**USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM**

**Procurement and Supply Management**

# 2017 CONTRACEPTIVE SECURITY INDICATORS REPORT

**November 8, 2018**

USAID
FROM THE AMERICAN PEOPLE

This publication was produced for review by the United States Agency for International Development. It was prepared by Chemonics International Inc. under Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) Contract No. Contract No. AID-OAA-I-15-00004; Task Order 03 Contract No. AID-OAA-TO-15-00010.

Recommended citation: USAID Global Health Supply Chain Program-Procurement and Supply Management Single Award IDIQ. 2018. Contraceptive Security Indicators Report. Washington, D.C.: Chemonics International Inc.

Chemonics Contact:

Rene A Berger
GHSC-PSM IDIQ Director
251 18th Street South, Suite 1200
Arlington, VA 22202
P 202-775-6923
rberger@ghsc-psm.org

# CONTENTS

# ACRONYMS

| | |
|---|---|
| CHW | community health worker |
| COC | combined oral contraceptive |
| CS | contraceptive security |
| DRC | Democratic Republic of the Congo |
| FP | family planning |
| FY | fiscal year |
| GHSC-PSM | Global Health Supply Chain-Procurement and Supply Management |
| IGF | internally generated fund |
| IUD | intrauterine device |
| LMIS | logistics management information system |
| NEML | National Essential Medicines List |
| NGO | nongovernmental organization |
| POP | progestin-only pill |
| QA | quality assurance |
| QC | quality control |
| RH | reproductive health |
| RHCS | reproductive health commodity security |
| SDP | service delivery point |
| SPARHCS | Strategic Pathway to Reproductive Health Commodity Security |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# EXECUTIVE SUMMARY

Countries are increasingly recognizing the importance and value of contraceptive security (CS) and regularly monitoring its progress. CS exists when every person can choose, obtain, and use quality contraceptives, whenever he or she needs them, for family planning or for prevention of HIV and AIDS or other sexually transmitted diseases.

This CS Indicators 2017 data report continues to build upon and refine the CS Indicators first developed in 2009 and presented in the USAID | DELIVER PROJECT paper, *Measuring Contraceptive Security in 36 Countries*.[1] Since then, CS Indicators have been collected, measured, and reported annually through 2015. The USAID Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) project, a follow-on to USAID | DELIVER and USAID's Supply Chain Management System project, has now assumed the role of collecting data and disseminating this survey — now in its eighth round — to benefit the global health community. This report presents data from 36 countries, which include updated indicators in the leadership and coordination, supply chain, and policy sections. The report also introduces two new sections, pharmaceutical quality and private-sector contributions, to bring the survey more in line with a total market approach. Several changes to previous questions, the addition of new questions, and a new requirement to specify data sources aim to increase the methodological rigor and relevance of the survey. Also, a new data collection and usage manual was developed to help guide responses. To help users of the data better interpret results within a larger country context, newly collected data for select measures from the former Contraceptive Security Index can be found in Annex C of this document.

The survey enables program managers, advocates, and decision-makers in countries as well as in the global health community to monitor progress toward contraceptive security, inform program planning, and advocate for improved policies and resources.

The report presents findings on leadership and coordination, finance, commodities, supply chain, policies, quality, and the private sector. Key findings include:

**Leadership and Coordination**

Of all countries surveyed:

- 97 percent have a national committee that works on CS.
- 81 percent have a CS champion[2].

[1] USAID | DELIVER PROJECT, Task Order 1. 2010.

[2] A CS champion is defined in the 2017 CS Indicators Data Collection and Usage Manual as someone who "serves as a catalyst in building good will and broad-based support across constituencies, including community, religious, and political leadership structures," and as a "positive voice for family planning programs. . . adds credibility to

## Finance and Procurement (Capital)

In the countries providing information on finance and procurement:

- Most (76 percent, or 26 of 34 countries reporting) spend government funds for public-sector contraceptive procurement.
- An average of 41 percent of financing comes from government sources and 59 percent from in-kind donations.
- 28 countries (80 percent) have a government budget line item specifically for contraceptives; in 23 of those countries (82 percent), the government spent funds on contraceptives in the most recently completed fiscal year.
- 45 percent have a funding gap between funding spent and estimated contraceptive need.

## Commodities

- On average, countries offer 10 of the 13 assessed contraceptive methods[3] in public-sector facilities, eight in nongovernmental facilities, eight through the commercial sector[4], and six through social marketing.
- 89 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector.

## Policies (Commitment)

Of the countries surveyed:

- All have either a CS or reproductive health commodity security (RHCS) strategy or a strategy that explicitly mentions increasing contraceptive access.
- 39 percent (22 of 36 countries reporting) have family planning (FP) commodities that are subject to duties, import taxes, or other fees.

---

advocacy interventions designed to galvanize resources and supportive environments for family planning program interventions. . ."

[3] The assessed methods include: combined oral contraceptive pills, progestin-only pills, injectables, implants, intrauterine devices (IUDs), male condoms, female condoms, emergency contraceptive pills, long-acting permanent methods for males (vasectomy), long-acting permanent methods for females (tubal ligation), contraceptive patches, vaginal contraceptive rings, and calendar-based awareness methods.

[4] When responding to the question regarding the availability of contraceptive methods in the commercial, public, NGO, or social marketing sector, there is a potential in some contexts for some contraceptives (especially injectables) to be perceived as private commercial sector offerings, when they are in fact directly or indirectly subsidized by a social marketing program. Socially marketed products benefit from subsidies and/or tax exemptions or product registration waivers, but they may be sold and distributed under the commercial brand names that are used in the private sector.

- 15 percent (five of 36 countries reporting) have policies that hinder the ability of the private sector to provide contraceptives.
- 17 percent restrict access to contraceptives by young people[5], and 8 percent, by unmarried people.
- On average, eight out of 12 methods[6] are included in the country's National Essential Medicines List (NEML).

On average, countries included eight of 12 methods on their NEML.

**Supply Chain**[7]

- Of the 33 countries providing information on the supply chain, 11 report zero stockouts at the central level of any FP/RH product.
- Average annual stockout rates at the **central medical store level** for the most common FP/RH methods[8] ranged as follows among countries reporting:
    - Combined oral contraceptives: 76 percent of countries reporting (25 countries) had no stockouts, while the remaining eight countries ranged from 8 percent (Angola and Guatemala) to 42 percent (Kenya) of stock status observations reported as stocked out.
    - Injectable contraceptives: 69 percent (22 countries) had no stockouts; the remaining 10 countries ranged from 11 (Madagascar) to 100 percent (Cameroon and El Salvador) stocked out.
    - IUDs: 75 percent (24 countries) had no stockouts; the remaining eight countries ranged from 1 percent (Bangladesh) to 83 percent (Kenya) stocked out.
    - Male condoms: 78 percent (25 countries) had no stockouts; the remaining seven countries ranged from 8 percent (Guatemala) to 92 percent (Angola) stocked out.

[5] This age group may be defined slightly differently across countries, depending on the particular age groups affected by the policies each country has identified in their response to this question.

[6] Methods referenced for the NEML indicator include: combined oral contraceptive pills, progestin-only oral pills, injectables, implants, copper-bearing IUDs, hormone-releasing IUDs, male condoms, female condoms, emergency contraceptive pills, contraceptive patches, vaginal contraceptive rings, and calendar-based awareness methods.

[7] Stockout rates are reported at the country/method level only and not aggregated across countries, as interpreting the data becomes difficult at higher levels of aggregation.

[8] An FP/RH "method" can be comprised of multiple FP/RH products; for example, the implants method includes one-rod and two-rod implants. When the term "method" is used here, it will refer to the group of one or more common product formulations. The term "product" will be used only to refer to a single formulation.

- Average annual stockout rates at the **service delivery point** level for the most common FP/RH methods ranged as follows:
    - Combined oral contraceptives: 21 percent (four countries) had no stockouts; the remaining 15 countries ranged from 3 percent (Burkina Faso) to 38 percent (Madagascar) stocked out.
    - Injectable contraceptives: 11 percent (two countries) had no stockouts; the remaining 17 countries ranged from 1 percent (Bangladesh) to 36 percent (Madagascar) stocked out.
    - IUDs: 11 percent (two countries) had no stockouts; the remaining 16 countries ranged from 1 percent (Bangladesh) to 70 percent (Madagascar) stocked out.
    - Male condoms: 10 percent (two countries) had no stockouts; the remaining 18 countries ranged from 1 percent (Haiti) to 59 percent (Madagascar) stocked out.

**Quality**

Of the countries providing information on quality:

- 97 percent (31 of 32 reporting) say that QC standards are routinely applied in the public and private sectors.
- 92 percent in the public sector and 89 percent in the private sector routinely test samples.
- 84 percent (27 of 32) implement post-marketing surveillance and pharmacovigilance.

**Private Sector**

Of the countries providing information on the private sector:

- 81 percent (29 of 36 reporting) require private-sector entities that provide family planning to report to or register with government agencies.
- 47 percent (16 of 34 reporting) have established or brokered one or more public/private partnerships in the last year to expand FP products and services.

# INTRODUCTION

The globally recognized concept of contraceptive security (CS) is the condition where everyone can choose, obtain, and use a wide range of high-quality and affordable contraceptive methods, when they need them, for family planning/reproductive health (FP/RH) and the prevention of sexually transmitted diseases.

Multiple factors across several sectors contribute to the availability and accessibility of contraceptives within countries, including political commitment, financial capital, partner coordination, capacity, client demand and use, and commodity availability. As demand for family planning continues to grow and outpace financing, the ability of governments and other stakeholders to direct resources and legislation in support of supply chains and service delivery increases in importance. The CS Indicators can assist stakeholders and countries in obtaining data and monitoring progress in support of such initiatives as FP2020 and in achieving the Sustainable Development Goals.

The USAID | DELIVER PROJECT developed the CS Indicators to help in-country and global aid program managers, advocates, and decision-makers to measure and track countries' progress in improving access to contraceptives, particularly for those areas requiring more focused interventions.

The CS Indicators build off the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS[9]) framework as an approach to assess, identify, and prioritize reproductive health (RH) issues around the "7 Cs": context, commitment, coordination, capital, capacity, commodities, and client demand and use. The CS Indicators were designed to complement the CS Index (collected every three years between 2003 and 2015). The CS Index provided insight into a mix of higher-level indicators to help countries identify strengths and weaknesses across five components — financing, supply chain, utilization, access, and health and social environment — and 17 CS Indicators. It has guided stakeholders in determining which countries are most in need, where to focus resources, and what type of assistance is needed. Data for the CS Index were obtained from secondary sources to develop a composite index. When taken together, the two tools have enabled high-level and granular analyses of CS constituent elements and contributing factors in fixed locations and in trends over time and across countries.

This study's immediate objective is to continue to follow outcomes in contraceptive security at the country and global levels, which have been monitored through this USAID-funded survey since 2009. This survey, now conducted by the USAID Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) project, will be made public on GHSC-PSM's website and other venues, contributing to the global knowledge base for population and reproductive health. Since the first CS Indicators, additional FP-related data sets have been collected, which complement the CS Indicators. For instance, Track20[10] produces annual estimates of indicators, including method mix, stock status, and FP expenditures. FPWatch[11] produces a nationally representative survey to estimate key FP market indicators. Also, two private-sector landscape studies analyzing pharmaceuticals, family planning

[9] Hare, L., et al., 2004.

[10] http://www.track20.org/

[11] http://www.actwatch.info/projects/fpwatch

commodities, and diagnostics in Nigeria, one qualitative and one quantitative, have been conducted by IQVIA (formerly QuintilesIMS) through the GHSC-PSM project.[12] The knowledge gleaned from the CS Indicators and similar research is intended to improve the effectiveness of public RH programs and private-sector health initiatives, to ensure that these programs' end users, including populations around the world, can access a wide variety of affordable, high-quality contraceptives, whenever they choose.

[12] The results of these studies are available upon request.

# METHODOLOGY

The CS Indicators methodology has been updated this round, and those changes are described on the following pages. As in previous rounds, the survey incorporates a combination of quantitative and qualitative elements, collected through key informant interviews and document review within each focus country. GHSC-PSM personnel led data collection and initial validation in countries where the project has a presence. In non-presence countries, these activities were led by USAID, Ministry of Health officials, or representatives of another donor or implementing partner.

For the 2017 report, data are available for 36 countries:

**Africa**

- Angola
- Benin
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Côte d'Ivoire
- Democratic Republic of the Congo (DRC)
- Ethiopia
- Ghana
- Guinea
- Kenya
- Madagascar
- Malawi
- Mali
- Mozambique
- Niger
- Nigeria
- Rwanda
- Senegal
- Tanzania
- Togo
- Uganda
- Zambia
- Zimbabwe

**Europe and Asia**

- Afghanistan
- Armenia
- Bangladesh
- India
- Nepal
- Pakistan
- Philippines

**Latin America and the Caribbean**

- Dominican Republic
- El Salvador
- Guatemala
- Haiti

Depending on the country context, key informants can include the Ministry of Health, Ministry of Finance, other government officials, managers, and policymakers for FP/RH programs, representatives from associations of pharmacists or health providers, representatives of nongovernmental organizations

(NGOs) or donor agencies, and representatives of private-sector retailers or manufacturers, or associations.

The analysis, where possible, includes an aggregation of most data elements across countries to develop a descriptive analysis of quantitative elements, using tables and graphics to depict frequencies, central tendencies, and measures of variation and position. Qualitative data are analyzed thematically and depicted through frequency charts. The survey tool is designed in Excel and includes a few basic automated calculations to determine budget gaps, forecast accuracy, and stockout rates. Further analysis has been conducted from several indicators to determine whether a country's CS Committee meets certain criteria that would suggest a higher level of committee functionality or activity. Some questions, such as stockout rates and forecast accuracy, will not be aggregated across countries but rather presented as country-level outcomes.

The survey was disseminated in September and October 2017 in English, French, Spanish, and Portuguese. Data collection began in October 2017 and continued through February 2018, while validation took place between November 2017 and May 2018. Survey analysis was conducted in May and June 2018.

## Changes in Methodology from Previous Report

GHSC-PSM, in close collaboration with USAID, reviewed the survey tool as well as its impact and use, and made several changes with the goal of increasing the survey's reliability and methodological rigor while also expanding the scope to increase the survey's usefulness to an expanded audience. To this end, the following changes have been made:

### Addition of Two New Sections[13]

*Section F. Quality* considers the ability of country pharmaceutical regulatory authorities to ensure contraceptive product quality.

*Section G. Private Sector* examines the extent of collaboration between the public and private sectors in ensuring contraceptive security. Also, other questions throughout the survey have been modified or added to capture additional information on private-sector contributions to contraceptive security, including commercial or for-profit entities, nonprofit organizations, community groups, informal vendors (drug shops, retail pharmacies, and wholesalers), and private providers. Questions are now more in line with a total market approach, a system in which all sectors — public, socially marketed, and private sector — work together to deliver health choices for all population segments.

### Addition of New Indicators

In addition to the two new sections, the following indicators have been added to existing sections:

Section A. Leadership and Coordination:

[13] USAID Global Health Supply Chain Program-Procurement and Supply Management, 2017.

- Did the committee develop or start development on any policies, procedures, and/or action plans in the last year?
- Is there evidence of adherence to policies and procedures, implementing action plans, and/or following up on and addressing issues raised at previous meetings?
- Description of the committee's work

Section D. Policies (Commitment):

- Are there charges to the client in the public sector for family planning that are informal, unofficial, or are difference than posted charges?
    - If yes, describe the charges.
- If a fee is charged for family planning services or commodities in the public sector, does public/government/national health insurance cover family planning?
    - If yes, what proportion of the population does this health insurance cover?
- Proportion of modern contraceptive use that is attributed to married women in each wealth quintile
- Has the country made an FP2020 commitment?
    - If the country has made an FP2020 commitment, what area(s) is it in?
- Is the country a Global Financing Facility (GFF) partner?

Section E. Supply Chain

- Average annual stockout rate by product and across products at the central medical store
- Average annual stockout rate by product and across products at service delivery points
- Overall comments about challenges and/or successes with contraceptive security (qualitative)
- Forecast error for the most recent complete fiscal year

**Data Source Standardization**

The survey tool now requires users to select from a drop-down list of common sources for up to two sources of data used. This feature is intended to increase the rigor of the data collected by: 1) limiting the data collected to a selection of acceptable and common sources, 2) increasing the reliability (consistency) of data collected across countries, and 3) controlling data quality by documenting the source used for each response to enable future data quality assessments.

**Reflecting GHSC-PSM Updates to Supply Chain-related Measures**

Several CS indicators in the original tool were similar to indicators that GHSC-PSM is now reporting quarterly or annually. For better alignment of indicators, some of the wording has been modified and/or additional questions added to ensure that these data can be compared, and to ease the burden of reporting for those countries where GHSC-PSM is operating. These include indicators for the national committee working on contraceptive security, sources of commodity financing, and commodity stockouts. The stockout indicator has been revised to capture the actual average stockout rate at the central warehouse and facility levels for specific commodities and for the group of commodities.

**Revisions to Some Questions**

Several survey questions have been modified from the 2015 version to elaborate more fully on the focus area or provide more clarity in interpretation, for example, questions about formal and informal policies that may affect access to contraceptives. Overall, these questions, in addition to the many unchanged questions, should remain comparable to previously reported CS Indicators data.

**Survey Frequency**

To reduce the burden of reporting, while still maintaining a data set that reflects the most recent useful data available, beginning in 2017 the survey will now be implemented biennially (once every other year) instead of annually.

## Survey Indicators

The 2017/2018 CS Indicators include the following. Updated and new indicators are rendered in italics. Indicators not included from the 2015 survey are also indicated.

**Leadership and Coordination**

- Existence of a national committee that works on contraceptive security and organizations represented
- Frequency of committee meetings
- *Whether the committee developed or started development on any policies, procedures, and/or action plans in the last year*
- *Whether there is evidence of adherence to policies and procedures, implementing action plans, and/or following up on and addressing issues raised at previous meetings*
- *Description of the committee's work*
- Existence of a contraceptive security champion and the organizational affiliation of the champion

Removed indicator: Does the committee have legal status?

**Finance and Procurement (Capital)**

- Estimated dollar value of contraceptives needed to be procured for the public sector for the most recently complete fiscal year
- Existence of a government budget line item specifically for the procurement of contraceptives
- Amount of government funds allocated and spent on contraceptive procurement by type of government funds in the most recently complete fiscal year
- Amount and source of contraceptive donations, cash and in-kind, for the most recently complete fiscal year
- Existence of a funding gap for public sector contraceptives in the last complete fiscal year
- Government entity that conducted the procurements

Removed indicators:

- Were Global Fund grants used to procured condoms?

- Were Global Fund grants used to procure contraceptives besides condoms?

**Commodities**[14]

Range of contraceptive methods offered:

- In public facilities
- In NGO facilities
- Through social marketing
- In commercial-sector facilities

**Policies (Commitment)**

- Existence of a national CS strategy and information about that strategy
- Policies hindering or enabling the ability of the private sector to provide contraceptive methods *(both formal and informal policies and barriers)*
- Existence of any other indirect policy barriers that make it difficult for unmarried people, young people, or other subpopulations to access effective family planning services
- Whether there are charges (formal) to the client in the public sector for family planning services or commodities
- Whether and what exemptions there are for people who cannot afford to pay
- *Whether and what charges exist to the client in the public sector for family planning that are informal, unofficial, or are different than posted charges*
- *Whether there is public/government/national health insurance that covers family planning if fees are charged, and the proportion of the population it covers*
- The lowest-level provider that is authorized to dispense each contraceptive method in the public and private sectors
- Inclusion of contraceptives on the National Essential Medicines List (NEML)
- *Proportion of modern contraceptive use that is attributed to married women in each wealth quintile (from CS Index)*
- *Country commitments to FP2020*
- *Partnership in the Global Financing Facility*

Removed indicator: Country information from the Poverty Reduction Strategy Paper

**Supply Chain**

[14] Commodities include combined oral contraceptive pills, progestin-only oral contraceptive pills, injectables, contraceptive implants, copper-bearing intrauterine devices (IUDs), hormone-releasing IUDs, male condoms, female condoms, emergency contraceptive pills, contraceptive patches, vaginal contraceptive rings, and calendar-based awareness methods.

- *Average annual stockout rate by product and across products at the central level*
- *Average annual stockout rate by product and across products at the service delivery point (SDP) level.*
- *Successes and challenges with stock management at any level (qualitative)*
- *Forecast error for the most recent complete fiscal year*

Removed indicators:

- Are stockouts a large problem at the service delivery point level?
- Are stockouts a large problem at the central level?

***Quality***

- *Existence of national drug regulatory authority*
- *Application of pharmaceutical quality control (QC) standards*
- *Regular testing of contraceptive products*
- *Existence of World Health Organization (WHO)-prequalified manufacturers in-country*
- *Existing standards for post-marketing surveillance and pharmacovigilance*

***Private Sector***

- *Registration requirements for private-sector entities*
- *Whether routine market or syndicated survey data are available*
- *Existence and nature of public-private partnerships*

# LIMITATIONS

Data presented in this survey reflect the most recently completed fiscal or calendar year in each country, provided by key informants based on the information they had access to at the time of the survey. Therefore, time periods reflected in the data between countries may vary due to availability of the most recent data and the differing survey completion dates.

Most of the data provided are from secondary sources. This is a centrally and remotely collected survey where the principal authors did not have direct access to the data sources. Some indicators were validated against other secondary data sources, while most relied on the key informants and their sources. As with any key informant survey, data rely on respondent knowledge and may be affected by reporting biases. Government officials may be prone to biases in reporting publicly on outcomes that reflect their country's position or standing. Where responses were unknown or not applicable at the time of survey completion, they have been removed from the denominator in calculating percentages.

When responding to the question regarding the availability of contraceptive methods in the commercial, public, NGO, or social marketing sector, there is a potential in some contexts for some contraceptives (especially injectables) to be perceived as private commercial sector offerings, when they are in fact directly or indirectly subsidized by a social marketing program. Socially marketed products benefit from subsidies and/or tax exemptions or product registration waivers, but they may be sold and distributed under the commercial brand names that are used in the private sector.

Regional comparisons have not been drawn in this survey, due to the limited numbers of respondent countries in several regions and the nonrandom nature of the countries responding in each region.

Although a data collection and use manual was made available to respondents, interpretations of questions may still vary.

Due to revisions to some questions and additions of others, comparisons with previous CS Indicator surveys are limited.

Further clarifications and limitations related to specific indicators can be found in explanations and footnotes within the relevant sections of this report.

Additional information on specific country data can be found in the full data set on the GHSC-PSM website (https://www.ghsupplychain.org/), or by contacting the GHSC-PSM project.

# KEY FINDINGS

Provided below is a summary of key 2017 CS Indicator findings.

**Leadership and Coordination**

Of all countries surveyed:

- 97 percent have a national committee that works on CS.
- 81 percent have a CS champion.

**Finance and Procurement (Capital)**

Of countries providing information on finance and procurement:

- Most (76 percent, or 26 out of 34 reporting) spend government funds for public-sector contraceptive procurement.
- An average of 41 percent of financing comes from government sources and 59 percent from in-kind donations.
- 28 countries (80 percent) have a government budget line item specifically for contraceptives, 23 of which spent government funds on contraceptives in the most recently completed fiscal year.
- 45 percent have a funding gap between funding spent and estimated contraceptive need.

**Commodities**

Of countries surveyed:

- On average, countries offer 10 of the 13 assessed contraceptive methods in public-sector facilities, eight in nongovernmental facilities, eight through the commercial sector, and six through social marketing.
- 89 percent offer at least eight of the 13 assessed contraceptive methods in the public sector.

**Policies (Commitment)**

Of countries surveyed:

- All have either a CS or reproductive health commodity security (RHCS) strategy or a strategy that explicitly mentions increasing contraceptive access.
- 39 percent (22 of 36 countries reporting) have FP commodities that are subject to duties, import taxes, or other fees.
- 15 percent (five of 36 countries reporting) cite policies that hinder the ability of the private sector to provide contraceptives.

- 17 percent have restrictions on access to contraceptives by young people and 8 percent, by unmarried people.
- On average, countries include eight of 12 methods on their NEML.

**Supply Chain**

- Of 33 countries providing information on the supply chain, 11 report zero stockouts at the central level of any FP/RH products.
- Average annual stockout rates at the **central medical store level** for the most common FP/RH methods ranged as follows among countries reporting:
    - Combined oral contraceptives: 76 percent of countries reporting (25 countries) had no stockouts, while the remaining eight countries ranged from 8 percent (Angola and Guatemala) to 42 percent (Kenya) of stock status observations reported as stocked out.
    - Injectable contraceptives: 69 percent (22 countries) had no stockouts; the remaining 10 countries ranged from 11 percent (Madagascar) to 100 percent (Cameroon and El Salvador) stocked out.
    - IUDs: 75 percent (24 countries) had no stockouts; the remaining eight countries ranged from 1 percent (Bangladesh) to 83 percent (Kenya) stocked out.
    - Male condoms: 78 percent (25 countries) had no stockouts; the remaining seven countries ranged from 8 percent (Guatemala) to 92 percent (Angola) stocked out.
- Average annual stockout rates at the **service delivery point** level for the most common FP/RH methods ranged as follows:
    - Combined oral contraceptives: 21 percent (four countries) had no stockouts; the remaining 15 countries ranged from 3 percent (Burkina Faso) to 38 percent (Madagascar) stocked out.
    - Injectable contraceptives: 11 percent (two countries) had no stockouts; the remaining 17 countries ranged from 1 percent (Bangladesh) to 36 percent (Madagascar) stocked out.
    - IUDs: 11 percent (two countries) had no stockouts; the remaining 16 countries ranged from 1 percent (Bangladesh) to 70 percent (Madagascar) stocked out.
    - Male condoms: 10 percent (two countries) had no stockouts; the remaining 18 countries ranged from 1 percent (Haiti) to 59 percent (Madagascar) stocked out.

**Quality**

Of the countries providing information on quality:

- 97 percent (31 of 32 countries reporting) say that QC standards are routinely applied in the public and private sectors.
- 92 percent in the public sector and 89 percent in the private sector routinely test samples.
- 84 percent (27 of 32 countries reporting) implement post-marketing surveillance and pharmacovigilance.

**Private Sector**

Of the countries providing information on the private sector:

- 81 percent (29 of 36 countries reporting) require private-sector entities that provide family planning to report to or register with government agencies.
- 47 percent (16 of 34 countries reporting) have established or brokered one or more public/private partnerships in the last year to expand FP products and services.

# LEADERSHIP AND COORDINATION

Strong leadership is needed among all CS partners representing the public, NGO, social marketing, and commercial sectors to leverage and maximize resources in every aspect of CS, from meeting client needs to ensuring adequate financing and developing an effective supply chain. The survey included indicators to measure coordination, looking at the existence of a CS Committee, its membership, meeting frequency, to what extent the committee has developed and/or implemented policies, procedures, and action plans, and if a CS champion is in place.

**Highlights**

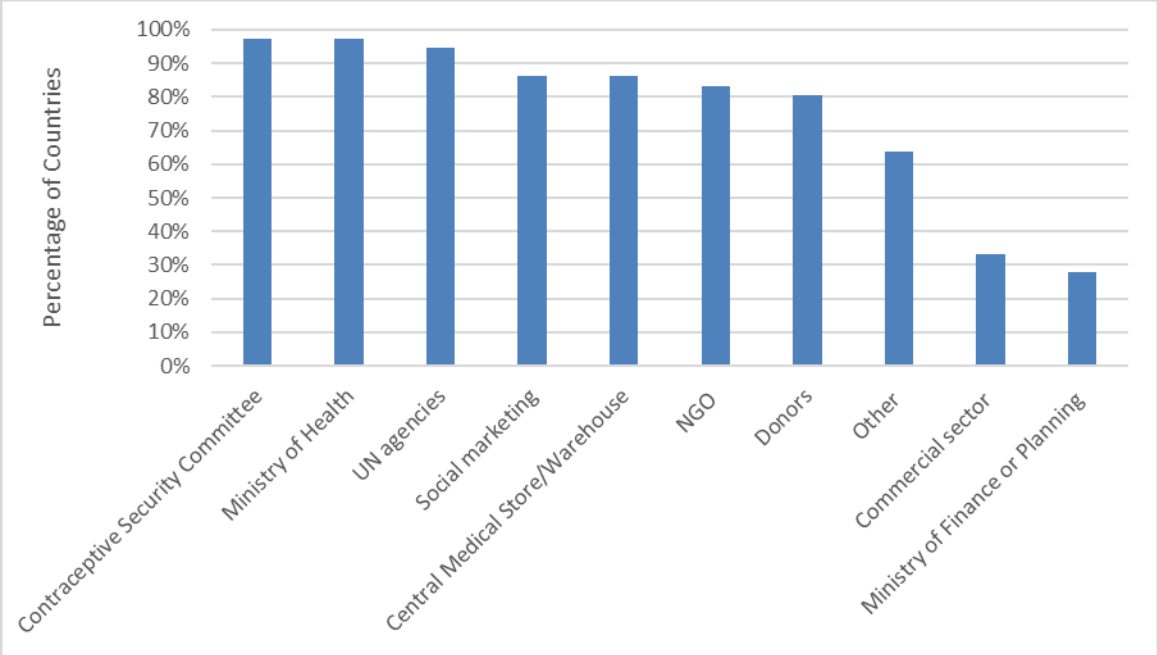
Of the countries surveyed:

- 97 percent have a national committee that works on CS.
- 81 percent have a CS champion in place.

