, loading/unloading, and vehicle maintenance.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. How are products delivered to/from the district? How often?
   - Generally, is that schedule maintained?
   - Are facilities informed when deliveries will be late or absent?
   - How do districts follow up on late or absent deliveries?
   - Do facilities return expired items to the district?

2. How are routes determined? Are routes determined based upon any of the following factors?
   - Stock levels/volume of stock to be delivered
   - Catchment area population
   - Resupply frequency
   - Road network or quality of roads

3. Are the designated routes accessible? At all times of the year? How are routes adjusted in the case of inclement weather/unforeseen conditions?

4. Do written procedures specify what type of distribution system should be used to distribute products between the district and the facilities (e.g., deliver when requested by the facility; deliver on a monthly schedule; distribute only when the stocks of all essential medicines are low; no delivery, so the facility staff go to the medical stores; or the facility receives stock from the district hospital)?

5. Are essential health products (e.g., contraceptives, essential drugs, tuberculosis drugs, or test kits and drugs for sexually transmitted infections, including HIV) distributed together or separately?

6. Does distribution take advantage of "backloads" (e.g., loading overstocked supplies of contraceptives to be redistributed at understocked facilities)?

7. What means of transportation are used (e.g., truck, bicycle, motorcycle, public transportation)? Does the district/facility have its own transportation (car, motorcycle, truck)? Does the district/facility contract with third parties/public transportation for distribution?

8. Are a sufficient number of functioning vehicles available, with petrol and drivers to meet the desired distribution schedule? How is vehicle maintenance handled?

9. Are vehicles regularly available for use in supervision visits between the district and facilities?

10. Are vehicles available for transporting biohazardous materials and sharps waste? In the case of no transport, how are biohazardous materials, sharps, and expired drugs disposed of?

11. What transportation method is used in the absence of operational vehicles (public transportation, bicycle, walking)?

12. Does the district/facility have a budget for any of the following aspects of transportation?
    - Vehicles
    - Fuel
    - Spare vehicle parts
    - Vehicle maintenance and repair
    - Salaries for drivers
    - Public transportation

Other Issues That You Think Are Important:

13. _____

14. _____

15. _____

Finance/Budgeting

The team working on this guide should include staff familiar with budgets, cost recovery systems, and client fees.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Is the funding level either "adequate" or "more than adequate" for the following items?
   - Contraceptives, essential drugs, medical equipment, instruments, and expendable supplies
   - Warehousing/storage
   - Maintenance of the logistics management information system
   - Transportation
   - Logistics staff development
   - Salaries for logistics staff
   - Waste management

2. Who finances the reproductive health and family planning program's annual budget? What process is used to develop the program's annual budget at the national, regional, and district levels?

3. How does the district ensure that facilities' requests are within budget?

4. Is there a cost recovery system for family planning services? For contraceptives?

For programs that charge client fees:

5. Are revenues generated from the cost recovery system used for any of the following?
   - Contraceptive costs
   - Logistics costs
   - Services delivery costs for staff, equipment and related supplies
   - Other costs

6. What percentage of the following costs is recovered through client fees (if applicable)?
   - Contraceptive cost
   - Logistics costs

- Services delivery costs for staff, equipment and related supplies
- Other costs

7. Is there a waiver system for those who cannot afford to pay for services and/or products?

8. What are the annual out-of-pocket (household) expenditures for the following contraceptive methods?
   a. Oral contraceptives
   b. Injectables
   c. Condoms (male and female)
   d. Cycle beads
   e. Hormonal implants
   f. Intrauterine device (IUD)
   g. Minilaparotomy
   h. Sterilization following cesarean delivery
   i. No-scalpel vasectomy

Other Issues That You Think Are Important:

9. _____

10. _____

11. _____

Planning

The team working on this guide should include staff familiar with district/facility relationships with communities, community health workers and volunteers, civil society organizations, community leaders, and the private sector.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

1. Is there an established community-facility committee for health?
   - How influential is that committee?
   - Who is involved in the committee? Is there gender equity on the committee?
   - Does the committee involve all relevant stakeholders?
   - Does the committee represent marginalized/vulnerable groups?
   - Does the committee hold meetings at specified intervals (e.g., quarterly, semiannually)?
   - Are there other coordination mechanisms in place?

2. Are community groups, traditional leaders, and local political leaders involved in reproductive health, family planning (FP), and contraceptive security? In what ways? Who are the key leaders/champions for contraceptive security?
   - Are local leaders committed to supporting maternal health, FP, and contraceptive security? To what extent?
   - Do civil society/community-based organizations have the capacity to advocate for maternal health, FP, and contraceptive security?
   - How are local leaders/community members mobilized or motivated to advocate for maternal health, FP, and contraceptive security?
   - Are all segments of society, particularly the vulnerable/disenfranchised, represented by civil society/community-based organizations that are advocating for maternal health, FP, and contraceptive security?

