USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM
Procurement and Supply Management

2023 Contraceptive Security Indicators Report

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The USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project is funded under USAID Contract No. AID-OAA-I-15-0004. GHSC-PSM connects technical solutions and proven commercial processes to promote efficient and cost-effective health supply chains worldwide. Our goal is to ensure uninterrupted supplies of health commodities to save lives and create a healthier future for all. The project purchases and delivers health commodities, offers comprehensive technical assistance to strengthen national supply chain systems, and provides global supply chain leadership.

GHSC-PSM is implemented by Chemonics International, in collaboration with Arbola Inc., Axios International Inc., IDA Foundation, IBM, IntraHealth International, Kuehne + Nagel Inc., McKinsey & Company, Panagora Group, Population Services International, SGS Nederland B.V., and University Research Co., LLC. To learn more, visit **ghsupplychain.org**

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Acronyms

CHW	community health worker
COC	combined oral contraceptive
CS	contraceptive security
DRC	Democratic Republic of the Congo
EC	emergency contraceptive pills
FP	family planning
FY	fiscal year
GHSC-PSM	Global Health Supply Chain Program-Procurement and Supply Management
ISO	International Organization of Standards
IUD	intrauterine device
LAC	Latin America and the Caribbean
LMIS	logistics management information system
mCPR	modern contraceptive prevalence rate
MOH	Ministry of Health
NEML	National Essential Medicines List
NGO	nongovernmental organization
NMRA	national medicines regulatory authority
NQCL	national quality control laboratory
POP	progestin-only pill
PSE	private-sector engagement
QA	quality assurance
RH	reproductive health
SDP	service delivery point
SF	substandard and falsified
SRA	stringent regulatory authority
USAID	United States Agency for International Development
WHO-PQ	World Health Organization-prequalified

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01.

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Executive Summary

Contraceptive Security (CS) exists when every person can choose, obtain, and use quality contraceptives, whenever he or she needs them, for family planning/reproductive health (FP/RH). Governments are increasingly recognizing the importance and value of contraceptive security and regularly monitoring its progress.

This 2023 CS indicators report updates the 2021 report building upon 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 since 2010 and starting biennially in 2017. The USAID Global Health Supply Chain Program-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 tenth round — to benefit the global health community. This report presents data from 42 countries,[2] which includes updates in question wording, response options, and/or additional questions in the Finance and Procurement, Commodities, Policies, Supply Chain, Private Sector, and Impact of COVID-19 Pandemic sections. Changes to previous questions, and the addition of new questions, aim to continually increase the methodological rigor and relevance of the survey. A data collection and usage manual helps guide responses. To help data users to better interpret results within a larger country context, data for select contextual measures (formerly part of the Contraceptive Security Index) can be found in Annex B 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.

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

2. A limited number of countries were removed from the dataset pending data sharing approval. Data for those countries has been anonymized and contributes to aggregate "all country" results (therefore, numerators and denominators reflect the anonymously included data from those countries).

This report presents findings on leadership and coordination, finance and procurement, policies, supply chain, quality, private sector, and the impact of the COVID-19 pandemic on contraceptive security. Key findings include:

Leadership and Coordination

– In 2023, 95 percent of countries have a national committee that works on CS (consistent with 96 percent of countries in 2021); 90 percent of those committees have formal written terms of reference.

– 82 percent of CS committees developed policies, procedures, recommendations, and/or action plans (an increase from 76 percent in 2021), and 100 percent of those reported adhering to policies and procedures or implementing action plans.

– The commercial/private sector participates in 45 percent of CS committees (18 of 40), up from 33 percent in 2021.

– More than half of the CS committees met four or more times in the previous year.

Finance and Procurement

– 29 respondent countries (71 percent), have a government budget line item specifically for contraceptives, 81 percent of countries allocated government funds for contraceptive procurement in the most recently completed fiscal year, and 71 percent spent government funds on contraceptives in the most recently completed fiscal year.

– An average of 34 percent of financing comes from government sources and 66 percent from in-kind donations.

– Expenditures on contraceptives in about half the countries reporting (49 percent, or 19 out of 39 countries) exceeded or met the country's forecasted demand. The remaining 51 percent had a funding gap between funding spent and estimated contraceptive need.

Commodities[3]

– Countries offer on average 9 of the 13 assessed contraceptive methods across all sectors: 10 in public-sector facilities, 10 through the commercial/private sector, 9 in nongovernmental organizations (NGOs), and 7 through social marketing.

– 100 percent of reporting countries offer combined oral contraceptives (COCs) and intrauterine devices (IUDs) in the public sector, while 100 percent offer male condoms in both the commercial/private sector and NGO sectors.

– In the public sector, 98 percent of countries offer the five most common contraceptive methods (male condoms, COCs, injectables, IUDs, and contraceptive implants), and 95 percent offer at least 8 of the 13 assessed contraceptive methods.

– The commercial/private sector offers the five most common contraceptives in 86 percent of reporting countries (36 out of 42 countries).

3. There were 13 assessed contraceptive methods including: combined oral contraceptives (COCs), intrauterine devices (IUDs), injectable contraceptives, contraceptive implants, emergency contraceptive pills (ECs), progestin-only pills (POPs), male condoms, female condoms, tubal ligation, vasectomy, calendar-based awareness methods, contraceptive patches, and vaginal contraceptive rings.

Policies

– 98 percent of countries have either a CS or reproductive health commodity security strategy or a strategy that includes objectives for contraceptive security.

– In 57 percent of countries (24 of 42 reporting), FP commodities are subject to duties in at least one sector (public, commercial/private, NGO, or social marketing).

– 87 percent of countries have policies that enable the private sector to provide contraceptives, while 10 percent of countries (4 out of 39) have policies that hinder that ability.

– More than half of the countries (61 percent) have at least 50 percent of their providers trained to remove or insert implants and IUDs. In 2021 this was 65 percent but 41 percent in 2019.

– 15 percent of countries restrict access to contraceptives by unmarried people ages 15–19, and 10 percent by married people ages 15–19.

– On average, countries included nine FP methods on their National Essential Medicines List (NEML).

– Mobile phone outreach (92 percent) and community mobilization/engagement (90 percent) are the most popular channels for promoting family planning.

– 88 percent of surveyed countries (37 out of 42) made or plan to make a Family Planning 2030 (FP2030) commitment. Among those, 100 percent committed to improving domestic financing for contraceptives.

Supply Chain[4]

– 93 percent of countries (39 out of 42) have a logistics management information system (LMIS) that includes contraceptives. Among those, 95 percent capture contraceptive stock data at the service delivery provider (SDP) level.

– Of the 34 countries providing information on central-level stockouts, 26 percent reported zero stockouts in the most recent complete year[5] for any of the following most common FP/RH products: COCs, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms.

– 15 percent of countries reported zero central-level stockouts of any contraceptive commodity in the most recent complete year.

– Average annual stockout rates at the central level for the most common FP/RH methods[6] ranged as follows among countries reporting stockout rates above 0 percent:

  – **COCs:** For 10 countries the stockout rate ranged from 8 percent (Kenya) to 100 percent (Côte d'Ivoire).

  – **Injectable contraceptives:** For 14 countries the stockout rate ranged from 8 percent (Dominican Republic) to 100 percent (Côte d'Ivoire).

  – **Implants:** For 17 countries the stockout rate ranged from 3 percent (DRC) to 100 percent (Botswana). Seven countries that offer two formulations of implants had no stockouts of either (Benin, Ethiopia, Mali, Mozambique,

4. 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.

5. The most recent complete year refers to the latest 12-month period for which both contraceptive commodity forecast data and expenditure data are fully available for the public sector.

6. An FP/RH method can consist of multiple FP/RH products; for example, the implant method includes one-rod and two-rod implants. For this report, the term "method" refers to the group of one or more common product formulations. The term "product" will be used to refer only to a single formulation.

Nigeria, Togo, and Zimbabwe).

  - **IUDs:** Stockouts in 12 countries had rates ranging from 7 percent (DRC) to 92 percent (Côte d'Ivoire).
  - **Male condoms:** The 10 countries that reporting stockouts had rates ranging from 5 percent (El Salvador) to 100 percent (Côte d'Ivoire) stocked out.

- Average annual stockout rates at the service delivery point (SDP) level for the most common FP/RH methods ranged as follows among countries reporting stockout rates above 0 percent:
  - **COCs:** 26 countries had stockout rates ranging from 1 percent (Haiti and Togo) to 59 percent (DRC)
  - **Injectables:** For the remaining 29 countries with data, stockout rates ranged from 1 percent (Haiti and Togo) to 64 percent (Zambia).
  - **Implants:** For the remaining 27 countries, stockouts rated ranged from 0.23 percent (Bangladesh) to 90 percent (Botswana).
  - **IUDs:** Twenty-seven countries ranged from 0.06 percent (Bangladesh) to 59 percent (Zambia) stocked out. One country with data reported no stockouts (Cape Verde)
  - **Male condoms:** Twenty-six countries with data ranged from 0.05 percent (Bangladesh) to 59 percent (Kenya). Cape Verde was the only country with data reporting no stockouts.

Quality

- 98 percent (40 of 41 countries) require registration of locally manufactured or imported contraceptives by the in-country national medicines regulatory authority (NMRA).
- The average lead time for registration of contraceptives is less than six months for 56 percent of countries (20 countries out of 36 reporting). This reflects an upward trend since 2019, when the average lead time for 50 percent of countries was six months to one year; in 2021, 49 percent of countries reported an average lead time of less than six months.
- 79 percent of countries require testing of contraceptives at the national quality control laboratory (NQCL).
- The testing of contraceptives, excluding condoms, has increased since 2021. In 2023, 58 percent of responding countries reported that 'most' or 'some' contraceptives were tested, compared to 42 percent in 2021.
- The percent of countries in which the NMRA conducts field surveillance monitoring to identify substandard and falsified (SF) contraceptives rose from 32 percent to 61 percent between 2021 and 2023, with nine new countries confirming NMRA monitoring.

Private Sector

- 82 percent (27 of 33 countries) have more than three wholesalers registered in the country to distribute FP products.
- By FP product, the percent of countries where there were no WHO-prequalified or SRA-approved products registered for distribution ranged from 5 percent (COCs) to 30 percent (female condoms).

– 58 percent (19 of 33 countries) have established private-sector engagement plans to expand private-sector FP products or services. Of those, 79 percent have taken at least some actions to implement the plan.

Impact of COVID-19 Pandemic

– 84 percent of countries (32 of 38) reported having an emergency preparedness plan in place for pandemics that includes impact on FP, similar to in 2021, with Peru since adding a plan. Yemen reported having a plan in 2021 but not in 2023.

– Out of the 37 reporting countries, 86 percent have an emergency preparedness plan in place for other types of emergencies that includes impact on FP, which represented an additional 4 countries that confirmed having a plan, when they had no plan, or it was unknown in 2021 (Ghana, Mali, Nigeria, and Togo). Yemen reported having a plan in 2021 but not in 2023.

– 82 percent of countries reported having FP/RH supplies prepositioned for emergencies.

– 72 percent of the countries surveyed reported no impact of the COVID-19 pandemic on frequency of CS committee meetings in 2023 (up from 50 percent in 2021), 23 percent (down from 40 percent in 2021) reported reduced frequency of CS committee meetings, while 5 percent reported the pandemic prevented their ability to meet (down from 10 percent in 2021).

– 75 percent of countries reported no impact of the COVID-19 pandemic on the approved budget line for contraceptives (up from 63 percent in 2021). All or most of the contraceptive budget was shifted to COVID-19 response in 8 percent (3 countries), down from 5 countries (12 percent) in 2021.

– 62 percent of countries reported no impact of the COVID-19 pandemic on the amount of government spending for contraceptives (up from 59 percent in 2021).

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Introduction

The globally recognized concept of contraceptive security (CS) is the condition in which 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).

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 (from 900 million women in 2000 to nearly 1.1 billion in 2020[7]), and other health priorities compete for scarce resource needs, the ability of governments and other stakeholders to direct resources and legislation in support of supply chains and family planning service delivery increases in importance. The CS Indicators can assist national family planning programs and other stakeholders in obtaining data and monitoring progress in support of such initiatives as Family Planning 2030 (FP2030) and in achieving the United Nations Sustainable Development Goals and country-specific family planning goals.

PHOTO CREDIT: GHSC-PSM

7. United Nations Department of Economic and Social Affairs, Population Division (2020). World Family Planning 2020 Highlights: Accelerating action to ensure universal access to family planning (ST/ESA/SER.A/450).

Background

The CS Indicators and CS Index both originated under the USAID | DELIVER PROJECT to help countries and global aid managers and decision-makers measure and track country progress in several different areas toward improving access to contraceptives.

The CS Indicators build on the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS[8]) 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, and biennially starting in 2017 in the form of the Contextual Measures).

The former CS Index, now presented as individual secondary metrics (called Contextual Measures), provides insight into a mix of higher-level indicators to help countries identify strengths and weaknesses across four components—financing, health and social environment, access, and utilization. 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 Contextual Measures are obtained from secondary sources such as the World Bank and UNICEF and are intended to complement the survey's findings with additional context. The data are collected at the same time as the CS Indicators and can be found on the online dashboard and in the downloadable dataset. The CS Indicators and Contextual Measures are reported together starting in 2017 under the USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project. This report updates the 2021 report, which can be found on the GHSC website (www.ghsupplychain.org).

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.

PHOTO CREDIT: GHSC-PSM

8. Hare, L., et al., 2004.

03.

PHOTO CREDIT: GHSC-PSM

Methodology

The 2023 CS Indicators methodology has been updated since the last round in 2021. Changes are described in 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 (MOH) officials, or representatives of another donor or implementing partner.

Country Selection

The country selection approach for the CS Indicators Survey is purposive, focusing primarily on USAID FP priority countries and USAID FP transitioned countries (countries that have transitioned away from receiving USAID FP procurement funding), as well as on countries that have or plan to make an FP2030 commitment or which are part of the Ouagadougou Partnership. The following list of countries represents the 41 USAID FP priority countries (updated in 2023), the eight USAID FP transitioned countries, and three other countries (Cape Verde, Kyrgyz Republic, and Lao PDR) in which the survey was conducted in 2021 and/or in 2023. Among those three countries, Kyrgyz Republic and Lao PDR are FP2030 commitment countries. Out of the 47 countries that were contacted for the survey in 2023, 40 countries both completed the survey and agreed to share the data publicly, representing an 85 percent response rate. This includes 28 in the Africa region, 6 in Asia and Middle East, and 6 in Latin America and the Caribbean (LAC). Countries that were recently added to USAID's FP priority list, including Cambodia, Jordan, and Timor-Leste, were not included in this survey round, but may be selected in future rounds.

PHOTO CREDIT: GHSC-PSM

Out of the 47 countries that were contacted for the survey in 2023, 40 countries both completed the survey and agreed to share the data publicly, representing an 85 percent response rate.

TABLE 1

Characteristics of selected and respondent countries

Country	USAID FP Priority Countries	USAID FP Transitioned Countries	Ouagadougou Partnership Countries	FP2030 Commitment Countries	CS Indicators 2021 Respondent Countries	CS Indicators 2023 Respondent Countries
Afghanistan	✓					
Angola	✓				✓	✓
Bangladesh	✓			✓	✓	✓
Benin	✓		✓	✓	✓	✓
Botswana		✓			✓	✓
Burkina Faso	✓		✓	✓	✓	✓
Burundi	✓			✓	✓	✓
Cambodia	✓					
Cameroon	✓			✓	✓	
Cape Verde					✓	✓
Côte d'Ivoire	✓		✓	✓		✓
Dominican Republic		✓				✓
DRC	✓			✓	✓	✓
Egypt	✓					
El Salvador		✓			✓	✓
Ethiopia	✓			✓	✓	✓
Ghana	✓			✓	✓	✓
Guatemala	✓				✓	✓
Guinea	✓		✓	✓	✓	✓
Haiti	✓				✓	✓
Honduras		✓		✓	✓	✓
India	✓			✓		
Indonesia		✓		✓		
Jordan	✓					
Kenya	✓			✓	✓	✓
Kyrgyz Republic				✓	✓	✓
Lao PDR				✓	✓	
Liberia	✓			✓	✓	✓
Madagascar	✓			✓	✓	✓
Malawi	✓			✓	✓	✓
Mali	✓		✓	✓	✓	✓
Mauritania	✓		✓	✓	✓	✓

Country	USAID FP Priority Countries	USAID FP Transitioned Countries	Ouagadougou Partnership Countries	FP2030 Commitment Countries	CS Indicators 2021 Respondent Countries	CS Indicators 2023 Respondent Countries
Mozambique	✓			✓	✓	✓
Nepal	✓			✓	✓	✓
Niger	✓		✓	✓	✓	
Nigeria	✓			✓	✓	✓
Pakistan	✓			✓	✓	✓
Peru		✓			✓	✓
Philippines	✓			✓	✓	✓
Rwanda	✓			✓	✓	✓
Senegal	✓		✓	✓	✓	✓
Sierra Leone	✓				✓	✓
South Africa		✓				
South Sudan	✓			✓	✓	✓
Sri Lanka		✓			✓	
Tanzania	✓			✓	✓	✓
Timor-Leste	✓					
Togo	✓		✓	✓	✓	✓
Uganda	✓			✓	✓	✓
Yemen	✓				✓	✓
Zambia	✓			✓	✓	✓
Zimbabwe	✓			✓	✓	

Survey Response and Validation Process

The survey tool was created in MS Excel and incorporates drop-down menus and free-text response elements. Responses to questions were collected through key informant interviews and document reviews within each focus country. In countries with project presence, GHSC personnel led the data collection and initial validation. Elsewhere, this was done by USAID, MOH officials, or representatives of another donor or implementing partner (e.g., UNFPA).

The survey was disseminated in June 2023, and responses were received between August and December 2023. Validation took place between August 2023 and April 2024.

Depending on local data collection opportunities and constraints, key informants may include staff at the MOH; Ministry of Finance; other government officials, managers, and policymakers for FP/RH programs; representatives from associations of pharmacists or health providers; representatives of NGOs or donor agencies; and representatives of private-sector retailers or manufacturers, or associations. Key informants in some cases may be able to cite official documents such as policies, budgets, or strategies in their responses. Survey respondents are requested to cite the sources they consulted to the extent possible for each response, and whether these sources are organizational entities and/or documents, databases, or information systems. These sources are captured in the documentation, which can be found in the downloadable database and listed in columns O and P of the surveys.

The GHSC-PSM and GHSC-Technical Assistance (GHSC-TA) Francophone Task Order home offices coordinated with in-country survey leads to validate the responses. This included ensuring that there is internal logic, consistency, and completion within each survey and with previous CS surveys completed

by the country. Secondary sources were referenced for some indicators, most notably the GHSC-PSM ARTMIS database for USAID procurement values, the Global Family Planning Visibility and Analytics Network (GFPVAN) for UN and other donor procurements, and the FP2030 website for details on country commitments.

Analysis

Responses for each section were aggregated across countries, within countries, or, where country aggregation is not meaningful, using other descriptive (non-inferential) methods. To present the commodity mix and stockout rates, for example, data are presented by FP method rather than by country. Percentages as well as the underlying numerators and denominators are presented in the summary tab of the online downloadable dataset.

Quantitative results for a selection of indicators are presented in the dashboard through descriptive statistics that allow users to view results by survey section and by indicator at a country or cross-country (global) level. A downloadable database with additional aggregated results as well as full country-by-country results is available for users to conduct additional analysis themselves, as needed.

Qualitative data are analyzed thematically and discussed throughout the survey report. Some qualitative indicators are depicted in frequency charts in the dashboard, while others are presented by country in the downloadable database summary tab. Full qualitative responses can be found in the country survey tabs of the downloadable database.

PHOTO CREDIT: GHSC-PSM

Changes in Methodology from Previous Report

GHSC-PSM, in close collaboration with USAID, reviewed the survey tool and made changes and updates to improve the clarity and utility of the survey. The main changes to note are found in Section C (Commodities), and Section H (Impact of the COVID-19 pandemic). In Section C, the 2023 survey more explicitly measures the conditions under which a contraceptive method is 'offered' within a sector (public, commercial, NGO, and social marketing). To be 'offered', a method must meet at least one of the following two conditions: 1) The method is required to be offered by a formal written policy, or 2) The method has been procured and/or distributed in the previous 12 months. In Section H, the survey follows up on the status of operational practices intended to facilitate access to FP/RH services and commodities during the peak of the COVID-19 pandemic, which were first reported in 2021, and asks a new question about whether FP/RH commodities have been pre-positioned for emergency preparedness. A few other minor changes were made throughout the survey to clarify question wording, response options, and skip patterns. The full survey tool can be found in Annex A.

Quantitative results for a selection of indicators are presented in the dashboard through descriptive statistics that allow users to view results by survey section and by indicator at a country or cross-country (global) level. Qualitative data are analyzed thematically and discussed throughout the survey report.

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PHOTO CREDIT: GHSC-PSM

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 rolling 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 many of the data sources. When possible, indicators were validated against other secondary data sources, though most relied on the key informants and their sources. As with all data provided by key informants, these data rely on respondent knowledge and may be affected by reporting biases. Where responses were unknown or not applicable at the time of survey completion, they have been removed from the denominator when calculating percentages.

The FP commodity funding gap in countries is depicted as the percent of U.S. dollars spent on FP commodities for the public sector out of the total FP commodity forecast for the public sector.

This measure can be difficult to interpret due to exchange rate fluctuations, changes in inflation rates and commodity costs, differing methodologies for commodity forecasting, and different ways government budgets account for contraceptive commodity costs. All of these could artificially increase or decrease the FP funding gap. In some cases, a government may not have visibility into all public sector FP commodity donations (for example, when donations go directly to social marketing organizations, as these commodities are included in public sector expenditures but not often captured in forecasts), thereby reflecting a larger-than-expected spending-to-forecast ratio (and therefore an artificially low funding gap). Other factors affecting this gap could include commodity deliveries planned for one year but occurring in a later period, forecasts that exclude commodities currently available in the pipeline (which could mask the true annual demand for contraceptives), or FP forecasts that do not include condom needs that are forecast under HIV programs.