**Contraceptive Security Committee**

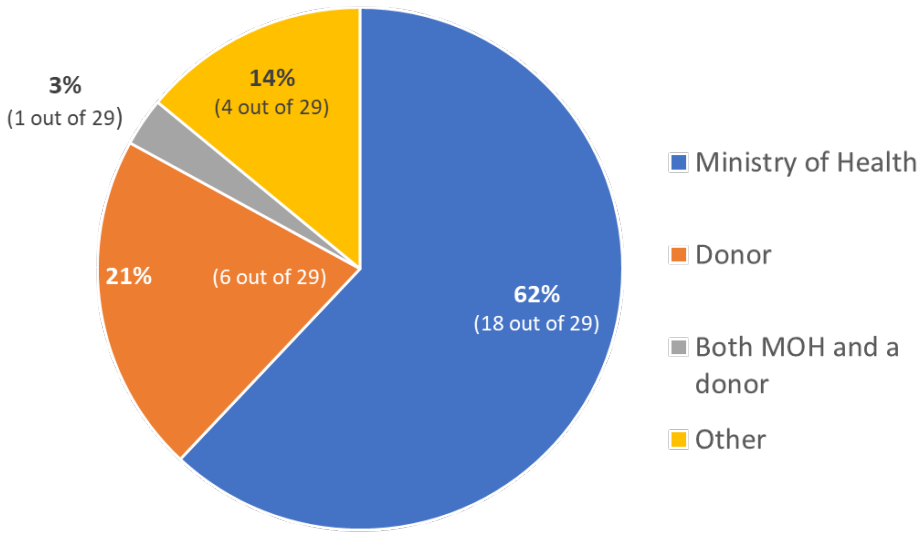
Of 36 countries responding, 97 percent report that a national committee is in place that works on contraceptive security (Figure 1). In 2015, 42 of 49 respondents (86 percent) had a contraceptive committee. The Ministry of Health is part of the CS committee in all countries (100 percent). United Nations (UN) agencies are part of most committees (97 percent), as are social marketing organizations (89 percent) and central medical stores (89 percent). NGOs (86 percent) and donors (83 percent) are also members of many committees. The commercial sector is part of the committee only 33 percent of the time, and the Ministry of Finance or Planning participates in only 29 percent of the respondent countries. Including this ministry is important to improve coordination and awareness of contraceptive security, especially for financing of procuring contraceptives.

**Figure 1. Percentage of countries that have CS committees, and their composition**




At least one CS champion is in place in 81 percent of the countries. When respondents were asked who the CS champion is, the Ministry of Health alone was mentioned most often (62 percent), followed by the donor alone (21 percent), and other (14 percent) (Figure 2). One country (Cameroon, 3 percent) listed both the Ministry of Health and a donor (United Nations Population Fund) as CS champions. Other champions included the logistics division of the government's national pharmacy directorate, a nonprofit consortium, the Prime Minister's wife, and the house of representatives/national government (each from one country).

**Figure 2. Contraceptive security champions**



Of the countries surveyed, 83 percent report having developed or started to develop policies, and 74 percent note evidence of adherence to the policies and procedures, implementation of action, or follow-up of an issue addressed in previous meetings.

Most CS Committees met three to five times over the last year (38 percent), while 32 percent met one to two times. Nearly a third (29 percent, or 10 countries) met six or more times, an indication that these committees are active and functioning. One country did not know how many times the committee met. CS Committees were considered active in 81 percent of the countries, based on the following criteria.[15]

- The committee met at least twice in the previous year.
- Representatives from relevant sectors participate regularly (Ministry of Health, donors, UN agencies, NGOs, social marketing, commercial sector, Ministry of Finance or Ministry of Planning, and others, as relevant).
- The committee had developed or had started developing any policies, procedures, and/or action plans in the previous year.
- The committee had shown evidence of adherence to policies and procedures, implementing action plans, and/or following up on and addressing issues raised at previous meetings.

The CS Committee in each country will focus on various tasks and priorities. Table 1 illustrates the areas of CS that were covered in 27 of the surveyed countries. Providing technical oversight and review (37 percent) is the focus for many countries, as is conducting commodity supply and procurement planning (30 percent) and developing or updating policies, procedures, action plans, and protocols (30 percent). Aside from coordination and supply chain functions, CS committees also mobilize funds and resources for contraceptives (26 percent), developing, updating, and/or monitoring strategic plans (12 percent).

[15] Committees were assessed similarly to the GHSC-PSM Indicator B10. *Existence of a functional logistics coordination mechanism*, as follows: 1) for the existence of the committee, 10 points; 2) for committees with one to four relevant government agencies participating, 5 points; for five to seven participating, 1 point; and for eight or more participating, 2 points; 3) for committees that met one to two times, 1 point; for three to five times or more, 2 points; 4) for committees that developed or started development of policies, procedures, or action plans, 1 point; 5) for committees that adhered to/followed up on policies, procedures, or action plans, 1 point. A total score of 14 or higher was considered "active."

**Table 1. Contraceptive security committee activities (n=27)**

| Contraceptive Security Task | Percentage |
|---|---|
| Providing technical oversight/review | 37% (10 countries) |
| Conducting supply/procurement planning | 30% (eight countries) |
| Developing or updating policies, procedures, action plans, and/or protocols | 30% (eight countries) |
| Facilitating collaboration/coordination among RH/FP partners | 26% (seven countries) |
| Reviewing stock levels and/or addressing stock imbalances | 26% (seven countries) |
| Providing advocacy/mobilizing funds/resources | 26% (seven countries) |
| Conducting quantification | 23% (six countries) |
| Developing, updating, and/or monitoring strategic plans | 12% (three countries) |

# FINANCE AND PROCUREMENT (CAPITAL)

Adequate financing for procuring contraceptives by country governments demonstrates commitment to contraceptive security. A country must have sustainable financing, usually from several sources. Monitoring government spending and in-kind donations and grants provides insight into whether estimated contraceptive need is being covered from year to year. The finance-related indicators in the survey give stakeholders the ability to see the value and share of spending by funding source.

### Highlights

- Most respondent countries (76 percent, or 26 of 34 reporting) spend government funds for public-sector contraceptive procurement:
    - 70 percent (18 of 26) use internally generated funds
    - 47 percent (12 of 26) use other government funds
- On average, the share of government spending as a percent of total spending on contraceptives is 33 percent.
- All but one country (Armenia) received in-kind donations or grants (in-kind donations for the Philippines constituted only 0.4 percent of total spending on contraceptives).
- Of total spending, an average of 41 percent of financing comes from government sources and 59 percent from in-kind donations.
- 28 respondent countries have a government budget line item specifically for contraceptives; 23 of those countries spent government funds in the most recent fiscal year.
- 45 percent of respondent countries had a funding gap between funding spent and estimated contraceptive need.

### Financing Sources and Expenditures for Public-Sector Contraceptives

Countries were asked to provide the government funding sources spent toward procuring contraceptives. Internally generated funds and other funds, which can include World Bank credits or loans, basket funds, and other funds provided to the government from a donor, comprised government funding sources. Because governments count these World Bank credits, basket funds, and other funds as part of their national budget and they decide how to allocate and spend these funds, they are considered part of government funding.

**Definition of Financing Sources for Public-Sector Contraceptives**

- **Government financing:**
  - *Internally generated funds*: These funds are drawn from government revenue sources — usually from various taxes, duties, or fees. They can be generated at the central or lower levels of government.
  - *Other government funds, including*:
    - Basket funds: The government manages these pooled funds, with input from financing partners. The funds originate from various sources, which may include donors and the government. These funds can be given as general support or can be earmarked for specific programs and activities.
    - World Bank assistance: This funding, either credits or loans, can be used for general budget support, sector budget support, or earmarked interventions. In each case, the government defines the priority area for which the funds will be used, so using World Bank assistance for contraceptive procurement shows the government's commitment to family planning.
    - Other funds: These funds include additional funds provided to the government by donors.
- **In-kind donations**: These funds include contraceptive supplies that donors provide to a government.
- **Global Fund grants**: These grants can be used to procure condoms or other contraceptives.

## Government Expenditures

Table 2 illustrates the amount of government funds spent on public-sector contraceptive procurement by country and government source. Of 35 country respondents, 86 percent allocated funds for contraceptive procurement for the most recent completed fiscal year (FY) (FY17). Of the countries that had the information, 76 percent (26 of 34) reported government funds were spent on contraceptives. In 2015, this figure was 58 percent (28 of 48).

**Table 2. Government spending by source, FY17 ($)**

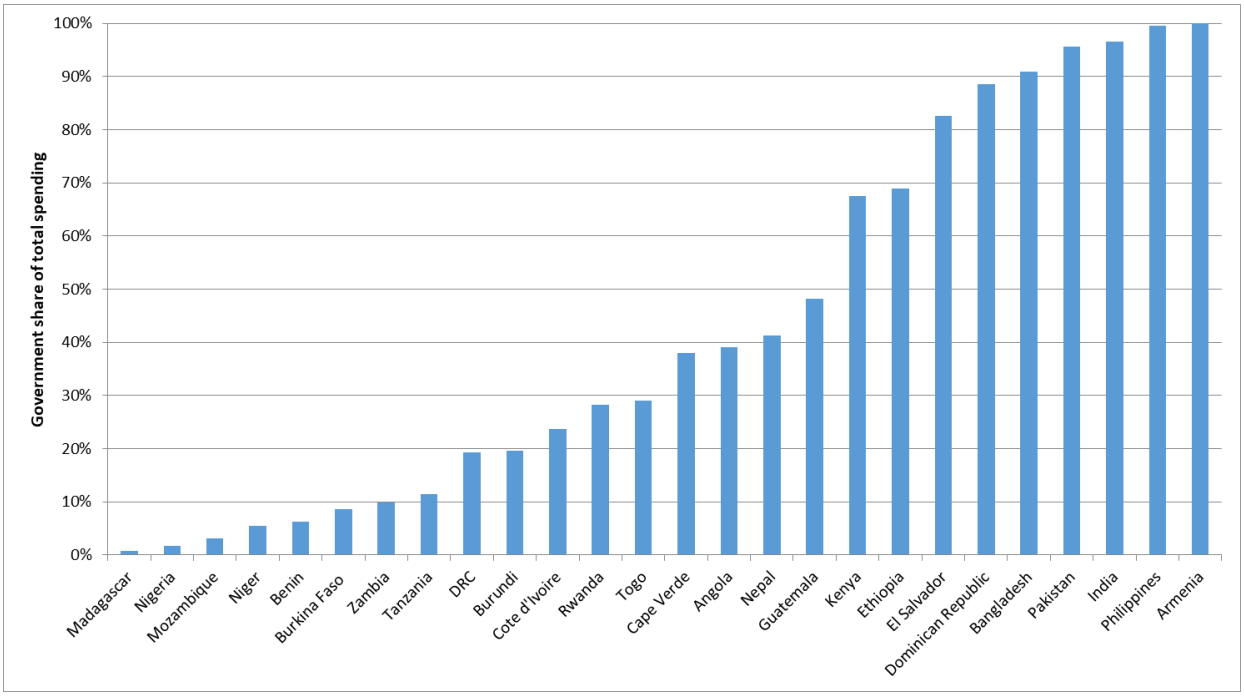
| Country | Internally generated funds spent | All other[16] government funds spent | Total government funds spent | Internally generated funds as a percent of total government funds spent |
|---|---|---|---|---|
| **Afghanistan** | 0 | 0 | **0** | 0% |
| **Angola** | 0 | 1,429,898 | **1,429,898** | 0% |
| **Armenia** | 95,458 | 0 | **95,458** | 100% |
| **Bangladesh** | 2,854,487 | 8,757,692 | **11,612,179** | 25% |
| **Benin** | 0 | 133,000 | **133,000** | 0% |
| **Burkina Faso** | 573,770 | 0 | **573,770** | 100% |
| **Burundi** | 111,000 | 0 | **111,000** | 100% |
| **Cameroon** | Unknown | Unknown | **Unknown** | Unknown |
| **Cape Verde** | 172,160 | 0 | **172,160** | 100% |
| **Côte d'Ivoire** | 0 | 1,000,000 | **1,000,000** | 0% |
| **Dominican Republic** | 1,440,353 | 0 | **1,440,353** | 100% |
| **DRC** | 0 | 1,000,000 | **1,000,000** | 0% |
| **El Salvador** | 1,774,207 | 0 | **1,774,207** | 100% |
| **Ethiopia** | 652,173 | 14,092,658 | **14,744,831** | 4% |
| **Ghana** | 0 | 0 | **0** | 0% |
| **Guatemala** | 2,993,414 | 0 | **2,993,414** | 100% |
| **Guinea** | 0 | 0 | **0** | 0% |
| **Haiti** | 0 | 0 | **0** | 0% |
| **India** | 18,890,000 | 0 | **18,890,000** | 100% |
| **Kenya** | 1,178,468 | 6,000,000 | **7,178,468** | 16% |
| **Madagascar** | 33,333 | 0 | **33,333** | 100% |
| **Malawi** | 0 | 0 | **0** | 0% |
| **Mali** | 0 | 0 | **0** | 0% |
| **Mozambique** | 0 | 235,800 | **235,800** | 0% |
| **Nepal** | 2,051,456 | 0 | **2,051,456** | 100% |
| **Niger** | 114,545 | 0 | **114,545** | 100% |
| **Nigeria** | 0 | 328,830 | **328,830** | 0% |
| **Pakistan** | 15,000,000 | 1,000,000 | **16,000,000** | 94% |
| **Philippines** | 14,966,674 | 0 | **0** | 100% |
| **Rwanda** | 0 | 860,038 | **860,038** | 0% |
| **Senegal** | Unknown | Unknown | **Unknown** | Unknown |
| **Tanzania** | 0 | 1,800,000 | **1,800,000** | 0% |
| **Togo** | 421,855 | 0 | **421,855** | 100% |
| **Uganda** | 0 | 0 | **0** | 0% |
| **Zambia** | 566,551 | 0 | **566,551** | 100% |
| **Zimbabwe** | 0 | 0 | **0** | 0% |

[16]Basket funds, World Bank credits or loans, and other funds the donors give to the government (e.g., direct budget support) are included in government funds because governments consider these funds as part of their budgets, count them as part of government funding, and have significant control over how they are spent. While all these forms of financing are included in this question, the question does not break out how much of each of these was allocated (USAID | DELIVER PROJECT, 2012).

Among the countries that used government funds to procure contraceptives for the public sector, the proportion of government financing ranged from 1 percent (Madagascar) to 100 percent (Armenia and the Philippines) (Figure 3). The government share of total spending on contraceptives made up most of the total spend for India (97 percent), Pakistan (96 percent), Bangladesh (91 percent), the Dominican Republic (89 percent), El Salvador (83 percent), Ethiopia (69 percent), and Kenya (67 percent). On average, the government share of total spending for public-sector contraceptives was 33 percent. Armenia was the only country that could cover the total estimated contraceptive need solely with internally generated funds.

The following countries did not spend any government funds to purchase commodities: Afghanistan, Ghana, Guinea, Haiti, Malawi, Mali, Uganda, and Zimbabwe. Cameroon and Senegal did not have information on whether any government funds were spent on contraceptives (these countries may have had in-kind donations or grants for procuring contraceptives).

**Figure 3. Total government spending as a share of total spending on public-sector contraceptives**




Of the 26 countries that did spend government funds on contraceptives, 18 (70 percent) used internally generated funds (IGFs) (Figure 4). In 14 countries, IGFs covered 100 percent of government funds spent on contraceptives. IGFs made up a portion of government funds in four countries: Ethiopia (4 percent), Kenya (16 percent), Bangladesh (25 percent), and Pakistan (94 percent).

**Figure 4. Share of government spending by government funding source**

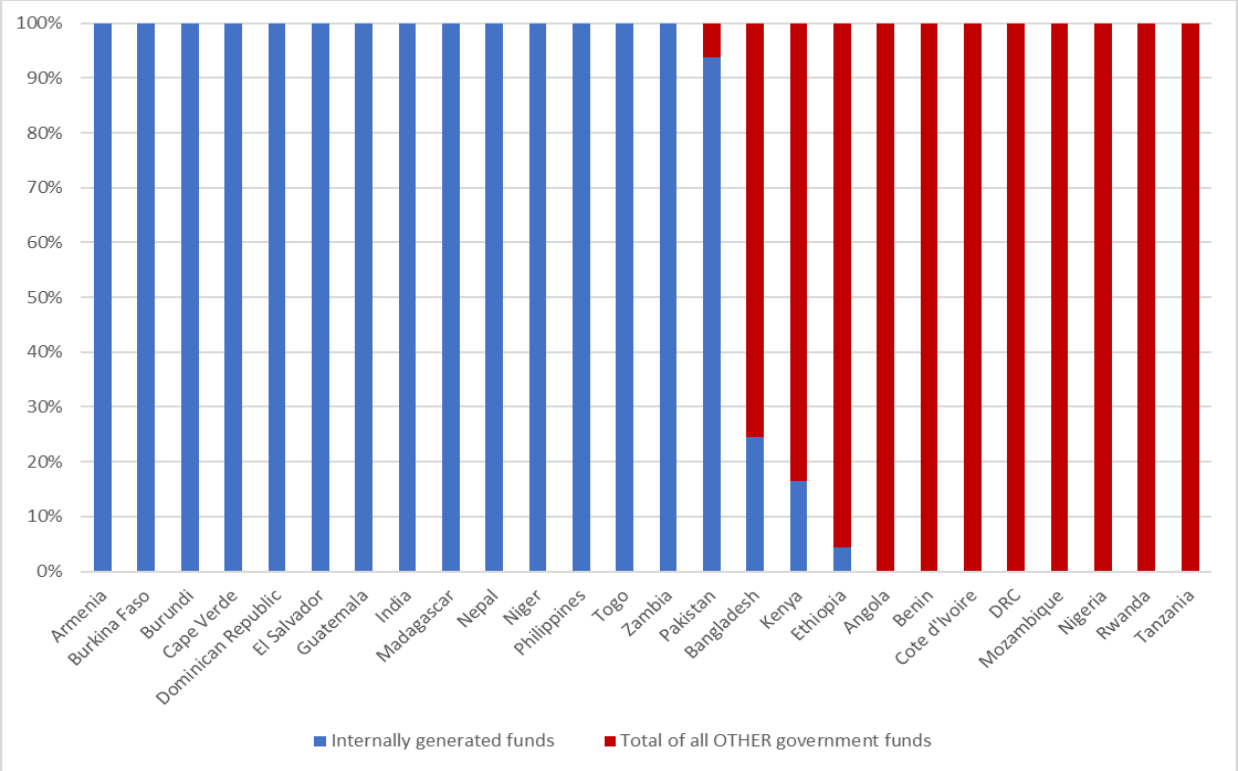
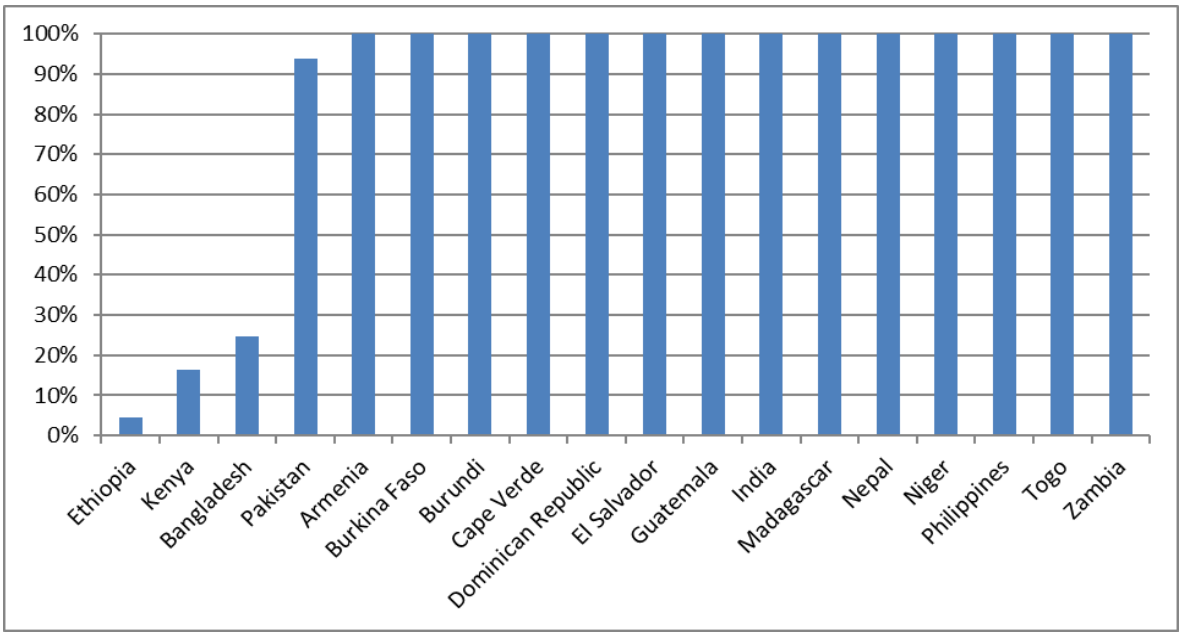


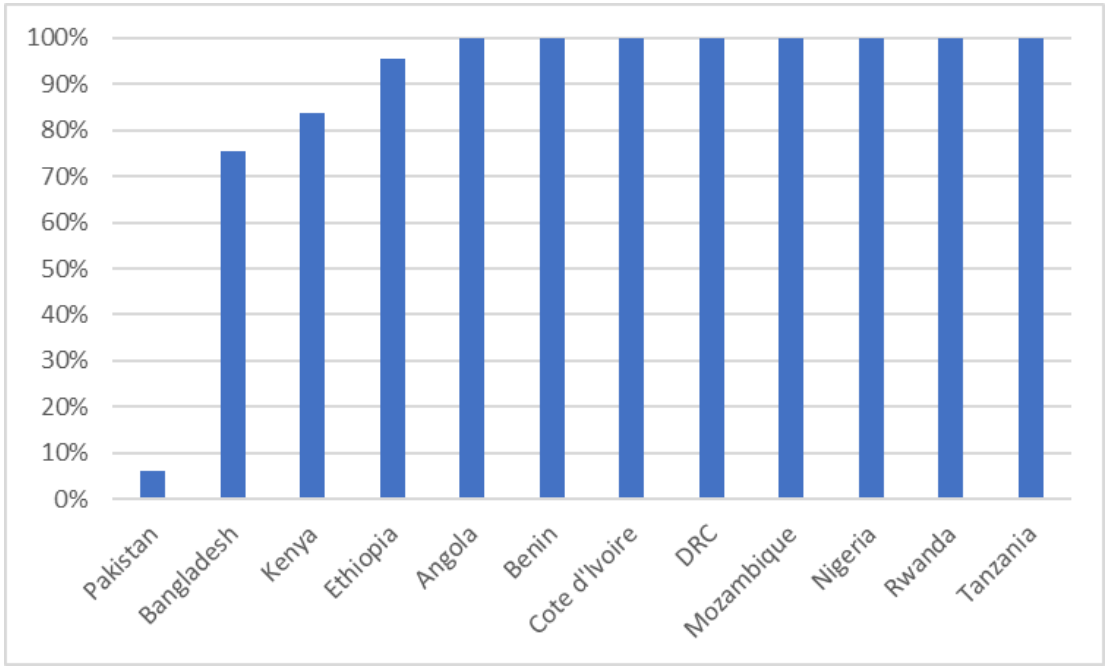

Figure 5 shows only the 18 countries that used IGFs from government funding sources to purchase contraceptives.

**Figure 5. Internally generated funds as a share of government funding for public-sector contraceptives**



A total of 12 countries used other government funds (these could include basket funds, World Bank credits or loans, and other funds donors provided to the government, such as direct budget support) (Figure 6). Of those 12 countries, eight used only other government funds and no internally generated funds to purchase contraceptives (Angola, Benin, Côte d'Ivoire, DRC, Mozambique, Nigeria, Rwanda, and Tanzania). Pakistan (6 percent), Bangladesh (75 percent), Kenya (84 percent), and Ethiopia (96 percent) used a portion of other government funds (plus IGFs) toward contraceptives. In other words, four countries — Bangladesh, Ethiopia, Kenya, and Pakistan — used internally generated funds and other government funds for contraceptives.

**Figure 6. Percentage of other government spending as a share of total government spending**




### In-Kind Donations and Global Fund Grants

Most countries relied on in-kind donations and grants.[17] Of the 36 countries that reported financing information, 35 countries were provided in-kind donations or grants (Table 3). Of these 35 countries, 10 relied solely on in-kind donations to procure contraceptives (Afghanistan, Cameroon, Ghana, Guinea, Haiti, Malawi, Mali, Senegal, Uganda, and Zimbabwe). For 17 other countries, reliance on in-kind donations made up 52 percent to 99 percent of contraceptive funding. In eight countries, in-kind donations made up 0.4 percent (Philippines) to 33 percent of public-sector funding for contraceptives.

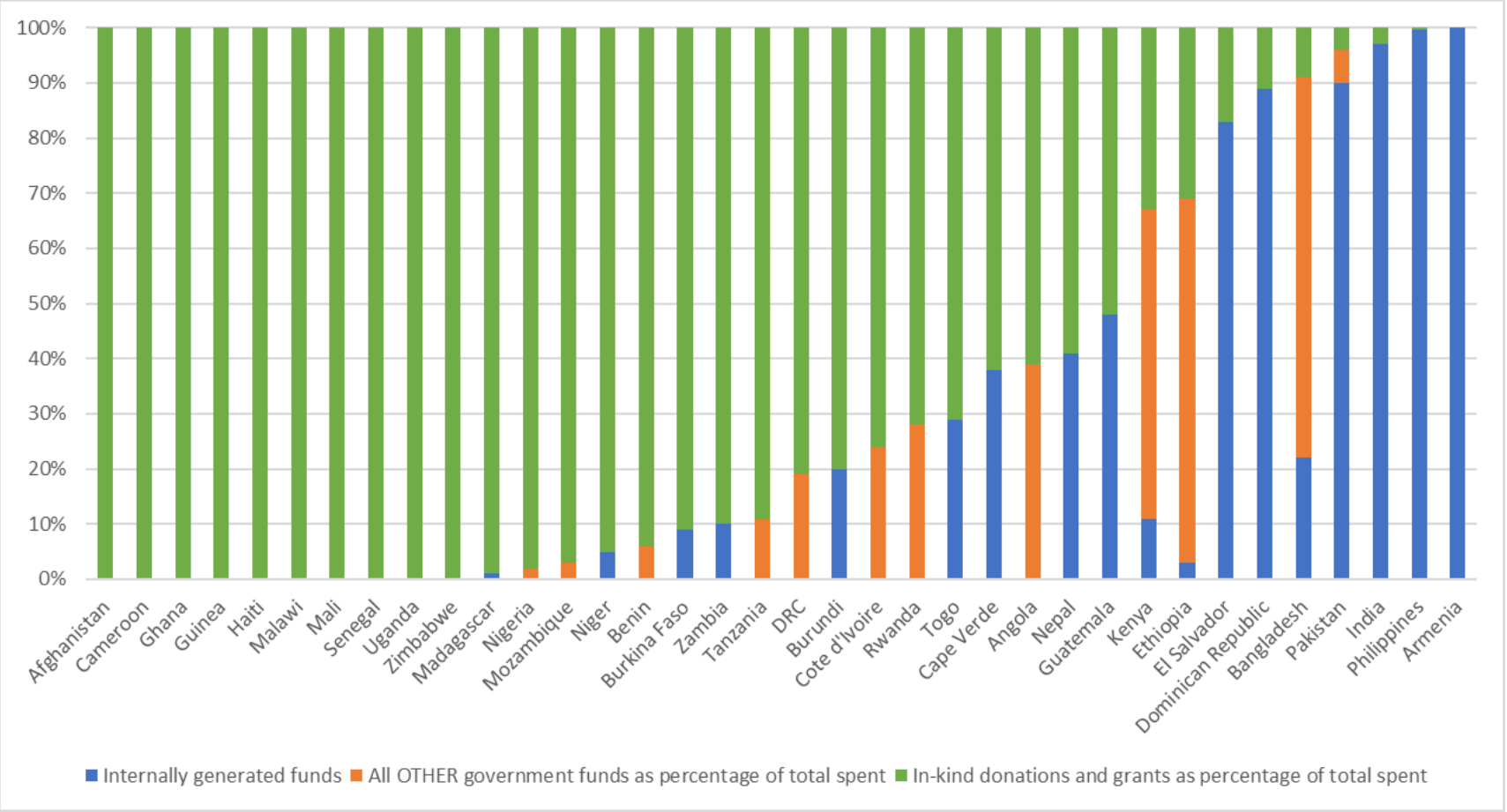
[17] In-kind donations for the public sector also include in some cases procurements for NGOs or social marketing organizations that obtain their supplies from the public sector.