3. During the last fiscal year, was funding for contraceptives and relevant supplies completely disbursed, was it overbudget, or was it underbudget? What were the ramifications of the funding level?

4. Are there leaders/champions for contraceptive security in the private sector (for example, among employers, labor organizations, or private clinics)?

5. How do the media cover maternal health, FP, and contraceptive security issues?

Other Issues That You Think Are Important:

6. _____

7. _____

8. _____

Medical Equipment, Instruments, and Expendable Supplies[2]

The teams working on this guide should include staff familiar with contraceptives, medical equipment, instruments, and expendable supplies, including clinicians, service providers, trainers, supervisors, maintenance workers, and logistics management personnel in this group.

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart or sheet of paper in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

If you are aware of a problem at your facility that is not addressed in this guide, please list it in "Other Issues That You Think Are Important," at the end of this guide.

Maintenance

1. Are there staff tasked with regularly maintaining and caring for medical equipment (autoclave, operating table, light sources)?

2. Are instructions for maintaining and caring for medical equipment readily accessible to staff in charge of these tasks?

3. Are supplies for maintaining and caring for medical equipment available (grease, spare parts)?

4. Is medical equipment maintained regularly, according to the instructions of the producer?

Availability of Medical Equipment, Instruments, and Expendable Supplies

In reviewing the checklists on the following pages, keep in mind that to have full contraceptive security, the district/facility must have available the necessary contraceptives, medical equipment, instruments, and expendable supplies to provide contraception to meet clients' needs. Not all facilities will offer all methods; however, within a district, at least one site (or a mobile service opportunity) should be able to offer a full range of short-acting methods and long-acting reversible and permanent methods of contraception. Therefore, staff involved in clinical service delivery, as well as maintenance and logistics management, will be involved in ensuring that the required items for service delivery are on hand.

To assist the group in this exercise, the following definitions and classifications of products and procedures will help you think through the requirements for service delivery. The lists and classifications reflect best practices common to family planning programs in relation to the medical equipment, instruments, and expendable supplies used in the provision of contraception in resource-constrained settings.

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2 Adapted from: Cagatay, Cordero & Jacobstein, 2010.

- A product is classified as “Unique” if it is used solely and exclusively to provide that contraceptive method or service.
- A product is classified as “Indispensable” if it is essential to providing the method and without it the service cannot be rendered.
- A product is classified as “Common” if it has multiple uses across a variety of surgical procedures and techniques, even beyond family planning. Common products are often just as needed as the indispensable and unique items; they are just more commonly found in clinics.

Male Sterilization via No-Scalpel Vasectomy (NSV)*

Instruments and Supplies	√ in stock/ available?
***Unique* instruments and contraceptive devices**	
1. NSV ringed clamp (forceps), 4mm	
2. NSV dissecting forceps	
***Common* medical instruments**	
1. Cup/bowl/gallipot	
2. Forceps, Rampley, sponge-holding, straight, 5.5 in.	
3. Needle holder, Mayo Hegar, 7 in. (17.8 cm)	
4. Scissors, operating, Mayo, straight, 5.5 in.	
***Common* expendable medical supplies**	
1. Soap or antiseptic agents (for surgical scrub)	
2. Small sterile towel (for hand drying)	
3. Alcohol-based hand rub	
4. Sterile gloves	
5. Iodine	
6. Sterile gauze	
7. Adhesive tape or Band-Aid	
8. Local anesthetic—lidocaine without epinephrine, 1% or 2%	
9. Distilled water to dilute lidocaine (if 2%)	
10. 10 ml syringe with 1.5 in., 27-gauge needle	
11. Chromic catgut or nonabsorbable silk or cotton suture for ligation	
12. Scrotal support (optional)	
13. Sterile fenestrated surgical drapes	
14. Sterile surgeon's and surgeon's assistant gowns	
15. Cap and face mask	
16. Client gown	
17. Drapes to cover surgical cushion table	
18. Drapes for packing instruments	
Pain management drugs†	
Analgesic, nonnarcotic	
1. Diclofenac	
2. Ibuprofen	

* All items are listed separately, although they may be supplied in a kit.

† Typically, only one of these medications is used for any given case, if needed.