Regional comparisons and comparisons between countries have not been drawn in this survey, due to the limited numbers of respondent countries in several regions and the non-random selection of the countries responding in each region.

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

Due to differences in reporting countries, revisions to some questions and additions of others, comparisons with previous CS Indicators surveys are limited.

Some indicator percentages intended to total 100 percent have been rounded in the narrative for ease of reading and therefore may not total 100 percent. In graphs, decimal places are hidden, enabling percentages to correctly sum to 100.

Additional information on specific country data can be found in the full data set on the GHSC-PSM website, or by contacting the GHSC-PSM project.

05.

PHOTO CREDIT: GHSC-PSM

Leadership and Coordination

Effective and strong leadership is necessary for effective coordination among in-country partners in the public, NGO, social marketing, and commercial/private sectors to ensure resources, financing, and information are used to strengthen CS. The survey collected data on the existence of a contraceptive security committee, composition of its membership, frequency of meetings, legal status, terms of reference, and whether the committee has started, developed, and/or implemented FP action plans or policies.

Highlights

95%

of countries have a national committee that works on CS, and 90 percent of those committees have formal written terms of reference.

51%

More than half of the CS committees met four or more times in the previous year.

82%

of CS committees developed policies, procedures, recommendations, and/or action plans (an increase from 76 percent in 2021), and 100 percent of those reported adhering to policies and procedures or implementing action plans.

45%

The commercial/private sector participates in 45 percent of CS committees, up from 33 percent in 2021.

Contraceptive Security Committee

Of 42 countries, 95 percent (40) have a committee that works on CS (Exhibit 1). This number has remained relatively stable since 2017. These committees continue to be prevalent in countries and remain highly active in terms of meeting frequency: 87 percent of committees met at least twice in the previous year, and 82 percent of committees developed policies, procedures, recommendations, and/or action plans. Of the countries with CS committees, 78 percent have legal or administrative status, and 90 percent have a formal written terms of reference. The MOH is represented on the committee in all countries. NGOs participate in 90 percent of CS committees; UN agencies, 95 percent; social marketing sector, 77 percent; central medical store/central warehouses, 90 percent; donors, 85 percent; other entities, 61 percent; Ministry of Finance or Planning, 35 percent; and the commercial/private sectors, 45 percent. The share of CS committees in which the commercial sector participates has been hovering at around one-third for the past several rounds of the survey. In this iteration, it reached 45 percent of countries reporting.

Eighty-two percent of the CS committees have developed policies, procedures, or action plans, and 100 percent of these responded that there is evidence that these policies and plans are taking place or being implemented (Exhibit 2).

Fifty-one percent of the CS committees met four or more times per year, while 36 percent met two to three times, 8 percent met once, and 5 percent did not meet at all (Exhibit 3).

The primary functions of CS committees among respondent countries continue to be:

– Monitoring FP stock levels and coordinating supply chain interventions, particularly forecasting and quantification (24 countries),
– Overseeing implementation of national FP strategies (23 countries),
– Making technical or policy recommendations (17 countries), and
– Increasing communication and collaboration among FP stakeholders (16 countries).

EXHIBIT 1

Percentage of countries that have CS committees, and their composition

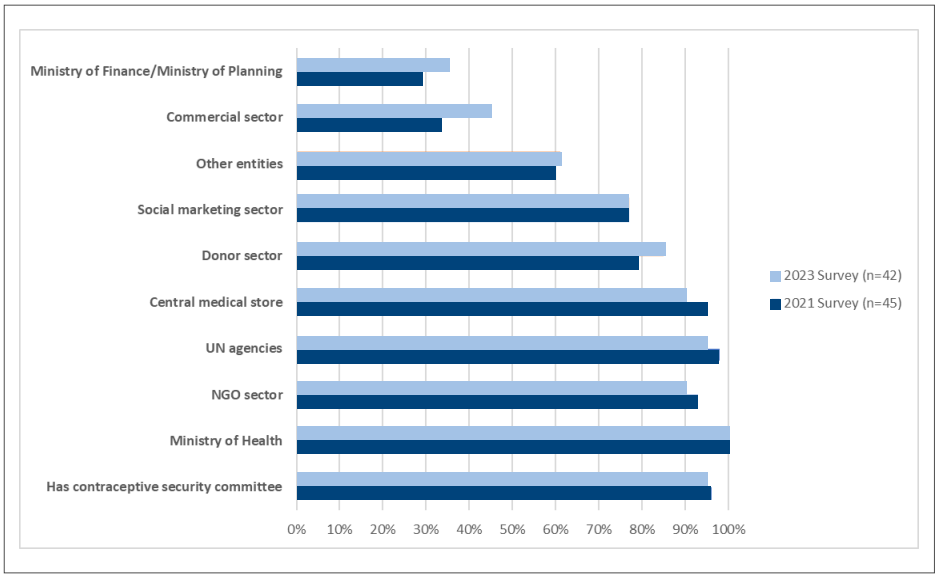


EXHIBIT 2

Activity of CS committees

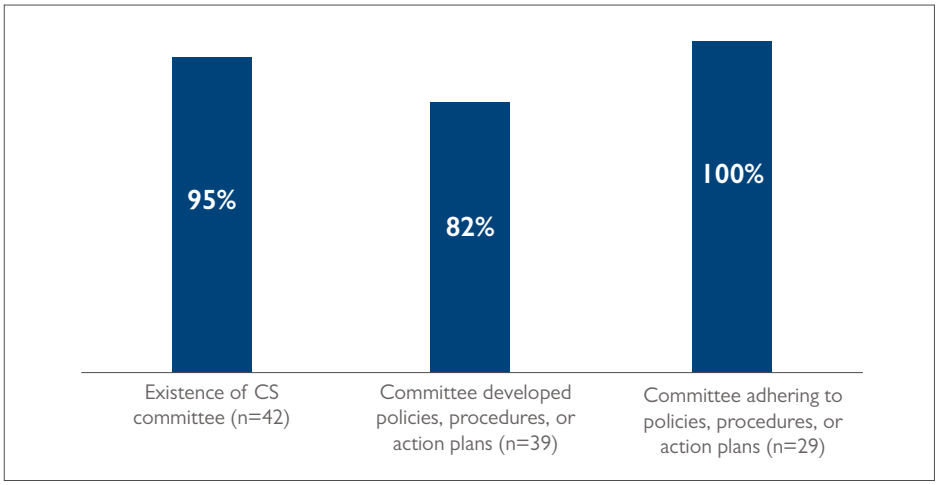
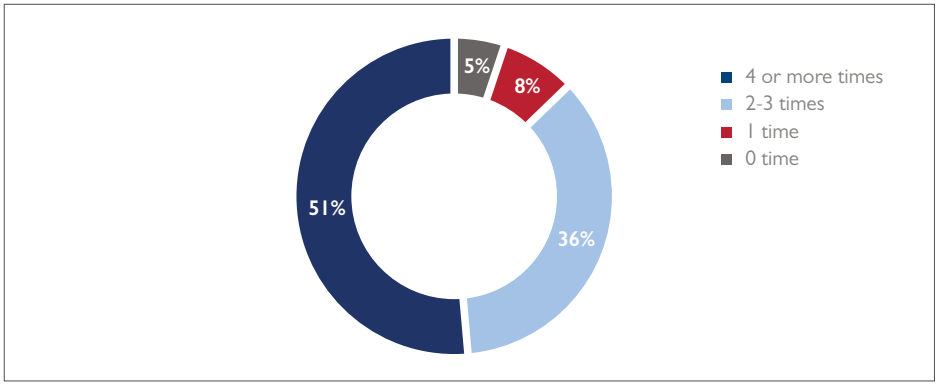


EXHIBIT 3

Frequency of CS committee meetings in the previous year (n=39)



06.

PHOTO CREDIT: GHSC-PSM

Finance and Procurement

A sufficient and reliable stream of financing for procuring contraceptives is essential to achieving contraceptive security. Tracking the different sources of financing, including government, in-kind donations, and grants from year to year reveals the availability of funding to cover estimated need and any financing gaps.

In the survey, a combination of indicators gauging a country's contraceptive-related forecasting, allocation, and actual expenditures is used to obtain an overall country-level picture of contraceptive financing from a variety of sources and to assess the country's sustainability of CS.

The average total expenditures on FP commodities across countries have decreased by nearly 10 percent from a reported $8,888,428 in 2021 to $8,056,996 reported in 2023, when comparing the 40 countries that reported in both survey rounds. The reported total expenditures do not account for inflation, which may account for some of the observed decrease in government spending. The potential influence of inflation, which jumped from 1.9 to 8 percent worldwide between 2020 and 2022, coupled with exchange rate fluctuations and other factors that may have influenced spending trends, warrants further investigation.[9]

Highlights

34%

An average of 34 percent of financing comes from **government sources** and 66 percent from in-kind donations. The government share of total spending represents a decrease from both 2021 and 2019 when governments spent a total of 47 and 48 percent, respectively. This large decrease was driven by five countries which previously spent government funds but did not release funds on time this assessment year, i.e. within the most recently completed 12-month period for which both contraceptive commodity forecast data and expenditure data are available.

51%

More than half of reporting countries had a funding gap between their forecast and spending, the same as in 2021. However, the amount of the funding gap greatly increased. In 2023, FP commodity funding across countries covered 78 percent of the demand, down from 92 percent in 2021.

71%

of respondent countries have a government budget line item specifically for contraceptives (down slightly from previous years).

81%

of countries allocated government funds for contraceptive procurement in the most recently completed fiscal year, and 71 percent spent government funds.

9. High inflation rates in some of the respondent countries may in part explain expenditure trends. A World Bank Inflation, Consumer Price Index table showing inflation rates in the 2023 CS Indicators Survey respondent countries between 2018 and 2022 can be found in Annex C.

PHOTO CREDIT: GHSC-PSM

Government funding sources comprise 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.

Financing Sources and Expenditures for Public-sector Contraceptives

Countries were asked to provide the government funding sources used toward procuring contraceptives. Government funding sources comprise 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. 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.

Government Expenditures

Of 42 country responses, 81 percent allocated funds toward public-sector contraceptive procurement, and 71 percent spent government funds on contraceptives for the most recently completed fiscal year.

EXHIBIT 4

Government spending by source, 2023 assessment year (U.S. dollars)

Country	Internally generated funds spent	All other government funds spent	Total government funds spent	Internally generated funds as a percent of total government funds spent
Angola	$0	$751,539	$751,539	0%
Bangladesh	$1,434,952	$18,571,429	$20,006,381	7%
Benin	$327,600	N/A	$327,600	100%
Botswana	$1,969,668	$0	$1,969,668	100%
Burkina Faso	$1,272,981	$0	$1,272,981	100%
Burundi	$60,876	$1,027,320	$1,088,196	6%
Cape Verde	$288,525	$0	$288,525	100%
Côte d'Ivoire	$800,000	$0	$800,000	100%
Dominican Republic	$2,099,869	$0	$2,099,869	100%
DRC	$2,097,680	$0	$2,097,680	100%
El Salvador	$0	$0	$0	N/A
Ethiopia	$1,895,064	$13,164,357	$15,059,422	13%
Ghana	$0	$590,381	$590,381	0%
Guatemala	$2,175,777	$0	$2,175,777	100%
Guinea	$1,300,000	$0	$1,300,000	100%
Haiti	$0	$0	$0	N/A
Honduras	$1,697,902	$0	$1,697,902	100%
Kenya	$0	$0	$0	N/A
Kyrgyz Republic	$83,720	$11,562	$95,282	88%

Country	Internally generated funds spent	All other government funds spent	Total government funds spent	Internally generated funds as a percent of total government funds spent
Liberia	$0	$0	$0	N/A
Madagascar	$203,000	$0	$203,000	100%
Malawi	$647,872	$1,236,582	$1,884,454	34%
Mali	$441,208	$0	$441,208	100%
Mauritania	$0	$0	$0	N/A
Mozambique	$241,584	$0	$241,584	100%
Nepal	$1,080,840	$0	$1,080,840	100%
Nigeria	$0	$0	$0	N/A
Pakistan	$11,430,704	$0	$11,430,704	100%
Peru	$20,290,780	$0	$20,290,780	100%
Philippines	$6,668,837	$0	$6,668,837	100%
Rwanda	$0	$656,883	$656,883	0%
Senegal	$769,230	$0	$769,230	100%
Sierra Leone	$0	$0	$0	N/A
South Sudan	$0	$0	$0	N/A
Tanzania	$1,382,890	$0	$1,382,890	100%
Togo	$166,667	$0	$166,667	100%
Uganda	$0	$0	$0	N/A
Yemen	$0	$0	$0	N/A
Zambia	$0	$0	$0	N/A
Zimbabwe	$1,700,000	$0	$1,700,000	100%

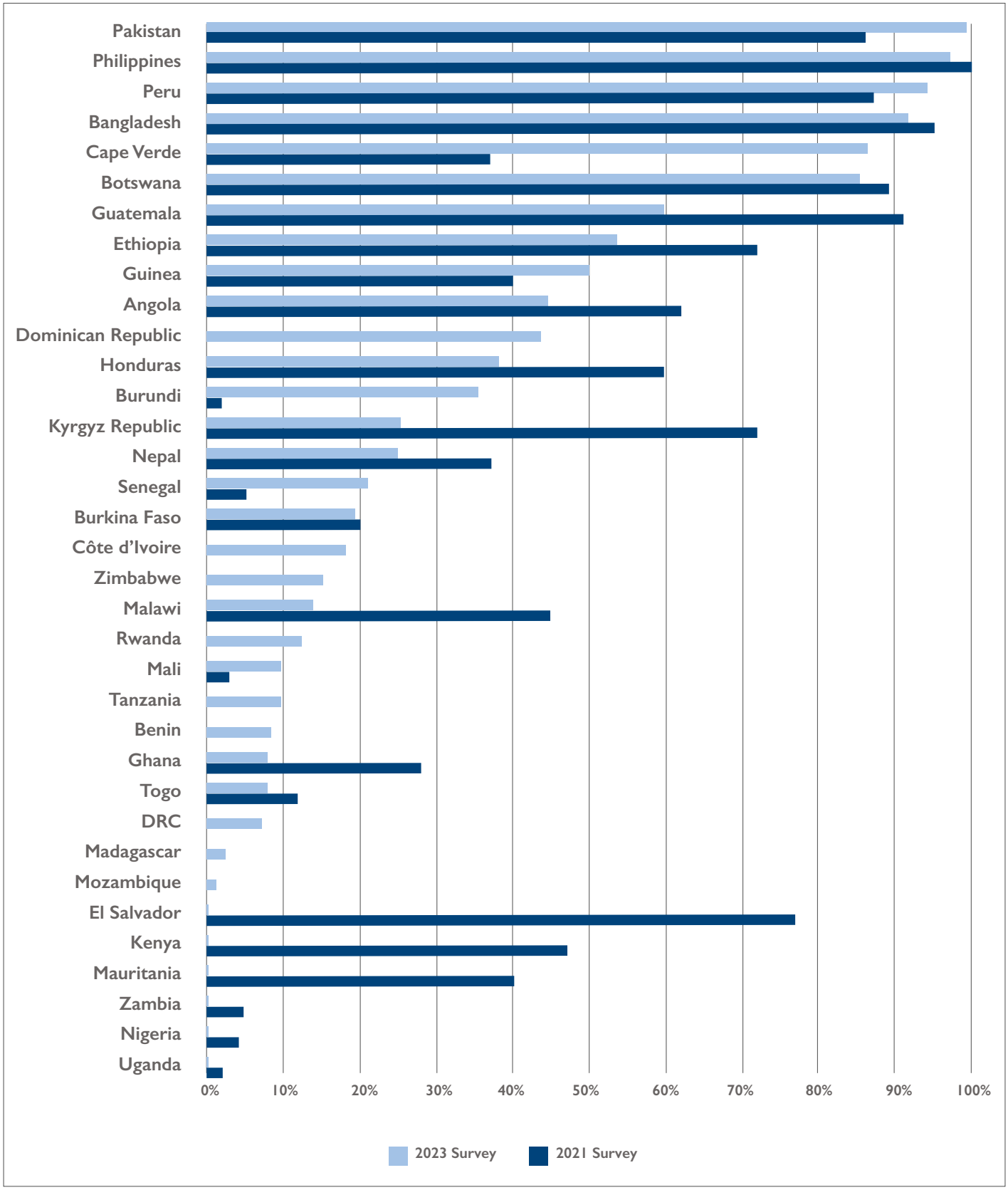
In twelve countries, no government funds were utilized for public-sector contraceptive procurement

Of the countries that did use government funds to procure contraceptives, the proportion of government financing ranged from 1 percent (Mozambique) to 99 percent (Pakistan), with the median rate being 24 percent. The government share of total spending constituted nearly the entire amount spent in the Philippines (97 percent), Peru (94 percent), and Bangladesh (91 percent). It also made up the majority of total spending in Cape Verde (86 percent), Botswana (85 percent), Guatemala (60 percent), Ethiopia (53 percent), and Guinea (50 percent). In twelve countries, no government funds were utilized for public-sector contraceptive procurement, including: Uganda, Nigeria, Zambia, Mauritania, Kenya, El Salvador, Haiti, Liberia, Sierra Leone, South Sudan, and Yemen. Five of these countries—Haiti, Liberia, Sierra Leone, South Sudan, and Yemen—spent 0 percent of government funds in both 2021 and 2023, resulting in their exclusion from Exhibit 5. In contrast, six countries—El Salvador, Kenya, Mauritania, Zambia, Nigeria, and Uganda—had government spending in 2021 but not in 2023; these countries still appear in Exhibit 5.

PHOTO CREDIT: GHSC-PSM

EXHIBIT 5

Total government spending as a share of total spending on public-sector contraceptives, 2021 and 2023[10]



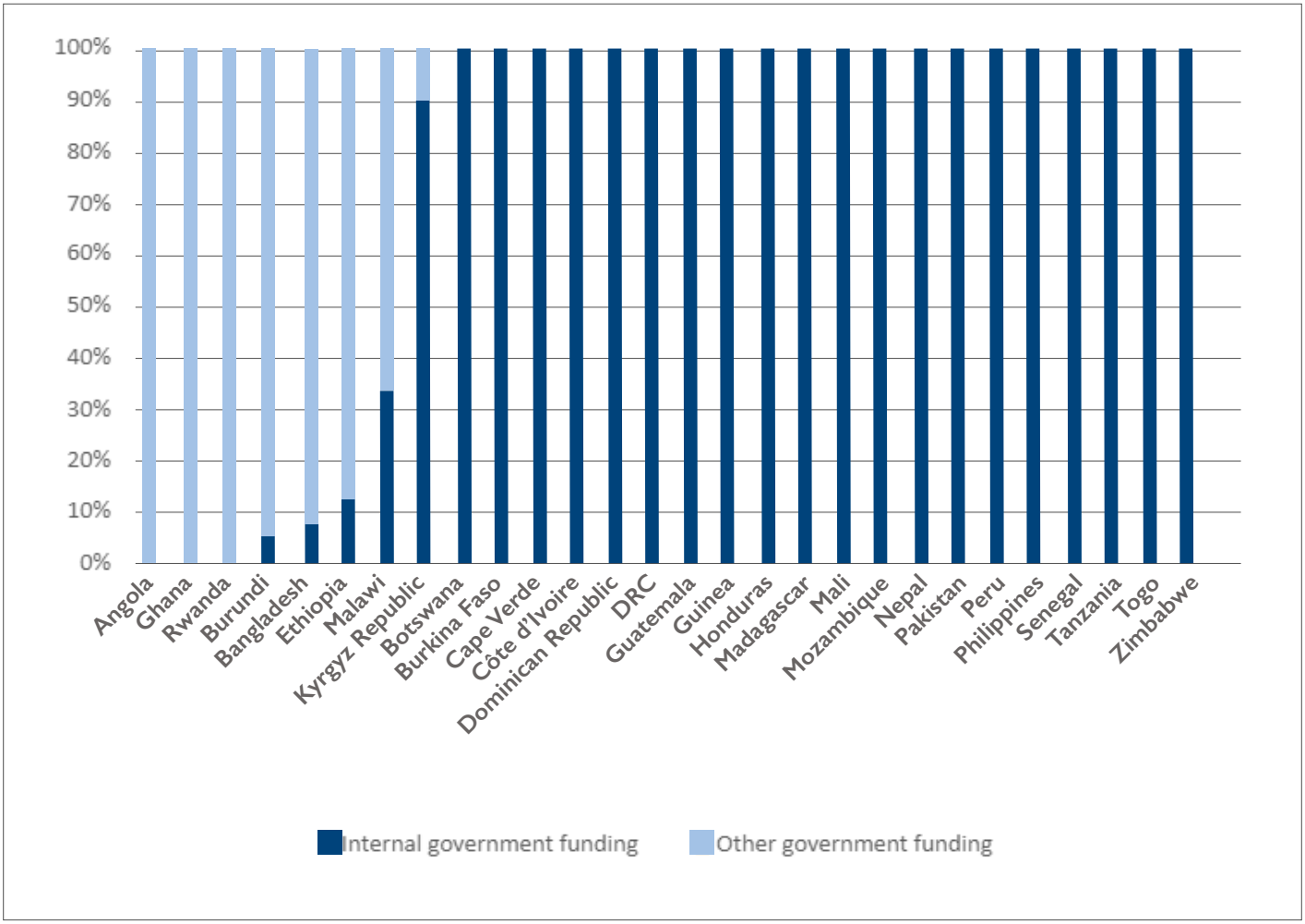
10. Excludes Haiti, Liberia, Sierra Leone, South Sudan, and Yemen where government spending was 0 percent in both 2021 and 2023.

Of the 28 countries that used government funds for contraceptives, in 20 countries (71 percent) internally generated funds were the only source of government funds used toward the purchase of contraceptives.

When looking at government funding sources as a total of contraceptive spending, internally generated funds made up 23 percent and other government funds made up 11 percent.