**Table 3. In-kind donations and grants as a percentage of total spending on public-sector contraceptives**

| Country | In-kind donations and grants ($) | In-kind donations and grants as a percentage of total spending |
|---|---|---|
| **Armenia** | 0 | 0% |
| **Philippines** | 59,600 | 0.4% |
| **Dominican Republic** | 184,778 | 11% |
| **Cape Verde** | 281,360 | 62% |
| **El Salvador** | 372,433 | 17% |
| **Senegal** | 378,668 | 100% |
| **Burundi** | 454,305 | 80% |
| **India** | 662,122 | 3% |
| **Pakistan** | 718,570 | 4% |
| **Togo** | 1,029,200 | 71% |
| **Bangladesh** | 1,150,000 | 9% |
| **Guinea** | 1,212,922 | 100% |
| **Mali** | 1,369,591 | 100% |
| **Afghanistan** | 1,985,386 | 100% |
| **Benin** | 1,993,799 | 94% |
| **Niger** | 2,000,789 | 95% |
| **Rwanda** | 2,178,504 | 72% |
| **Angola** | 2,215,531 | 61% |
| **Malawi** | 2,600,503 | 100% |
| **Nepal** | 2,914,853 | 59% |
| **Cameroon** | 2,923,694 | 100% |
| **Ghana** | 3,043,685 | 100% |
| **Côte d'Ivoire** | 3,218,706 | 76% |
| **Guatemala** | 3,222,980 | 52% |
| **Kenya** | 3,460,752 | 33% |
| **DRC** | 4,200,641 | 81% |
| **Haiti** | 4,498,762 | 100% |
| **Madagascar** | 4,970,003 | 99% |
| **Zambia** | 5,216,159 | 90% |
| **Burkina Faso** | 6,046,266 | 91% |
| **Ethiopia** | 6,628,893 | 31% |
| **Mozambique** | 7,488,220 | 97% |
| **Zimbabwe** | 12,615,150 | 100% |
| **Tanzania** | 13,981,879 | 89% |
| **Uganda** | 18,525,151 | 100% |
| **Nigeria** | 20,002,302 | 98% |

Of total spending, an average of 41 percent of financing came from government sources and 59 percent from in-kind donations (Figure 7). Looking closer at government funding sources, of total spending on contraceptives, 26 percent came from internally generated funds and 15 percent from other government funds.

**Figure 7. Percentage of total spending on public-sector contraceptives by funding source**



### Budget Line Item

Of the 34 countries that had the information, 28 (80 percent) reported having a government budget line item for contraceptive procurement (in 2015 it was 29 out of 48, or 60 percent). Having a budget line item can demonstrate a country's commitment to contraceptive security, but it does not guarantee funds will be spent to purchase contraceptives.

Of the 28 countries that have a line item, 23 (82 percent) spent government funds on contraceptives. Three countries (11 percent) that have a budget line item —Malawi, Mali, Uganda — did not use government funds. In contrast, two countries (7 percent), Cape Verde and Dominican Republic, spent government funds, even though they do not have a budget line item for contraceptives. Angola spent government funds but did not know if it had a budget line item for contraceptives. Finally, five countries— Afghanistan, Haiti, Ghana, Guinea, Zimbabwe — did not have a budget line item and did not spend government funds.

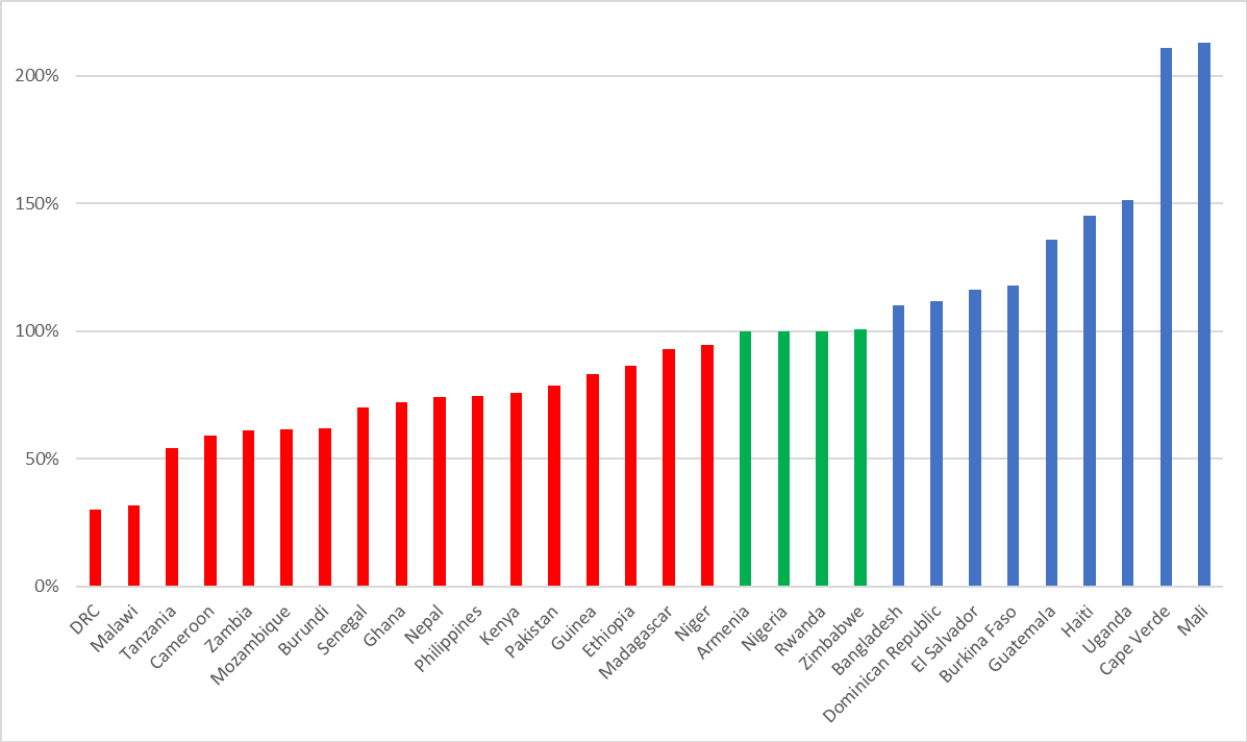
### Financing Gap for Procurement of Public Sector Contraceptives

Of the countries providing responses on the question of a funding gap, 45 percent (14 of 31) noted a gap between contraceptive spending and the estimated value of contraceptives needed (five did not know if there was a funding gap). Tables 2 and 3 demonstrate how much funds were spent on contraceptives and not on actual public-sector estimated needs. Government spending may make up a large percentage of total spending, but the amount may not be sufficient to cover actual need.

For example, although the Philippines' government funds made up 100 percent of the spending on contraceptive procurement, the country still had a financing gap because there were insufficient funds and no in-kind donations or grants to make up the difference of the total estimated contraceptive need. Similarly, in Ethiopia, Kenya, and Pakistan, where government financing was the main financing source to procure contraceptives (see Figure 7 above), funding gaps still existed.

Figure 8 shows that the quantified need covered for countries having information ranged from 30 percent (DRC) to Togo (596 percent). Armenia, Nigeria, and Rwanda (100 percent) had sufficient funding to cover actual need. The countries in red indicate where there was a funding gap between funds spent and quantified need. For the remaining countries, spending surpassed actual quantified need. A variety of reasons can lead to these apparent funding gaps, including conducting a quantification without enough data on demand; poor stock data; different timeframes between the quantification and expenditures; and contraceptive costs.

**Figure 8. Percentage of quantified need covered by any source of funding**[18,19,20]




When asked whether governments have allocated funds for contraceptives in the *current* fiscal year, 82 percent (28 of 34 respondents) responded yes, and two did not know.

[18] Togo (596 percent), Côte d'Ivoire (422 percent), and Angola (341 percent) are not shown.

[19] Also not shown are Afghanistan, Benin, and India, which did not have information on estimated value of contraceptive need.

[20] Interpretations on the question of the value of in-kind donations and government procurement of commodities varied widely between countries and between indicators within the same country, ranging from the value of commodities procured, agreed to be delivered, shipped, or delivered in the specified time. It is also possible that some country forecasts did not account for the full amount needed for NGOs and social marketing entities, in addition to the traditional public sector.

# COMMODITIES

Clients' ability to choose from a range of products best suited for them is a key aspect of contraceptive security. Respondents were asked which contraceptives are offered in commercial, public, and NGO facilities, and through social marketing, regardless of whether they are available. The survey included the following 13 methods:

- Combined oral contraceptive (COC) pills
- Progestin-only pills (POPs)
- Injectables
- Implants
- IUDs
- Male condoms
- Female condoms
- Emergency contraceptive pills
- Long-acting permanent methods for males (vasectomy)
- Long-acting permanent methods for females (tubal ligation)
- Contraceptive patches
- Vaginal contraceptive rings
- Calendar-based awareness methods

Respondents were asked to indicate if any other methods were offered.

**Highlights**

- On average, countries offer 10 of the 13 assessed contraceptive methods in public-sector facilities, eight in nongovernmental facilities, eight through the commercial sector, and six through social marketing.

- 86 percent (31 out of 36 countries) offer all the following most commonly offered methods in public-sector facilities: male condoms, combined oral contraceptives, IUDs, tubal ligations, and injectables.

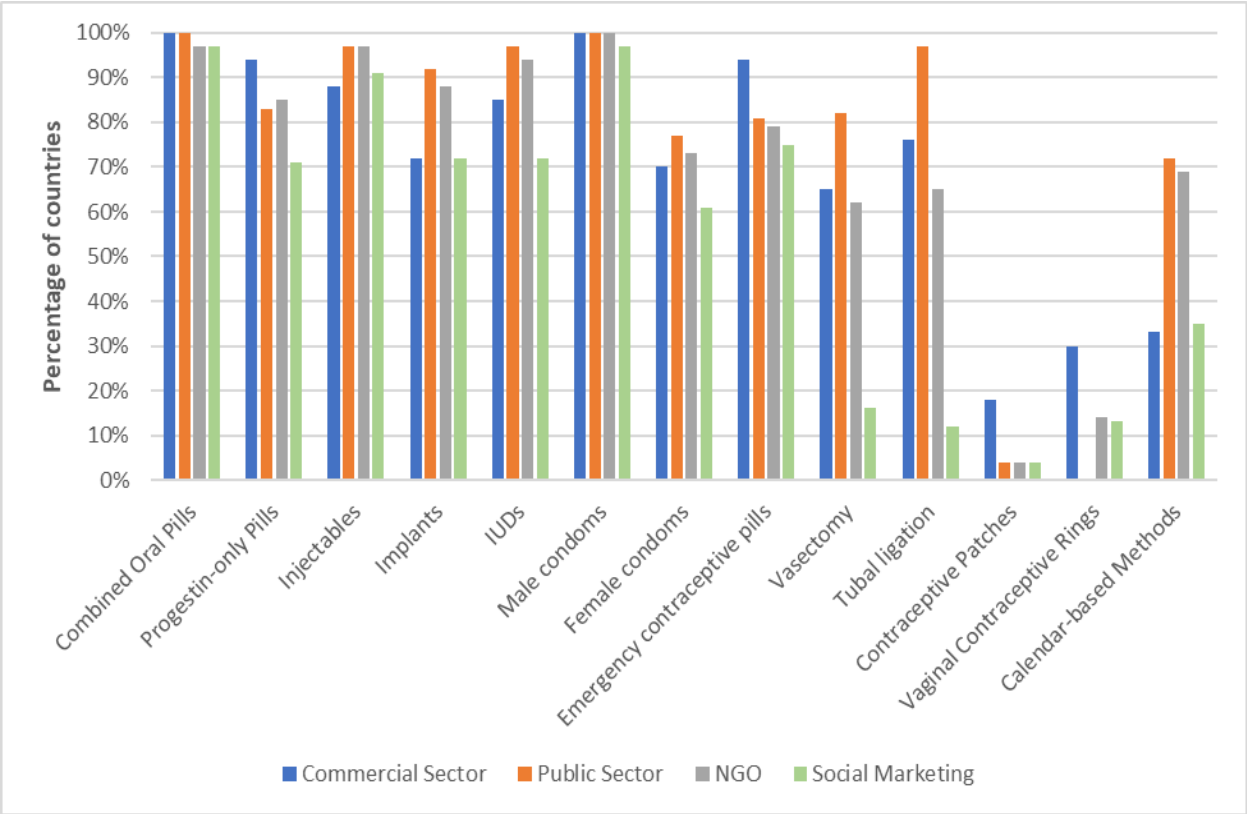
- 89 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector.

- Public-sector facilities are the least likely to offer contraceptive patches and vaginal contraceptive rings (no public facilities in the countries surveyed offer either method).

**Methods Offered by Sector**

In general, some methods are offered more often in one sector than another. For instance, tubal ligation (97 percent) is offered most often in the public sector than in any other sector; POPs and emergency contraceptive pills are more likely to be found in the commercial sector; and implants and vasectomies are more likely to be offered in the public sector (Figure 9). All 13 methods can be found in the commercial sector and through social marketing.

**Figure 9. Percentage of contraceptive methods offered by sector**




## Public Sector

Of the countries surveyed, 89 percent offer at least eight of the 13 assessed contraceptive methods in the public sector, and 86 percent offer all five of the most commonly offered methods in public-sector facilities (male condoms, injectables, pills, tubal ligations, and IUDs).

Most surveyed countries offer COCs (100 percent), male condoms (100 percent), injectables (97 percent), tubal ligation (97 percent), IUDs (97 percent), and implants (92 percent) through public-sector facilities (Table 4). POPs are offered in 83 percent of the countries, vasectomies in 92 percent, and emergency contraceptive pills in 81 percent of public-sector facilities. This sector is slightly less likely to offer female condoms (77 percent) and calendar-based methods (72 percent) and unlikely to offer contraceptive patches (4 percent). Vaginal contraceptive rings are not offered in any country through the public sector.

**Table 4. Method mix by sector (percentage of countries that offer the following contraceptive methods by sector)**

| | Commercial sector | Public sector | NGOs | Social marketing |
|---|---|---|---|---|
| **COCs** | 100% | 100% | 97% | 97% |
| **POPs** | 94% | 83% | 85% | 71% |
| **Injectables** | 88% | 97% | 97% | 91% |
| **Contraceptive implants** | 72% | 92% | 88% | 72% |
| **IUDs** | 85% | 97% | 94% | 72% |
| **Male condoms** | 100% | 100% | 100% | 97% |
| **Female condoms** | 70% | 77% | 73% | 61% |
| **Emergency contraceptive pills** | 94% | 81% | 78% | 74% |
| **Vasectomy** | 65% | 82% | 60% | 15% |
| **Tubal ligation** | 76% | 97% | 65% | 12% |
| **Contraceptive patches** | 14% | 0% | 4% | 5% |
| **Vaginal contraceptive rings** | 30% | 0% | 14% | 13% |
| **Calendar-based awareness methods** | 33% | 72% | 69% | 35% |

### NGOs

Except for tubal ligations (65 percent), the NGO sector offers similar methods as often as the public sector: male condoms (100 percent), COCs (97 percent), injectables (97 percent), IUDs (94 percent), contraceptive implants (88 percent), and POPs (85 percent) are offered most often through the NGO sector. Emergency contraceptive pills (78 percent) and female condoms (73 percent) are offered less often, followed by calendar-based awareness methods (69 percent), tubal ligation (65 percent), and vasectomy (60 percent). Vaginal contraceptive rings (14 percent) and contraceptive patches (4 percent) are not commonly found in the NGO sector.

### Commercial Sector

Emergency contraceptive pills are found more often (94 percent) in the commercial sector than in any other sector. The five most common methods can also be found in the commercial sector[21], although contraceptive implants (72 percent) are less commonly offered in the commercial sector than in other sectors. Vaginal contraceptive rings (30 percent) are more likely to be found in the commercial sector.

[21] There is a potential in some contexts for some contraceptives (especially injectables) to be perceived as private commercial sector offerings, when they are in fact directly or indirectly subsidized by a social marketing program. Socially marketed products benefit from subsidies and/or tax exemptions or product registration waivers, but they may be sold and distributed under the commercial brand names that are used in the private sector.

### Social Marketing

The five most common methods can be found through social marketing, but POPs (71 percent), contraceptive implants (72 percent), and IUDs (72 percent) are less likely to be found in this sector. Vasectomy (15 percent) and tubal ligation (12 percent) would be least likely to be offered through social marketing.

### Methods Offered by Country Overall (in at Least One Sector)

In the countries surveyed, 13 methods are available.

# POLICIES (COMMITMENT)

Policies indicate the level of government commitment to contraceptive security, as well as influence practices that can promote or hinder CS. Having supportive FP/RH policies is integral to ensuring successful health systems and strong FP programs. A supportive (or enabling) policy environment is defined as one in which:

- Laws and executive orders mandate provision of products and services without imposing undue restrictions on providers or eligibility requirements on clients.
- Government and civil society leaders speak openly in favor of FP/RH care and healthy practices.
- Public and private resources are adequate to ensure full population coverage.
- The policy formulation process is characterized by good planning principles and broad participation.

**Highlights:**

- All countries have either a CS or RHCS strategy or a strategy that explicitly mentions increasing contraceptive access.
- In 39 percent (22 of 36 countries reporting), FP commodities are subject to duties, import taxes, or other fees.
- 15 percent (five of 34 countries reporting) have policies that hinder the ability of the private sector to provide contraceptives.
- 17 percent restrict access to contraceptives by young people, and 8 percent, by unmarried people.
- On average, countries included eight of 12 methods on their National Essential Medicines List.

All countries have either a CS or RHCS strategy or a strategy that explicitly mentions increasing contraceptive access — an increase from 92 percent in the 2015 indicators. The strategy is being implemented in 97 percent of countries, with 100 percent noting follow-up and action are taking place on issues raised in the strategy.

### Policy Barriers Impacting Access or Provision to Contraceptives

#### Taxes, Duties, Fees

In 39 percent (22 of 36) of surveyed countries, FP commodities are subject to duties, import taxes, or other fees. In 2015 this was 67 percent (33 of 49). Armenia has a 20 percent value-added tax (VAT) on the value of the product. Pakistan has a customs duty of 20 percent, and Tanzania charges 18 percent VAT and 25 percent import duty on the invoice value.

**Policies that impact the ability of the private sector to provide contraceptives**

Of all country respondents, 15 percent (five of 34) reported that policies hinder the ability of the private sector to provide contraceptives. In 2015, this was 37 percent (17 of 46).

- In Madagascar, NGOs must pay taxes and customs duties on contraceptives.
- In Bangladesh, the private sector must receive permission from the Ministry of Health to import contraceptives.
- In the Philippines, regulated drugs, including contraceptives, cannot be advertised in mass media.

Two countries did not know if policies hinder the private sector.

However, in 94 percent (30 of 32) of surveyed countries, policies enable the private sector to provide contraceptive methods, compared with 73 percent (33 of 45) in 2015. Examples include:

- Freely allocating contraceptives to NGOs
- Expanding FP methods in private pharmacies through the social marketing programs in a country's reproductive and maternal health strategy
- Establishing public-private partnerships to ensure the private sector can provide contraceptives
- Training the private sector before providing any services
- Working with the national health insurance schemes in expanding coverage to include family planning services
- Abiding by laws stating anyone working in reproductive health must provide clients with complete information on all contraceptive methods

Four countries did not know if policies enabled the private sector to provide contraceptives.

**Dispensing Restrictions**

Restrictions on those who can dispense certain contraceptives can be barriers that prevent clients from easily accessing the method of choice.

For the five most common methods offered — male condoms, COCs, IUDs, tubal ligations, and injectables — the community health worker (CHW) is the lowest-level provider who can either sell or dispense the method in the public sector in most countries, except for IUDs (nurses are the lowest-level provider dispensing or selling in most countries, as with contraceptive implants) (Figure 10).

Other findings from the public sector include the following:

- For COCs, the CHW (67 percent) or an auxiliary nurse midwife is the lowest level of provider who can sell or dispense this method. In one country (Armenia), clients must see a doctor to receive COCs.

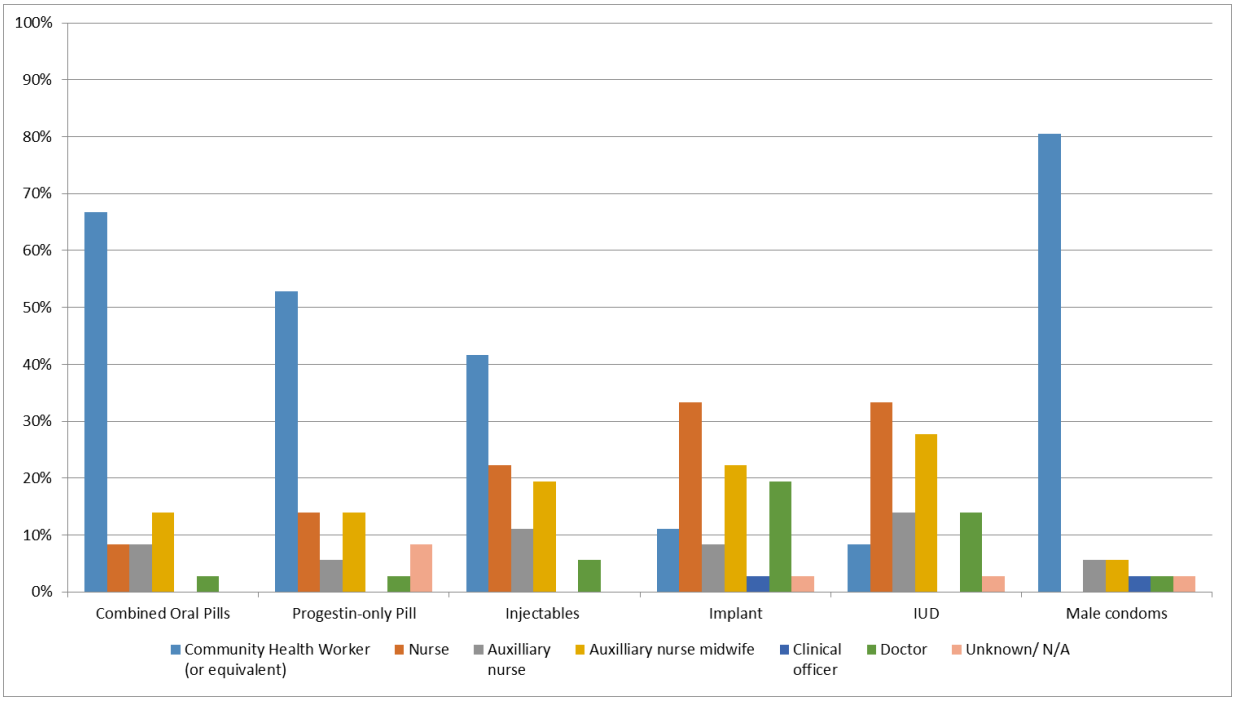
- For POPs, the CHW (53 percent), followed by the auxiliary nurse midwife (14 percent) and nurse (14 percent), is the lowest-level provider who can sell or dispense this method. In one country (Armenia), clients must see a doctor to receive a POP.

- For injectables, the CHW can provide this method in 42 percent of countries, as can a nurse (22 percent), an auxiliary nurse midwife (19 percent), and auxiliary nurse (11 percent). Clients in two countries (Armenia and India) must see a doctor for an injectable.

- For contraceptive implants, clients in 33 percent of the countries can go to a nurse, auxiliary nurse midwife (22 percent), or doctor (19 percent) to receive this method. In 11 percent of countries, clients can go to a CHW, while 8 percent can go to an auxiliary nurse or clinical officer (3 percent).

- For IUDs, clients in 33 percent of the countries can go to a nurse (33 percent), auxiliary nurse midwife (28 percent), or doctor (14 percent) to receive this method. In 8 percent of countries, clients can go to a CHW, while 14 percent can go to an auxiliary nurse.

**Figure 10. Percentage of countries with the lowest-level provider who can dispense or sell contraceptive methods in the public sector**

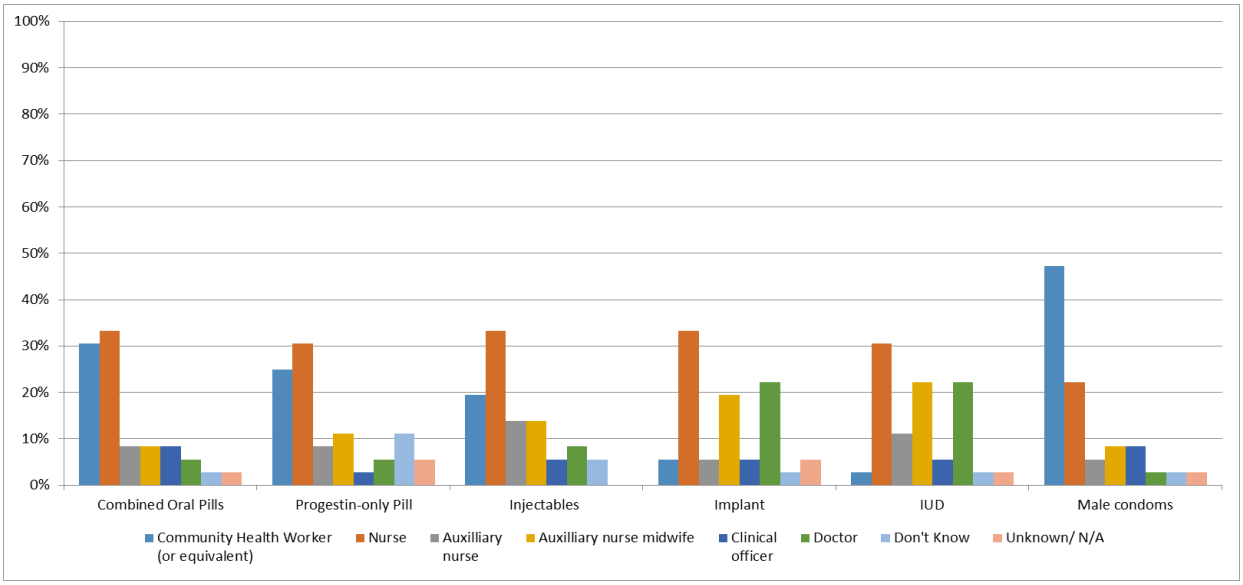



Statistics from the private sector (Figure 11) include the following:

- For COCs, as is true for the public sector, most clients can access this method through a CHW (31 percent), a nurse (33 percent), or an auxiliary nurse (8 percent) or auxiliary nurse midwife (8 percent) in the private sector.