Female Sterilization via Minilaparotomy

Instruments and Supplies	√ in stock/ available?
Unique **instruments and contraceptive devices**	
1. Tubal hook*	
2. Uterine elevator, Ramathibodi*	
Indispensable **instruments for the procedure†**	
1. Abdominal retractor, Richardson-Eastman (2-piece set) or Army-Navy retractor (2-piece set), double-ended	
Common **(and *indispensable*) medical instruments**	
1. Forceps, intestinal, Allis, delicate (5x6 teeth), 6 in. (2)	
2. Forceps, intestinal, baby Babcock, 5.5 in. (2)	
3. Artery forceps, Kelly, straight, 5.5 in. (2)	
4. Vaginal retractor, Jackson, or vaginal speculum, Graves, medium (1.38 in. x 4 in. or 3.5 cm x 10.2cm)	
5. Forceps, Schroeder-Braun, uterine tenaculum, 9.75 in.	
6. Cup/bowl/gallipot (2)	
7. Forceps, dressing, standard pattern, 5 in.	
8. Forceps, tissue, delicate pattern, 5.5 in.	
9. Needle holder, Mayo Hegar, 7 in.	
10. Scissors, tonsil, Metzenbaum, curved, 7 in. (17.8 cm)	
11. Scissors, operating, Mayo, curved, 6.75 in.	
12. Scalpel handle, no. 3	
13. Forceps, sponge, Foerster, straight, 9.5 in.	
14. Forceps, sponge, Foerster, curved, 9.5 in.	
Common **expendable medical supplies**	
1. Soap, or antiseptic agent (for surgical scrub)	
2. Small sterile towel (for hand-drying)	
3. Alcohol-based hand rub	
4. Sterile gloves	
5. Iodine	
6. Sterile gauze	
7. Local anesthetic—lidocaine without epinephrine, 1% or 2%	
8. Distilled water to dilute lidocaine, if 2%	
9. 10–20 ml syringe with 1.5 in., 27-gauge needle	
10. Absorbable suture (on an atraumatic needle)	
11. Scalpel blade (no. 10)	
12. Surgical adhesive tape	
13. Sanitary pads	
14. Sterile surgical drapes	
15. Sterile surgeon's and surgeon's assistant gowns	

Female Sterilization via Minilaparotomy *(cont.)*

Instruments and Supplies	√ in stock/ available?
***Common* expendable medical supplies** *(cont.)*	
16. Cap and face mask	
17. Client gown	
18. Drapes to cover surgical cushion table	
19. Drapes for packing instruments	
Medical equipment	
1. Adjustable operating table	
2. Stepstool	
3. Operating light (fixed, or portable with stand)	
4. Instrument tray on a Mayo table	
5. Auxiliary table	
6. IV stand	
7. Waste bucket	
8. Plastic bucket (for instrument decontamination)	
9. Sphygmomanometer (one in each area: operating theater, recovery, etc.)	
10. Stethoscope	
11. Medicine cabinet	
12. Stretcher with wheels and sides, or a wheelchair	
Pain management drugs‡	
Premedication	
1. Atropine sulfate injection	
2. Promethazine injections	
Sedative	
1. Diazepam	
2. Midazolam (alternative to diazepam)	
Analgesic, narcotic	
1. Fentanyl injection	
2. Pentazocine injection	
3. Meperidine (Pethidine) injection	
4. Nalbuphine injection	
Analgesic, nonnarcotic	
1. Diclofenac	
2. Ibuprofen	

* The tubal hook and the uterine elevator, though not indispensible to a tubal ligation procedure on a regular basis, are indispensible in certain situations (e.g., obese clients, clients with a high level of anxiety, or clients with an acutely retroverted uterus).

† A minilaparotomy kit should contain all of the listed instruments.

‡ Typically, only one of these medications is used for any given case.

Intrauterine Device (IUD)

Instruments and Supplies	√ in stock/ available?
Unique **contraceptive devices**	
1. TCu 380A, Multiload, or LNG-IUS	
Indispensable **instruments for IUD insertion**	
1. Uterine sound, Sims, 13 in.	
2. Forceps, Schroeder-Braun, uterine tenaculum, 9.75 in.	
3. Speculum, vaginal, Graves, medium (1.38 in. x 4 in.)	
4. Scissors, Mayo, curved, 6.75 in.	
Indispensable **instruments for IUD removal**	
1. Speculum, vaginal, Graves, medium (1.38 in. x 4 in.)	
2. Forceps, Bozeman, uterine dressing, straight, 10.5 in.	
3. IUD removal forceps, alligator jaw, 8 in.*	
4. IUD string retriever*	
Common **medical instruments**	
1. Cup/bowl/gallipot	
2. Sponge forceps, Foerster, straight, 9.5 in.	
Common **expendable medical supplies**	
1. Small towel for hand drying	
2. Exam gloves	
3. Iodine	
4. Sterile gauze	
5. Drapes (to cover client's thighs and pubic area and to put beneath her buttocks)	
6. Drapes for packing instruments	
7. Sanitary pad	
Medical equipment	
1. Examination table (preferably with stirrups)	
2. Light source	
Pain management drugs†	
Analgesic, nonnarcotic	
1. Ibuprofen	
2. Paracetemol	

* The alligator jaw IUD removal forceps and IUD string retriever are only needed if the IUD string is not visible and the IUD cannot be removed with Bozeman forceps alone.