EXHIBIT 6

Share of government spending on contraceptives by government funding source (n=28)[11]

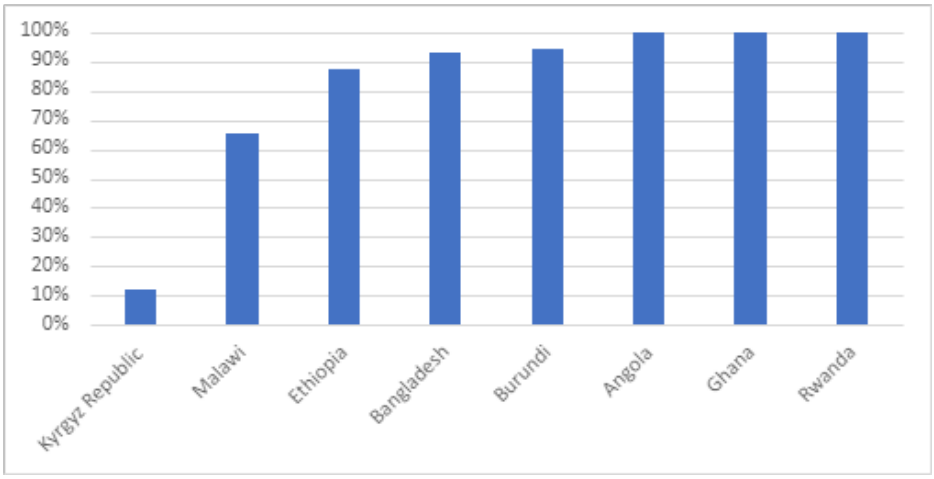


11. Excludes El Salvador, Haiti, Kenya, Liberia, Mauritania, Nigeria, Sierra Leone, South Sudan, Uganda, Yemen, and Zambia where government funding was 0 percent, and Benin, where other government funding was unknown.

For the eight countries that used other government funds (basket funds, World Bank credits or loans, and other funds donors provided to the government, such as direct budget support), this source accounted for 12 percent (Kyrgyz Republic) to 100 percent (Angola, Ghana, and Rwanda) of total government funding (see Exhibit 7). In other words, among countries that utilized other government funds, the proportion of these funds varied within the overall government financing.

EXHIBIT 7

Percentage of other government spending as a share of total government spending on contraceptives, non-zero countries shown (n=28)

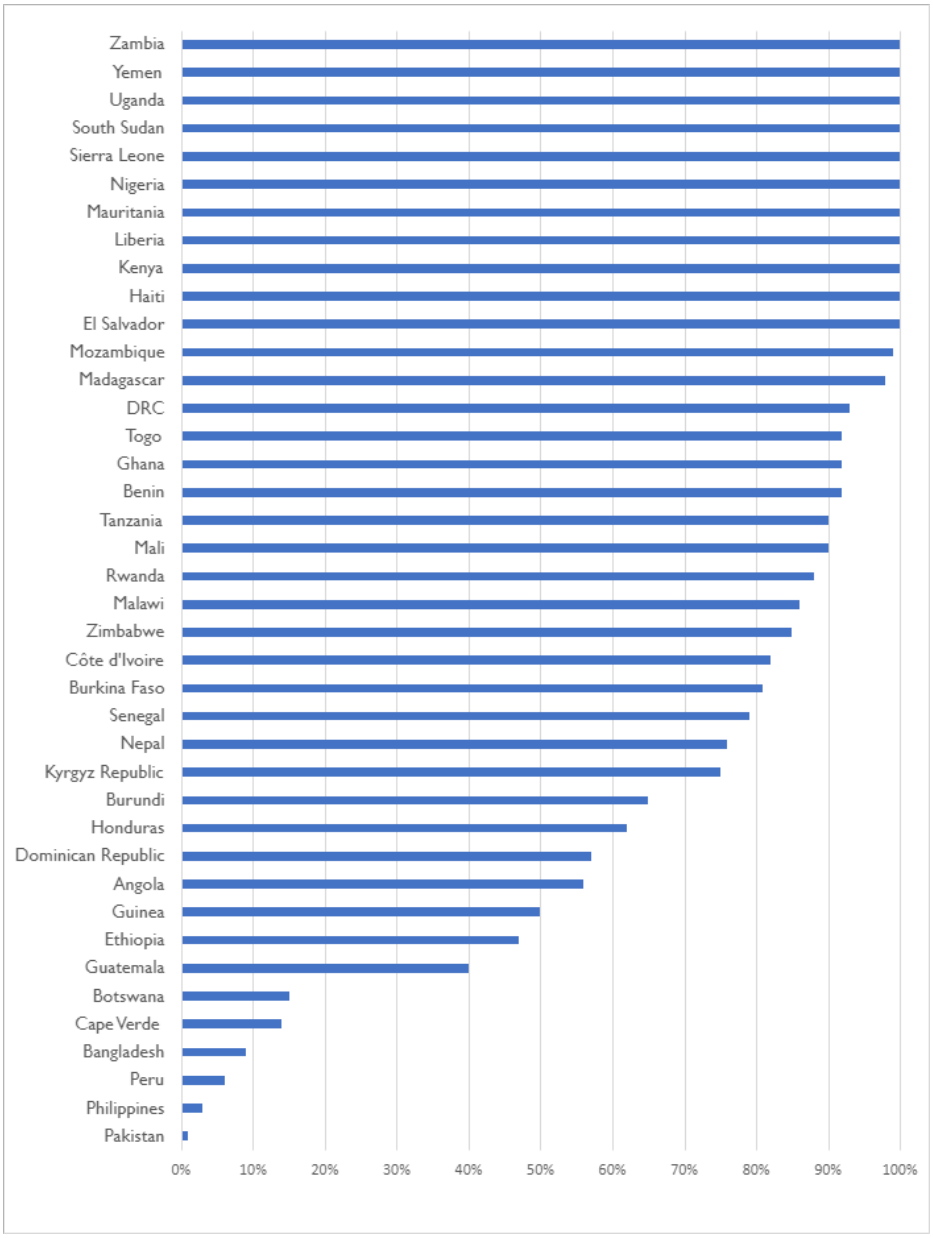


In-Kind Donations and Global Fund Grants

Of 40 country responses, all received in-kind donations (Exhibit 8). For 11 countries, in-kind donations were the sole funding source for procuring contraceptives. For 21 countries, in-kind donations comprised 50 percent to 99 percent of total contraceptive funding. In the remaining 8 countries, funding from in-kind donations ranged from 1 percent (Pakistan) to 47 percent (Ethiopia). Donations from the UN accounted for the largest amount (37 percent), followed by USAID (20 percent), Global Fund and other donations (each 4 percent), and other bilateral organizations (1 percent). UN and USAID donations have increased since 2021 from 29 percent and 14 percent, respectively.

EXHIBIT 8

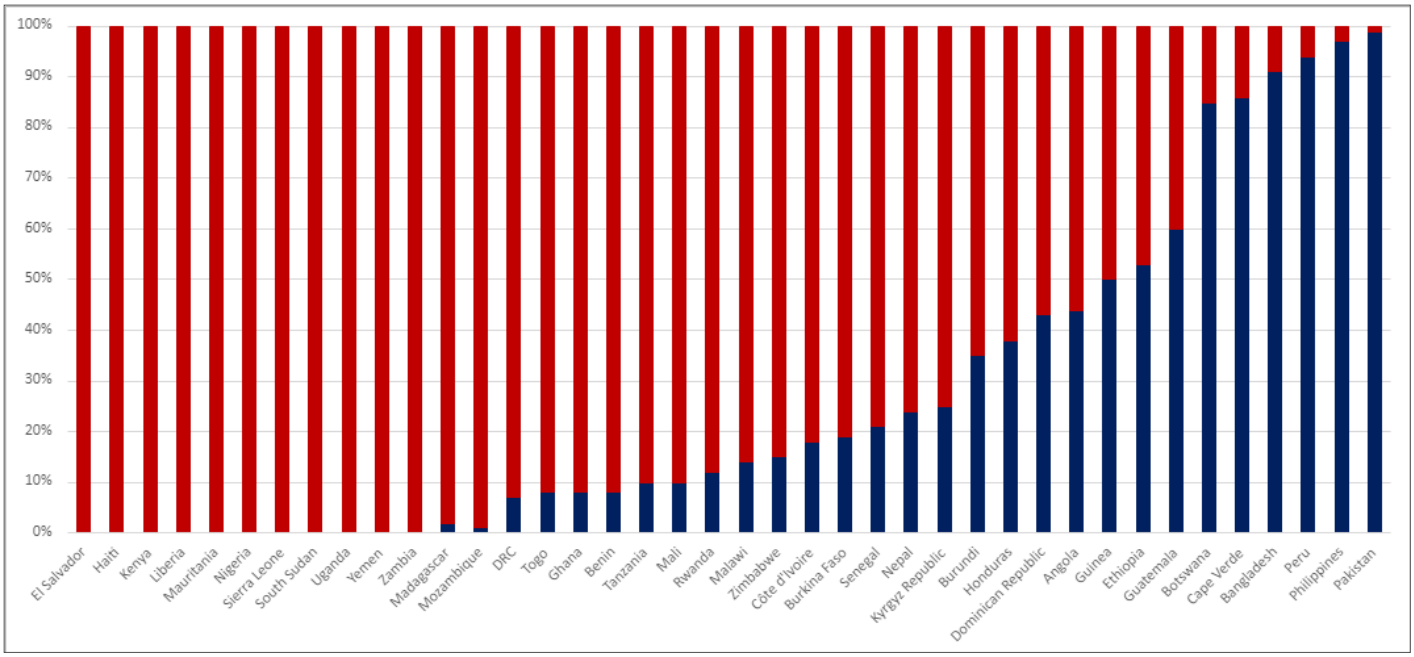
In-kind donations and grants as a percentage of total spending on public-sector contraceptives (n=40)



In terms of total spending, 34 percent of financing for contraceptives came from government sources and 66 percent from in-kind donations (Exhibits 9 and 10). These percentages are similar to those from 2019, where contraceptive financing was composed of 38 percent government financing and 62 percent in-kind donations. In 2021, there was a shift toward a greater share of government financing (47 percent) compared to in-kind donations (53 percent).

EXHIBIT 9

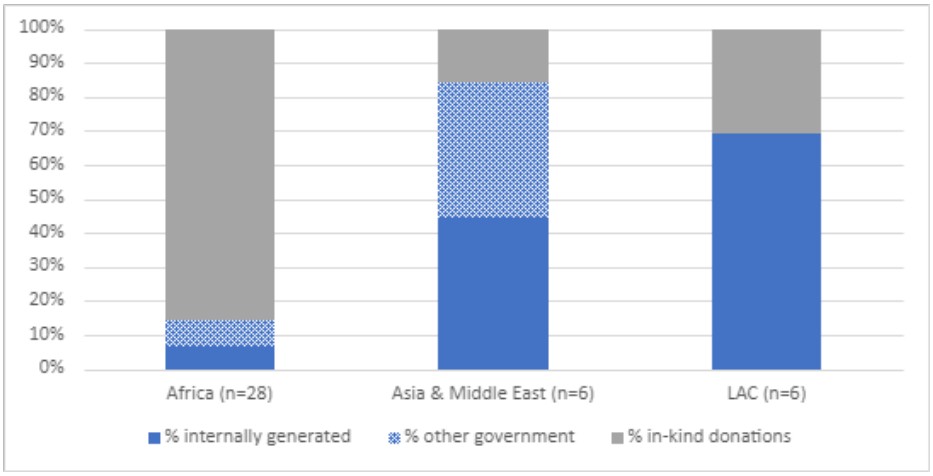
Percentage of total spending on public-sector contraceptives by funding source (n=40)



The Asia and Middle East region used the greatest amount of total government spending toward procuring public-sector contraceptives (84 percent, down from 91 percent in 2021), followed by LAC (69 percent, up from 66 percent in 2021) and Africa (15 percent, down from 23 percent in 2021). The Africa region used mainly in-kind donations (86 percent), while in-kind donations made up 31 percent in the LAC region.

EXHIBIT 10

Total contraceptive spending by source and region (n=40)



Budget Line Item

The existence of a budget line item for procuring contraceptives is a demonstration of a country's commitment to contraceptive security but does not necessarily guarantee funds will actually be spent to purchase contraceptives. In 2023, 29 out of 41 reporting countries had a budget line item for FP commodities. This was 32 out of 44 reporting countries in 2021. Of those countries that reported in both survey rounds, Liberia and Tanzania only reported having budget line items for contraceptives in 2021 while Madagascar and Zimbabwe only reported having a budget line item for contraceptives in 2023. Eighty-one percent of countries allocated government funds toward the purchase of FP commodities. Seventy-one percent of countries spent government funds on FP commodities, similar to the share of government spending in 2021 (70 percent).[12] Six countries have a budget line item but did not use government funds (Haiti, Kenya, Mauritania, Nigeria, Uganda, Zambia), while another six used government funds to procure contraceptives, but did not have a dedicated budget line (Botswana, Dominica Republic, Ghana, Mali, Philippines, Tanzania). Five countries do not have a budget line item and did not spend government funds (El Salvador, Liberia, Sierra Leone, South Sudan).

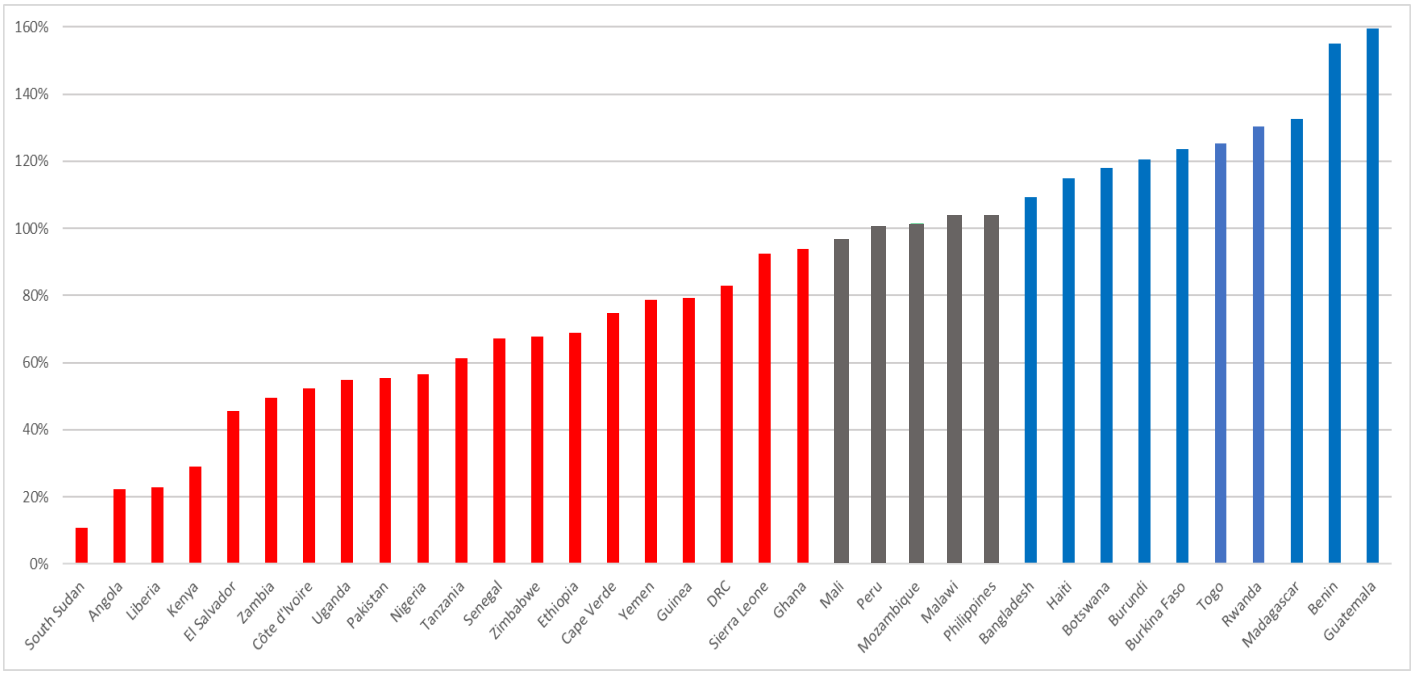
Financing Gap for Procurement of Public-sector Contraceptives

Of 39 countries, 20 (51 percent) had a funding gap between the forecasted need and available financing (Exhibit 11).[13]

Even though the number of countries with a funding gap remained constant from 2021, the total gap in funding widened. This was due to the large drop in government spending, offset slightly by an increase in donations (from an average of $4.3 million in 2021 to $5.2 million in 2023). Five countries that previously spent government funds on contraceptives (Zambia, Kenya, Nigeria, El Salvador, and Mauritania) did not do so in the current assessment year due to governments not releasing funds on time.

EXHIBIT 11

Percentage of quantified need covered by any source of funding (n=38)[14]



Key: Red = 0–94 percent of funding need met, Grey = 95–105 percent of funding need met, Blue = 106+ percent of funding need met.

12. Spending on contraceptives in this survey is defined as the value in U.S. dollars of contraceptives actually delivered (in cases where delivery data were available) in the country's most recently completed 12-month period for which data were available at the time of the survey. Commodities delivered in one year may have been planned for an earlier or later year. Similarly, commodities may have been planned for a year but not actually delivered in that year.

13. The Limitations section discusses some of the explanations for the fluctuations in this indicator result.

14. Outliers not shown: Honduras 262 percent, Dominican Republic 284 percent, Nepal 410 percent.

07.

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Commodities

Having a range of contraceptive methods gives clients the ability to choose a method that best meets their needs. Respondents were asked which contraceptive methods are offered through the public, commercial/ private, NGO, and social marketing sectors.

The survey gathered information on the following 13 methods:

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

Highlights

86%

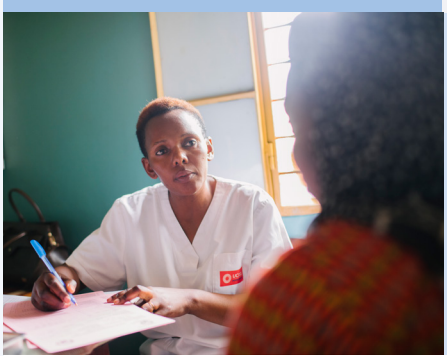
The commercial/private sector offers the five most common contraceptives (male condoms, COCs, injectables, intrauterine devices, and contraceptive implants) in 86 percent of reporting countries.

9

Countries offer on average 9 of the 13 assessed contraceptive methods: 10 in public-sector facilities, 10 through the commercial/private sector, 9 in NGOs, and 7 through social marketing

100%

of reporting countries now offer combined oral contraceptives and IUDs in the public sector, while 100 percent offer male condoms in both the commercial and NGO sectors.



98%

In the public sector, 98 percent of countries offer the five most common contraceptive methods, and 95 percent offer at least 8 of the 13 assessed contraceptive methods.

Methods Offered by Sector

Short-term methods such as male condoms, COCs, and injectables are commonly offered across all four sectors. Long-term methods such as IUDs are offered in 100 percent of countries through the public sector, through NGOs in 98 percent of countries, and through the commercial/private sector in 95 percent of countries, while implants are offered in the public sector in 98 percent of surveyed countries and through NGOs in 95 percent of the countries. Permanent methods—vasectomy and tubal ligation—are more often offered through the public sector than through any other sector. Emergency contraceptives are more commonly offered in the commercial/private sector than in other sectors.

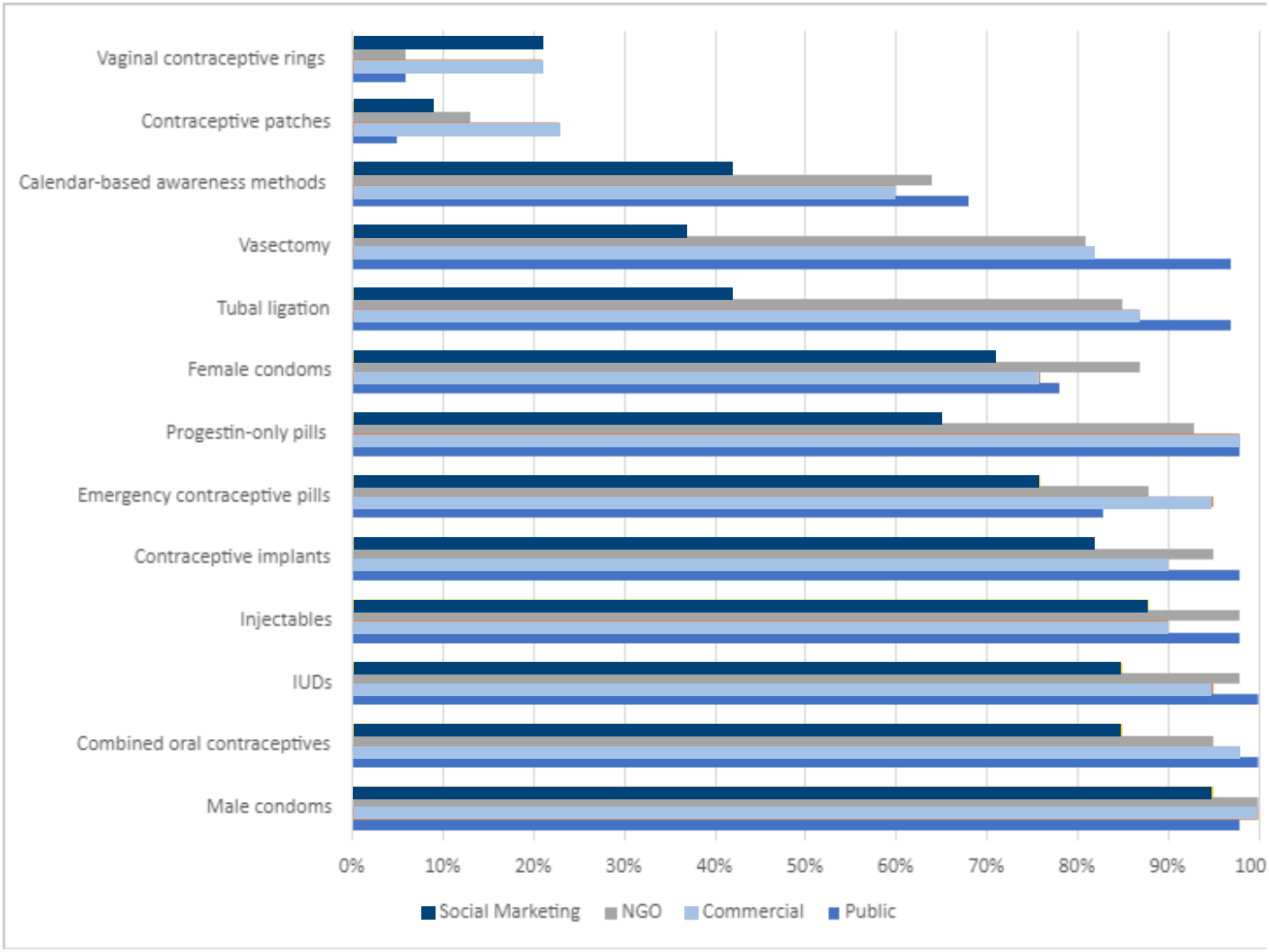
Public Sector

Of all countries surveyed, an average of 10 methods are offered in the public sector, and at least 8 methods are offered in the public sector in 95 percent of countries. Furthermore, 98 percent provide all five of the most offered methods in public-sector facilities (male condoms, COCs, injectables, IUDs, and implants) (Exhibit 12). In 2021, this was 89 percent and 91 percent, respectively.