- For POPs, in 31 percent of countries, the client can obtain POPs from a nurse and in 25 percent of countries, from a CHW. In 6 percent of countries, the client is required to see a doctor for COCs and POPs.
- For injectables, women can go to a nurse in 33 percent of the countries; 19 percent can go to a CHW, and 14 percent to an auxiliary nurse or auxiliary nurse midwife; 8 percent must see a doctor.
- For implants, 33 percent can visit a nurse, while 22 percent must see a doctor and 19 percent must see an auxiliary nurse midwife. In 6 percent of countries, CHWs can dispense or sell implants.
- For IUDs, findings are similar to those for implants.
- For male condoms, this method can be obtained from a CHW in nearly 50 percent of countries, followed by a nurse (22 percent), auxiliary nurse (6 percent), or auxiliary nurse midwife (8 percent).

**Figure 11. Percentage of countries with the lowest-level providers who can dispense or sell contraceptive methods in the private sector**




**Policies Restricting Access to Subpopulations**

Of those countries surveyed, 17 percent responded that laws, regulations, or policies make it difficult for some population segments to access FP services, compared with 6 percent (three of 47) in 2015. Restrictions on young people are found in 17 percent (6 of 36) of the countries, and on unmarried people, 8 percent (3 of 36). These figures were 12 percent (5 of 49) and 10 percent (6 out of 49), respectively, in 2015.

When asked, "Does the country have other policy barriers that do *not* directly prevent a subpopulation from accessing family planning but that have a secondary effect in making it difficult for the subpopulation to access effective family planning services? (for example, youth in the country prefer to use retail sites but retail sites in the country are not allowed to sell contraceptives, limiting youth's access to contraceptives?)," only 3 percent replied unmarried and young people are affected by this.

**Charges**

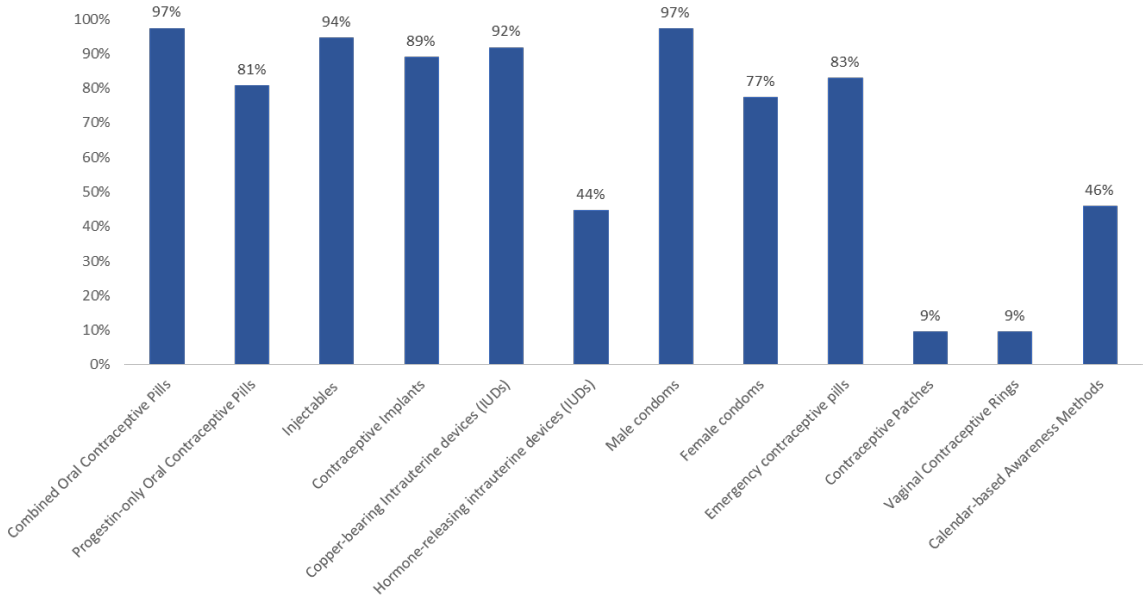
Of the countries surveyed, 33 percent report clients are charged for FP services according to official policy, and 31 percent are charged for contraceptives. In comparison to 2015, this percentage has increased from 23 percent (11 of 48) for charges for services and contraceptives. Of those countries indicating that clients are charged for FP services, 71 percent (12 of 17) indicate exemptions are made for those who cannot afford to pay compared to 67 percent (10 of 15) in 2015.

When countries were asked if informal, unofficial, or no-posted charges exist in the public sector for FP services or contraceptives, 13 percent responded yes, while 28 percent noted that when fees are charged, government health insurance covers the public-sector family planning fee. Of those countries where health insurance exists, six countries responded on the coverage of the population as follows: the whole population: Cape Verde and Angola; 80 percent: Togo; 17 percent: Mali; less than 20 percent: Zimbabwe; and less than 10 percent: Kenya.

**National Essential Medicine List**

On average, countries included eight of 12 methods on their National Essential Medicines List (NEML) (Figure 12). Most countries had COCs (97 percent) and male condoms (97 percent), injectables (94 percent), and copper-bearing IUDs (92 percent) on the NEML, while 89 percent had implants, 83 percent had emergency contraceptive pills, and 81 percent had POPs.

**Figure 12. Percentage of countries with the contraceptive included in the NEML**



# SUPPLY CHAIN

Having a reliable supply chain is essential for commodities to reach the intended destination and ultimately the client, the focus of contraceptive security. Accurately estimating the forecasted need is key to ensuring that the correct amount of contraceptives is procured to provide a regular, uninterrupted supply of commodities. Accurate forecasting also improves financial management, as well as program efficiency and effectiveness.

Countries were asked to provide the number of stockouts observed during the fiscal year at the central level. At the SDP level, data were collected on the number of contraceptives stocked out at the end of a reporting period. Countries were also asked about the supply chain challenges they face.

**Highlights**

- For the 28 countries that provided data on forecast error for COCs, error ranges from 1 percent (Senegal) to 209 percent (Philippines) for COCs.
- The forecast error for injectables ranges from 1 percent (Zimbabwe) to 256 percent (Uganda).
- The forecast error for IUDs ranges from 4 percent (Uganda) to 570 percent (Nepal).
- The forecast error for male condoms ranged from zero percent (Malawi) to 496 percent (Guinea).
- Of the 33 countries that provided information on stockouts, 11 reported zero stockouts at the central level for any FP/RH product.
- Average annual stockout rates at the **central medical store level** for the most common FP/RH methods ranged as follows among countries reporting:
    - COCs: 76 percent of countries reporting (25 countries) had no stockouts, while the remaining eight countries ranged from 8 percent (Angola and Guatemala) to 42 percent (Kenya) of stock status observations reported as stocked out.
    - Injectable contraceptives: 69 percent (22 countries) had no stockouts; the remaining 10 countries ranged from 11 percent (Madagascar) to 100 percent (Cameroon and El Salvador) stocked out.
    - IUDs: 75 percent (24 countries) had no stockouts; the remaining eight countries ranged from 1 percent (Bangladesh) to 83 percent (Kenya) stocked out.
    - Male condoms: 78 percent (25 countries) had no stockouts; the remaining seven countries ranged from 8 percent (Guatemala) to 92 percent (Angola) stocked out.
- Average annual stockout rates at the **service delivery point** level for the most common FP/RH methods ranged as follows:

- COCs: 21 percent (four countries) had no stockouts; the remaining 15 countries ranged from 3 percent (Burkina Faso) to 38 percent (Madagascar) stocked out.
- Injectable contraceptives: 11 percent (two countries) had no stockouts; the remaining 17 countries ranged from 1 percent (Bangladesh) to 36 percent (Madagascar) stocked out.
- IUDs: 11 percent (two countries) had no stockouts; the remaining 16 countries ranged from 1 percent (Bangladesh) to 70 percent (Madagascar) stocked out.
- Male condoms: 10 percent (two countries) had no stockouts; the remaining 18 countries ranged from 1 percent (Haiti) to 59 percent (Madagascar) stocked out.

**Forecast Error**

For each product offered by the public sector in the country where public sector forecast and consumption data are available, respondents were asked to enter the actual quantity consumed (in units), along with the forecasted consumption for the most recent completed fiscal year to determine the difference between a forecast and the actual consumption over the same time. This indicator is also known as the absolute percentage consumption forecast error, or APE, but will be referred to here simply as "forecast error."

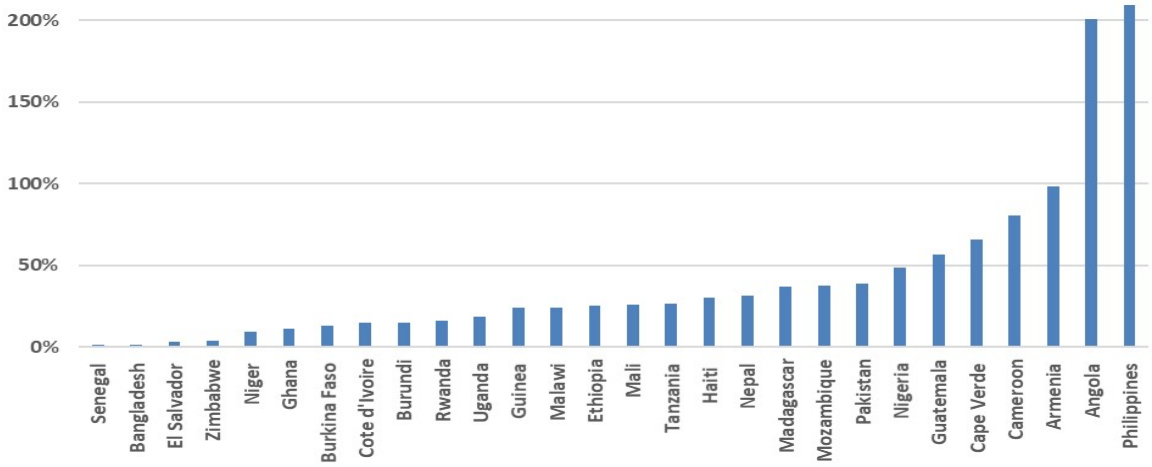
The forecast error is calculated as follows:

(Actual quantity consumed) – (Forecasted consumption)/Actual quantity consumed

The forecast error was estimated for COCs, POPs, injectables, one-rod and two-rod implants, copper IUDs, male and female condoms, emergency contraceptive pills, and calendar-based awareness methods. Graphs for COCs, POPs, injectables, implants, and male condoms are shown below, while those for female condoms, emergency contraceptives, and calendar-based awareness methods can be found in Annex A.

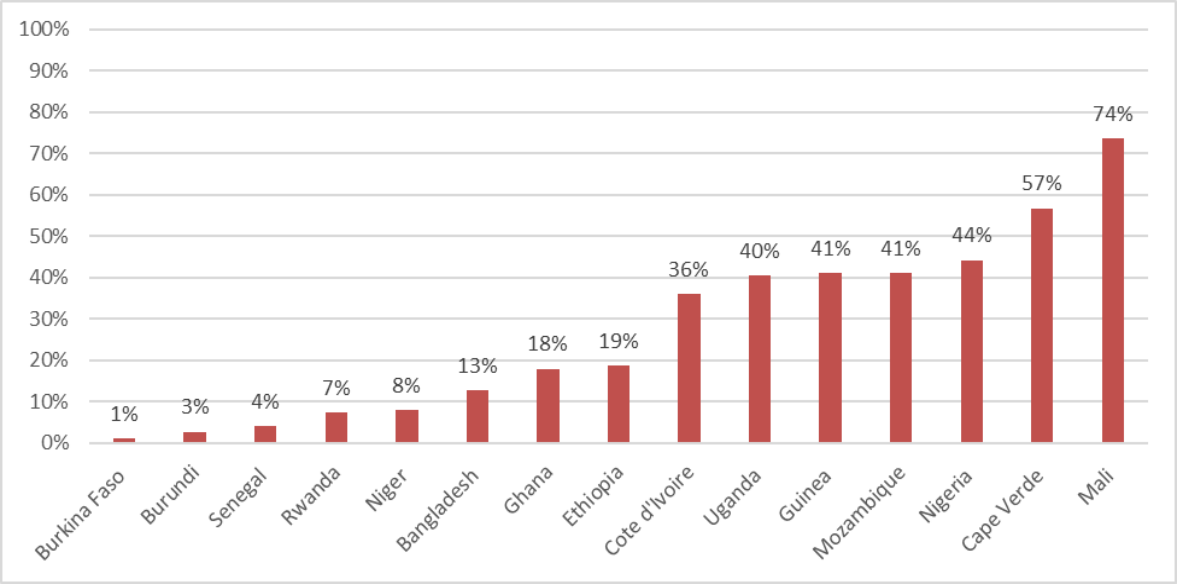
For the 28 countries that provided data the forecast error ranged from 1 percent (Senegal) to 209 percent (Philippines) for COCs (Figure 13).

**Figure 13. Forecast Error for COCs (n=28)**



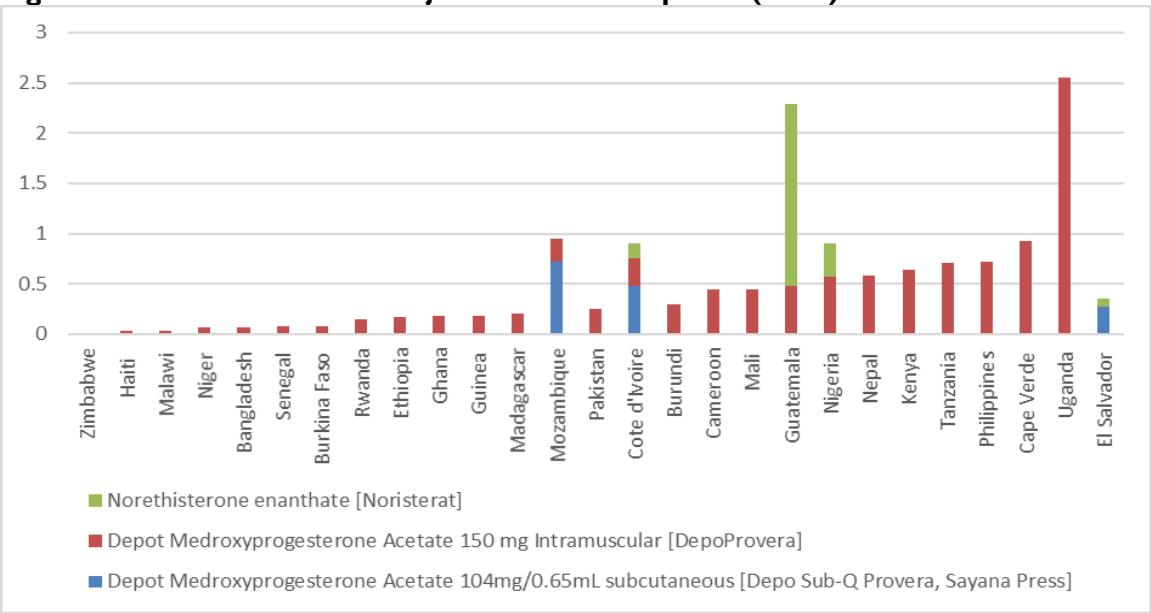
For the 17 countries that provided data on POPs, the forecast error ranged from 1 percent (Burkina Faso) to 30,885 percent (Cameroon). Pakistan's forecast error was 486 percent. If these two outliers are removed, the average forecast error for POPs is 27 percent (Figure 14).

**Figure 14. Forecast error for POPs (n=17)**[22]




The forecast error range for injectables (Figure 15) was also wide, from 1 percent (Zimbabwe) to 256 percent (Uganda).

**Figure 15. Forecast error for injectable contraceptives (n=28)**[23]

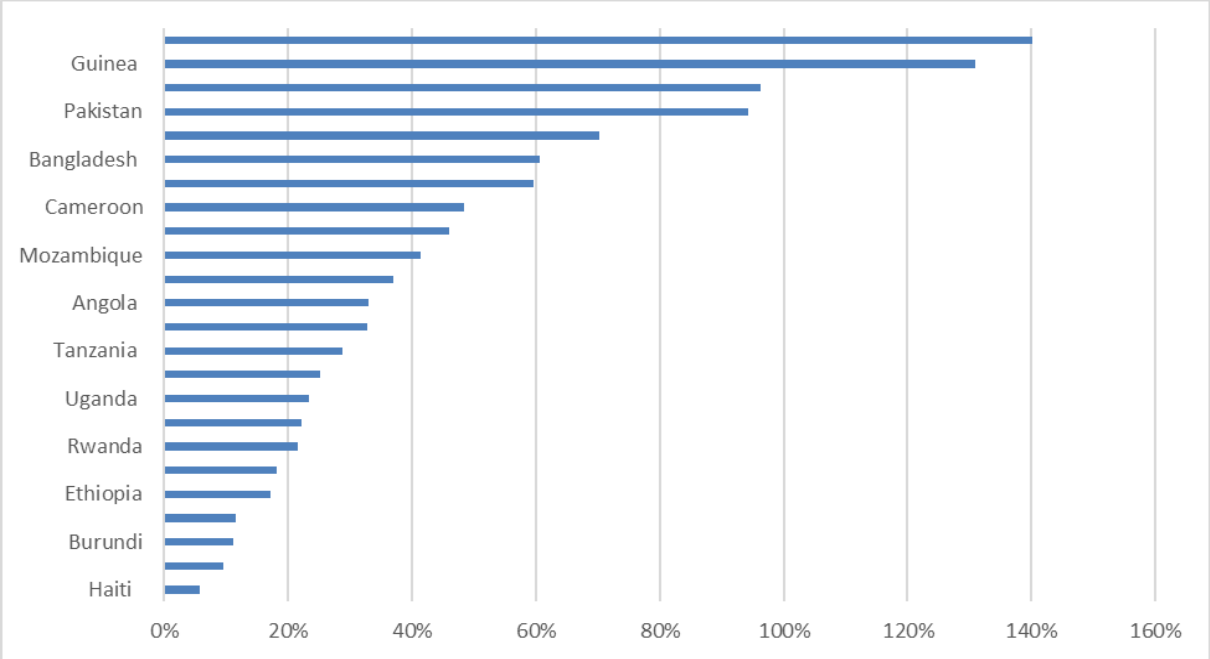



[22] Outliers not shown: Pakistan (486 percent) and Cameroon (30,885 percent)

[23] Outlier not shown: Angola (233 percent for Depo Provera and 1,241 percent for Noristerat)

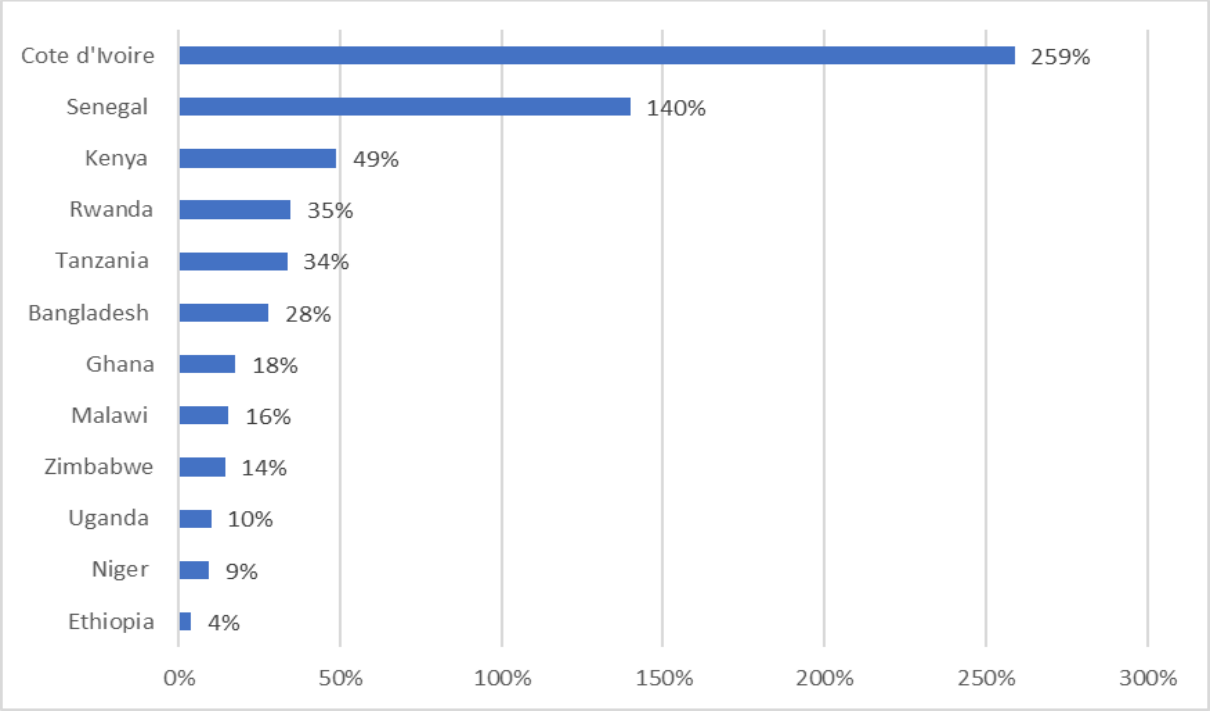
The forecast error for two-rod implants (Figure 16) ranged from 6 percent (Haiti) to 140 percent (Guinea).

**Figure 16. Forecast error for two-rod implants (levonorgestrel 75mg/rod)**



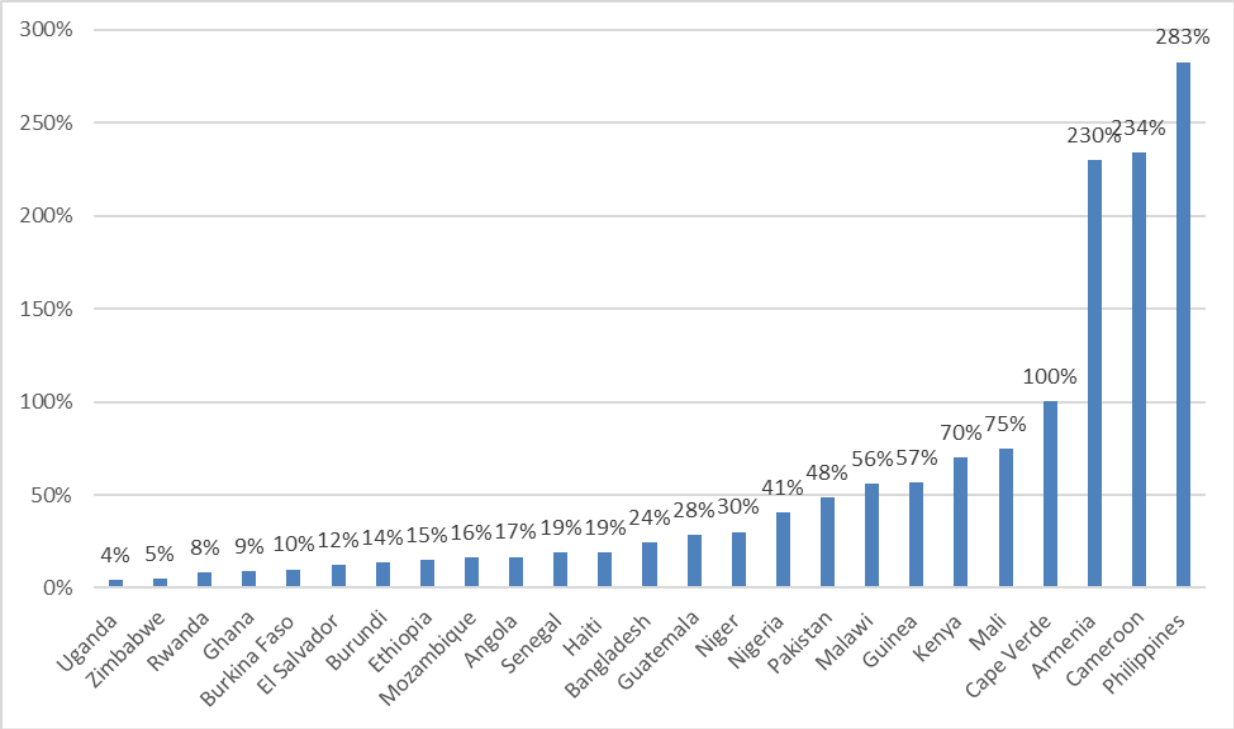

The forecast error for one-rod implants (Figure 17) ranged from 4 percent (Ethiopia) to 259 percent (Côte d'Ivoire).

**Figure 17. Forecast error for one-rod implants (etonogestrel 68mg/rod)**



The forecast error for IUDs (Figure 18) ranged from 4 percent (Uganda) to 570 percent (Nepal).

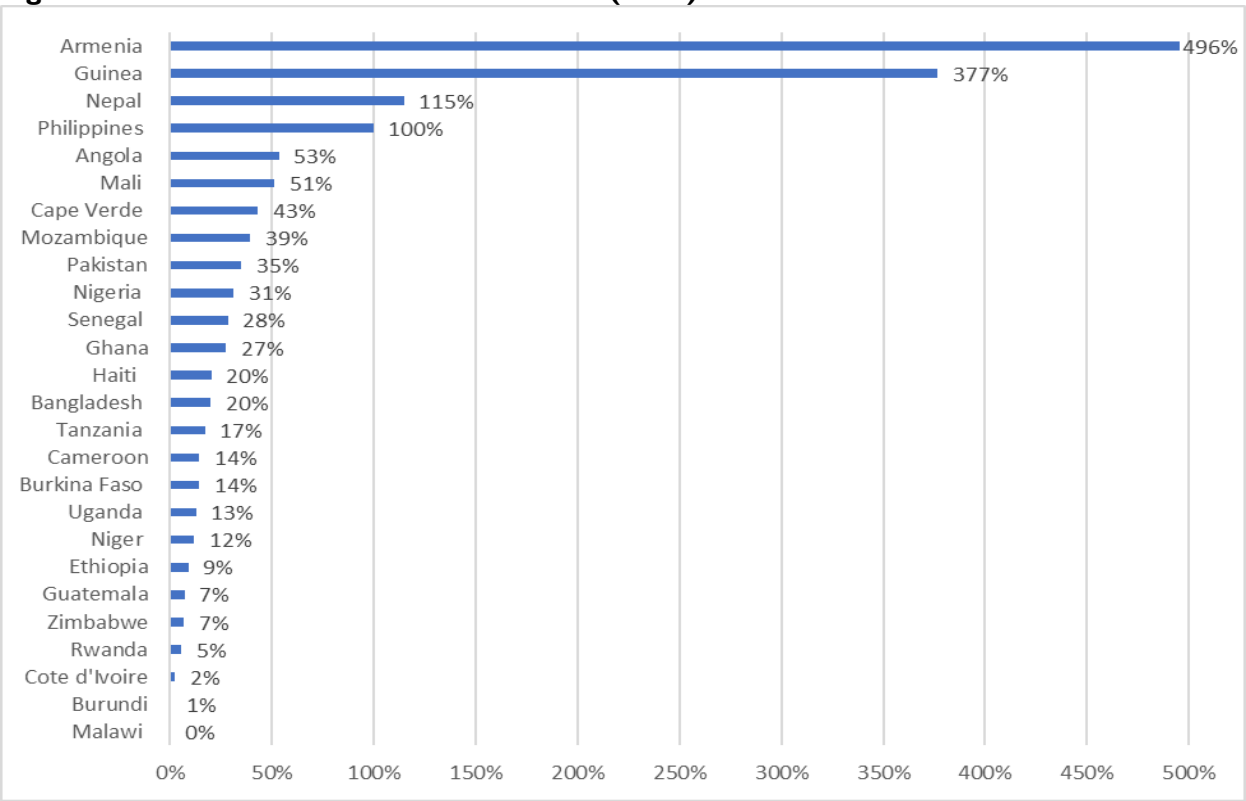
**Figure 18. Forecast error for copper-bearing IUDs (n=26)[24]**




[24] Outlier not shown: Nepal (570 percent)

The forecast error for male condoms ranged from zero percent (Malawi) to 496 percent (Guinea).