† Pain medications may be provided to IUD clients in exceptional cases.

Hormonal Implants

Instruments and Supplies	√ in stock/ available?
***Unique* instruments and contraceptive devices**	
1. Contraceptive implants (Jadelle, Sino-implant (II), Implanon)	
2. Trocar (#10) and cannula *[required separately if implant does not come pre-loaded, in a kit]*	
***Indispensable* instruments for insertion and removal**	
1. Forceps, mosquito, straight, 5 in. (removal)	
2. Forceps, mosquito, curved, 5 in. (insertion and removal)	
***Common* instruments**	
1. Cup/bowl/gallipot	
2. Forceps, Rampley, sponge-holding, straight, long, 5.5 in.	
3. Scalpel handle (No. 3)	
***Common* expendable medical supplies**	
1. Soap and antiseptic agent (hand hygiene)	
2. Small towel for hand drying	
3. Iodine	
4. Sterile gauze	
5. Sterile gloves	
6. Local anesthetic (1% lidocaine without epinephrine)	
7. 5 ml syringe with 1.5-in. needle	
8. Scalpel blade (No. 11)	
9. Band-Aid	
10. Arm bandage	
11. Sterile small drape	
12. Sterile fenestrated drape	
13. Drapes (for packing instruments)	
Medical equipment	
1. Examining table	
2. Support for arm (optional)	
3. Lighting	
Pain management drugs*	
Analgesic, nonnarcotic	
1. Paracetemol	
2. Ibuprofen	

* Pain medications can be provided to hormonal implant clients in exceptional cases.

Short-Acting Methods

Instruments and Supplies	√ in stock/ available?
Unique **instruments and contraceptive devices**	
1. Injectable hormonal contraceptives (Depo-Provera DMPA-IM 150 mg/1 ml; Depo-SubQ provera 104 DMPA-SC 104 mg/0.65ml; Lunelle 5 mg)	
2. Vaginal contraceptive ring (i.e., NuvaRing)	
3. Contraceptive patch (i.e., OrthoEvra)	
Common **expendable medical supplies for injectables**	
1. Cotton	
2. Alcohol	
3. 2 ml syringe with needle	
Oral contraceptives	
1. Progestin-only pills	
2. Combined oral contraceptives	
3. Emergency contraceptive pills† (e.g., NorLevo, Optinor, Postinor, Pregnon)	
Barrier methods	
1. Male condoms	
2. Female condoms	
Rhythm methods	
1. Fertility awareness beads	

* For more information about short-acting methods, see: Hatcher et al., 2011.

† For more information on the global availability of emergency contraception, see the International Consortium for Emergency Contraception database at: www.cecinfo.org/database/pill/viewAllCountry.php.

Supply Requirements for Providing Quality LA/PM Services: A Checklist

The following products should already be available at hospitals for proper service provision:	√ in stock/ available?
Infection prevention expendable supplies*	
1. Alcohol	
2. Cotton	
3. Chlorine bleach	
4. Detergent	
5. Cleaning brush	
6. Disinfectants	
7. Puncture-resistant boxes (for sharps disposal)	
8. Utility gloves	
Infection prevention equipment	
1. Autoclave (sterilizer)	
2. Steam cooker/portable steam cooker†	
3. Drums	
4. Metal pans and metal covers	
5. Plastic buckets, different colors	
6. Garbage buckets	
Infection prevention infrastructure	
1. Source of clean water	
2. Source of electricity	
3. Generator	
4. Fuel or coal	
Emergency management drugs	
1. Adrenaline	
2. Aminophylline	
3. Diphenhydramine	
4. Dopamine	
5. Flumazenil	
6. Hydrocortisone	
7. Intravenous solutions (normal saline and 5% dextrose in water)	
8. Naloxone	
9. Physostigmine	
Emergency resuscitation equipment	
1. Ambu bag (a self-inflating breathing bag with a mask)	
2. Oxygen cylinder	

*These are basic equipment, supplies, and infrastructure that are not listed in the method-specific checklist.
†Adapted from Hatcher et al., 2011.

Action Plan and Follow-Up Forms for Contraceptive Security

Action Plan

Problem	Cause(s)	Recommendation	By Whom	By When	Completed?

Action Plan Follow-Up

Problem	Cause(s)	Recommendation	Status	Comments

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