All countries offer COCs and IUDs in the public sector. Nearly all countries offer POPs. Only the Kyrgyz Republic does not offer injectables, implants, or male condoms in the public sector. Most countries offer tubal ligation and vasectomy (both 97 percent), emergency contraceptive pills (83 percent), female condoms (78 percent), and calendar-based methods (68 percent) in the public sector. Only a small percentage offer vaginal contraceptive rings (6 percent) and contraceptives patches (5 percent).

EXHIBIT 12

Method mix by sector (percentage of countries that offer the following contraceptive methods by sector) (n=42)



NGOs

The NGO sector is another good source of a variety of contraceptives for clients. In most countries, male condoms (100 percent), COCs and implants (both 95 percent), IUDs and injectables (both 98 percent), ECs (88 percent), female condoms (87 percent) and POPs (93 percent), can be found through the NGO sector. Countries with NGOs providing female condoms increased from 71 percent in 2021 to 87 percent in 2023. Calendar-based methods (64 percent), contraceptive patches (13 percent), and vaginal contraceptive rings (6 percent) are not as commonly found at NGO facilities. An average of 9 of 13 methods are available in the NGO sector, and the five most common methods can be found in the NGO sector in 88 percent of reporting countries.

Commercial/Private Sector

COCs and male condoms are available through the commercial/private sector in almost all countries (98 percent and 100 percent, respectively). ECs (95 percent), POPs (98 percent), injectables (90 percent) and IUDs (95 percent) are also commonly offered. Implants have shown a substantial increase in the commercial/private sector (from 79 percent in 2021 to 90 percent in 2023), as has vasectomy (from 68 percent to 82 percent in the same period). Calendar-based methods offered in this sector have also increased, from 37 percent of countries in 2021 to 60 percent in 2023. Female condoms (76 percent), vaginal contraceptive rings (21 percent), and contraceptive patches (23 percent) are offered less frequently in the commercial/private sector. An average of 10 of 13 methods are available in the commercial/private sector, and all five of the most common methods can be found in the commercial/private sector in 86 percent of reporting countries, an increase from the reported 73 percent for all five methods in 2021.

Countries with NGOs providing female condoms increased from 71 percent in 2021 to 87 percent in 2023.

Social Marketing

Male condoms (95 percent), COCs and IUDs (both 85 percent), and injectables (88 percent) are offered through social marketing in most countries. The percentage of countries in which IUDs and injectables are offered in this sector has increased from 76 percent and 77 percent in 2021, respectively. Availability of implants, POPs, ECs, and female condoms can be found in 65 percent to 82 percent of countries. Calendar-based methods (42 percent), contraceptive patches (9 percent), and vaginal contraceptive rings (3 percent) are less commonly found through social marketing, as are vasectomy (37 percent) and tubal ligation (42 percent). An average of 7 of the 13 methods are available in the social marketing sector, and the five most common methods can be found in the social marketing sector in 71 percent of reporting countries.

The number of countries offering vasectomy and tubal ligation in the social marketing sector has nearly tripled since 2021 (from 5 and 6 countries to 14 and 15 countries, respectively).

PHOTO CREDIT: GHSC-PSM

08.

PHOTO CREDIT: GHSC-PSM

Policies

Policies supportive of contraceptive security are essential to provide an enabling environment for client access and awareness of contraceptives, and to allow health workers to provide and prescribe them as needed. Supportive policies demonstrate a government commitment to strengthen contraceptive security.

A supportive (or enabling) CS environment is defined[15] 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

98%

of countries have either a CS or reproductive health commodity security strategy or a strategy that explicitly mentions increasing contraceptive access.

57%

In 57 percent of countries, FP commodities are subject to duties in at least one sector (public, commercial/private, NGO, or social marketing).

87%

of countries have policies that enable the private sector to provide contraceptives, while 10 percent of countries have policies that hinder that ability.

61%

of countries have at least 50 percent of their providers trained to remove or insert implants and IUDs. In 2021 this was 65 percent but 41 percent in 2019.

15%

of countries have laws, policies, or regulations that make it difficult for unmarried people ages 15–19 to access family planning services or contraceptives, and 10 percent of countries reported this for married people ages 15–19.

9

On average, countries included 9 FP methods on their NEML.

15. USAID Data for Impact project, Policy Environment overview, Family Planning and Reproductive Health Indicators Database, (https://www.data4impactproject.org/prh/health-systems/policy-environment/).

National Strategy with Objectives for Contraceptive Security

Most national FP/RH strategies (specifically their contraceptive security components) aim to influence overall family planning outcomes, such as increasing the availability of and access to FP services and commodities; reducing unmet need; increasing demand for FP and ultimately increasing the modern contraceptive prevalence rate (mCPR); improving maternal and child health; and reducing maternal, neonatal, and child mortality. The strategies and sub-objectives for achieving these higher-level goals are varied, but a common theme is health system strengthening, especially through capacity building. Within this overarching theme, several countries cited objectives to improve service delivery and FP product quality, strengthen aspects of the supply chain, and improve monitoring and evaluation.

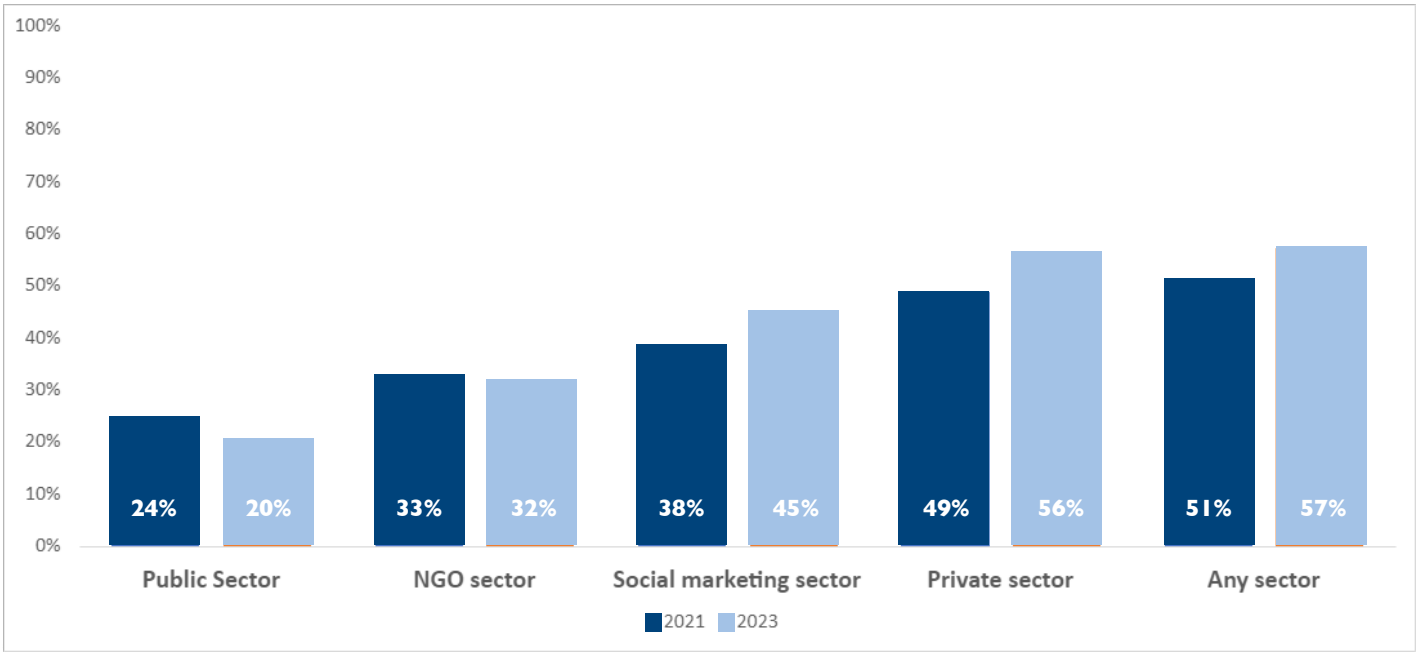
Policy Barriers Impacting Access or Provision to Contraceptives

Duties

Fifty-seven percent of countries reported that FP commodities are subject to duties for at least one sector (Exhibit 13). In 20 percent of countries (8 of 40), public-sector FP commodities are subject to duties. Duties are applied to the social marketing sector in 45 percent of the countries and the NGO sector in 32 percent of the countries. The percentage of countries subject to duties on FP commodities in the commercial/private sector increased from 49 percent in 2021 to 56 percent in 2023; DRC and El Salvador reported private sector duties in 2023 but not in 2021.

EXHIBIT 13

Percentage of countries where FP commodities are subject to duties by sector



Policies that impact the ability of the private sector to provide contraceptives Of all country respondents, 10 percent (4 of 39) reported there are policies that hinder the ability of the private sector to provide contraceptives (Exhibit 14).

The percentage of countries reporting the existence of policies hindering the private sector's distribution of contraceptives has declined over the survey years from 43 percent of countries in 2010 (15 of 35) to 10 percent in 2023 but has remained relatively steady since 2017. Examples of such barriers include specific permission needed to import contraceptives, branding or advertising restrictions, high taxes on contraceptives, price controls, and bans on mass media promotion.

National governments continued the trend of coordinating with the private sector to expand contraceptive access. Most countries (87 percent) reported having enabling policies, while only 4 countries cited policies that hinder the private sector's provision of contraceptives. Some of the specific enabling policies cited include governments supporting training for private sector providers, subsidizing contraceptives in the private sector, facilitating private imports, such as through tax exemptions, public/private provider networks and franchises, accreditation services and regulations allowing for over-the-counter sale of contraceptives. However, the number of countries that impose duties on FP commodities in the private sector has increased; two countries that did not report that duties were imposed in 2021 now reported duties in 2023.

In 87 percent of surveyed countries (34 of 39), there are policies that enable or support the private sector provision of contraceptives. This was 93 percent (38 of 41) in 2021, 90 percent (35 of 39) in 2019, 94 percent (30 of 32) in 2017, and 73 percent (33 of 45) in 2015.

EXHIBIT 14

Policies that enable or hinder private-sector provision of contraceptives (n=39)

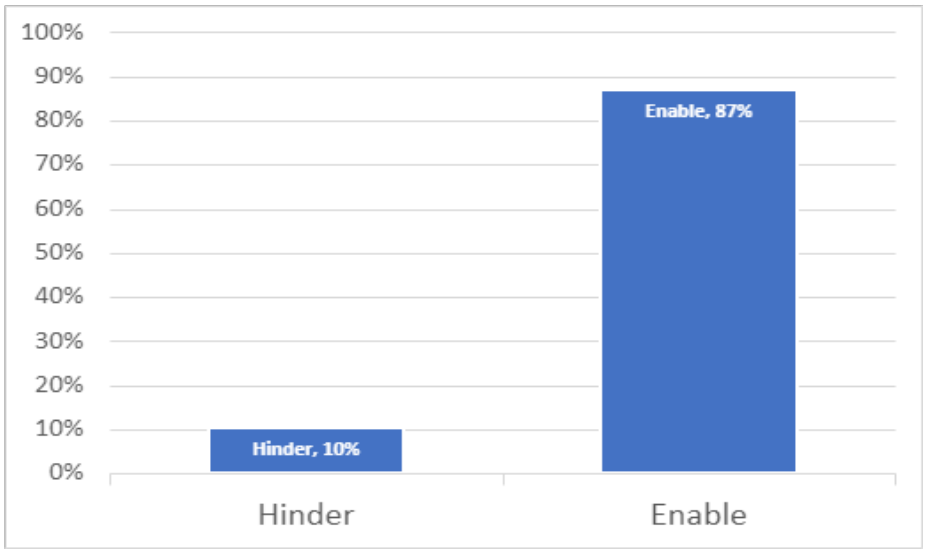
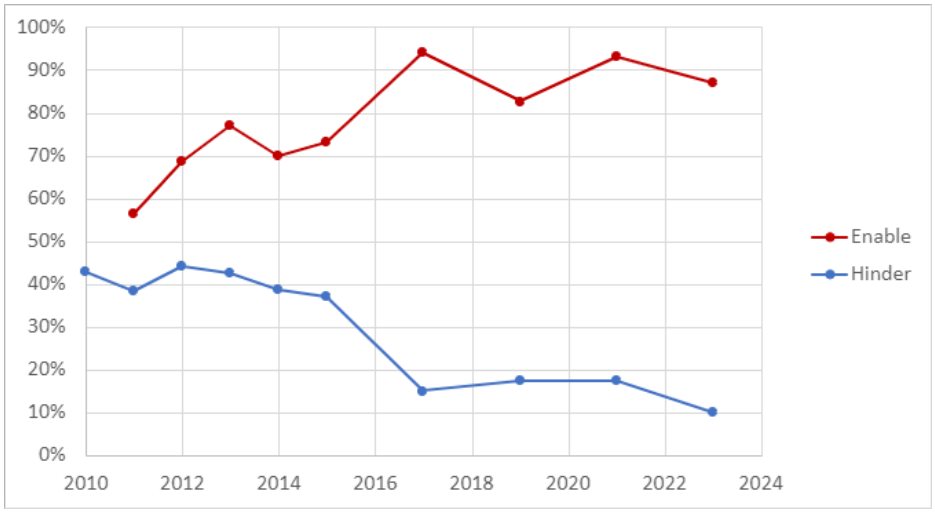


EXHIBIT 15

Trend over time in policies that impact private-sector distribution of contraceptives



Dispensing restrictions

Restrictions on those who can dispense certain contraceptives can be barriers preventing clients from easily accessing the method of their choice. In the commercial/private sector, a greater percentage of countries reported that community health workers (CHWs) were authorized to distribute condoms, combined oral contraceptives (COCs), progestin-only pills (POPs), and (emergency contraceptive pills) ECs compared to in 2021. In the public sector, the authorizations have stayed roughly the same since 2021 for these methods, except a greater percentage of countries reported CHWs were authorized to distribute condoms in 2023.

In the public sector, CHWs were the most cited lowest level provider across all methods (6 out of 13 methods), mostly short-term methods. For long-acting reversible methods—implants and IUDs—clients must go to higher-level providers in the public sector in most countries to receive the method. In the private sector, nurses and CHWs were the most frequently cited lowest level providers for 4 methods out of the 13 each; for CHWs, these were mostly short-term methods while nurses were the lowest-level providers for ECs, injectables, implants, and contraceptive patches. For short-term methods, CHWs are the lowest-level provider who can sell or dispense male and female condoms (90 percent and 81 percent, respectively) in the public sector (Exhibit 16). COCs can be provided by CHWs in most countries through the public sector (71 percent), although less frequently in the private sector (34 percent). For COCs in the private sector, the percentage of auxiliary nurse midwives as the lowest level provider has shown a consistent rise from 5 percent in 2019 to 15 percent in 2023. Subcutaneous (54 percent) and intramuscular injectables (28 percent), a popular method, are less frequently reported to be dispensed by CHWs in the public sector, and even less in the private sector (26 and 16 percent, respectively). The percentage of countries where CHWs can provide subcutaneous injectables in the public sector has nearly doubled since 2021 (29 percent of countries).

Exhibit 16.

Lowest level provider allowed to dispense/sell contraceptive methods in the public sector

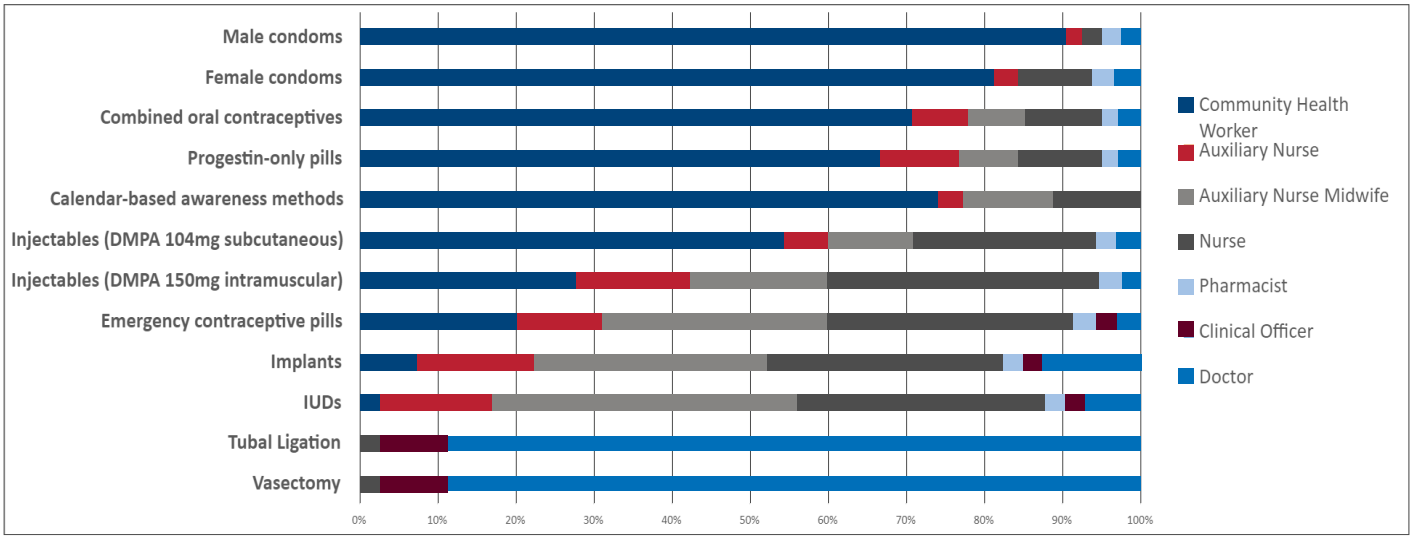
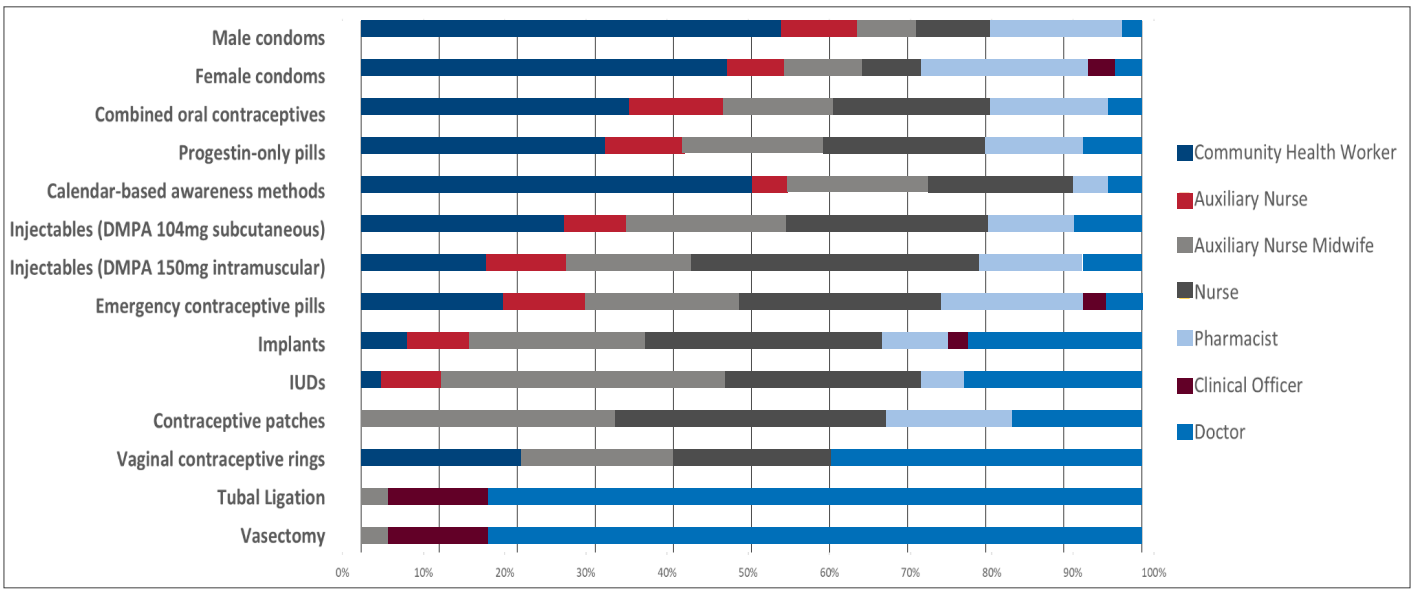


Exhibit 17.