**Figure 19. Forecast error for male condoms (n=26)**




## Product Availability

Having products available is essential to meeting client needs. Respondents were asked to report on the number of stock status observations where there was a stockout during the fiscal year at the central and SDP level for the following eight contraceptive methods:

- COCs
- POPs
- Injectables
- Implants
- IUDs
- Condoms (male and female)
- Emergency contraceptive pills
- Calendar-based methods

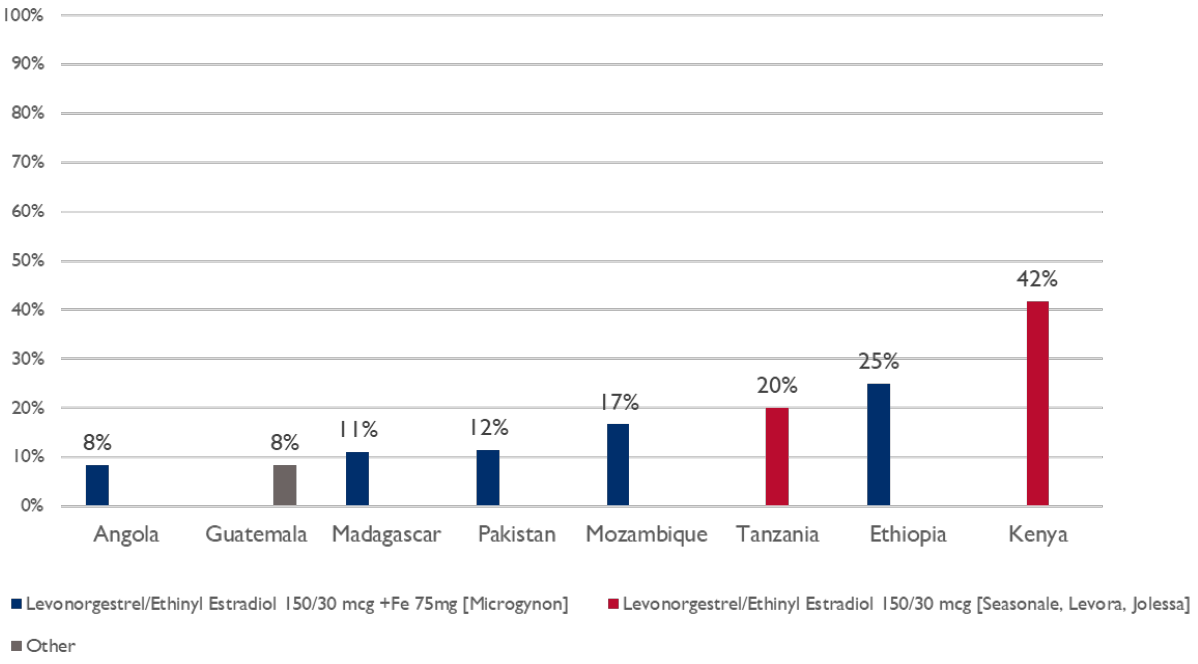
Of the 33 countries providing information, 11 reported zero stockouts among all products offered within the eight methods at the central level: Armenia, Benin, Cape Verde, Dominican Republic, Guinea, Haiti, Malawi, Mali, Nepal, Senegal, and Zambia.

This section provides information on the average stockout rate at the central and SDP level by contraceptive method by country.

### Central-level Product Availability

For 25 countries, there were no stockouts of COCs (in either formulation): Armenia, Bangladesh, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Côte d'Ivoire, Dominican Republic, DRC, El Salvador, Ghana, Guinea, Haiti, Malawi, Mali, Nepal, Niger, Nigeria, Philippines, Senegal, Togo, Uganda, Zambia, and Zimbabwe. For the remaining eight countries, the average stockout rate ranged from 8 percent (Angola and Guatemala) to 42 percent (Kenya) (Figure 20).

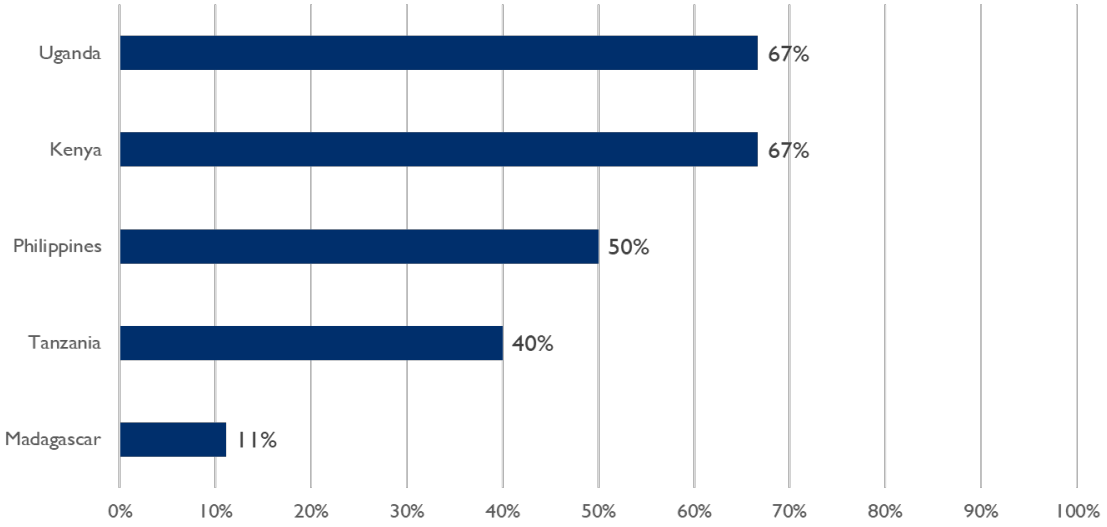
**Figure 20. Average stockout rate for combined oral contraceptives at the central level**[25]
(For countries with reported stockout rates greater than zero percent)




Among five countries with reported stockouts, the average stockout rate for POPs (Figure 21) ranged from 11 percent (Madagascar) to 67 percent (Kenya and Uganda). The remaining 21 countries (81 percent) did not report any stockouts for POPs at the central level: Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Côte d'Ivoire, Dominican Republic, DRC, Ethiopia, Ghana, Guinea, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Togo, and Zambia.

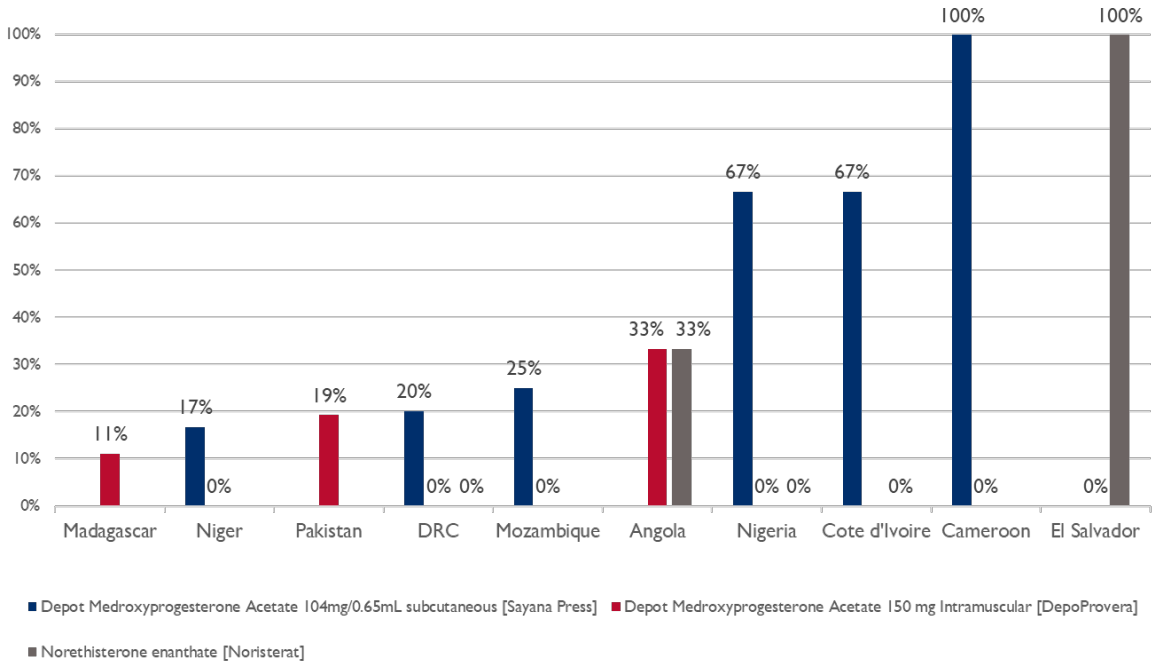
[25] Pakistan's highest level of stock management is the provincial/regional level; however, for this survey, its four regions and four provinces were combined to represent the equivalent of a "central" level. Pakistan defines a stockout at the provincial/regional level as fewer than five months of usable stock on hand, based on average consumption rates. All other countries that reported defined a stockout as zero usable units of stock on hand.

**Figure 21. Average stockout rate for progestin-only pills (levonorgestrel 30 mcg) at the central level** (For countries with reported stockout rates greater than zero percent)



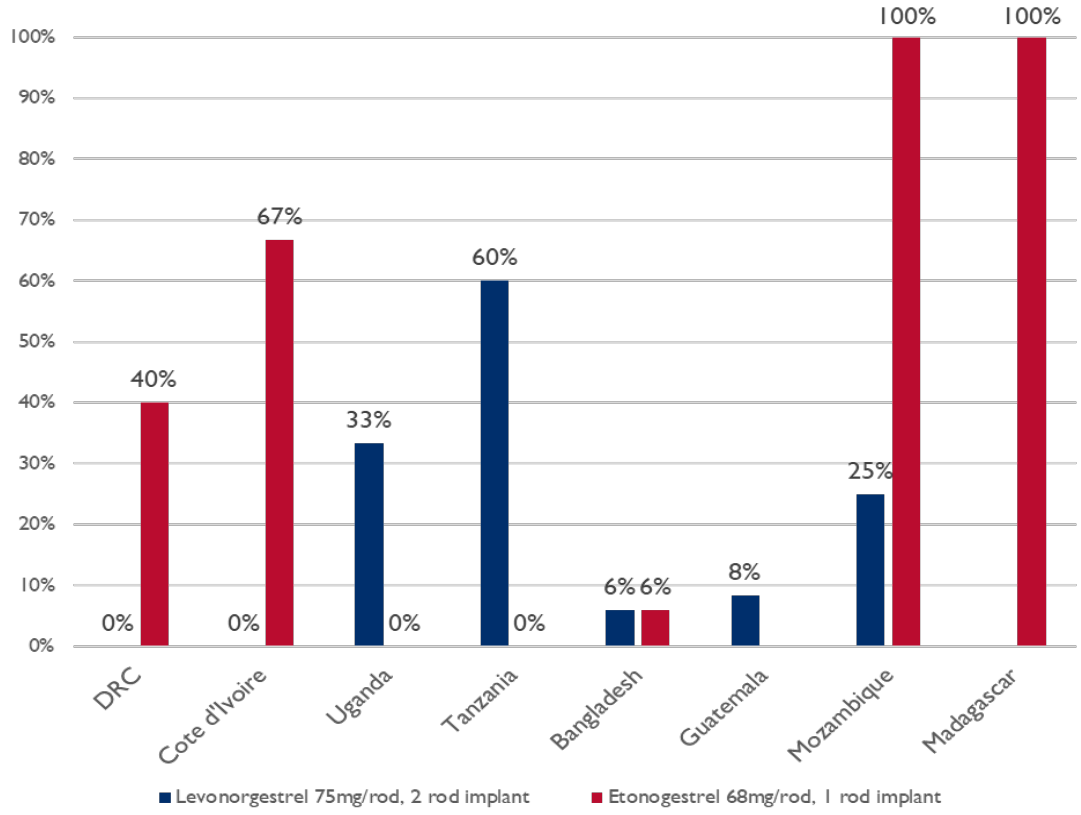

For injectables among the three formulations, 10 countries reported stockouts (Figure 22) with the average annual stockout rate ranging from 11 percent (Madagascar) to 100 percent (Cameroon and El Salvador). A total of 22 countries did not have any stockouts of injectables: Bangladesh, Benin, Burkina Faso, Burundi, Cape Verde, Dominican Republic, Ethiopia, Ghana, Guatemala, Guinea, Haiti, Kenya, Malawi, Mali, Nepal, Philippines, Senegal, Tanzania, Togo, Uganda, Zambia, and Zimbabwe.

**Figure 22. Average stockout rate for injectable contraceptives at the central level**
(For countries with reported stockout rates greater than zero percent for one of the two products)



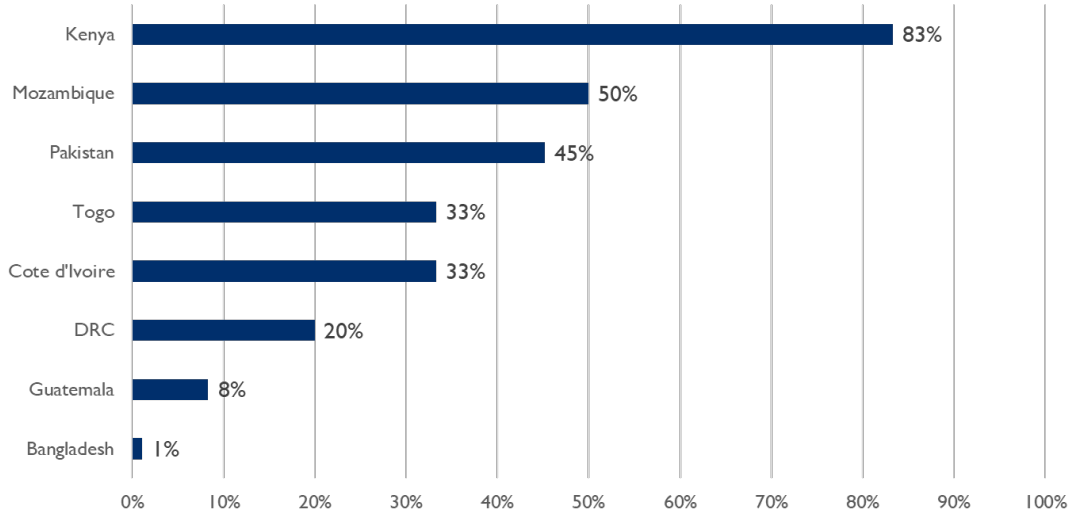
The average annual stockout rate for implants ranged from 6 percent (Bangladesh) to 100 percent (Madagascar); however, Mozambique reported a 100 percent stockout rate for one product and 25 percent for the other (Figure 23). Four countries that offer two formulations of implants had no stockouts of one of them: Côte d'Ivoire, DRC, Tanzania, and Uganda. The remaining 21 countries did not have stockouts of either formulation of implants offered: Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Dominican Republic, Ethiopia, Ghana, Guinea, Haiti, Kenya, Malawi, Mali, Nepal, Niger, Nigeria, Senegal, Togo, Zambia, Zimbabwe.

**Figure 23. Average stockout rate for contraceptive implants at the central level**
(For countries with reported stockout rates greater than zero percent for one of the two products)



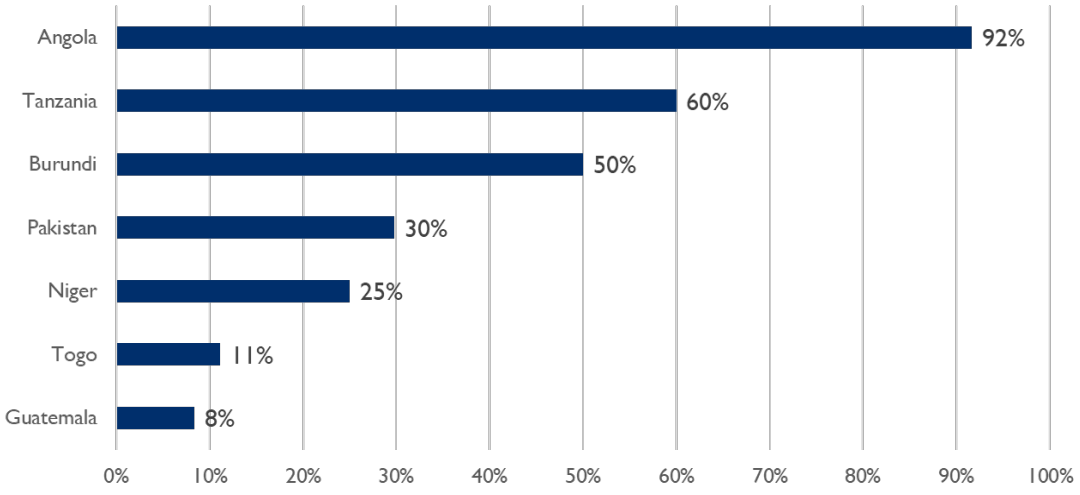

The average stockout rate for IUDs (Figure 24) ranged from 1 percent (Bangladesh) to 83 percent (Kenya). A total of 24 countries reported no stockouts of IUDs (32 countries had IUD stockout data): Angola, Armenia, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Dominican Republic, Ethiopia, Ghana, Guinea, Haiti, Madagascar, Malawi, Mali, Nepal, Niger, Nigeria, Philippines, Senegal, Tanzania, Uganda, Zambia, Zimbabwe.

**Figure 24. Average stockout rate for copper-bearing IUDs at the central level**
(For countries with reported stockout rates greater than zero percent)



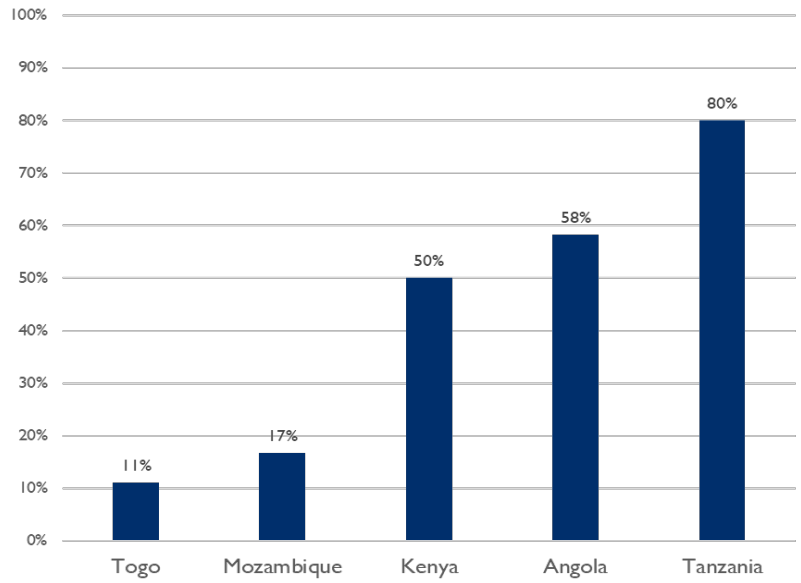

The male condom average stockout rate (Figure 25) ranged from 8 percent (Guatemala) to 92 percent (Angola). The remaining 25 countries reported no stockouts of male condoms: Armenia, Bangladesh, Benin, Burkina Faso, Cameroon, Cape Verde, Côte d'Ivoire, Dominican Republic, DRC, Ethiopia, Ghana, Guinea, Haiti, Kenya, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Philippines, Senegal, Uganda, Zambia, and Zimbabwe.

**Figure 25. Average stockout rate for male condoms at the central level**
(For countries with reported stockout rates greater than zero percent)



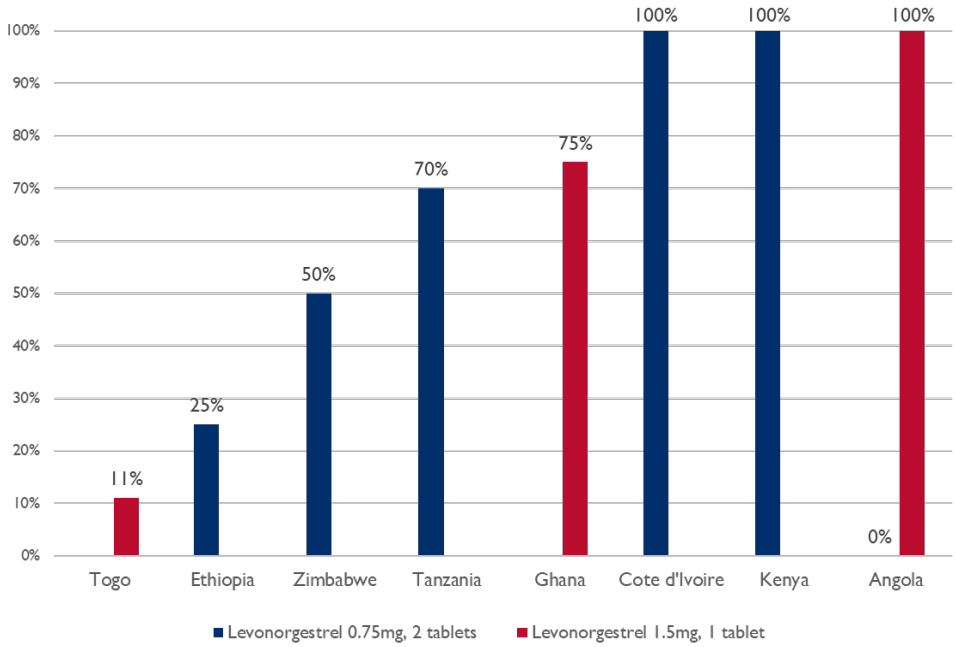

For female condoms, the average stockout rate (Figure 26) ranged from 11 percent (Togo) to 80 percent (Tanzania). A total of 16 countries did not have any female condom stockouts: Burundi, Cameroon, Cape Verde, Côte d'Ivoire, DRC, Ethiopia, Ghana, Madagascar, Malawi, Mali, Niger, Nigeria, Senegal, Uganda, Zambia, and Zimbabwe.

**Figure 26. Average stockout rate for female condoms at the central level**
(For countries with reported stockout rates greater than zero percent)




Emergency contraceptives (Figure 27) had an average stockout rate at the central level ranging from 11 percent (Togo) to 100 percent (Angola, Côte d'Ivoire, and Kenya); however, Angola reported a 100 percent stockout rate for one product but zero percent for the other. Nine countries did not have any emergency contraceptive stockouts: Armenia, Benin, Burundi, DRC, Madagascar, Malawi, Mozambique, Senegal, and Uganda.

**Figure 27. Average stockout rate for emergency contraceptives at the central level**
(For countries with reported stockout rates greater than zero percent for one of the two products)

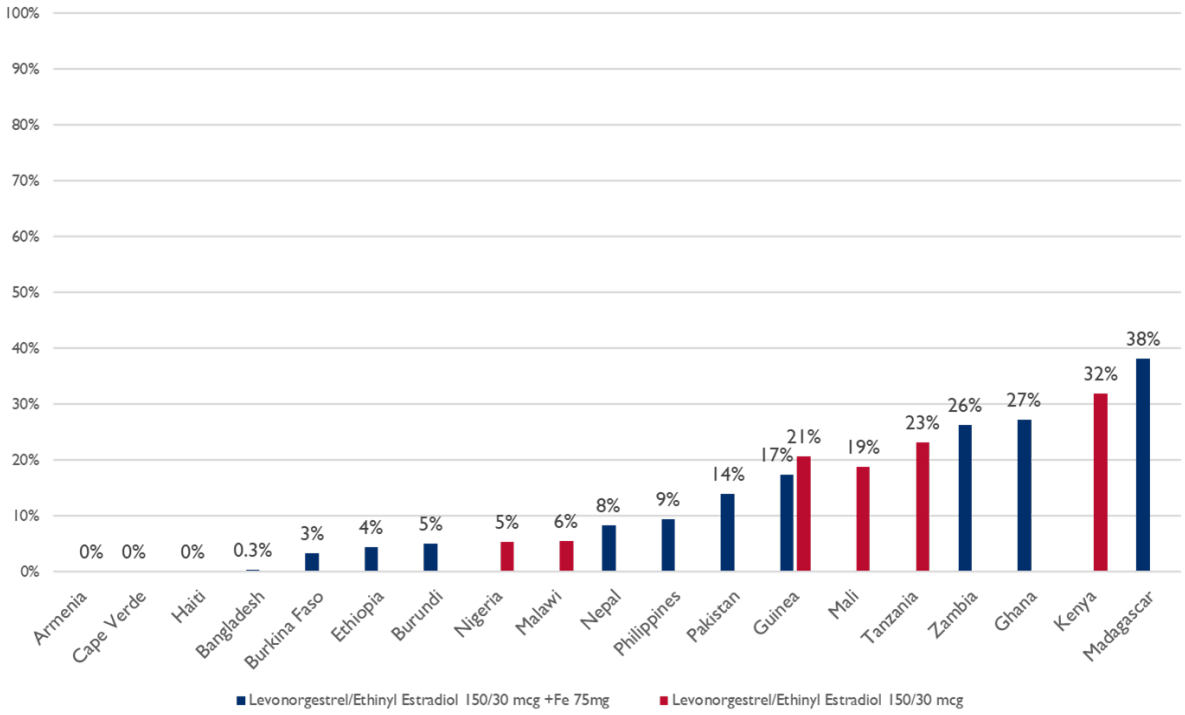


### Service Delivery Point Product Availability

Countries provided stockout data for the SDP level for the last fiscal year, where available. This section provides average stockout data for COCs, injectables, implants, IUDs, and male condoms. Data for female condoms, emergency contraceptives, and calendar-based awareness methods can be found in Annex A.

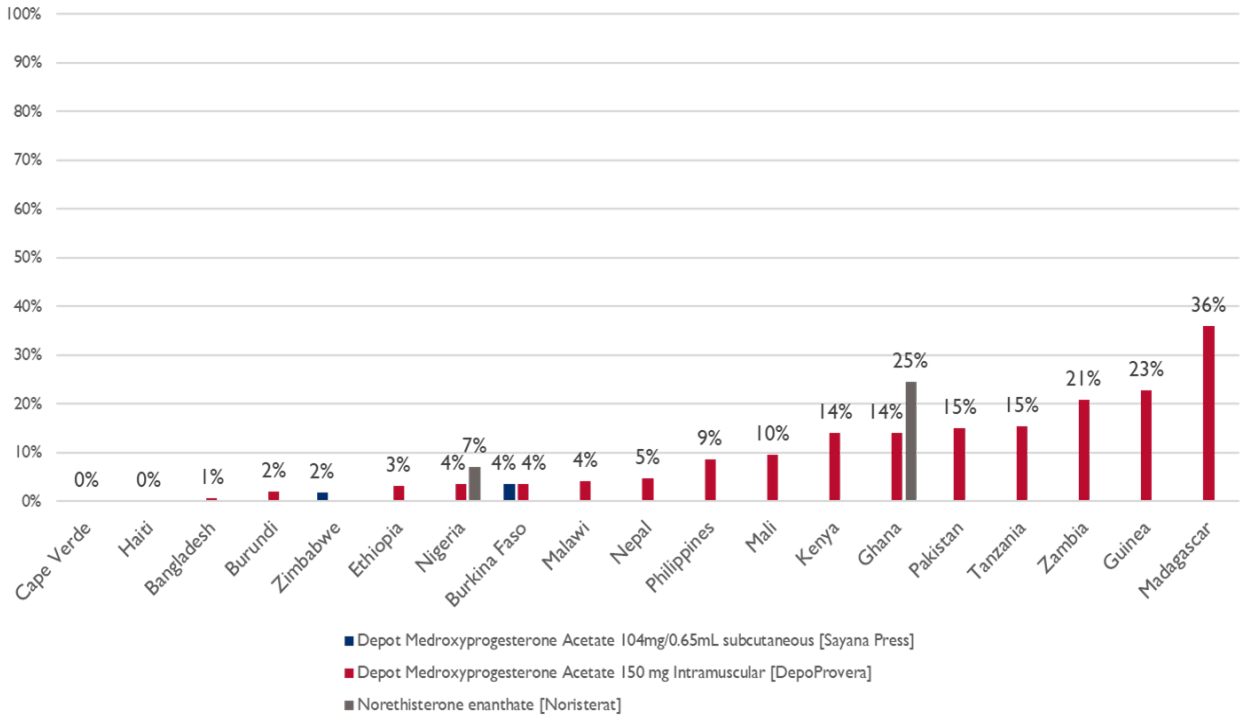
The average stockout rate for COCs (Figure 28) ranged from 0.3 percent (Bangladesh) to 38 percent (Madagascar). Three countries did not have any stockouts: Armenia, Cape Verde, and Haiti.

**Figure 28. Average stockout rate for combined oral contraceptives at service delivery points**



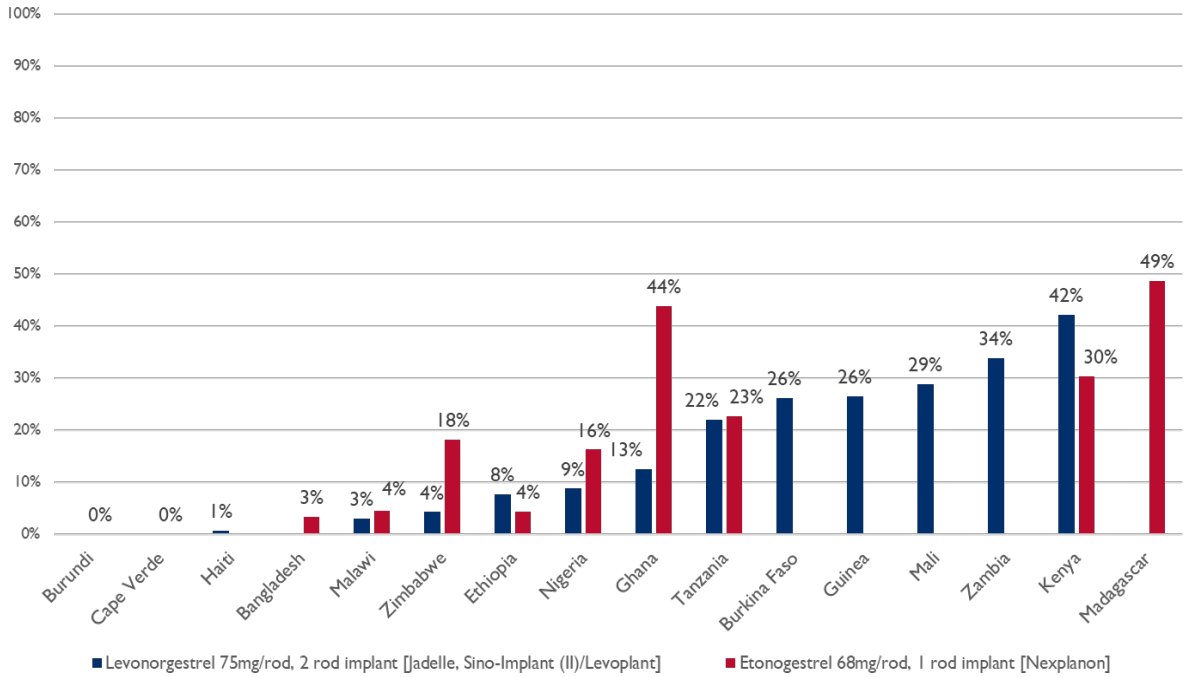

Injectable stockout rates at the SDP level (Figure 29) ranged from 1 percent (Bangladesh) to 36 percent (Madagascar). Cape Verde and Haiti did not have any stockouts of this product.

**Figure 29. Average stockout rate for injectable contraceptives at service delivery points**



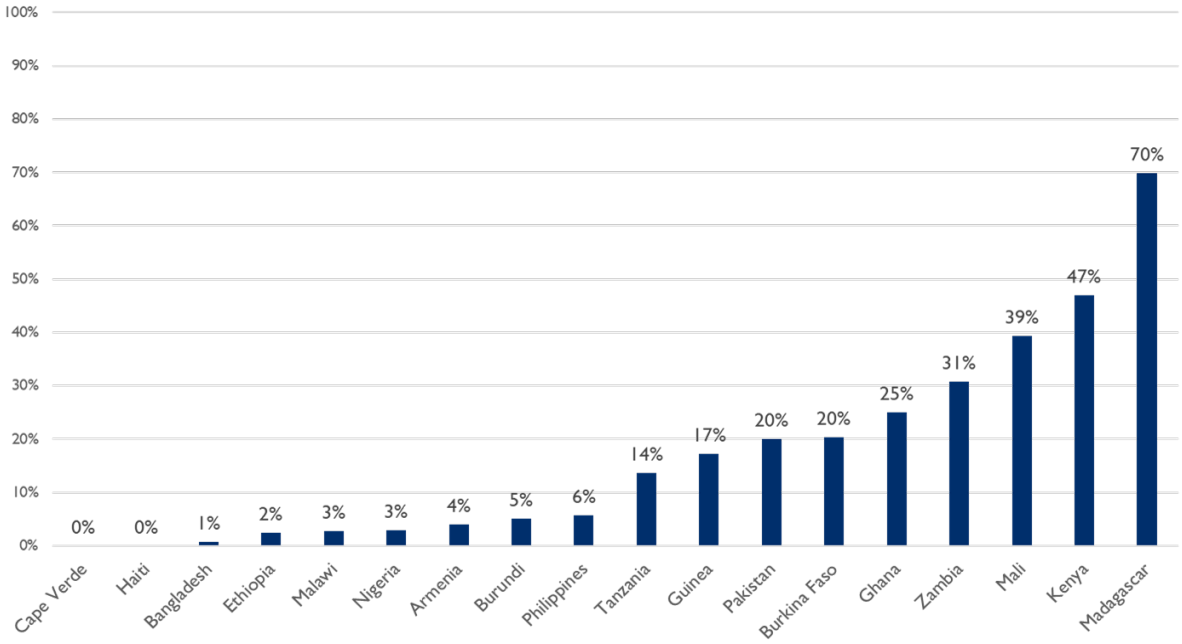

For implants (Figure 30), average stockout rates ranged from 1 percent (Haiti) to 49 percent (Madagascar). Burundi and Cape Verde did not have any stockouts of implants.

**Figure 30. Average stockout rate for contraceptive implants at service delivery points**



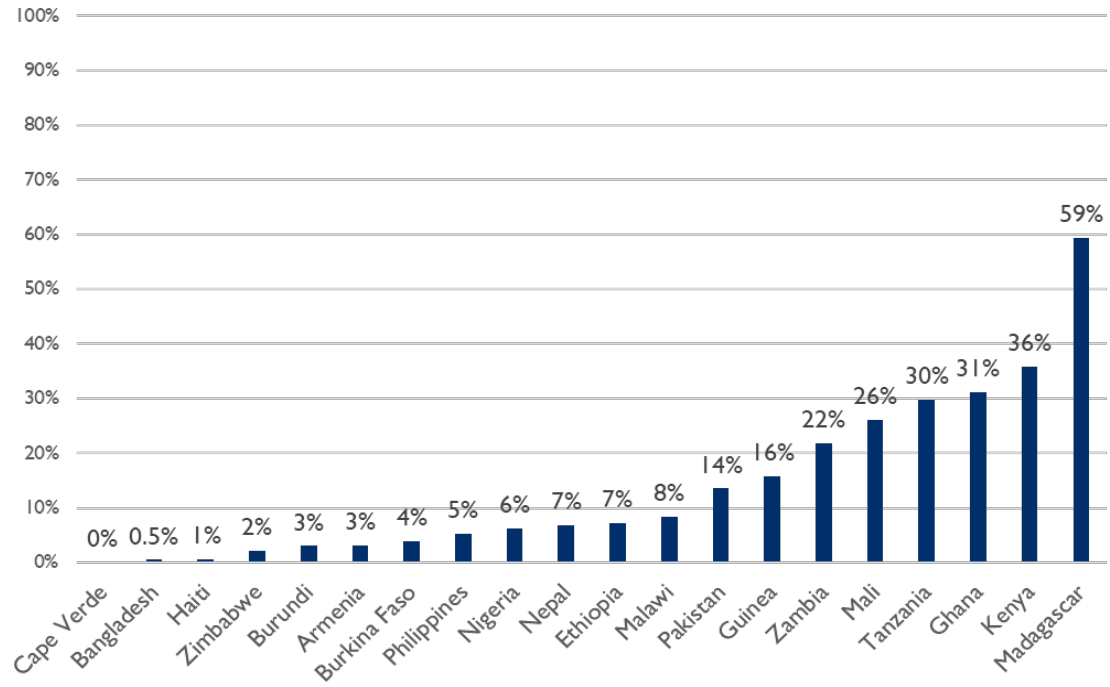
The average stockout rate for IUDs (Figure 31) spanned from 1 percent (Bangladesh) to 70 percent (Madagascar). Cape Verde and Haiti did not have any IUD stockouts at the SDP level.

**Figure 31. Average stockout rate for copper-bearing IUDs at service delivery points**



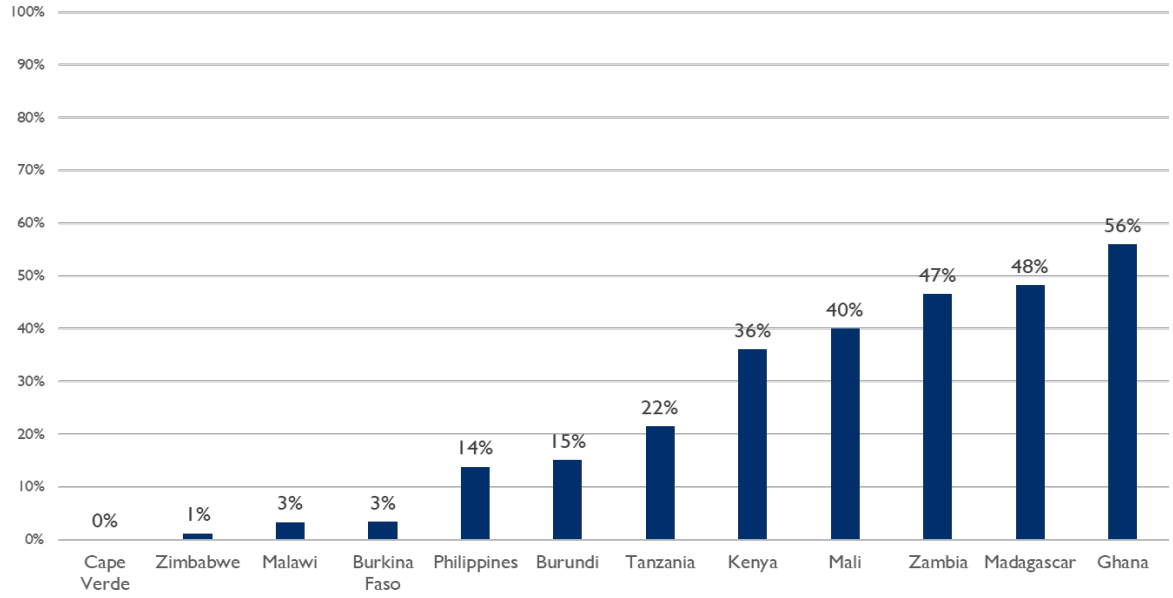

For male condoms (Figure 32), average stockout rates ranged from 0.5 percent (Bangladesh) to 59 percent (Madagascar). Cape Verde reported zero stockouts for male condoms.

**Figure 32. Average stockout rate for male condoms at service delivery points**



For male progestin-only pills (Figure 33), average stockout rates ranged from 1 percent (Zimbabwe) to 56 percent (Ghana). Cape Verde reported zero stockouts for male condoms.

**Figure 33. Average stockout rate for progestin-only pills (levonorgestrel 30mcg) at service delivery points**




These data should be interpreted with care for several reasons:

- The duration of the stockout is uncertain.
- A stockout could be recurrent for a particular method.
- A stockout at the central level does not necessarily mean a stockout at the SDP level, and vice versa.

## Supply Chain Successes and Challenges

A total of 13 countries cited a variety of supply chain challenges spanning from the logistics management information system (LMIS) to human resources. To achieve better contraceptive security, these issues need to be addressed. Table 5 presents the challenges and successes the countries noted.

**Table 5. Respondent supply chain challenges and successes**

| Challenges | Successes |
|---|---|
| **LMIS** | |

| | |
|---|---|
| • Weak linkages between health centers and health posts for resupply; therefore, health posts have stock shortages<br>• Poor-performing quantification system<br>• Lack of a functional LMIS<br>• Data quality problems (for example, SDPs report on implants and IUDs even when they don't provide the service, which inflates the stockout rate) | • Real-time tracking of product use, availability, and stockouts through LMIS<br>• Regularly updating a table to track stock distribution<br>• Weekly surveillance of contraceptive stocks<br>• Ability to quantify [stocks] twice a day<br>• Quarterly logistics tracking through LMIS |
| **Procurement** | |
| • Lack of adherence to supply plans<br>• Procurement delays, or procurements not done in accordance with the supply plan<br>• Delayed shipments (to the country) | • Supply plan monitoring reports |
| **Distribution** | |
| • Distribution channel goes down only to the district level<br>• Delayed distribution (within the country) | • Integrated distribution system for FP commodities and supplies |
| **Storage** | |
| • Limited storage capacity in government central medical stores and at the facility level | |
| **Human Resources** | |
| • High staff turnover | • Qualified logistics personnel (pharmacists and logisticians) |
| **Client Demand and Use** | |
| • Low level of knowledge of contraceptives and stereotypes about its dangers among the population and even the medical community (despite training provided to the general population and to doctors), leading to low use of contraceptives and overstocking<br>• Limited brand mix for the public sector | • Free provision of medicines to vulnerable populations and the broader population |
| **Financing** | |
| • Resources mobilized are insufficient to meet funding needs | • Government contributions toward contraceptive procurement<br>• Sufficient financial commitment from donors |
| **Coordination** | |
| | • Functional steering committee for securing RH products<br>• Functionality of the technical coordination committee for managing HIV, tuberculosis, and RH/FP commodities<br>• Good coordination of actors |

# QUALITY

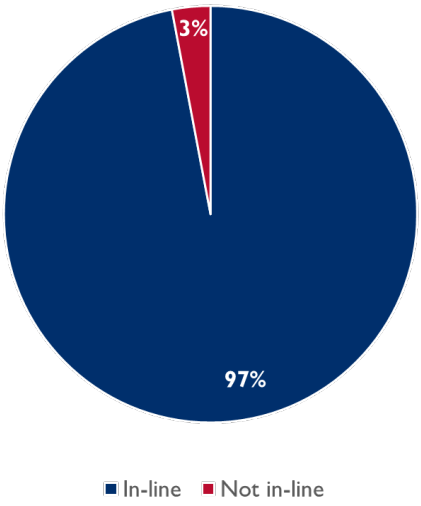
Closely monitoring contraceptive quality ensures that the products provided by all sectors meet specific standards. By ensuring that FP commodities are consistently produced and monitored, quality assurance (QA) of FP commodities protects patient safety and helps achieve reliable results and maximum benefits. QA includes registering drug manufacturers and using recognized and trusted suppliers who provide good-quality products and backup services.

**Highlights**

Of the countries providing information on quality:

- 97 percent (34 of 35 countries reporting) have QC standards for contraceptives that are in line with international standards.
- 97 percent (31 of 32 countries reporting) have QC standards that are routinely applied in the public and private sectors.
- 92 percent in the public sector and 89 percent in the private sector routinely test samples.
- 84 percent (27 out of 32 countries reporting) implement post-marketing surveillance and pharmacovigilance.
- 97 percent (34 of 35 countries reporting) have QC standards for contraceptives that are in line with international standards (Figure 34). Mozambique was the only country that noted it does not have QC standards (Rwanda did not know).

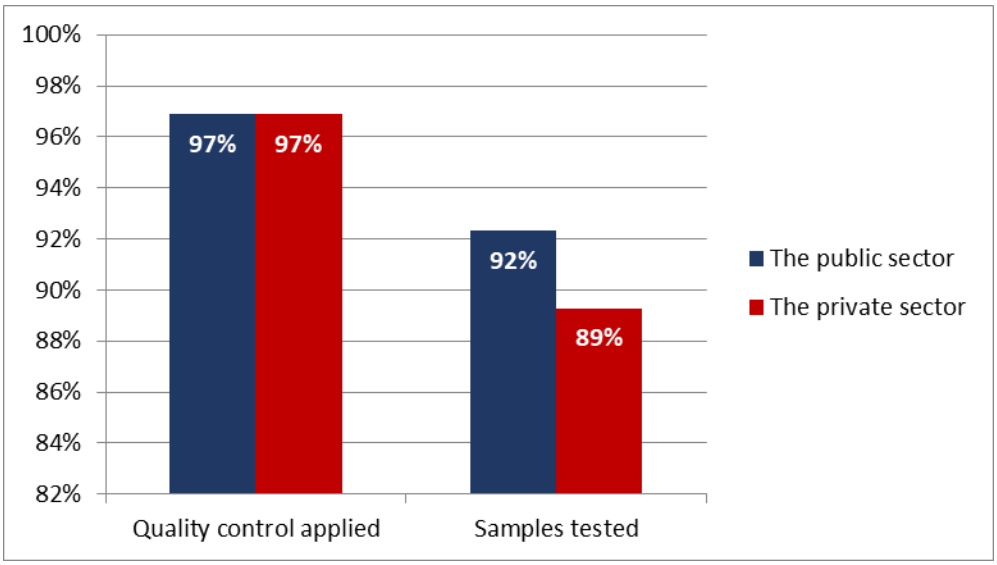
**Figure 34. Percentage of countries with QC standards for pharmaceuticals, including contraceptives, that are in line with international standards (n=35)**



Of the countries providing information, 97 percent (31 of 32) reported that QC standards are routinely applied in the public and private sectors (Figure 35). Afghanistan and Burundi did not know if the standards are applied in the public sector. Niger was the only country that does not have QC standards in either sector. Mozambique and Rwanda noted they are not applicable in either sector.

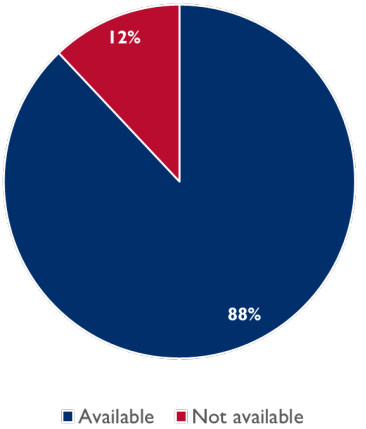
Samples are routinely tested in 92 percent of the public sector and 89 percent of the private sector.

**Figure 35. Percent of countries in which QC standards for pharmaceuticals are routinely applied (n=32) or tested (n=29) in the public and private sectors**



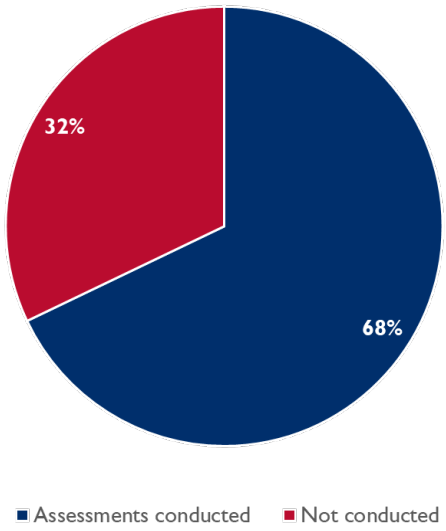

Of the countries surveyed, 88 percent have procured contraceptives from World Health Organization (WHO)-prequalified manufacturers when a choice is offered during the procurement process (Figure 36). The products from these manufacturers must meet acceptable standards of quality, safety, and efficacy to ensure the funds spent are maximized on quality products that will meet client needs.

**Figure 36. Percentage of countries in which contraceptive commodities from WHO-prequalified manufacturers are available (n=24)**



Of the 31 respondents, 68 percent conduct regular assessments of quality and price of contraceptives provided by pharmacies (Figure 37).

**Figure 37. Percentage of countries in which regular assessments of quality and price are conducted for contraceptive products available in pharmacies (n=31)**




Of 33 countries providing information, all have standards for post-marketing surveillance and pharmacovigilance that are based on international standards. These practices monitor the safety of pharmaceutical drugs after they have been released into the market to ensure no adverse reactions and to minimize any possible risks to clients. Post-marketing surveillance and pharmacovigilance are implemented in 84 percent (27 of 32) of the countries responding. These practices are important for ensuring a country's drug safety.

# PRIVATE SECTOR

Collaboration and coordination with the private sector give clients additional access to contraceptives, choice of brands, and price points to help meet the population's varied demands. The private sector is increasingly recognized as a vital partner in global efforts to provide RH and FP services and commodities.

**Highlights**

Key to a total market approach is working with the private sector to expand the provision of health services. Of the countries providing information on the private sector:

- 81 percent (29 of 36 reporting) require private-sector entities that provide family planning to report or register with government agencies.
- 52 percent (13 of 25 reporting) conduct routine market data surveys or syndicated data, such as Quintiles IMS or Nielson.
- 47 percent (16 of 34 reporting) have established or brokered one or more public/private partnerships in the last year to expand FP products and services.
- 81 percent (29 of 36 reporting) require private-sector entities that provide family planning to report or register with government agencies. Agencies mentioned include the Ministry of Health, directorates of reproductive health, and food and drug or medical authorities.

In Kenya, as part of the Ministry of Health's broad strategy to increase FP uptake and further increase modern contraceptive prevalence rate, the ministry works closely with public- and private-sector hospitals and clinics, providing contraceptives to both for free. In Togo a private-sector platform has been set up and is working with the Ministry of Health through the Mother and Child and the Family Planning Health Department for the availability of contraceptives in private health facilities. Also, several NGOs have been strengthened to provide FP services.

# CONCLUSIONS

With concrete information on contraceptive security, countries and stakeholders can not only monitor the progress of CS overall but also by country to identify areas that need more support. The CS Indicators provide insight into financing, commitment, and leadership, as well as a snapshot of the supply chain, pharmaceutical quality, and private-sector contribution and participation. The new requirement of reporting data sources, coupled with the practice of repeatedly collecting the CS Indicators, will continue not only to increase awareness of CS but also to provide information to track each country's CS evolution.

The 2018 CS Indicators show that CS is holding steady with signs of progress. Of the countries providing information:

- 97 percent have a national committee with a specific focus on CS, and 100 percent have a strategy explicitly addressing increasing contraceptive access.
- 76 percent spend government funds on contraceptives.
- 89 percent offer at least eight of the 13 assessed contraceptive methods in the public sector.
- 97 percent routinely apply QC standards in the public and private sectors.
- 47 percent have established or brokered one or more public/private partnerships in the last year to expand FP products and services.

However, many areas still need attention:

- Of the countries surveyed, 45 percent have a funding gap between funding spent and estimated contraceptive need.
    - Continual advocacy is needed to mobilize resources within the country's budget and from partners, as well as prevent funding gaps for contraceptive procurement.
- On average, the share of government spending as a percent of total spending is 33 percent.
    - Increasing the government share of spending will contribute to sustainability and institutionalizing financing for contraceptives.
- On average, countries offer 10 of the 13 assessed contraceptive methods in public-sector facilities. Additional work can be done to increase the number of choices currently available in other sectors: eight in nongovernmental facilities, eight through the commercial sector, and six through social marketing.
- Restrictions on young people are found in 17 percent of the countries and on unmarried people, 8 percent.
    - Reducing restrictions will give more users the ability to choose and access their contraceptive of choice.

With the encouragement of CS champions and partners, countries are expected to see the value in including these indicators in their regular monitoring and reporting as part of the effort to improve contraceptive security.

# REFERENCES

Hare, L., Hart, C., Scribner, S., Shepherd, C., Pandit, T. (ed.), and Bornbusch, A. (ed.). 2004. *SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation.* Baltimore, Maryland: Information and Knowledge for Optimal Health (INFO) Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

USAID Global Health Supply Chain Program-Procurement and Supply Management Single Award IDIQ. 2017. Contraceptive Security Indicators Data Collection and Usage Manual. Washington, D.C.: Chemonics International Inc.

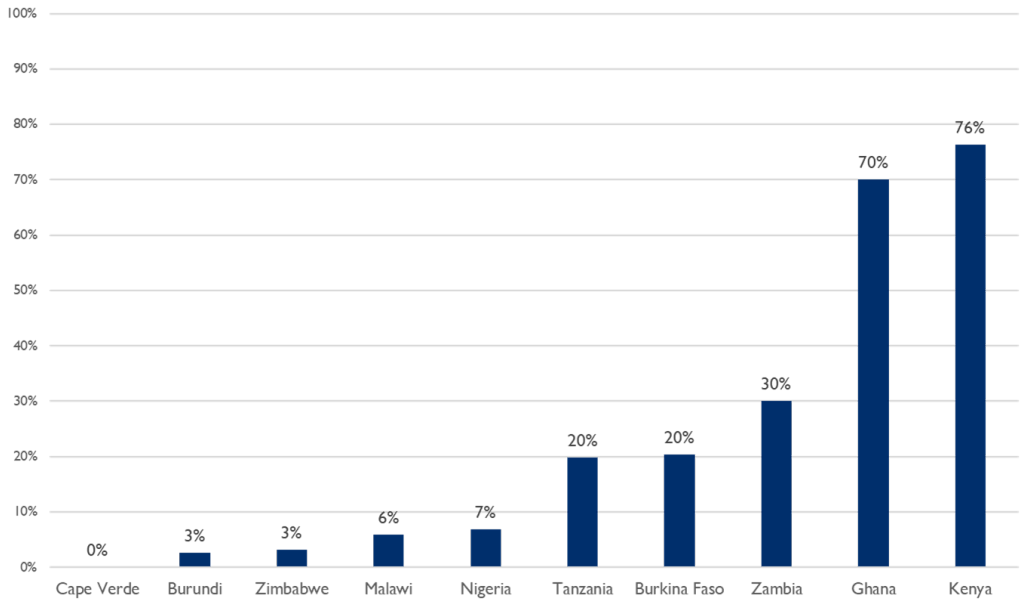
USAID | DELIVER PROJECT, Task Order 4. (2012). Measuring Contraceptive Security Indicators in 2011. Arlington, Virginia.: USAID | DELIVER PROJECT, Task Order 4.

USAID | DELIVER PROJECT, Task Order 1. 2010. Measuring Contraceptive Security Indicators in 36 Countries. Arlington, Virginia.: USAID | DELIVER PROJECT, Task Order 1.