Lowest level provider allowed to dispense/sell contraceptive methods in the private sector

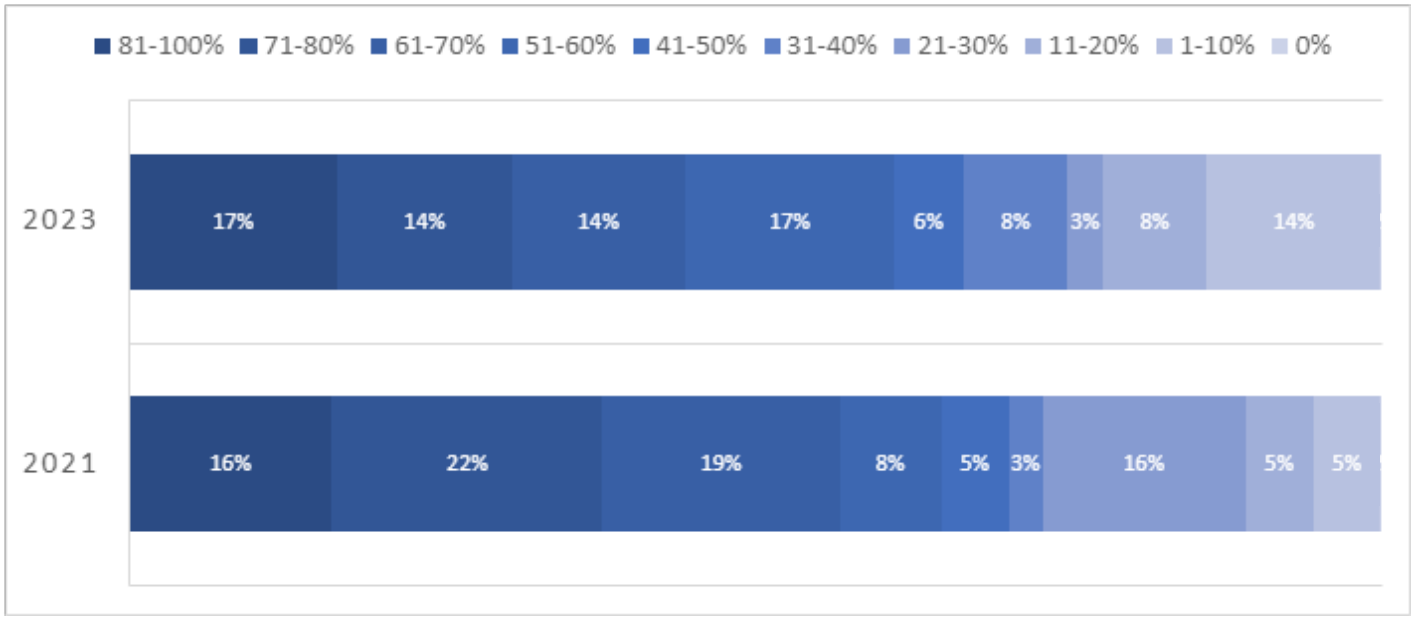


Provider skills in implant and IUD insertion and removal

The survey asked the approximate percentage of public-sector FP providers trained in implant and IUD insertion and removal (Exhibit 18). Seventeen percent said 81–100 percent of providers are trained, 14 percent responded 71–80 percent, and another 14 percent responded that 61–70 percent are trained, 17 percent said 51–60 percent are trained, 6 percent said 41–50 percent, 8 percent responded that 31–40 percent are trained, 3 percent said 21–30 percent are trained, 8 percent responded that 11–20 percent are trained, and 14 percent said 1–10 percent are trained. In 2021, 57 percent of countries had at least 61 percent of public sector FP providers who could place and remove implants and IUDs. In 2023, that percentage decreased to less than half of reporting countries (45 percent).

EXHIBIT 18

Approximate percentage of public sector FP providers trained in implant and IUD insertion and removal



Policies that impact the ability of sub-populations to access family planning services and contraceptives

The survey asked whether there are laws, regulations, or policies that either increase or decrease access to family planning services and commodities for sub-populations: unmarried youth, married youth, rural, disadvantaged sub-regions, populations with lower educational attainment, lower-income populations, disabled, minority populations (ethnic or religious groups), and other (e.g., migrants, internally displaced populations).

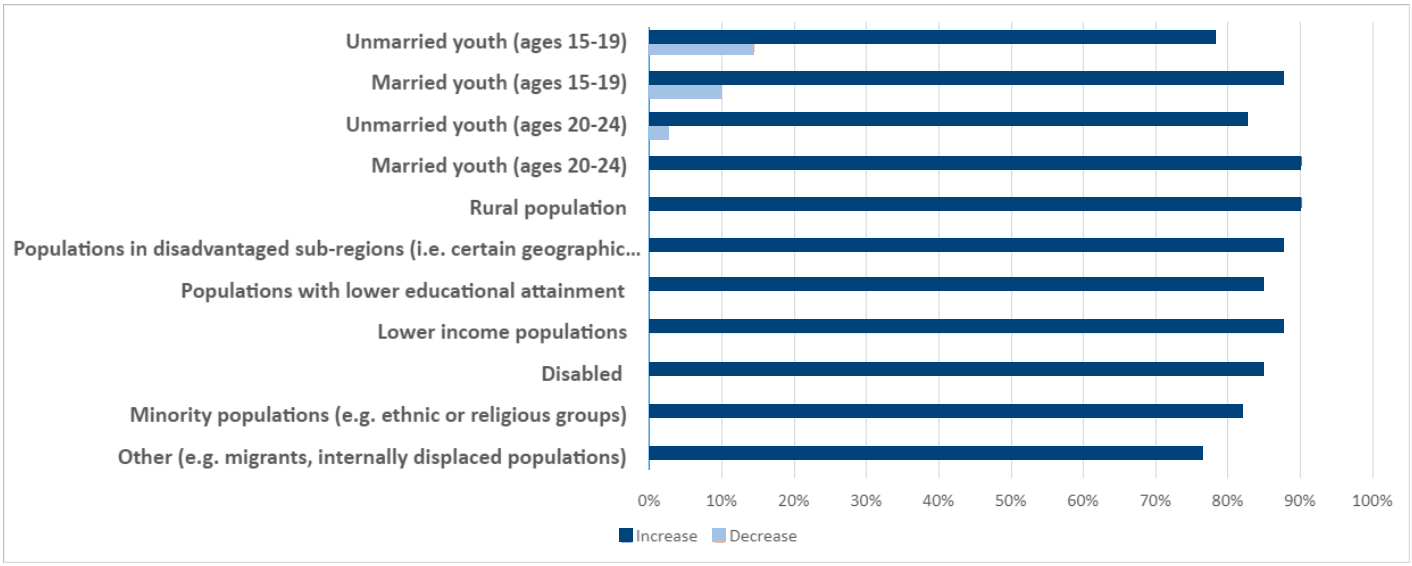
Most countries have supportive policies for family planning among the sub-populations (Exhibit 19). These include for unmarried youth in 78 percent (ages 15–19 years) and 83 percent (ages 20–24 years) of countries, and for married youth in 88 percent (ages 15–19 years) and 90 percent (ages 20–24 years) of countries.

Ninety percent of countries reported having policies to enable access to FP for the rural population, 87 percent for those in disadvantaged sub-regions, 85 percent for those with lower education, 88 percent for those with lower incomes, 85 percent for those who are disabled, 82 percent for minority populations, and 76 percent for those who are considered migrants or internally displaced populations. These data are similar to 2021, except for a decrease in 2023 of policies for migrants or internally displaced populations from 83 percent to 76 percent.

There are countries that have policies hindering access to FP for those between 15 and 19 who are either unmarried (15 percent) or married (10 percent) and those who are unmarried between the ages of 20 and 24 (2 percent, or one of 41 countries — Bangladesh). The latter shows a decrease from 7 percent, or three of 45 countries — Bangladesh, Honduras and Yemen in 2021.

EXHIBIT 19

Laws, regulations, or policies that enable or hinder access to FP services among sub-populations (n=41)



The most commonly cited policy approach to increasing access to contraceptives among sub-populations is to focus on adolescents and youth (cited by 17 countries). Many countries have specific youth-focused RH or reproductive, maternal, newborn and child health (RMNCH) strategies or policies. Other common policies aimed at increasing access include offering free family planning services and/or commodities (five countries) and community health worker or health extension programs designed to better reach rural populations (five countries).

Only a few countries cited laws or policies that negatively impact FP/RH access among sub-populations. Seven countries cited these barriers, which included policies limiting access to contraceptives below a minimum age (five countries), or a nominal marriage requirement for accessing contraceptives (two countries: Bangladesh and Pakistan). In the case of Pakistan, however, this requirement is reportedly not enforced in practice.

Cultural and operational practices that impact the ability of sub-populations to access family planning services and contraceptives

The survey also asked if there are operational, cultural, or other practices that may either increase or decrease access to FP services for the same sub-populations as noted in the above section.

Eighty-three percent of countries have supportive practices toward unmarried youth (ages 15–19) and 79 percent for unmarried youth ages 20–24. Supportive practices exist for married youth ages 15–19 in 83 percent of responding countries and for married youth ages 20–24 in 79 percent (Exhibit 20). Practices exist that increase access to FP for rural populations (82 percent), disadvantaged sub-regions (76 percent), lower education (79 percent), lower income (77 percent), disabled and minority populations (both 76 percent), and migrants or internally displaced populations (67 percent). Less than half of the countries responded that there are cultural practices that hinder access for unmarried youth ages 15–19 (46 percent). These cultural and operational barriers were also noted in 40 percent of the countries for married youth in the same age group. For the 20–24 age group it is 33 percent for unmarried youth, and 25 percent for married youth.

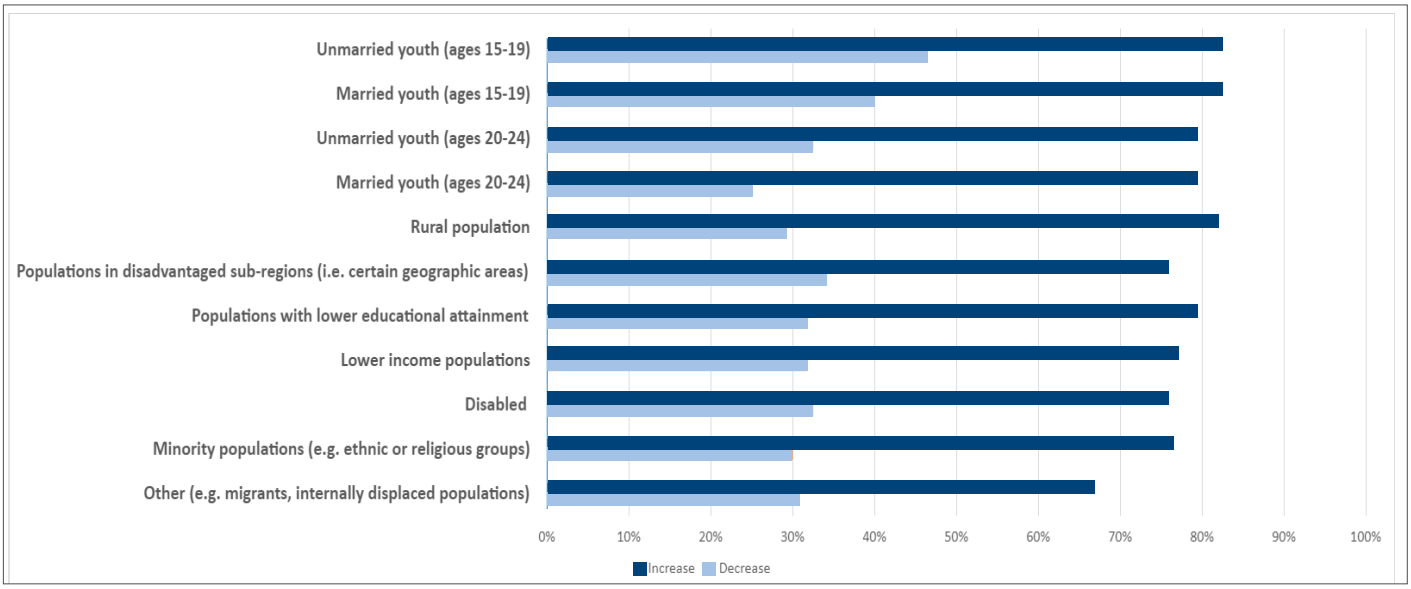
In 29 percent of the countries, practices hinder access for rural populations, 33 percent for disabled, 30 percent for minority populations, and 32 percent each for those with lower education or lower income. Similar percentages exist for disadvantaged sub-regions (34 percent) and migrants or internally displaced populations (31 percent).

The most commonly cited practices that countries implement to increase access to FP/RH are those aimed at education, awareness-raising, and behavior change (cited by 12 countries). This may include collaborating with traditional leaders (such as religious or other local leaders), making communication materials more accessible to under-reached populations (such as disseminating information in Braille and in sign language), implementing awareness-raising campaigns (whether through large gatherings, radio campaigns, or through social networks), employing CHWs or mobile health clinics, or targeting youth through peer-to-peer and school-based communication, among other strategies.

The main cultural or operational barriers to accessing FP/RH services and commodities continue to be religious institutional barriers or beliefs (cited by 11 countries); and social norms, misconceptions, or taboos (nine countries); in addition to negative perceptions specifically about youth access to FP (eight countries). Other frequently cited barriers were geographic access difficulties (seven countries), inaccessibility of services for people with disabilities (six countries), and a lack of knowledge about FP services (four countries).

EXHIBIT 20

Operational and cultural practices that enable or hinder access to FP services among sub-populations



Charges to Clients

Fees are charged to clients for family planning services in 29 percent of countries, and for commodities in 20 percent of countries. In comparison, in 2021, 31 percent of countries charged fees to clients for FP services and 24 percent for commodities. In 2019 this was 31 and 37 percent, respectively; in 2017 this was 33 and 31 percent, respectively; 23 for both in 2015, and 15 and 24 percent, respectively, in 2010.

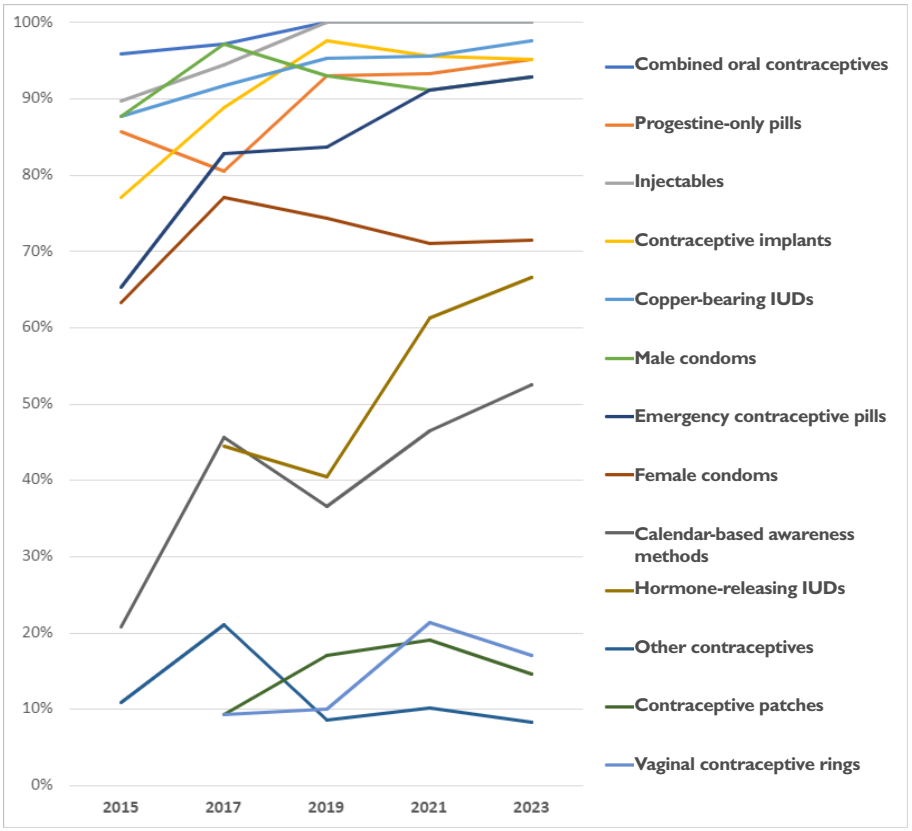
Government health insurance covers FP fees in 31 percent of countries, which is in line with the 33 percent of countries in 2021. This was not applicable in 26 countries where no fees were charged.

National Essential Medicines List

An average of nine contraceptives are on the NEML of reporting countries. All countries include COCs and injectables on their NEML, while nearly all countries include IUDs (copper bearing) (98 percent), POPs and implants (both 95 percent), and male condoms and ECs (both 93 percent) (Exhibit 21). Fewer countries include female condoms (71 percent), hormone-releasing IUDs (67 percent), contraceptive patches (15 percent), vaginal contraceptive rings (17 percent), calendar-based methods (53 percent), and other contraceptives (8 percent). The data remains largely constant relative to that reported in the 2021 survey, with all percentage changes being within six percent.

EXHIBIT 21

Percentage of countries with methods included in the NEML, 2015–2023 surveys



Promotion of Family Planning

The survey asked if FP is actively promoted through social marketing, mass media, mobile phone outreach/education, or community mobilization/engagement channels either extensively, somewhat, or not at all (Exhibit 22). Respondents could indicate multiple channels. When looking at channels used either "extensively" or "some," mobile phone outreach/education is the most popular channel (92 percent), followed by community mobilization/engagement (90 percent), social marketing (85 percent), and mass media (85 percent). Fifteen percent do not do any promotion through social marketing or mass media, 10 percent do not do any promotion through community mobilization/engagement, and 8 percent do not promote through mobile phone outreach/education. There was a 11-percentage point reduction between 2021 and 2023 in the share of countries using mass media as a channel for promoting family planning. Use of all other channels remained about the same.

FP2030 Commitments

The majority of reporting countries (88 percent) made or plan to make an FP2030 commitment. As noted in the methodology section, this was one of the main criteria for countries to be selected for the survey. All the countries reporting on specific commitment areas in their existing or planned FP2030 commitment reported that improving domestic financing for contraceptives and improving access to or availability of contraceptives are key areas of their commitment (Exhibit 23).

Among countries that made or plan to make an FP2030 commitment, all of them (100 percent) committed to improving domestic financing for contraceptives and improving access or availability of contraceptives, while 92 percent committed to increasing affordability of contraceptives for clients (see Exhibit 24). Two countries that already provide free or highly subsidized contraceptives to clients (Pakistan and Sierra Leone) were excluded from the denominator for the commitment to increase affordability of contraceptives.

EXHIBIT 22

Promotion of FP by channel

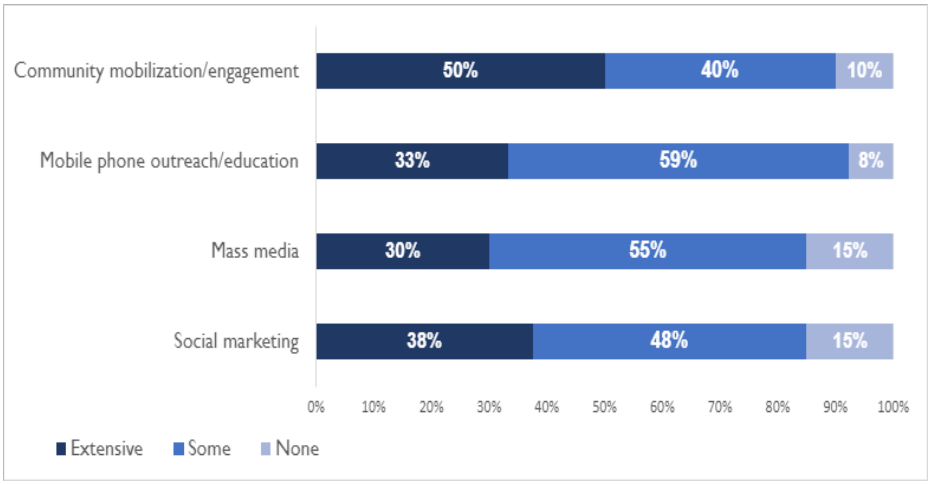


EXHIBIT 23

Percentage of countries that made or plan to make an FP2030 commitment

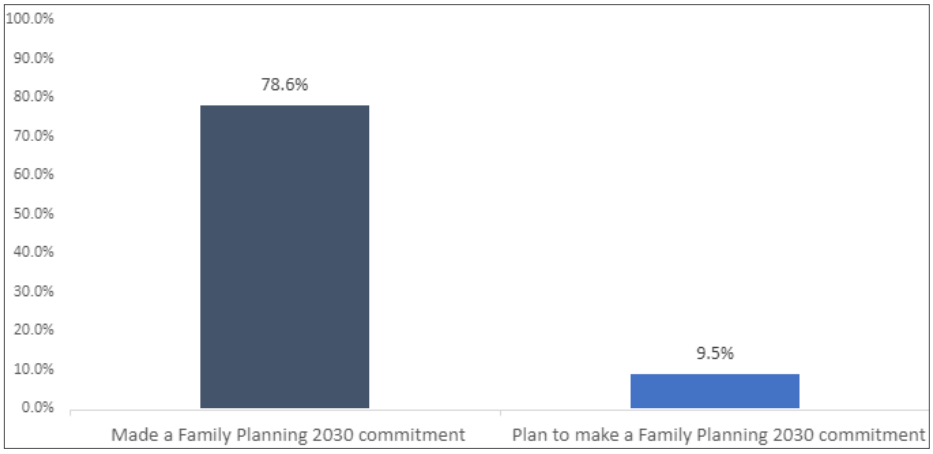
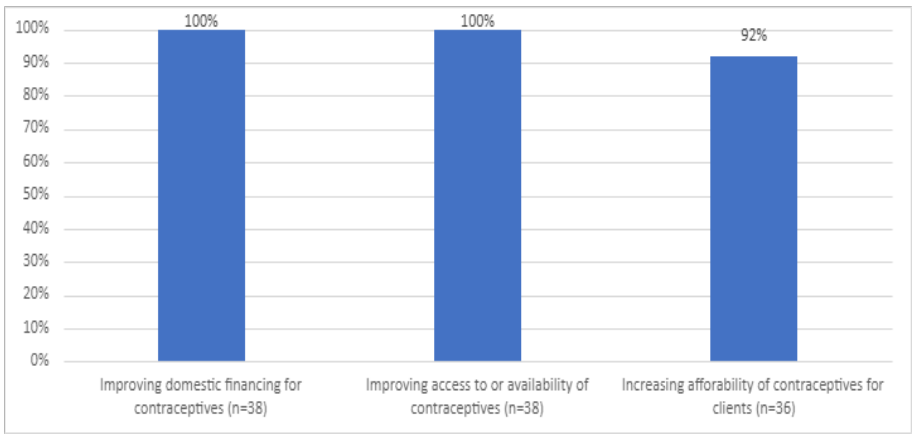