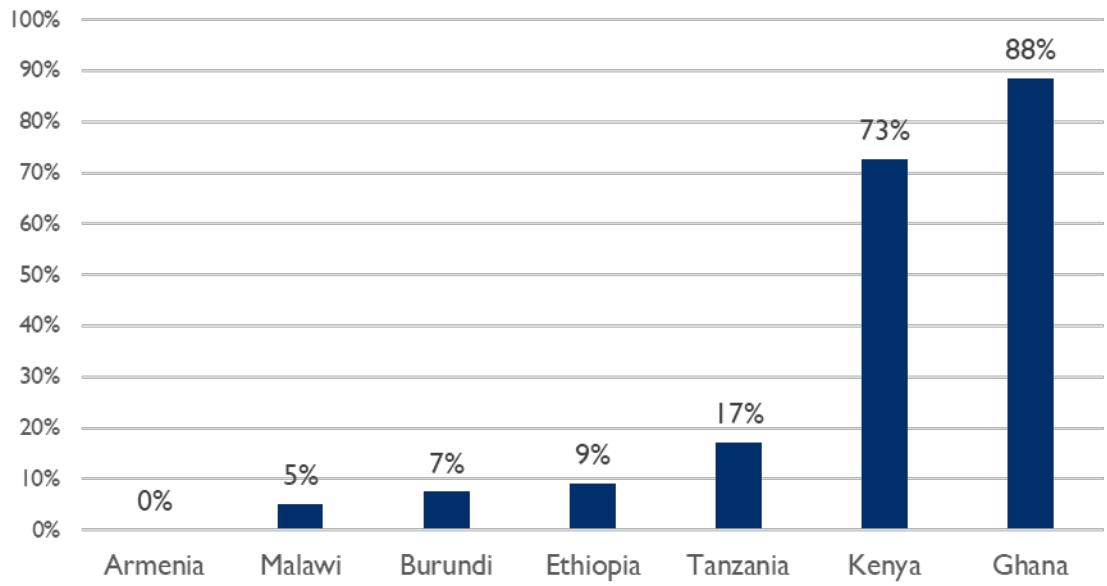
# ANNEX A

## Additional Supply Chain Data

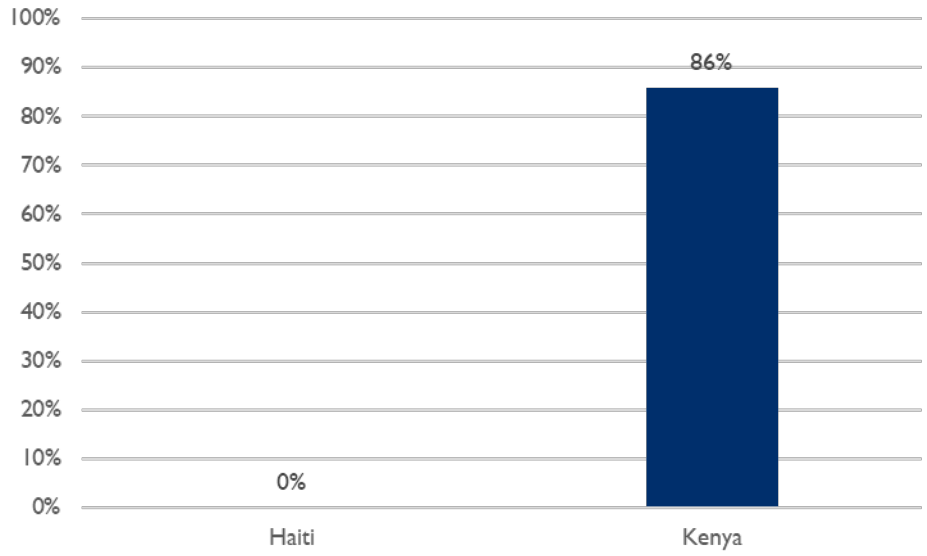
**Average stockout rate for female condoms at service delivery points**



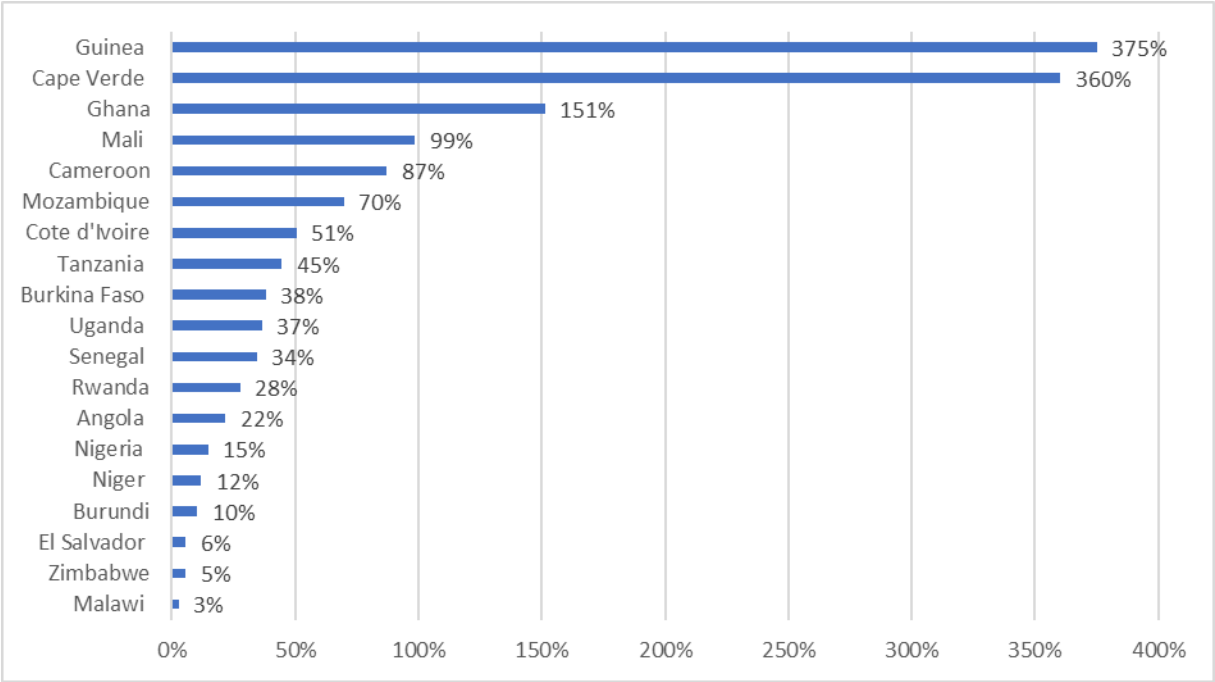

**Average stockout rate for emergency contraceptives (levonorgestrel 0.75mg, two tablets) at service delivery points**



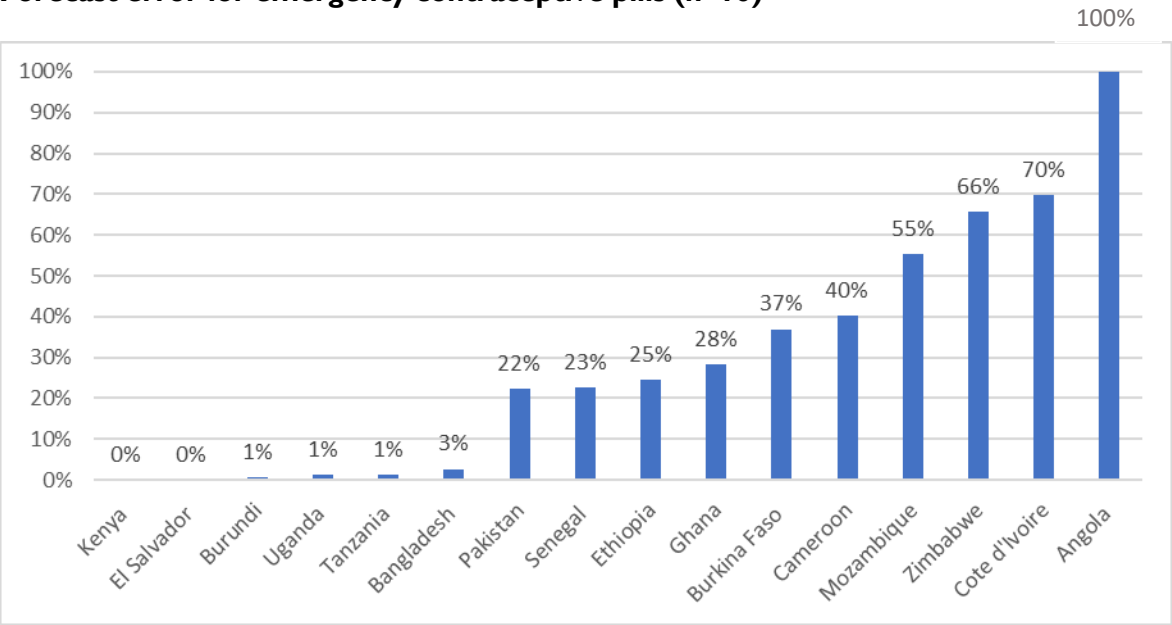
**Average stockout rate for calendar-based awareness methods at service delivery points**



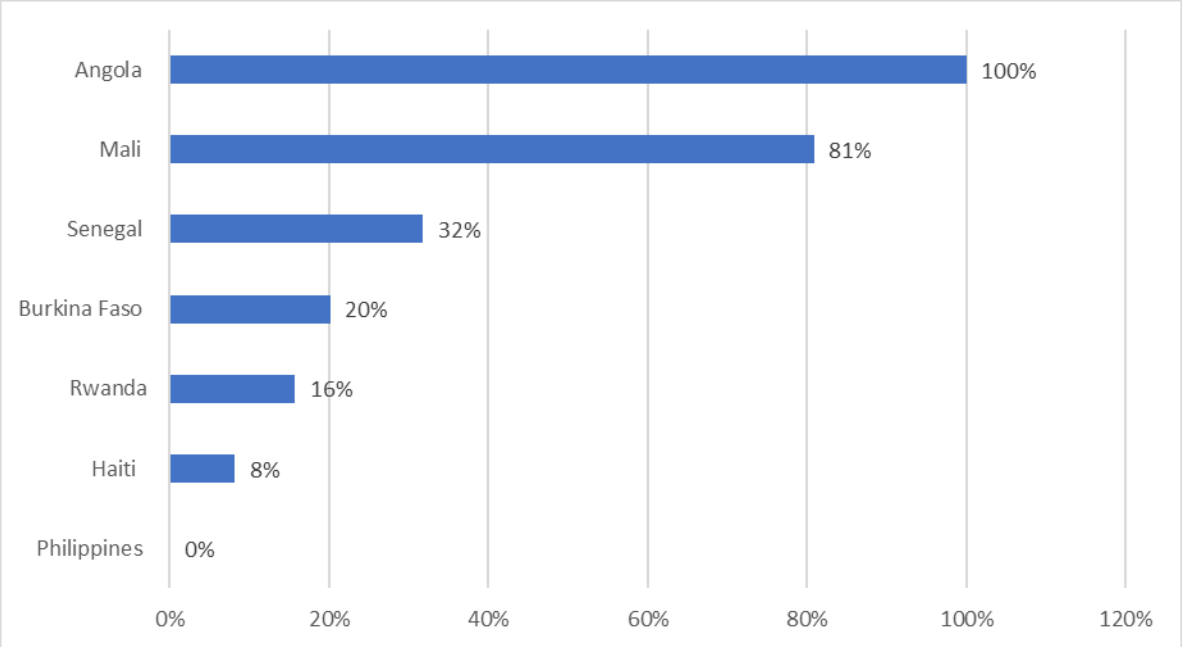

**Forecast error for female condoms (n=19)**



**Forecast error for emergency contraceptive pills (n=16)**[26]




**Forecast error for calendar-based awareness methods (n=8)**[27]




[26] Outlier not shown: Armenia (2,082 percent)

[27] Outlier not shown: Nigeria (2,951 percent)

# ANNEX B

## Contraceptive Security Indicators Survey Questionnaire

USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM
PROCUREMENT AND SUPPLY MANAGEMENT

**Respondent's name (survey point person):**
**Job title:**
**Organization:**
**E-mail:**
**Telephone:**
**Date (dd/mm/yy):**

## Contraceptive Security (CS) Indicators Survey, 2017

**Country:**

The CS Indicators are presented in the following sections:
A. Leadership & Coordination B. Finance & Procurement C. Commodities D. Policies E. Supply chain F. Quality G. Private Sector

Instructions:
- Please indicate your answers in the yellow and white spaces. Most questions contain dropdown lists for your selection.
- Please select from the dropdown lists in columns O and P to indicate the main and, if applicable, additional data sources used.
- To help keep track of survey completion, response cells highlighted in yellow will change back to white once the response has been selected or filled in.
- Dependent questions may be grayed out based on an earlier response.
- If the answer is longer than the space provided, you can either manually adjust the row height or autofit the row height in order to see the whole response. (To autofit the row height, select the answer(s) and go to Home tab - Cells group - Format - Autofit Row Height in newer versions of Excel or Format - Row - Autofit in older versions of Excel.)

The accompanying Data Collection and Usage Manual provides detailed definitions of the indicators and guidance on data sources and collection methods.

| **A. Leadership and Coordination** | | | | | | | |
|---|---|---|---|---|---|---|---|
| A1. | Is there a national committee that works on contraceptive security?<br>Committee should have some aspect of contraceptive security as part of its Terms of Reference, even if it is known by a different name, for example: Family Planning, Reproductive Health, Maternal Mortality, Essential Medicine Committee, etc. | | | | | Comments: | |
| a. | What is the name of the committee? | | | | | | |
| A2. | Are the following organizations represented on the committee? | (Y/N dropdown) | | | | | |
| a. | Social marketing, (*for example: PSI, DKT, SFH, etc.)* | | If yes, specify name(s) of organizations | | | | |
| b. | NGO<br>*(for example: service delivery, advocacy, Planned Parenthood affiliate, Marie Stopes affiliate, faith-based organizations, etc.)* | | If yes, specify name(s) of organizations | | | | |
| c. | Commercial sector<br>*(for example: wholesalers, distributors, pharmacy associations, manufacturers, etc.)* | | If yes, specify name(s) of organizations | | | | |
| d. | Donors | | If yes, specify name(s) of donors | | | | |
| e. | UN agencies | | If yes, specify name(s) of agencies | | | | |
| f. | Ministry of Health<br>*(for example: logistics, reproductive health, family planning, maternal and child health, HIV/AIDS, pharmacy units, etc.)* | | If yes, specify name(s) of units | | | | |
| g. | Central Medical Store or Central Warehouse | | If yes, specify | | | | |
| h. | Ministry of Finance or Ministry of Planning | | If yes, specify | | | | |
| i. | Other<br>*(for example: partners)* | | If yes, specify | | | | |
| A3. | How many times did the committee meet during the last year? | | | | | Comments (Describe the work of the committee): | |
| A4. | Has the committee developed or started development on any policies, procedures, and/or action plans in the last year? | | | | | | |
| a. | If yes, is there evidence of adherence to policies and procedures, implementing action plans, and/or following up on and addressing issues raised at previous meetings? | | | | | | |
| A5. | Is there a Contraceptive Security "champion"?<br>Someone who consistently brings up and advocates for contraceptive supplies | | If yes, specify person's organization | | Specify person's job title | | |

| B. Finance and Procurement (Capital) | | | | | | | |
|---|---|---|---|---|---|---|---|
| B1. | What is the timeline of the country government's fiscal year? | Beginning month | | Ending month | | Comments | |
| B2. | What was the estimated dollar value of contraceptives needed to be procured for the public sector* for the most recent complete fiscal year? (in USD)<br>*This can include cases where the ministry provides contraceptives for NGOs or social marketing. | | | | | | |
| B3. | One-year time period covered by the forecast/quantification amount noted in B2 | Beginning mm/yyyy | | Ending mm/yyyy | | | |
| | a. Who conducted the forecast/quantification? (Specify organizations.) | | | | | | |
| | b. Frequency of forecast update | | | | | | |
| | c. Mean absolute percent consumption forecast error (MAPE) for the most recent complete fiscal year<br>For each of the following products offered by the public sector in the country where public sector forecast and consumption data are available, please enter the actual quantity consumed (in units) in column J, and the forecasted consumption (in units) for the most recently completed fiscal year in column K. The MAPE will automatically calculate in column LMN. | | | | | | |
| | *(Formula: \|(Actual quantity consumed) - (Forecasted consumption)/ Actual quantity consumed \|)* | | | | Actual quantity consumed | Forecasted consumption | Mean absolute percent consumption forecast error |
| | i. Combined oral contraceptive pills | | | | | | |
| | Levonorgestrel/Ethinyl Estradiol 150/30 mcg +Fe 75mg [Microgynon] | | | | | | #DIV/0! |
| | Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Seasonale, Levora, Jolessa] | | | | | | #DIV/0! |
| | Other combined oral contraceptive pills | Specify product: | | | | | #DIV/0! |
| | ii. Progestin-only oral contraceptive pills | | | | | | |
| | Levonorgestrel 30 mcg [Norgeston, Microlut] | | | | | | #DIV/0! |
| | Progestin-only oral contraceptive pills: Other | Specify product: | | | | | #DIV/0! |
| | iii. Injectable contraceptives | | | | | | |
| | Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press] | | | | | | #DIV/0! |
| | Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera] | | | | | | #DIV/0! |
| | Norethisterone enanthate [Noristerat] | | | | | | #DIV/0! |
| | Other injectable contraceptives | Specify product: | | | | | #DIV/0! |
| | iv. Contraceptive implants | | | | | | |
| | Levonorgestrel 75mg/rod, 2 rod implant [Jadelle, Sino-Implant (II)/Levoplant] | | | | | | #DIV/0! |
| | Etonogestrel 68mg/rod, 1 rod implant [Nexplanon] | | | | | | #DIV/0! |
| | Other contraceptive implants | Specify product: | | | | | #DIV/0! |
| | v. Copper-bearing intrauterine devices (IUDs) (for example, Optima Copper T) | | | | | | #DIV/0! |
| | vi. Hormone-releasing intrauterine devices (IUDs) (for example levonorgestrel-releasing [Mirena]) | | | | | | #DIV/0! |
| | vii. Male condoms | | | | | | #DIV/0! |
| | viii. Female condoms | | | | | | #DIV/0! |
| | ix. Emergency oral contraceptive pills | | | | | | |
| | Levonorgestrel 0.75mg, 2 tablets | | | | | | #DIV/0! |
| | Levonorgestrel 1.5mg, 1 tablet | | | | | | #DIV/0! |
| | x. Calendar-based awareness methods (for example, CycleBeads) | | | | | | #DIV/0! |
| B4. | Is there a government budget line item specifically for the procurement of contraceptives?<br>Please select from the dropdown list. | | | | | Comments: | |

Please complete the questions below regarding **government allocations** for contraceptive procurement.
Allocated funds are those originally designated for contraceptives, *whether or not* they ended up being spent on contraceptives.

| | | | | |
|---|---|---|---|---|
| B5. | Were government funds **allocated** (i.e., committed) for contraceptive procurement in the most recent complete fiscal year (FY '16-'17)?<br>This question refers to funds planned to be spent on contraceptives, whether or not they ended up being spent.<br>(Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.) | | Comments: | |

In the table below, the time period should reflect when the allocations were supposed to be spent, and will ideally be the most recent complete fiscal year.

| B6. | Source of government funds allocated for contraceptive procurement | Amount allocated (in USD) | Time period (mm/yy-mm/yy) | Data source (for example: Ministry records) | Comments |
|---|---|---|---|---|---|
| a. | Internally generated funds **allocated** for contraceptive procurement | | | | |
| b. | Total of all other government funds **allocated** for contraceptive procurement. (For example, these other government funds could include basket funds, World Bank credits or loans, and other funds donors give to the government [e.g., direct budget support]) | | | | |
| c. | TOTAL government funds **allocated** for contraceptive procurement<br>**This will auto-calculate.** *(It will sum a & b above.)* | $ - | | | |

Please complete the questions below to indicate **government expenditures** on contraceptive procurement, by source, in the most recent complete fiscal year.
*This is how much was spent on contraceptive procurement (not what was allocated). How much of this spending was provided from each source?*

| | | |
|---|---|---|
| B7. | Were government funds **spent** on contraceptive procurement in the most recent complete fiscal year?*<br>(Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.)<br>*(This can include cases where the Ministry funded contraceptive supply for NGOs or social marketing.) | |

In the table below, the time period should reflect when the funds were spent, and will ideally be the most recent complete fiscal year.

| B8. | Source of government funds spent on contraceptive procurement | Was this a source? *(Y/N)* | Amount spent (in USD) | Time period (mm/yy-mm/yy) | Comments |
|---|---|---|---|---|---|
| a. | Internally generated funds **spent** on contraceptive procurement | | | | |
| | i. Specify source(s) of internally generated funds spent *(for example, from taxes)* | | | | |
| b. | Total of all other government funds **spent** on contraceptive procurement. (For example, these other government funds could include basket funds, World Bank credits or loans, and other funds donors gave to the government [e.g., direct budget support]) | | | | |
| | i. Specify source(s) of other government funds spent *(for example: basket funding or specific donor)* | | | | |
| c. | TOTAL government funds **spent** on contraceptive procurement<br>**This will auto-calculate.** *(It will sum a & b above.)* | | $ - | | |

Please complete the table below to indicate **in-kind donations and grants*** for contraceptives in the most recent complete fiscal year.
The time period should be the same for all sources of funding.
*This can include cases where donors provided products to the Ministry for NGOs or social marketing.

| B9. | Source of donations of contraceptives for the public sector | In-kind or cash? | Value of donation | Time period (mm/yy-mm/yy) | Details of donations |
|---|---|---|---|---|---|
| a. | USAID | | | | |
| b. | UN agencies | | | | |
| c. | Global Fund | | | | |
| d. | Other bilateral | | | | |
| e. | Other | | | | |
| f. | TOTAL value of in-kind donations and grants spent on contraceptive procurement<br>**This will auto-calculate.** *(It will sum a-e above.)* | | $ - | | |

The answers to B10 - B12 should calculate automatically based on the information you provide. Please review the answers to ensure they make sense to you, and if you have additional information to add, please note it in the comment boxes provided.

The values will auto-calculate and the formulas used can be seen by selecting that cell. If the answers do not calculate automatically, please provide relevant information in the comments boxes.

| | | | |
|---|---|---|---|
| B10. | **Government share of funds spent on contraceptive procurement for the public sector -** Of the total amount spent on contraceptives for the public sector in the most recent complete fiscal year (including government and donor funds), what percent was covered by government funds (including internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government)? | ***#DIV/0!*** | Comments: |
| B11. | **Internally generated share of the government funds spent on contraceptive procurement for the public sector -** Of the total amount of government funds spent on contraceptives for the public sector in the most recent complete fiscal year, what percent was covered by government internally generated funds? | ***#DIV/0!*** | Comments: |
| B12. | **Total expenditures on public sector contraceptives as percent of amount that needed to be procured -** Of the estimated value of the contraceptives needed to be procured for the public sector for the most recent complete fiscal year, what percent was provided by any source (whether government or donor)? | ***#DIV/0!*** | Comments: |
| B13. | If B12 did not calculate automatically, please answer the following question: Was there a funding gap for public sector contraceptives in the last complete fiscal year? | | Comments: |
| B14. | If the government financed any contraceptive procurement in the most recent complete fiscal year, which entity conducted the procurement(s)? (Please select from the dropdown.) | | Comments: |
| | a. Specify entity | | |
| B15. | Please note any additional comments about finance and procurement. | | |

The previous questions were about the *most recently completed fiscal year*. This question refers to the **current fiscal year**.

| | | | | |
|---|---|---|---|---|
| B16. | Have funds been allocated by the government for the procurement of contraceptives for the current fiscal year? | | Comments: | |
| | a. If yes, please describe the allocations (source and quantity if available). | Source | Amount (in USD) | Comments |
| | | | | |
| | | | | |

**C. Commodities**

C1. Are the following contraceptive methods offered through the commercial sector, public sector, NGOs, or social marketing? (Please indicate which methods are intended to be offered, not whether the method is currently in stock.)

| Contraceptive Method | Please select from the dropdown list | | | |
|---|---|---|---|---|
| | Commercial Sector | Public Sector | NGO | Social Marketing |
| a. Combined Oral Contraceptive Pills (for example, Levonorgestrel/Ethinyl Estradiol 150/30 mcg +Fe 75mg, Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], drosiperenone/Ethinyl Estradiol 3mg/20mcg [Yaz], Norethindrone Acetate/Ethinyl Estradiol [Loestrin, Junel]) | | | | |
| b. Progestin-only Oral Contraceptive Pills (for example, Levonorgestrel 30 mcg [Norgeston, Microlut], Norethindrone 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [Cerazette, Aizea], Ethynodiol Diacetate [Femulen]) | | | | |
| c. Injectables (for example, Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press], Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera], Norethisterone enanthate [Noristerat]) | | | | |
| d. Contraceptive Implants (for example, Levonorgestrel 75mg [Jadelle, Sino-Implant (II)/Levoplant], Etonogestrel 68mg [Nexplanon]) | | | | |
| e. Intrauterine devices (IUDs) (for example, copper-bearing [Optima Copper T], levonorgestrel-releasing [Mirena]) | | | | |
| f. Male condoms | | | | |
| g. Female condoms | | | | |
| h. Emergency contraceptive pills (for example, levonorgestrel 0.75mg, levonorgestrel 1.5mg) [Postinor] | | | | |
| i. Long-acting permanent method for males (vasectomy) | | | | |
| j. Long-acting permanent method for females (tubal ligation) | | | | |
| k. Contraceptive Patches (for example, Norelgestromin/Ethinyl Estradiol 150/35mcg [Xulane, Evra]) | | | | |
| l. Vaginal Contraceptive Rings (for example, Etonogestrel/Ethinyl Estradiol 120/15mcg [NuvaRing], progesterone-releasing [Progering]) | | | | |
| m. Calendar-based Awareness Methods (for example, CycleBeads) | | | | |
| n. Other contraceptive methods (Please provide the name(s) of any other contraceptive(s) offered in the spaces below and then select from the dropdown lists for each sector). | | | | |
| i. Other method: | | | | |
| ii. Other method: | | | | |
| iii. Other method: | | | | |
| C2. Please note any comments about the commodities offered. | | | | |

| D. Policy (Commitment) | | | |
|---|---|---|---|
| D1. Is there a contraceptive security or reproductive health commodity security strategy or is a strategy for increasing contraceptive access explicitly detailed in any other country strategy? | | If yes, describe the strategy | |

IF NO, SKIP TO QUESTION D2.

| | | | |
|---|---|---|---|
| a. Strategy name | | Comments: | |
| b. Years covered (including strategy updates) | | | |
| c. Is the strategy formally approved by the Ministry? | | | |
| d. Regarding the contraceptive security strategy, is there evidence of the following: | | | |
| i. Adherence to contraceptive security strategy? | | | |
| ii. Implementation of action items that are part of the contraceptive security strategy, and/or follow up on addressing issues raised in the strategy? | | | |
| D2. Are any family planning commodities subject to duties, import taxes, or other fees? | | | |
| a. If yes, for which sectors (public, NGO, social marketing, commercial)? | | | |
| b. If yes, how much are the duties, taxes, or fees? (In USD) | | | |
| D3. Are there policies that **hinder** the ability of the private sector (commercial sector, NGOs, or social marketing) to provide contraceptive methods? For example: price controls, distribution limitations, taxes/duties, advertising bans, etc. | | | |
| a. If yes, describe the policies. | | | |
| D4. Are there policies that **enable** the private sector (commercial sector, NGOs, or social marketing) to provide contraceptive methods? (For example: policy reform, fostering public/private alliances, provider networks and franchises, accreditation, training and continuing education for private sector providers, and financing mechanisms, such as social marketing, vouchers, incentives, and the government contracting out delivery of services to the private sector). | | | |
| a. If yes, describe the policies. | | | |
| D5. Please describe any other policies or regulations that restrict who can sell or dispense particular contraceptive methods. (For example, are pharmacists allowed to provide the methods, such as injectables or implants? Are methods available over the counter?) Please note which methods and sectors the policies/regulations apply to. | | | |

Please complete the following table to indicate the country's policies regarding the lowest provider cadre that is allowed to sell or dispense particular contraceptive methods.
Please select from the dropdown list if possible. If you cannot find a provider cadre that fits, you may write it in.