EXHIBIT 24

Areas of FP2030 commitments among countries that made or plan to make an FP2030 commitment



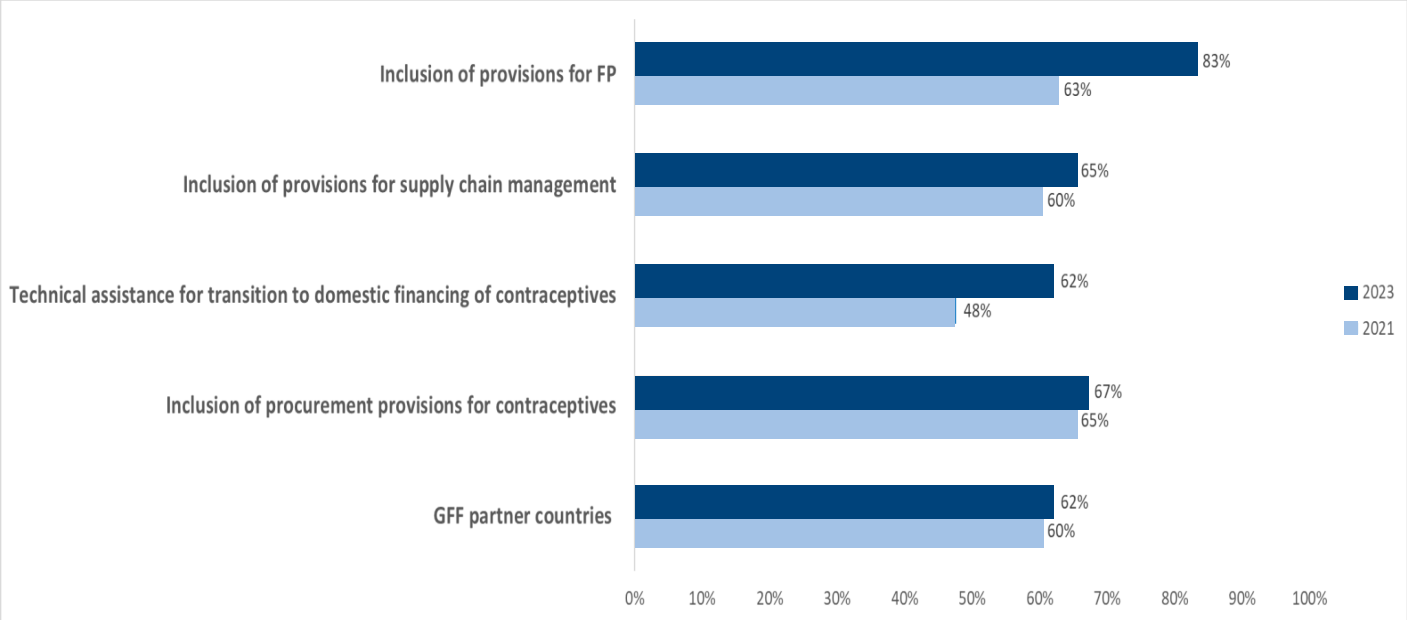
Global Financing Facility

In 2023, 62 percent of countries surveyed are Global Financing Facility (GFF) partners (Exhibit 25). Of these, 62 percent include the partnership area technical assistance for the transition to domestic financing of contraceptives and 65 percent include provisions for supply chain management. Countries with Global Financing Facility partnerships have a higher rate of inclusion of provisions for family planning included in the partnership (83 percent) compared to the previous survey in 2021 (63 percent), as well as procurement provisions for contraceptives (67 percent, compared to 65 percent in 2021).

EXHIBIT 25

Global Financing Facility partnership areas among GFF partner countries (n=26)

Note: Among the 26 GFF partner countries, the percentages for each partnership area are based on countries that had information to report on those areas.



9.

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Supply Chain

A reliable supply chain is essential for commodities to reach the intended destination. This section encompasses questions on country logistics management information systems (LMIS), contraceptive stock availability, channels for procurement, frequency of forecasts and delivery levels within the supply chain.

Questions in this section regarding the LMIS gauge the level of visibility into the public health supply chain for FP commodities, including the extent to which the public sector LMIS captures data from other sectors, the lowest supply chain level captured in the LMIS, and if applicable, how data is reported at the service delivery point level (i.e., the extent of electronic or paper reporting).

The survey reports contraceptive commodity stockout rates by FP product at both the central medical stores and service delivery point (SDP) levels and asks about potential factors driving high stockout rates.

Stockout rates should be interpreted with care for several reasons:

- The duration of the stockouts 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.
- Country LMISs differ in the proportion of health facilities covered, including some that include only public-sector facilities, and others that also include some private and/or public facilities.
- The frequency of stock status reporting varies by country.

Highlights

93%

of countries have an LMIS that includes contraceptives. Among those, 95 percent capture contraceptive stock data at the service delivery provider (SDP) level.

15%

of countries reported zero central-level stockouts of any contraceptive commodity.

26%

Of the 34 countries providing information on central-level stockouts, 26 percent reported zero stockouts at the central level of any of the following most common FP/RH products: COCs, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms.

Annual stockout rates at the central medical store level for the most common FP/RH methods ranged as follows among countries reporting:

COCs
For 10 countries the stockout rate ranged from 8 percent (Kenya) to 100 percent (Côte d'Ivoire).

IUDs
Stockouts in the 12 countries with stockouts had rates ranging from 7 percent (DRC) to 92 percent (Côte d'Ivoire).

INJECTABLE CONTRACEPTIVES
For 14 countries, the stockout rate ranged from 8 percent (Dominican Republic) to 100 percent (Côte d'Ivoire).

MALE CONDOMS
The 10 countries with stockouts had rates ranging from 5 percent (El Salvador) to 100 percent (Côte d'Ivoire) stocked out.

IMPLANTS
For 17 countries, the stockout rate ranged from 3 percent (DRC) to 100 percent (Botswana). Seven countries that offer two formulations of implants had no stockouts of either (Benin, Ethiopia, Mali, Mozambique, Nigeria, Togo, and Zimbabwe).

Annual stockout rates at the SDP level for the most common FP/RH methods ranged as follows:

COCs
27 countries had stockout rates ranging from 0.041 percent (Bangladesh) to 59 percent (DRC)

IUDs
For the 27 countries reporting stockouts, rates ranged from 0.06 percent (Bangladesh) to 74 percent (El Salvador) stocked out.

INJECTABLE CONTRACEPTIVES
For the 29 countries reporting stockouts, rates ranged from 0.03 percent (Bangladesh) to 71 percent (El Salvador).

MALE CONDOMS
Of the 26 countries reporting stockouts, rates ranged from 0.05 percent (Bangladesh) to 59 percent (Kenya) stocked out.

IMPLANTS
Of the 27 countries reporting stockouts, ratesranged from 0.23 percent (Bangladesh) to 90 percent (Botswana).

LMIS

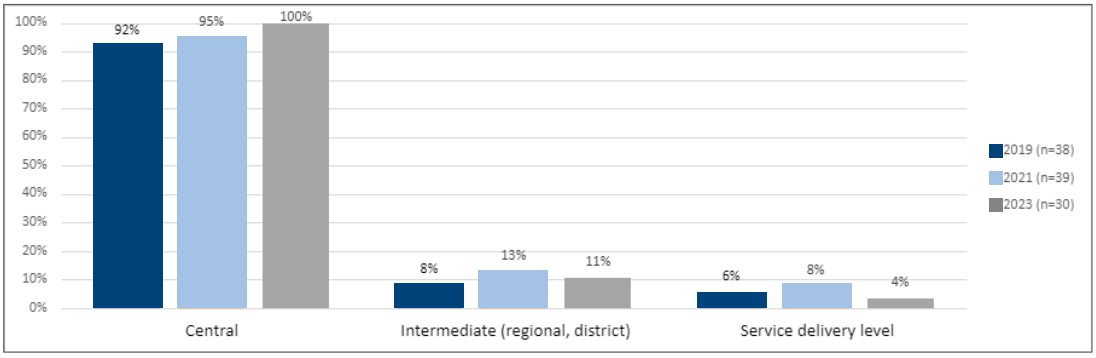
Out of 42 countries, 93 percent have an LMIS that includes contraceptives, and 95 percent of those countries capture stock data at the SDP level. When asked how commodity data is collected at the SDP level, 84 percent report that at least some sites report electronically, up from 68 percent in 2021. Only eight percent of countries with facility-level stock data have exclusively manual reporting at the SDP level, including Bangladesh, Botswana, and Sierra Leone.

Procurement

This section discusses the 30 countries that did use government funds to procure contraceptives. Procurement of government-financed contraceptives takes place at the central level in all 30 of these countries. (Exhibit 26). Only 11 percent and 4 percent of countries responded that procurement takes place at either the intermediate (regional or district) or service delivery level, respectively. Pakistan and Nepal are some of the countries which procured at an intermediate level. Procurement can take place in more than one location. Only countries where government financed procurement occurred in the assessment year are included in this indicator.

EXHIBIT 26

Locations of government-financed procurement (n=30)[16]

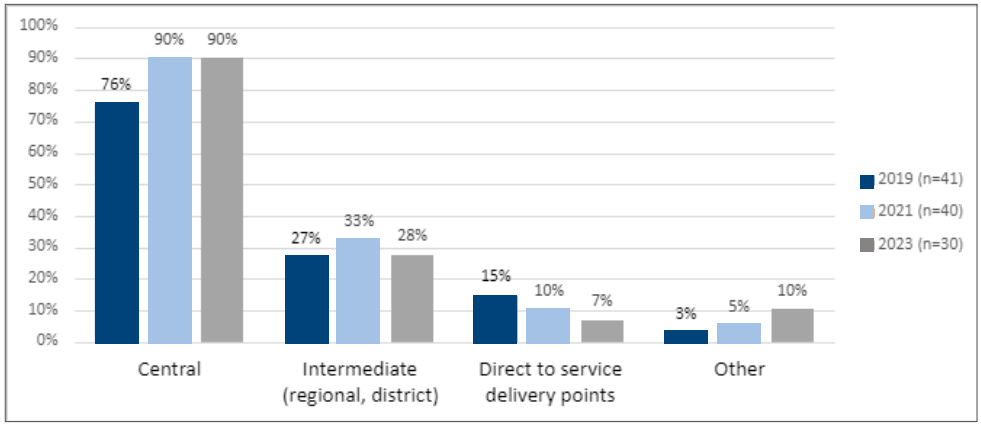


Supplier Delivery Points

The survey asked, regardless of central or decentralized procurement, the level(s) to which suppliers deliver commodities (for government-financed procurement only). Delivery may be to more than one level. For 90 percent of countries, the supplier delivers to the central level (Exhibit 27). For 28 percent, the supplier also delivers to an intermediate level (regional or district), 7 percent of suppliers deliver directly to the SDP, and 10 percent report to an "other" delivery point ("other" delivery points may vary by country and were not specified).

EXHIBIT 27

Supplier delivery points for government-procured contraceptives (n=30)



16. Procurement can occur at more than one location in a country, so percentages may not add up to 100 percent.

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 most recent year when data was available, at both the central and SDP levels, for the following contraceptive methods:

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

Of the 34 countries providing information on central–level stock availability, 15 percent reported zero stockouts among all products offered within the eight methods at the central level.
This section provides information on stockout rates at the central and SDP level by contraceptive method by country.

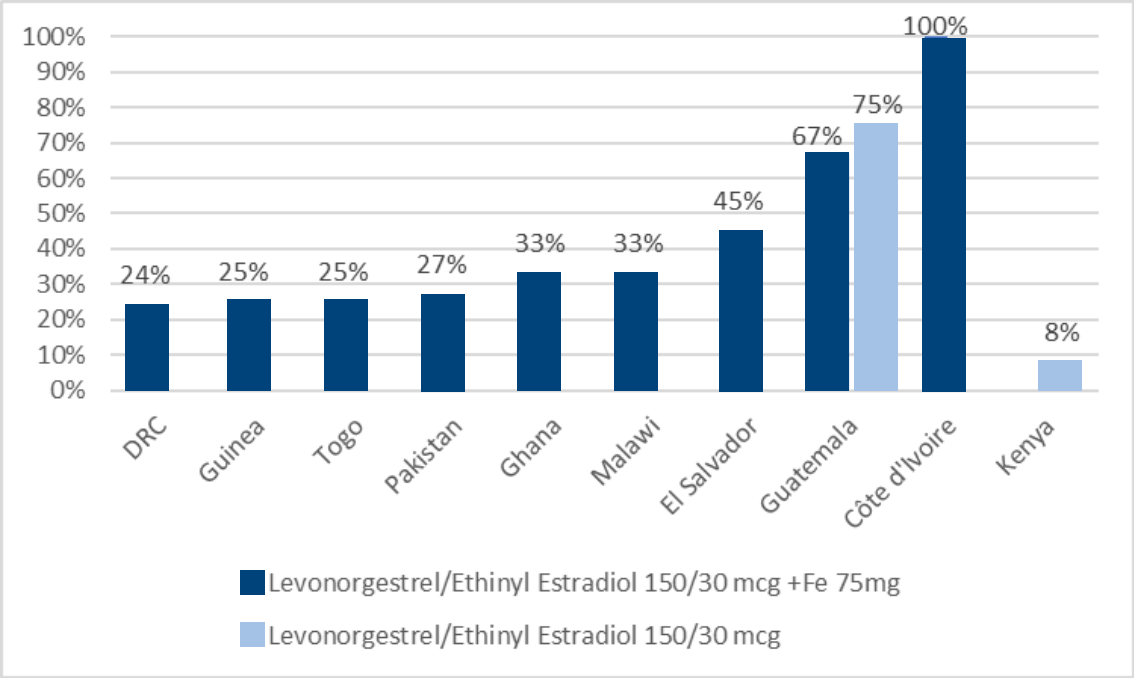
Central-level product availability

Combined oral contraceptives

For COCs, 20 countries that offer one formulation (levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg) reported zero stockouts. For 10 countries, the stockout rate of COCs ranged from 8 percent (Kenya) to 100 percent (Côte d'Ivoire) (Exhibit 28). Guatemala had stockouts of both formulations (levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg and levonorgestrel/ethinyl estradiol 150/30 mcg). One country, Madagascar, reported no stockouts of COCs in either formulation. Eleven countries had no data.

EXHIBIT 28

Central-level stockout rates of combined oral contraceptives, non-zero responses shown

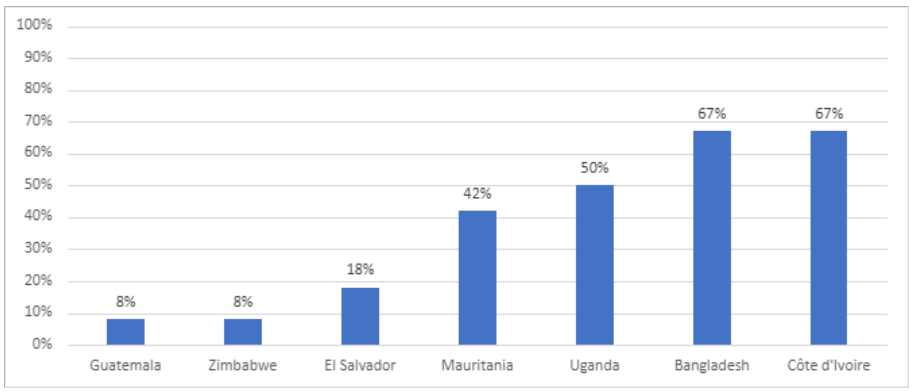


Progestin-only pills

Among seven countries with reported stockout rates greater than zero, the stockout rate for POPs (Exhibit 29) ranged from 8 percent (Guatemala and Zimbabwe) to 67 percent (Bangladesh and Côte d'Ivoire). The remaining 17 reporting countries reported a stockout rate of zero for POPs at the central level: Botswana, Burundi, Cape Verde, Dominican Republic, DRC, Ghana, Haiti, Kyrgyz Republic, Madagascar, Malawi, Mali, Nepal, Pakistan, Senegal, South Sudan, Togo, Yemen.

EXHIBIT 29

Central-level stockout rates for progestin-only pills (levonorgestrel 30 mcg), non-zero values shown (n=24)



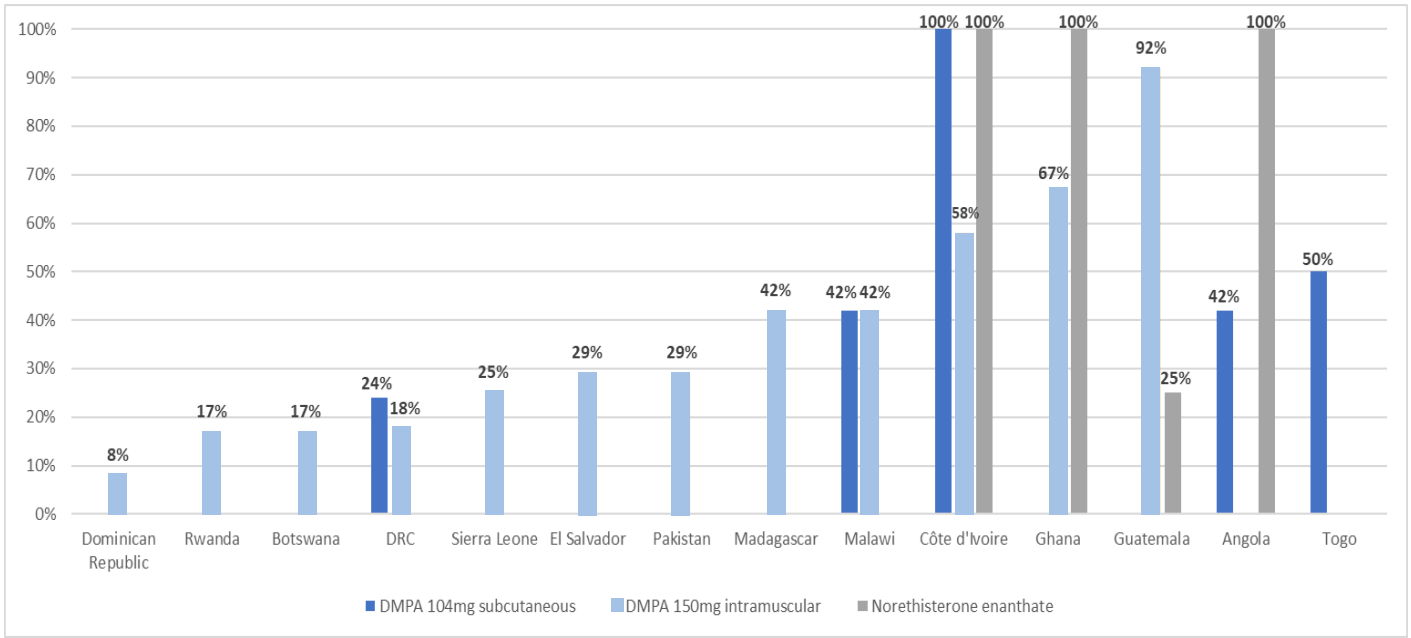
Injectable contraceptives

For injectables among the three formulations (DMPA 104mg subcutaneous, DMPA 150mg intramuscular, and norethisterone enanthate), 14 countries of 32 with data (44 percent) reported stockouts (Dominican Republic, Rwanda, Botswana, DRC, Sierra Leone, El Salvador, Pakistan, Madagascar, Malawi, Côte d'Ivoire, Ghana, Guatemala, Angola, and Togo) (Exhibit 30), with annual stockout rates ranging from 8 percent (Dominican Republic for DMPA 150mg intramuscular) to 100 percent in Côte D'Ivoire (DMPA 104mg subcutaneous and norethisterone enanthate) and Ghana and Angola (norethisterone enanthate).

DRC and Malawi had stockouts of both DMPA 104mg subcutaneous and DMPA 150mg intramuscular. Ghana and Guatemala reported stockouts of DMPA 150mg intramuscular and norethisterone enanthate. Angola had stockouts of DMPA 104mg subcutaneous and norethisterone enanthate. Côte d'Ivoire had stockouts of all three formulations. A total of 18 countries (56 percent) did not have any stockouts of injectables at the central level. Ten countries did not report data.

EXHIBIT 30

Central-level stockout rates of injectable contraceptives (n=32)

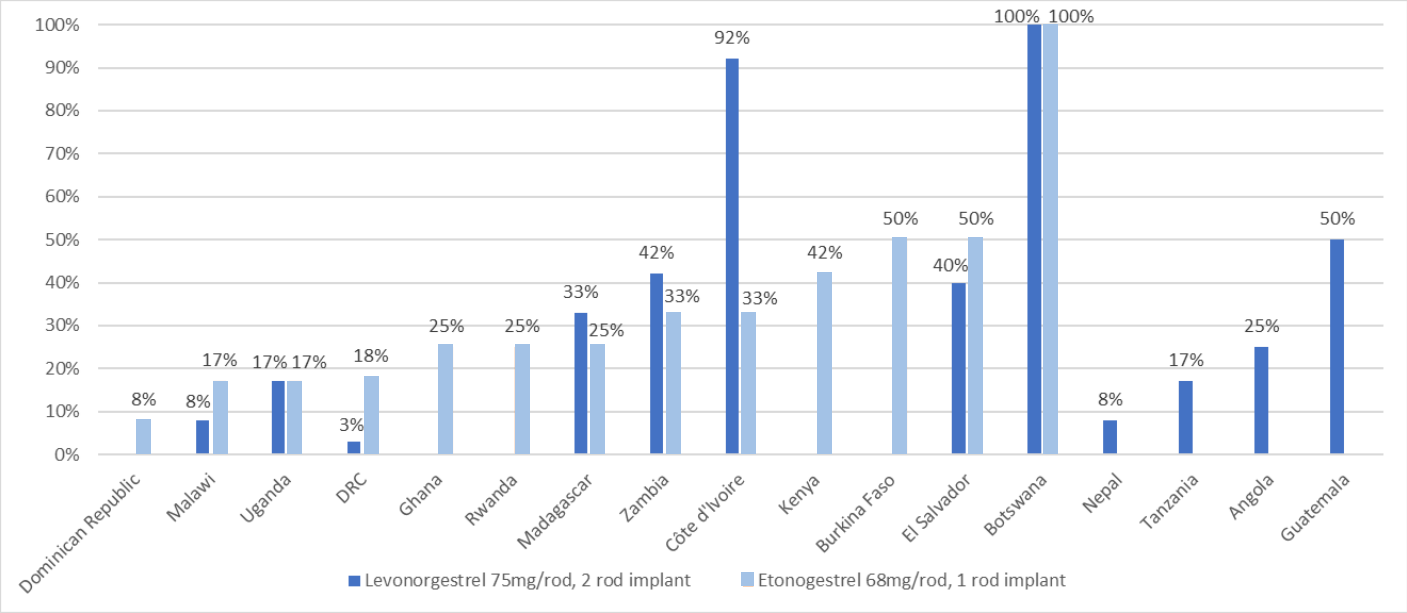


Contraceptive implants

For 17 countries of 31 that had data, the annual stockout rates among both formulations of implants (levonorgestrel 75mg/rod [two-rod implant] and etonogestrel 68mg/rod [one-rod implant]) ranged from 3 percent (DRC, two-rod implants) to 100 percent (Botswana, both formulations) (Exhibit 31). Seven countries that offer two formulations of implants had no stockouts of either (Benin, Ethiopia, Mali, Mozambique, Nigeria, Togo, and Zimbabwe). Nine countries had stockouts of one formulation (Dominican Republic, Ghana, Rwanda, Kenya, Burkina Faso, Nepal, Tanzania, Angola, and Guatemala), and eight had stockouts of both (Malawi, Uganda, DRC, Madagascar, Zambia, Côte d'Ivoire, El Salvador, and Botswana). In total, 14 countries (45 percent) did not have stockouts of implants. Eleven countries did not have data.

EXHIBIT 31

Central-level stockout rates of contraceptive implants, non-zero values shown (n=31)

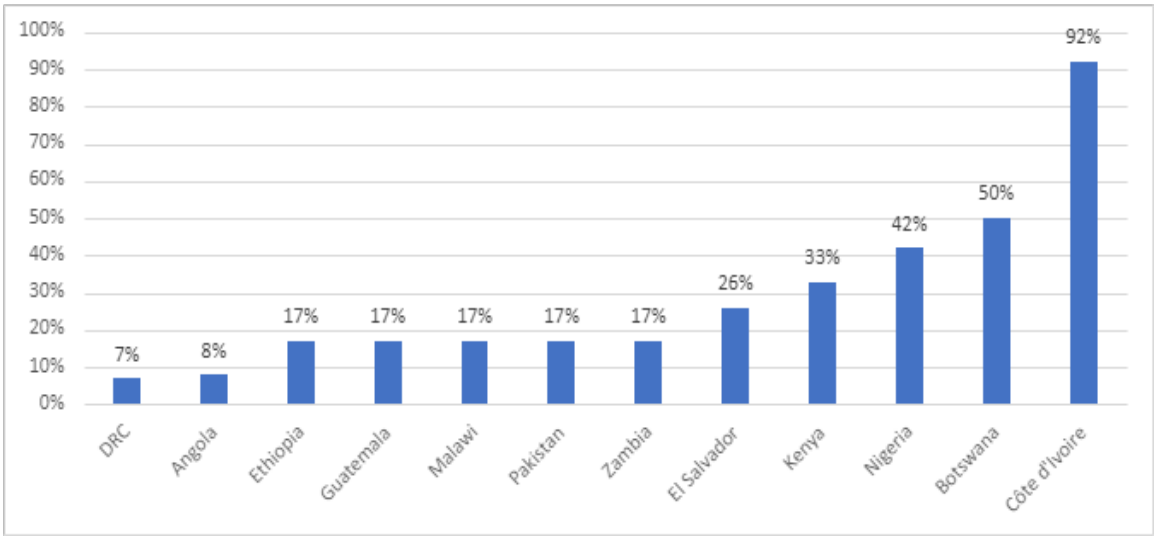


Copper-bearing intrauterine devices

For 12 countries of 31 that had data and a non-zero stockout rate, the stockout rate for IUDs ranged from 7 percent (DRC) to 92 percent (Côte d'Ivoire) (Exhibit 32). A total of 19 countries (61 percent) reported no stockouts of IUDs. Eleven countries did not have data. Apart from Botswana, which showed an increase in stockouts of 17 percent from 2021 to 2023, central-level stockout rates of copper-bearing intrauterine devices generally improved.

EXHIBIT 32

Central-level stockout rates of copper-bearing intrauterine devices, non-zero values shown (n=31)

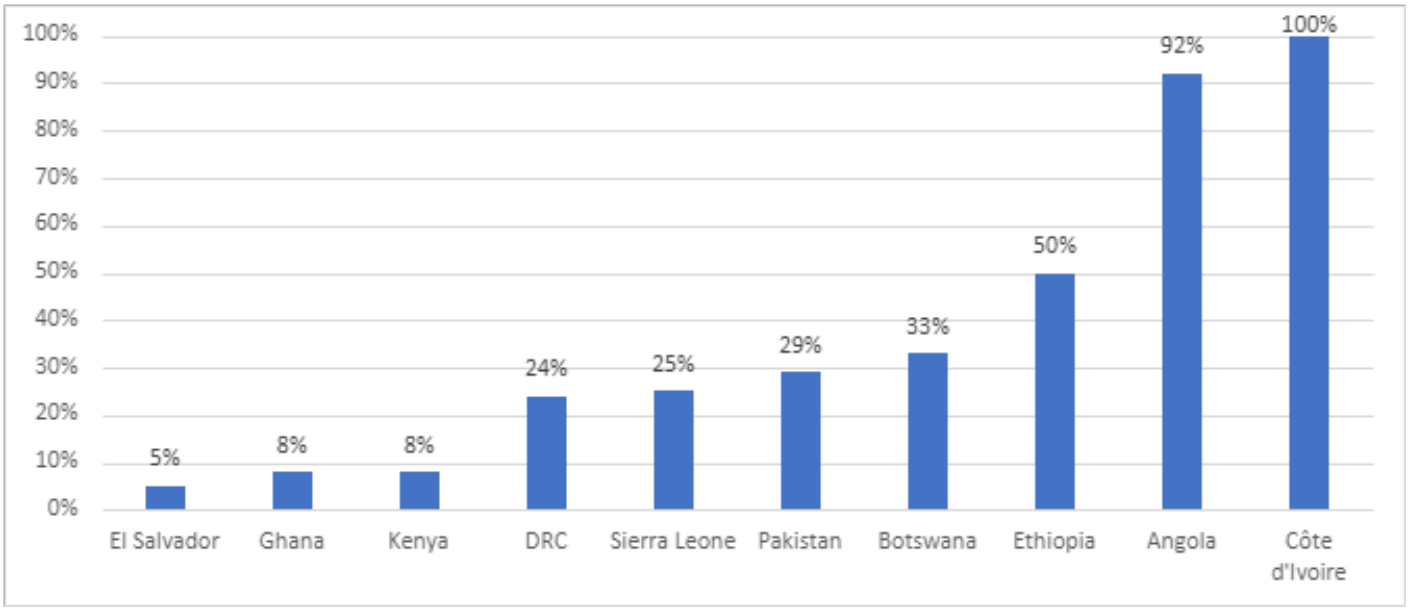


Condoms

Twenty of 30 countries with data had zero central-level stockouts of male condoms in the last 12–month period. The male condom stockout rate for the other 10 countries ranged from 5 percent (El Salvador) to 100 percent (Côte d'Ivoire) (Exhibit 33). Twelve countries did not have available data.

EXHIBIT 33

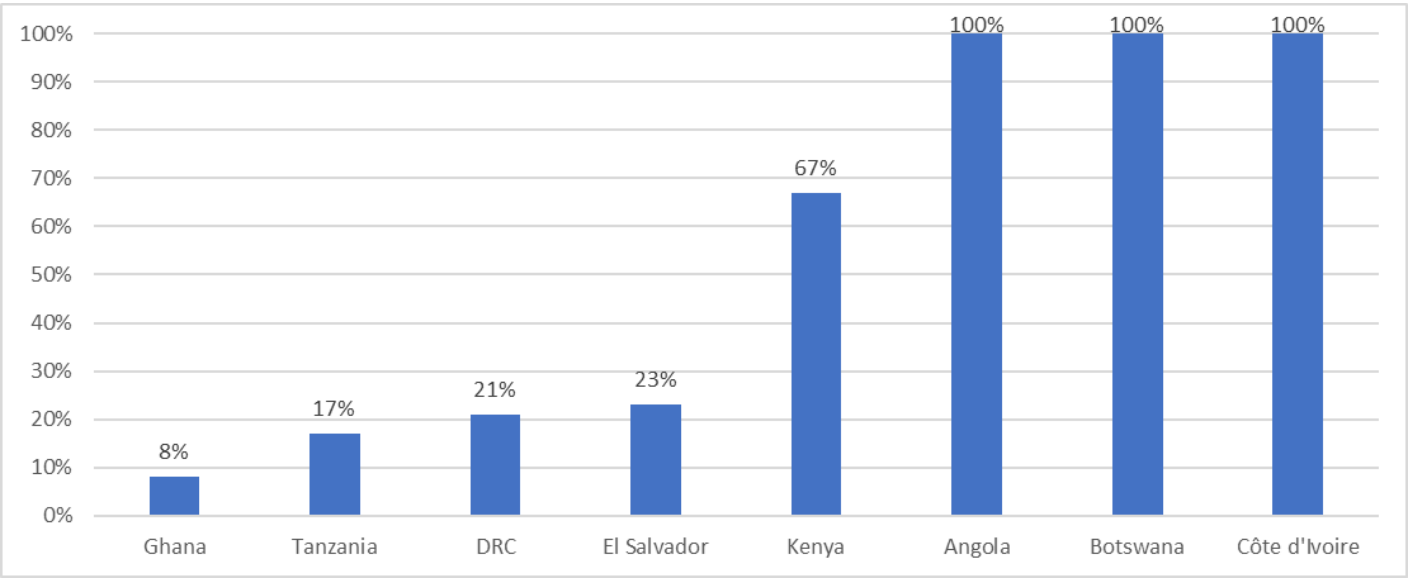
Central level stockout rate of male condoms, non-zero values shown (n=30)



For female condoms, the stockout rate ranged from 8 percent (Ghana) to 100 percent (Angola, Botswana, and Côte d'Ivoire) (Exhibit 34). A total of 17 countries had a stockout rate of zero for female condoms: Benin, Burkina Faso, Burundi, Cape Verde, Dominican Republic, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, Zambia, and Zimbabwe. Seventeen countries did not report on this method.

EXHIBIT 34

Central level stockout rates for female condoms at the central level, non-zero values shown (n=25)

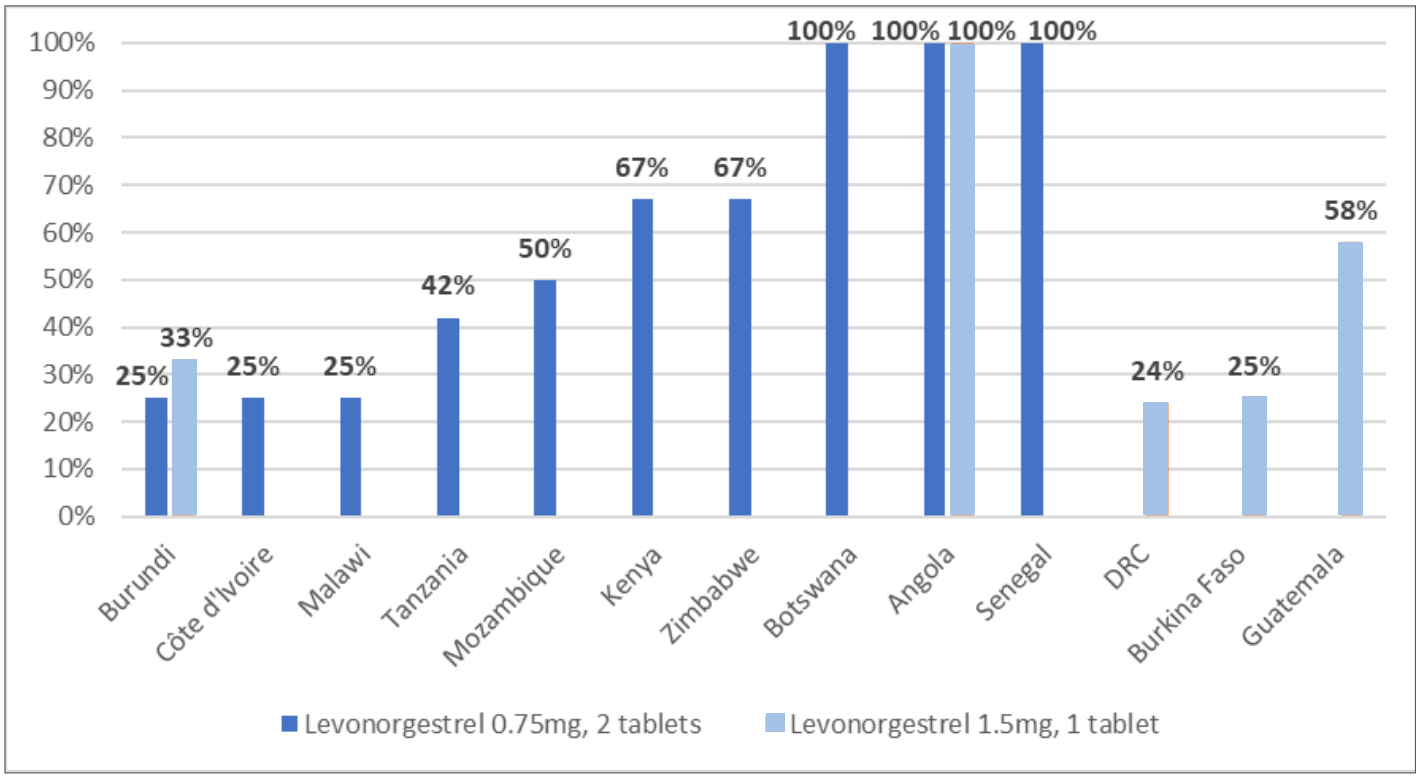


Emergency contraceptives

In 13 countries of 22 reporting, the stockout rates among both formulations of emergency contraceptives (levonorgestrel 0.75mg, two tablets; and levonorgestrel 1.5mg, one tablet) at the central level ranged from 24 percent (DRC) to 100 percent (Botswana, Angola, and Senegal) (Exhibit 35). Angola reported 100 percent stockouts of both products. A total of nine countries had stockout rates of zero for the one formulation they reported on. Twenty countries did not report data.

EXHIBIT 35

Central-level stockout rates for emergency contraceptives, non-zero values shown (n=22)



Service Delivery Point Product Availability

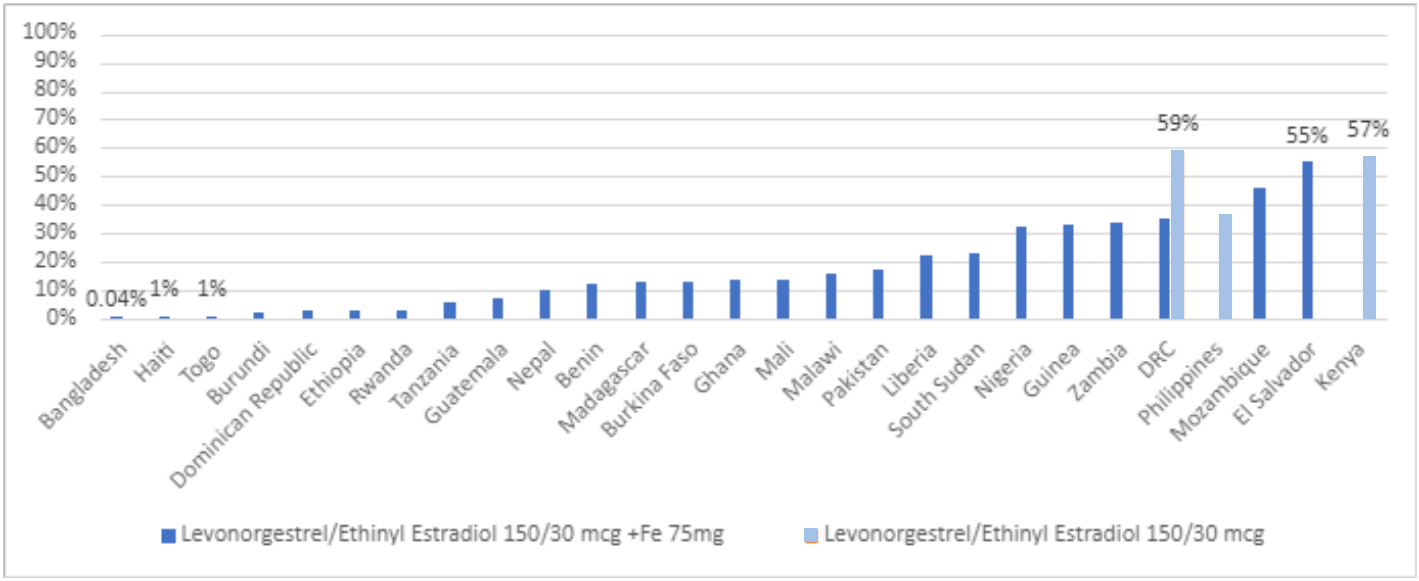
Countries provided stockout data for the SDP level for the most recently completed twelve-month period, where available. This report presents stockout data for COCs, injectables, implants, IUDs, male condoms, and progestin only pills.

Combined oral contraceptives

Of 28 countries with data, one (Cape Verde) had zero stockouts of COCs (Exhibit 36). Stockout rates for the other 26 countries ranged from 0.04 percent (Bangladesh) to 59 percent (DRC) among two formulations. Fourteen countries did not provide data.

EXHIBIT 36

Service delivery point stockout rates of combined oral contraceptives, non-zero values shown (n=28)

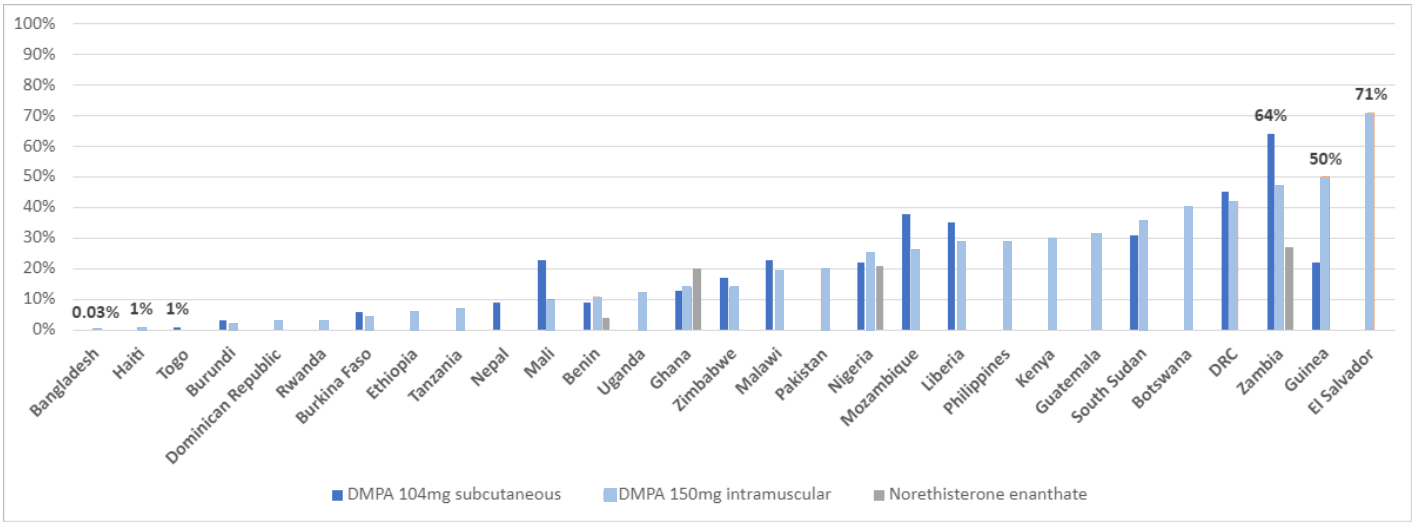


Injectable contraceptives

For 29 of the 31 countries with data, the injectable stockout rates for a single product at the SDP level ranged from 0.03 percent (Bangladesh) to 71 percent (El Salvador) among three formulations (DMPA 104mg subcutaneous, DMPA 150mg intramuscular, and norethisterone enanthate) (Exhibit 37). Two countries did not have any stockouts: Madagascar and Cape Verde. Benin, Ghana, Nigeria, and Zambia offer all three formulations, all of which reported stockouts of all three contraceptives. Eleven countries did not have data.