| D6. Contraceptive Method(s) | Note the lowest level provider that is allowed to sell or dispense the method in the **public sector** | Note the lowest level provider that is allowed to sell or dispense the method in the **private sector** | Comments |
|---|---|---|---|
| a. Combined Oral Contraceptive Pills (for example, Levonorgestrel/Ethinyl Estradiol 150/30 mcg +Fe 75mg, Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], drosiperenone/Ethinyl Estradiol 3mg/20mcg [Yaz], Norethindrone Acetate/Ethinyl Estradiol [Loestrin, Junel]) | | | |
| b. Progestin-only Oral Contraceptive Pills (for example, Levonorgestrel 30 mcg [Norgeston, Microlut], Norethindrone 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [Cerazette, Aizea], Ethynodiol Diacetate [Femulen]) | | | |
| c. Injectables (for example, Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press], Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera], Norethisterone enanthate [Noristerat]) | | | |
| d. Contraceptive Implants (for example, Levonorgestrel 75mg [Jadelle, Sino-Implant (II)/Levoplant], Etonogestrel 68mg [Nexplanon]) | | | |
| e. Intrauterine devices (IUDs) (for example, copper-bearing [Optima Copper T], Levonorgestrel-releasing [Mirena]) | | | |
| f. Male condoms | | | |
| g. Female condoms | | | |
| h. Emergency contraceptive pills (for example, Levonorgestrel 0.75mg, Levonorgestrel 1.5mg) [Postinor] | | | |
| i. Long-acting permanent method for males (vasectomy) | | | |
| j. Long-acting permanent method for females (tubal ligation) | | | |
| k. Contraceptive Patches (for example, Norelgestromin/Ethinyl Estradiol 150/35mcg [Xulane, Evra]) | | | |
| l. Vaginal Contraceptive Rings (for example, Etonogestrel/Ethinyl Estradiol 120/15mcg [NuvaRing], progesterone-releasing [Progering]) | | | |
| m. Calendar-based Awareness Methods (for example, CycleBeads) | | | |
| n. Other contraceptive methods - specify (Please provide the name of the other contraceptive(s) offered, and the lowest level cadre that can provide it, by sector.) Type of contraceptive: | | | |

| D7. Does the country have laws, regulations, or policies that make it difficult for the following sub-populations to access effective family planning services? | Y/N (dropdown) | If yes, describe laws/regulations/policies affecting access | Are the rules/policies implemented or enforced? |
|---|---|---|---|
| a. Unmarried people | | | |
| b. Young people | | | |
| c. Other | | | |

| | | | | |
|---|---|---|---|---|
| D8. | Does the country have other policy barriers that do not directly prevent a sub-population from accessing family planning but that have a secondary effect in making it difficult for the sub-population to access effective family planning services? (for example, youth in the country prefer to use retail sites but retail sites in the country are not allowed to sell contraceptives, limiting youth's access to contraceptives?) | Y/N (dropdown) | If yes, describe laws/regulations/policies affecting access | Are the rules/policies implemented or enforced? |
| | a. Unmarried people | | | |
| | b. Young people | | | |
| | c. Other | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| D9. | Are there charges (by policy, not under-the-table charges) to the client in the public sector for family planning: | | | | | |
| | a. Services? | | | Comments: | | |
| | b. Commodities? | | | | | |
| | c. If yes, are there exemptions for people who cannot afford to pay? | | | | | |
| | i. If yes, describe the exemptions. | | | | | |
| | d. Are there charges to the client in the public sector for family planning that are informal, unofficial, or are different than posted charges? | | | | | |
| | i. If yes, describe the charges. | | | | | |
| D10. | If a fee is charged for family planning services or commodities in the public sector, does public/government/national health insurance cover family planning? | | | | | |
| | a. If yes, what proportion of the population does this health insurance cover? | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| D11. | Proportion of modern contraceptive use that is attributed to married women in each wealth quintile | Quintile 1 (Top 20%) | Quintile 2 | Quintile 3 (Middle 20%) | Quintile 4 | Quintile 5 (Lowest 20%) |
| | | | | | | |

| | | | | |
|---|---|---|---|---|
| D12. | Are the following contraceptives included in the country's National Essential Medicine List (NEML) or other equivalent priority list? (for example, the National Medical Device List) | | | |
| | a. Combined Oral Contraceptive Pills (for example, Levonorgestrel/Ethinyl Estradiol 150/30 mcg +Fe 75mg, Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], drosiperenone/Ethinyl Estradiol 3mg/20mcg [Yaz], Norethindrone Acetate/Ethinyl Estradiol [Loestrin, Junel]) | | Comments: | |
| | b. Progestin-only Oral Contraceptive Pills (for example, Levonorgestrel 30 mcg [Norgeston, Microlut], Norethindrone 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [Cerazette, Aizea], Ethynodiol Diacetate [Femulen]) | | | |
| | c. Injectables (for example, Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press], Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera], Norethisterone enantate [Noristerat]) | | | |
| | d. Contraceptive Implants (for example, Levonorgestrel 75mg [Jadelle, Sino-Implant (II)/Levoplant], Etonogestrel 68mg [Nexplanon]) | | | |
| | e. Copper-bearing Intrauterine devices (IUDs) (for example, Optima Copper T) | | | |
| | f. Hormone-releasing intrauterine devices (IUDs) (for example levonorgestrel-releasing [Mirena]) | | | |
| | g. Male condoms | | | |
| | h. Female condoms | | | |
| | i. Emergency contraceptive pills (for example, levonorgestrel 0.75mg, levonorgestrel 1.5mg) | | | |
| | j. Contraceptive Patches (for example, Norelgestromin/Ethinyl Estradiol 150/35mcg [Xulane, Evra]) | | | |
| | k. Vaginal Contraceptive Rings (for example, Etonogestrel/ Ethinyl Estradiol 120/15mcg [NuvaRing], progesterone-releasing [Progering]) | | | |
| | l. Calendar-based Awareness Methods (for example, CycleBeads) | | | |
| | m. Any other contraceptive(s)? | | | |
| | i. If yes, name(s) of other contraceptive(s) on the list(s) | | | |
| D13. | What year(s) is the list(s) from? | | | |
| D14. | Name of the list(s) | | | |
| D15. | Notes about the list(s) | | | |
| D16. | Has the country made an FP2020 commitment? | | | |
| | a. If the country has made an FP2020 commitment, what area(s) is it in? (Please list one or more of the following areas: Objective, Policy & Political, Financial, Program & Service Delivery) | | | |
| D17. | Is the country a Global Financing Facility (GFF) partner? | | | |

| E. Supply Chain (Capacity) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| E1. | Please provide the stockout rates for contraceptive commodities for the period of **end of August 2016 through end of August 2017** for the central and service delivery point levels for the following product categories.<br><br>For a method containing multiple products listed in rows below it, only complete the cells for each product offered under that method.<br><br>(If a method is not intended to be offered in public sector facilities or data is not available for that level and/or product, please indicate that stockouts are not applicable (type "n/a").) | a. Central level (i.e., central level warehouse for the public sector) | | | b. Service delivery point (SDP) level (i.e., public sector health facilities) *(At the aggregate level, this is the percentage of all commodity observations at all SDPs which were stocked out during the year)* | | | |
| | | Number of stock status observations where the commodity was stocked out during the fiscal year (numerator) | Total stock status observations during the year (denominator) | Annual stockout rate at the central level<br><br>**Automatically calculates by dividing column H by column I** | Sum of the number of SDPs stocked out of the commodity as of the ending balance of all monthly/quarterly logistics reports for the fiscal year (numerator) | Sum of the total numbers of SDPs reporting across all monthly/ quarterly logistics reports for the fiscal year (denominator) | Annual stockout rate at SDPs<br><br>**Automatically calculates by dividing column K by column L** | Comments |
| | a. Combined oral contraceptive pills | | | | | | | |
| | i. Levonorgestrel/Ethinyl Estradiol 150/30 mcg +Fe 75mg [Microgynon] | | | #DIV/0! | | | #DIV/0! | |
| | ii. Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Seasonale, Levora, Jolessa] | | | #DIV/0! | | | #DIV/0! | |
| | iii. Other combined oral contraceptive pills *(not included for aggregate calculation)* Specify: | | | | | | | |
| | b. Progestin-only oral contraceptive pills (Levonorgestrel 30 mcg [Norgeston, Microlut]) | | | #DIV/0! | | | #DIV/0! | |
| | c. Injectable contraceptives | | | | | | | |
| | i. Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press] | | | #DIV/0! | | | #DIV/0! | |
| | ii. Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera] | | | #DIV/0! | | | #DIV/0! | |
| | iii. Norethisterone enanthate [Noristerat] | | | #DIV/0! | | | #DIV/0! | |
| | d. Contraceptive implants | | | | | | | |
| | i. Levonorgestrel 75mg/rod, 2 rod implant [Jadelle, Sino-Implant (II)/Levoplant] | | | #DIV/0! | | | #DIV/0! | |
| | ii. Etonogestrel 68mg/rod, 1 rod implant [Nexplanon]) | | | #DIV/0! | | | #DIV/0! | |
| | e. Copper-bearing intrauterine devices (IUDs) (for example, Optima Copper T) | | | #DIV/0! | | | #DIV/0! | |
| | f. Hormone-releasing intrauterine devices (IUDs) (for example levonorgestrel-releasing [Mirena]) | | | #DIV/0! | | | #DIV/0! | |
| | g. Male condoms | | | #DIV/0! | | | #DIV/0! | |
| | h. Female condoms | | | #DIV/0! | | | #DIV/0! | |
| | i. Emergency oral contraceptive pills | | | | | | | |
| | i. Levonorgestrel 0.75mg, 2 tablets | | | #DIV/0! | | | #DIV/0! | |
| | ii. Levonorgestrel 1.5mg, 1 tablet | | | #DIV/0! | | | #DIV/0! | |
| | j. Calendar-based awareness methods (for example, CycleBeads) | | | #DIV/0! | | | #DIV/0! | |
| | k. Total stock out rate for all commodities **This will auto-calculate.** (It will sum H and I and divide H by I, and will sum K and L and divide by L) | 0 | 0 | #DIV/0! | 0 | 0 | #DIV/0! | |
| E2. | Please note any overall comments about challenges and/or successes with contraceptive security in your country. | | | | | | | |

| F. Quality | | | | |
|---|---|---|---|---|
| F1. | What is the name of the national drug regulatory authority (NRA)? | | Comments: | |
| F2. | Are there quality control standards for pharmaceuticals, including contraceptives that are in line with international standards? | | | |
| | If yes, are these routinely applied to: | | | |
| | a. the public sector? | | Comments: | |
| | b. the private sector? | | | |
| F3. | If the NRA does have access to a quality control facility, are samples of contraceptives routinely tested from: | | | |
| | a. the public sector? | | Comments: | |
| | b. the private sector? | | | |
| F4. | Are contraceptive commodities from WHO prequalified manufacturers available in the country? | | | |
| | a. If yes, are they given preference during procurement? | | | |
| F5. | Are regular assessments done of contraceptive products available in pharmacies, including their quality and prices? (e.g. purchase of retail audit data from research firms, systematic surveys by public sector staff) | | | |
| F6. | Do standards exist for post-marketing surveillance and pharmacovigilance? | | | |
| | a. If yes, are they based on international standards? | | | |
| | b. Are they implemented? | | | |

| G. Private Sector | | | | |
|---|---|---|---|---|
| G1. | Are private sector entities that provide FP required to report to and/or register with government agencies such as the MoH? | | Comments: | |
| | a. If so, which ones? | | | |
| G2. | Are routine market data surveys or syndicated data such as Quintiles IMS or Nielson available in the country? | | | |
| | a. If so, which ones? | | | |
| G3. | What private sector manufacturers are registered in the country? (Excludes WHO pre-qualified products. May attach list if available.) | | | |
| G4. | Have any public/private partnerships been established or brokered in the last year with the purpose of expanding private sector provision of health services including family planning products and services? Example: contracting out of family planning services to private providers by the government; development of a voucher program where the government distributes vouchers that can be used for family planning services by private providers; joint public-private research on new contraceptive technologies or service delivery mechanisms | | Comments: | |
| | a. If yes, please list/describe them. | | | |

# ANNEX C

Contextual Reference Measures (Formerly from the Contraceptive Security Index)

| Indicator | Description | Afghanistan | Angola | Armenia | Bangladesh | Benin | Burkina Faso | Burundi | Cameroon | Cape Verde | Cote d'Ivoire | Dominican Republic | DRC | El Salvador | Ethiopia | Ghana | Guatemala | Guinea | Haiti |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Finance** | | | | | | | | | | | | | | | | | | | |
| **1** Domestic general government health expenditure *(% of general government expenditure)* | Defined as the domestic government expenditure on health as a percentage of total domestic government expenditures, this indicator is a measure of a government's political commitment to funding its public health system compared to other priorities. The greater the overall funding envelope for public health, the more that can be devoted to family planning and reproductive health, and the better the likelihood that those most in need will be covered by health services, including FP/RH. * Source: World Bank's World Development Indicators, 2015 (https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS) | 2.0% | 3.7% | 6.1% | 2.8% | 3.4% | 7.2% | 11.8% | 3.1% | 10.8% | 5.0% | 9.5% | 5.0% | 19.1% | 6.0% | 7.1% | 14.9% | 2.7% | 3.3% |
| **2** Per Capita Gross National Income (GNI), purchasing power parity (PPP) *(constant 2011 international $)* | Per capita gross national income helps to represent the ability of households to pay for goods and services, including contraceptives and family planning/reproductive health services. A higher GNI is generally associated with a higher level of contraceptive security. This indicator is measured in constant 2011 international dollars and purchasing power parity, which adjusts for the different market prices for goods in each country. * Source: World Bank's World Development Indicators. Data for were available from years ranging from 2011 to 2017. (https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.KD) | $ 1,822 | $ 5,790 | $ 9,144 | $ 3,677 | $ 2,061 | $ 1,650 | $ 721 | $ 3,315 | $ 5,983 | $ 3,481 | $ 13,921 | $ 796 | $ 6,868 | $ 1,719 | $ 4,096 | $ 7,278 | $ 2,067 | $ 1,665 |
| **3** Poverty level *(Percentage of the national population living below the nationally defined poverty line)* | While per capita gross national income measures the average person's ability to pay for goods and services, a higher poverty level, defined as the percentage of the national population living below the nationally defined poverty line, can indicate increased income inequality and an increased proportion of the population reliant on the public health system. This measure may indicate a need to target public health goods and services toward the poorest segments of the population. Higher poverty levels are generally associated with lower levels of contraceptive security. * Source: World Bank's World Development Indicators. Data were available from years ranging from 2008 to 2016. (http://wdi.worldbank.org/table/1.1) | 36% | 37% | 29% | 24% | 40% | 40% | 65% | 38% | 35% | 46% | 31% | 64% | 38% | 30% | 24% | 59% | 55% | 59% |
| **Health & Social Environment** | | | | | | | | | | | | | | | | | | | |
| **4** Governance | Regulatory quality, an element of good governance, is a composite measure that captures "perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development" (World Bank's Worldwide Governance Indicators, 1996-2016). Countries with a strong regulatory environment are more likely to attract international financing, and the private sector is more likely to invest in creating or expanding the market for contraceptives. This indicator assigns countries a percentile rank from 0 to 100, where 100 is the strongest regulatory quality. * Source: World Bank's Worldwide Governance Indicators, 2016. (http://info.worldbank.org/governance/wgi/#reports) | | | | | | | | | | | | | | | | | | |
| Regulatory Quality *(Percentile rank: 0 to 100)* | | 7 | 13 | 63 | 22 | 30 | 38 | 21 | 23 | 43 | 40 | 53 | 8 | 57 | 12 | 46 | 47 | 19 | 8 |
| **5** Women's education *(% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio)* | Women's education is measured by the percent of females enrolled in secondary school out of the applicable age group, also known as the gross enrollment ratio. Women who are educated beyond the primary level are more likely to use contraceptives, and more likely to advocate for the protection of family planning/reproductive health programs. * Source: UNESCO's Institute for Statistics UIS.STAT database. Data were available from years ranging from 2011 to 2017. (http://data.uis.unesco.org/) | 39.7 | 20.7 | 88.4 | 72.5 | 48.9 | 34.9 | 47.6 | 57.1 | 88.4 | 38.8 | 80.7 | 36.0 | 74.2 | 34.4 | 59.6 | 61.8 | 31.9 | n/a |
| **6** Adult HIV Prevalence | This measure has a complex relationship with contraceptive security. Higher burdens of HIV can put greater strains on the health system, leaving fewer health resources available for FP/RH services. However, countries are increasingly linking HIV/AIDS and FP/RH programs, which boosts awareness of both. Furthermore, women who are HIV-positive and know their status are more likely to use family planning methods. This indicator is defined as the percentage of adults aged 15-49 who were infected with the HIV virus as of the end of 2016. * Source: UNAIDS, 2017. (http://aidsinfo.unaids.org/) | n/a | 1.9% | 0.2% | 0% | 1% | 0.8% | 1.1% | 3.7% | 0.6% | 2.8% | 0.9% | 0.7% | 0.6% | 0.9% | 1.7% | 0.4% | 1.5% | 1.9% |

| Indicator | Description | India | Kenya | Madagascar | Malawi | Mali | Mozambique | Nepal | Niger | Nigeria | Pakistan | Philippines | Rwanda | Senegal | Tanzania | Togo | Uganda | Zambia | Zimbabwe |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Finance** | | | | | | | | | | | | | | | | | | | |
| **1** Domestic general government health expenditure *(% of general government expenditure)* | Defined as the domestic government expenditure on health as a percentage of total domestic government expenditures, this indicator is a measure of a government's political commitment to funding its public health system compared to other priorities. The greater the overall funding envelope for public health, the more that can be devoted to family planning and reproductive health, and the better the likelihood that those most in need will be covered by health services, including FP/RH. * Source: World Bank's World Development Indicators, 2015 (https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS) | 3.4% | 6.3% | 15.6% | 10.8% | 4.5% | 1.2% | 5.5% | 4.6% | 5.3% | 3.7% | 7.4% | 6.2% | 4.2% | 7.4% | 5.7% | 5.6% | 6.8% | 8.1% |
| **2** Per Capita Gross National Income (GNI), purchasing power parity (PPP) *(constant 2011 international $)* | Per capita gross national income helps to represent the ability of households to pay for goods and services, including contraceptives and family planning/reproductive health services. A higher GNI is generally associated with a higher level of contraceptive security. This indicator is measured in constant 2011 international dollars and purchasing power parity, which adjusts for the different market prices for goods in each country. * Source: World Bank's World Development Indicators. Data for were available from years ranging from 2011 to 2017. (https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.KD) | $ 6,026 | $2,961 | $ 1,339 | $ 1,064 | $ 1,953 | $ 1,093 | $ 2,471 | $ 906 | $ 5,326 | $ 5,311 | $ 9,154 | $ 1,811 | $ 2,384 | $ 2,557 | $ 1,453 | $ 1,658 | $ 3,196 | $ 1,683 |
| **3** Poverty level *(Percentage of the national population living below the nationally defined poverty line)* | While per capita gross national income measures the average person's ability to pay for goods and services, a higher poverty level, defined as the percentage of the national population living below the nationally defined poverty line, can indicate increased income inequality and an increased proportion of the population reliant on the public health system. This measure may indicate a need to target public health goods and services toward the poorest segments of the population. Higher poverty levels are generally associated with lower levels of contraceptive security. * Source: World Bank's World Development Indicators. Data were available from years ranging from 2008 to 2016. (http://wdi.worldbank.org/table/1.1) | 22% | 36% | 71% | 51% | 44% | 46% | 25% | 45% | 46% | 30% | 22% | 39% | 47% | 28% | 55% | 20% | 54% | 72% |
| **Health & Social Environment** | | | | | | | | | | | | | | | | | | | |
| **4** Governance | Regulatory quality, an element of good governance, is a composite measure that captures "perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development" (World Bank's Worldwide Governance Indicators, 1996-2016). Countries with a strong regulatory environment are more likely to attract international financing, and the private sector is more likely to invest in creating or expanding the market for contraceptives. This indicator assigns countries a percentile rank from 0 to 100, where 100 is the strongest regulatory quality. * Source: World Bank's Worldwide Governance Indicators, 2016. (http://info.worldbank.org/governance/wgi/#reports) | | | | | | | | | | | | | | | | | | |
| Regulatory Quality *(Percentile rank: 0 to 100)* | | 41 | 42 | 26 | 20 | 28 | 25 | 24 | 26 | 18 | 27 | 54 | 58 | 49 | 36 | 23 | 46 | 33 | 3 |
| **5** Women's education *(% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio)* | Women's education is measured by the percent of females enrolled in secondary school out of the applicable age group, also known as the gross enrollment ratio. Women who are educated beyond the primary level are more likely to use contraceptives, and more likely to advocate for the protection of family planning/reproductive health programs. * Source: UNESCO's Institute for Statistics UIS.STAT database. Data were available from years ranging from 2011 to 2017. (http://data.uis.unesco.org/) | 75.8 | n/a | 38.2 | 35.3 | 36.6 | 31.5 | 75.0 | 19.9 | 53.5 | 41.1 | 92.1 | 38.4 | 48.4 | 30.3 | n/a | n/a | n/a | 46.7 |
| **6** Adult HIV Prevalence | This measure has a complex relationship with contraceptive security. Higher burdens of HIV can put greater strains on the health system, leaving fewer health resources available for FP/RH services. However, countries are increasingly linking HIV/AIDS and FP/RH programs, which boosts awareness of both. Furthermore, women who are HIV-positive and know their status are more likely to use family planning methods. This indicator is defined as the percentage of adults aged 15-49 who were infected with the HIV virus as of the end of 2016. * Source: UNAIDS, 2017. (http://aidsinfo.unaids.org/) | 0.2% | 4.8% | 0.3% | 9.6% | 1.2% | 12.5% | 0.2% | 0.3% | 2.8% | 0.1% | 0.1% | 2.7% | 0.4% | 4.5% | 2.1% | 5.9% | 11.5% | 13.3% |

| Indicator | Description | Afghanistan | Angola | Armenia | Bangladesh | Benin | Burkina Faso | Burundi | Cameroon | Cape Verde | Cote d'Ivoire | Dominican Republic | DRC | El Salvador | Ethiopia | Ghana | Guatemala | Guinea | Haiti |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access** | | | | | | | | | | | | | | | | | | | |
| **7** Access to FP Methods | Access to family planning methods (or health services in general) is typically understood to encompass multiple dimensions such as geographical distance from service delivery points, as well as economic, administrative, and/or psychosocial access. This particular measure is from a survey that assesses the extent to which the entire population has ready and easy access to each of the below-listed methods, from a scale of 1 to 10. The scale is then converted to an access rating score ranging from 0 to 100%, where 100% is the highest level of access, indicating greater contraceptive security.<br>*Source: Track20's National Family Planning Effort Index (FPE), 2014. (http://www.track20.org/pages/data_analysis/policy/FPE.php) | | | | | | | | | | | | | | | | | |
| Percent of the population with access to IUDs | | 27% | N/A | 64% | 63% | 69% | N/A | 71% | 39% | N/A | 29% | 60% | 33% | 62% | 39% | 34% | 32% | N/A | 22% |
| Percent of the population with access to contraceptive | | 64% | N/A | 36% | 91% | 79% | N/A | 77% | 72% | N/A | 62% | 76% | 44% | 80% | 84% | 71% | 61% | N/A | 76% |
| Percent of the population with access to injectables | | 54% | N/A | 7% | 80% | 79% | N/A | 76% | 40% | N/A | 57% | 55% | 38% | 74% | 87% | 60% | 61% | N/A | 89% |
| Percent of the population with access to condoms | | 67% | N/A | 67% | 88% | 84% | N/A | 81% | 95% | N/A | 79% | 79% | 69% | 92% | 90% | 83% | 72% | N/A | 80% |
| Percent of the population with access to female | | 15% | N/A | 14% | 66% | 22% | N/A | 32% | 18% | N/A | 10% | 64% | 22% | 76% | 19% | 34% | 38% | N/A | 31% |
| Percent of the population with access to male | | 3% | N/A | 7% | 60% | 13% | N/A | 19% | 16% | N/A | 5% | 15% | 7% | 28% | 13% | 21% | 14% | N/A | 18% |
| **8** Public Sector Targeting *(Proportion of a country's contraceptives distributed through public sector channels that go to poor and near-poor family planning clients)* | Public sector targeting is a measure of the proportion of a country's contraceptives distributed through public sector channels that go to poor and near-poor family planning clients (defined by the 40 percent of the population with the lowest incomes). Better targeting of free or subsidized public sector resources toward the poor can mean greater overall coverage, as those who can afford to pay will use other options.<br>*Source: Demographic and health surveys. Data for these surveys range from 2005 to 2017. (https://dhsprogram.com/Where-We-Work/Country-List.cfm) | | | | | | | | | | | | | | | | | | |
| **Utilization** | | | | | | | | | | | | | | | | | | | |
| **9** Percent unmet need for family planning | Unmet need for family planning is defined by the World Health Organization as the gap between women's reproductive intentions and their contraceptive behavior. It is a measure of the percent of sexually active women who are not using any method of contraception, and who report not wanting any more children or wanting to delay the next child. The higher the unmet need, the worse the prospects are for contraceptive security.<br>* Source: Track20's Family Planning Estimation Tool (FPET), using data from DHS/MICS/PMA2020/National survey data, and country service statistics data where possible. (www.track20.org/pages/data_analysis/core_indicators/StatTrack.php) | 25% | 38% | n/a | 19% | 36% | 25% | 33% | 34% | n/a | 29% | n/a | 40% | n/a | 24% | 34% | n/a | 26% | 36% |
| **10** Modern Contraceptive Prevalence Rate (mCPR) | Contraceptive prevalence rate, the percentage of married women of reproductive age currently using a modern method of family planning, is the most common measure of contraceptive security. Higher contraceptive use indicates better access and availability of contraceptives to the beneficiary population.<br>*Source: Track20's Family Planning Estimation Tool (FPET), using data from DHS/MICS/PMA2020/National survey data, and country service statistics data where possible. (www.track20.org/pages/data_analysis/core_indicators/StatTrack.php) | 14% | 27% | n/a | 45% | 16% | 22% | 16% | 22% | n/a | 21% | n/a | 10% | n/a | 25% | 22% | n/a | 11% | 24% |

| Indicator | Description | India | Kenya | Madagascar | Malawi | Mali | Mozambique | Nepal | Niger | Nigeria | Pakistan | Philippines | Rwanda | Senegal | Tanzania | Togo | Uganda | Zambia | Zimbabwe |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Access** | | | | | | | | | | | | | | | | | | | |
| **7** Access to FP Methods | Access to family planning methods (or health services in general) is typically understood to encompass multiple dimensions such as geographical distance from service delivery points, as well as economic, administrative, and/or psychosocial access. This particular measure is from a survey that assesses the extent to which the entire population has ready and easy access to each of the below-listed methods, from a scale of 1 to 10. The scale is then converted to an access rating score ranging from 0 to 100%, where 100% is the highest level of access, indicating greater contraceptive security.<br>*Source: Track20's National Family Planning Effort Index (FPE), 2014. (http://www.track20.org/pages/data_analysis/policy/FPE.php) | | | | | | | | | | | | | | | | | |
| Percent of the population with access to IUDs | | 61% | 55% | 38% | 19% | 51% | 44% | 44% | 45% | 37% | 49% | 46% | 66% | 66% | 43% | 65% | 35% | 30% | 42% |
| Percent of the population with access to contraceptive | | 61% | 74% | 81% | 75% | 74% | 76% | 75% | 81% | 62% | 62% | 63% | 93% | 85% | 79% | 84% | 71% | 74% | 88% |
| Percent of the population with access to injectables | | 14% | 73% | 74% | 79% | 64% | 69% | 64% | 70% | 58% | 52% | 47% | 90% | 76% | 73% | 82% | 67% | 56% | 72% |
| Percent of the population with access to condoms | | 84% | 77% | 79% | 84% | 85% | 88% | 78% | 79% | 81% | 73% | 70% | 90% | 90% | 84% | 87% | 72% | 81% | 91% |
| Percent of the population with access to female | | 83% | 31% | 24% | 49% | 27% | 24% | 50% | 15% | 12% | 44% | 44% | 62% | 37% | 34% | 21% | 35% | 27% | 33% |
| Percent of the population with access to male | | 61% | 10% | 18% | 11% | 14% | 7% | 49% | 5% | 6% | 26% | 36% | 60% | 32% | 26% | 16% | 27% | 18% | 19% |
| **8** Public Sector Targeting *(Proportion of a country's contraceptives distributed through public sector channels that go to poor and near-poor family planning clients)* | Public sector targeting is a measure of the proportion of a country's contraceptives distributed through public sector channels that go to poor and near-poor family planning clients (defined by the 40 percent of the population with the lowest incomes). Better targeting of free or subsidized public sector resources toward the poor can mean greater overall coverage, as those who can afford to pay will use other options.<br>*Source: Demographic and health surveys. Data for these surveys range from 2005 to 2017. (https://dhsprogram.com/Where-We-Work/Country-List.cfm) | | | | | | | | | | | | | | | | | | |
| **Utilization** | | | | | | | | | | | | | | | | | | | |
| **9** Percent unmet need for family planning | Unmet need for family planning is defined by the World Health Organization as the gap between women's reproductive intentions and their contraceptive behavior. It is a measure of the percent of sexually active women who are not using any method of contraception, and who report not wanting any more children or wanting to delay the next child. The higher the unmet need, the worse the prospects are for contraceptive security.<br>* Source: Track20's Family Planning Estimation Tool (FPET), using data from DHS/MICS/PMA2020/National survey data, and country service statistics data where possible. (www.track20.org/pages/data_analysis/core_indicators/StatTrack.php) | 19% | 17% | 26% | 19% | 27% | 26% | 26% | 21% | 26% | 29% | 32% | 24% | 27% | 28% | 35% | 33% | 24% | 12% |
| **10** Modern Contraceptive Prevalence Rate (mCPR) | Contraceptive prevalence rate, the percentage of married women of reproductive age currently using a modern method of family planning, is the most common measure of contraceptive security. Higher contraceptive use indicates better access and availability of contraceptives to the beneficiary population.<br>*Source: Track20's Family Planning Estimation Tool (FPET), using data from DHS/MICS/PMA2020/National survey data, and country service statistics data where possible. (www.track20.org/pages/data_analysis/core_indicators/StatTrack.php) | 40% | 45% | 32% | 46% | 13% | 31% | 39% | 13% | 15% | 21% | 26% | 29% | 16% | 29% | 23% | 27% | 35% | 49% |