EXHIBIT 37

Service delivery point stockout rates of injectable contraceptives, non-zero values shown (n=31)

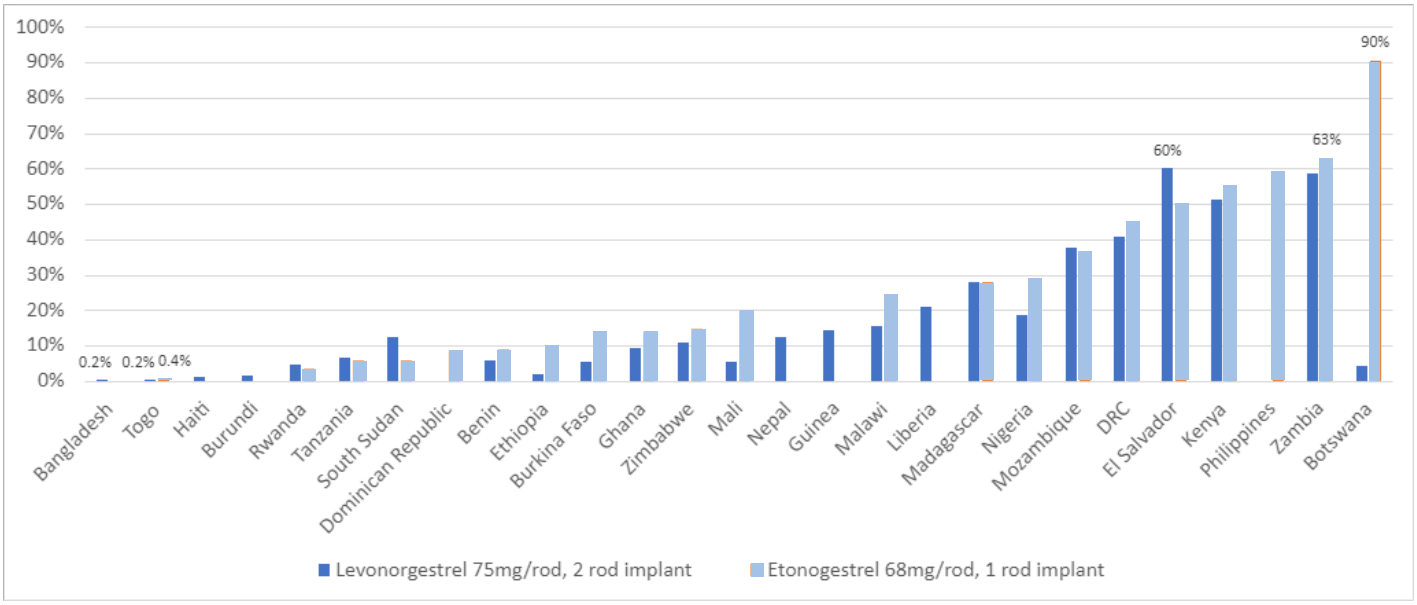


Contraceptive implants

Of the 28 countries that offer and reported on implants, one country reported zero stockouts (Cape Verde). For the other 27 countries, the stockout rates ranged from 0.2 percent (Bangladesh and Togo, two-rod implant) to 90 percent (Botswana, one-rod implant). Fourteen countries did not have data.

EXHIBIT 38

Service delivery point stockout rates of contraceptive implants, non-zero values (n=28)

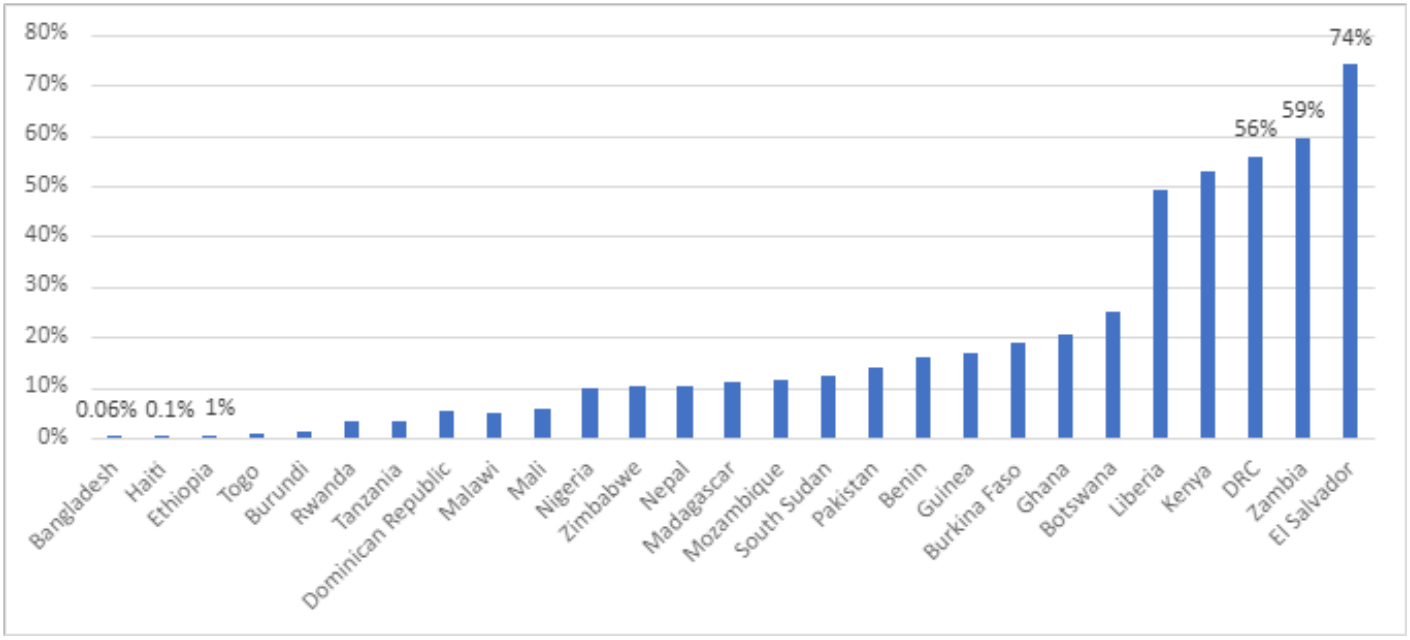


Copper-bearing intrauterine devices

One out of 28 countries with data reported zero stockouts for copper-bearing IUDs at the SDP level (Cape Verde). For the remaining 27 countries with stockouts, the stockout rates for IUDs (Exhibit 39) spanned from 0.06 percent (Bangladesh) to 74 percent (El Salvador). Fourteen countries did not have data.

EXHIBIT 39

Service delivery point stockout rates of copper-bearing intrauterine devices, non-zero values (n=28)

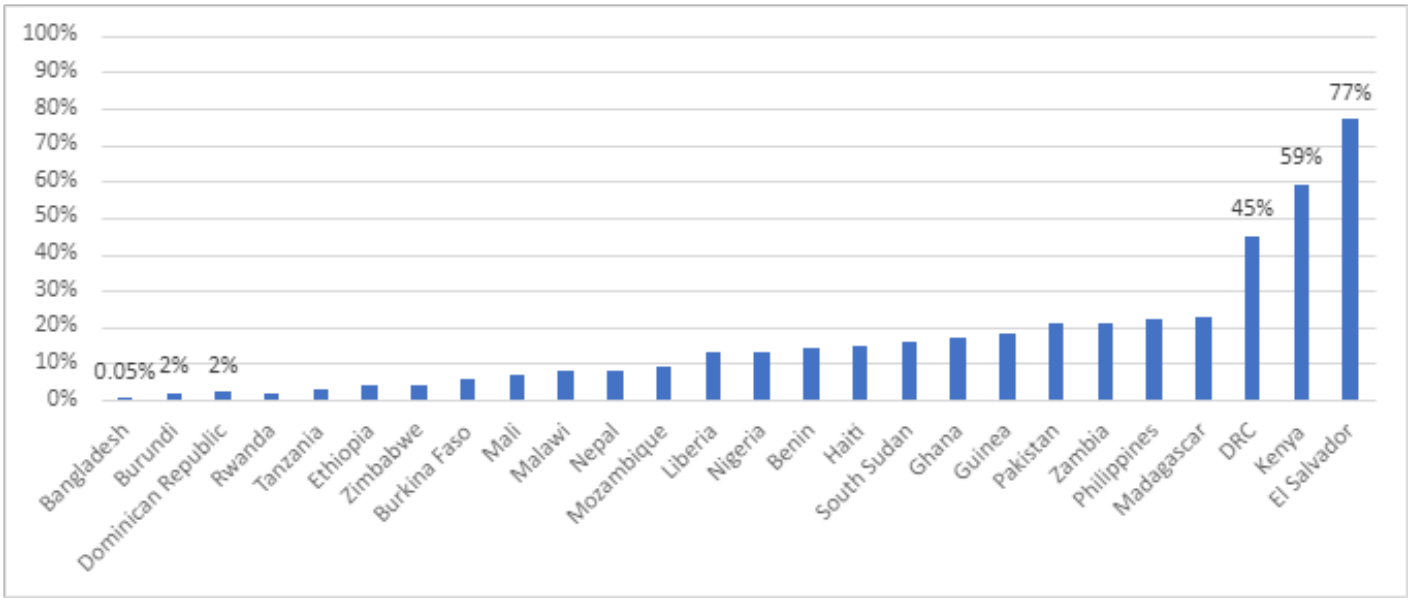


Condoms

For male condoms (Exhibit 40), out of 27 countries that had data, 1 country reported zero stockouts (Cape Verde). Among the remaining 26 countries that had stockouts, rates ranged from 0.05 percent (Bangladesh) to 77 percent (El Salvador). Sixteen countries did not have available data.

EXHIBIT 40

Service delivery point stockout rates of male condoms, non-zero values shown (n=27)

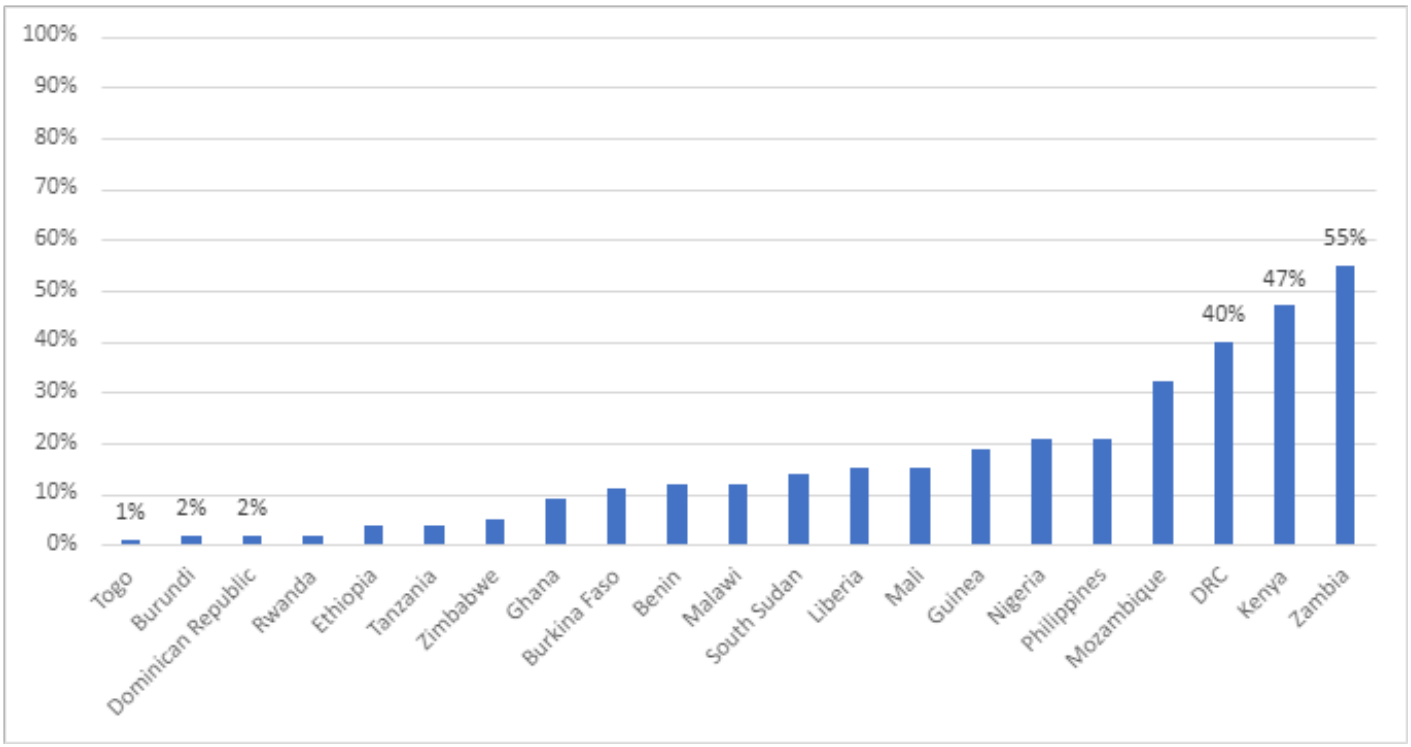


Progestin-only pills

For progestin-only pills (levonorgestrel 30 mcg), 2 of the 23 countries (Cape Verde and Madagascar) that offer this product reported zero stockouts (Exhibit 41). For the remaining 21 countries with data, stockout rates ranged from 1 percent (Togo) to 55 percent (Zambia). Nineteen countries did not have data available.

EXHIBIT 41

Service delivery point stockout rates of progestin-only pills, non-zero values shown (n=23)



10.

PHOTO CREDIT: GHSC-PSM

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, QA testing of commodities post-shipment, conducting field surveillance to identify substandard and falsified (SF) commodities, and using recognized and trusted suppliers who provide good-quality products and backup services.

Highlights

Of the countries providing information on quality:

3x

The testing of most contraceptives (excluding condoms) nearly tripled from 17 percent in 2021 to 46 percent in 2023.

98%

of countries require registration of locally manufactured or imported contraceptives by the in-country NMRA.

61%

The percent of countries in which the NMRA conducts field surveillance monitoring to identify SF contraceptives rose from 32 percent to 61 percent between 2021 and 2023, with nine new countries confirming NMRA monitoring.

<6 months

The average lead time for registration of contraceptives is less than six months for 56 percent of countries. This reflects an upward trend since 2019, when the average lead time for 50 percent of countries was six months to one year; in 2021, 49 percent of countries reported an average lead time of less than six months.

79%

require testing of contraceptives at the NQCL.

Registration Requirements

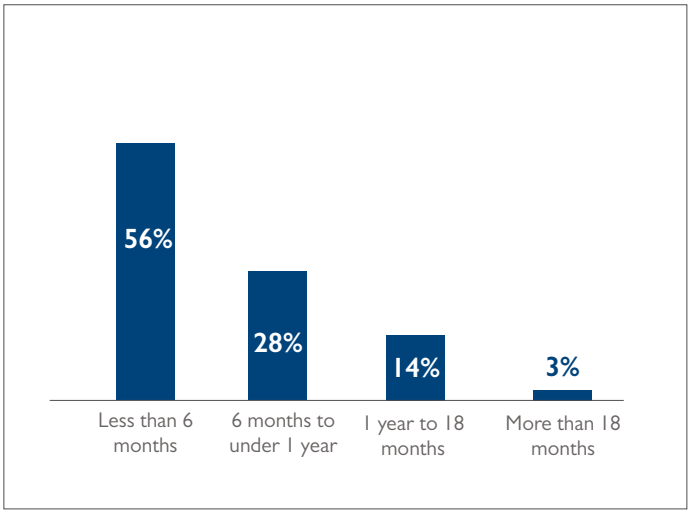
Most countries (98 percent) require registration of locally manufactured or imported contraceptives by the in-country NMRA. The Dominican Republic is the only country that currently does not have registration requirements for contraceptives.

Similarly, 97 percent strictly adhere to drug registration requirements. The level of adherence in Peru was not known. And South Sudan does not adhere to registration requirements; The Drug and Food Control Authority (DFCA) Act 2012 requires the registration of all regulated products, but its implementation has been delayed due to limited capacity. Additionally, there are no locally manufactured contraceptives.

The average registration lead time is less than six months for 56 percent of countries, while 28 percent take six months to one year, 14 percent take one year to 18 months, and 3 percent take more than 18 months (Exhibit 42).

EXHIBIT 42

Average lead time for registration of contraceptive products (n=36)

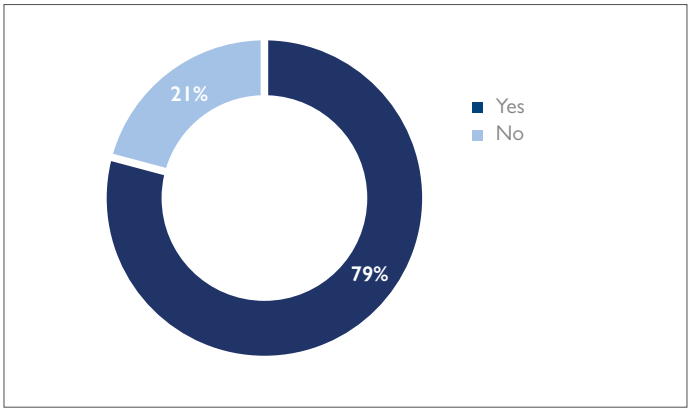


Quality Control

The requirement for contraceptives, whether imported or locally manufactured, to be tested by the in-country NQCL is in place for 79 percent of countries (Exhibit 43). The rates of the NQCL testing either most or some contraceptives (excluding condoms) rose in 2023 to 58 percent, an increase from 41 percent in 2021. The NQCL tested most or some condoms post-shipment in 75 percent of countries in 2023 (Exhibit 45), an increase from 21 percent in 2021.

EXHIBIT 43

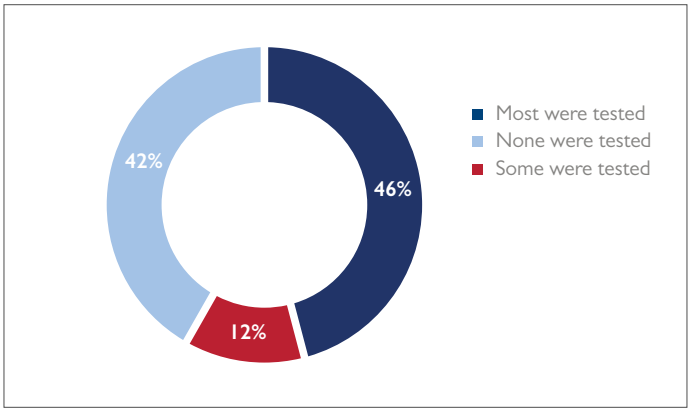
Requirement to test contraceptives at the national quality control laboratory (n=39)



In 46 percent of the countries, the NQCL tested most contraceptives (excluding condoms), 12 percent tested some, and 42 percent tested no contraceptives post-shipment (Exhibit 44). In 2021, 17 percent tested most contraceptives (including condoms), while 58 percent tested none.

EXHIBIT 44

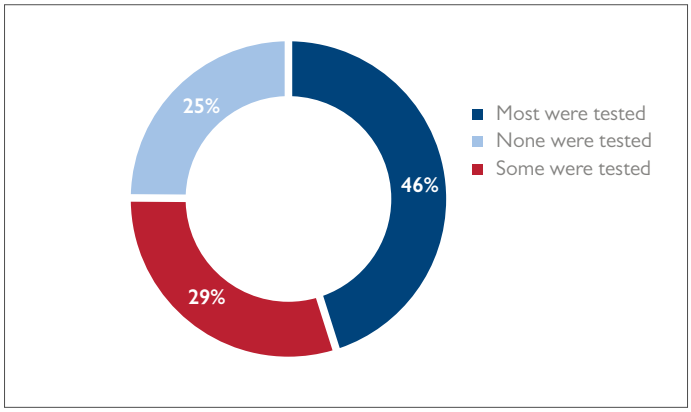
Extent to which the NQCL tested contraceptives, excluding condoms, post-shipment in the past year (n=26)



The NQCL tested most condoms post-shipment in 46 percent of countries, while 29 percent tested some, and 25 percent tested none (Exhibit 45). In 2021, most or some condoms were tested post-shipment in 21 percent of countries, and 59 percent tested none.

EXHIBIT 45

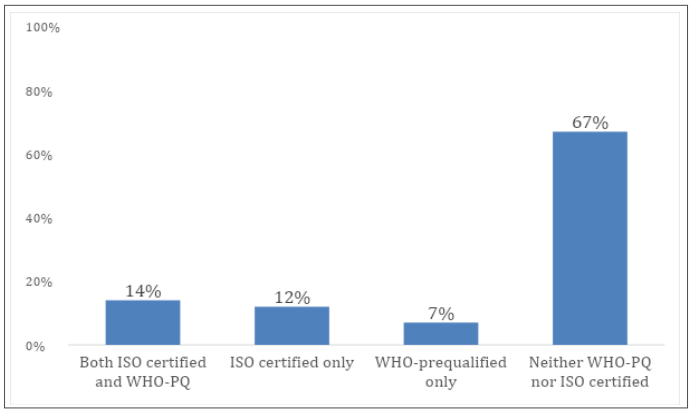
Extent to which the NQCL tested condoms post-shipment in the past year (n=28)



The NQCL is both ISO 17025 certified and WHO-prequalified in 14 percent of the countries (6 of 42) (Exhibit 46). The NQCL in 12 percent of countries is ISO certified only, while 7 percent are WHO-prequalified only, and 67 percent have neither qualification.

EXHIBIT 46

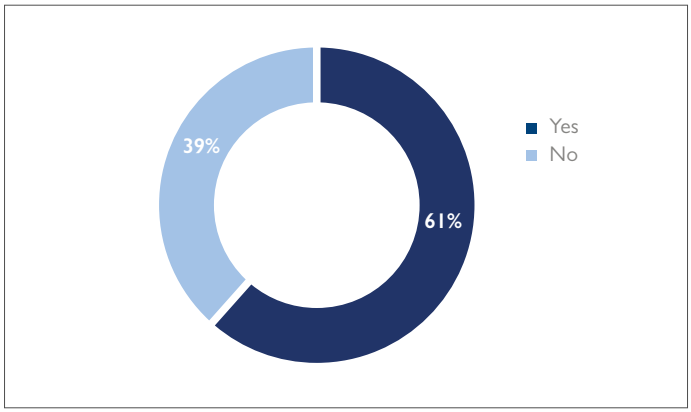
National quality control laboratory ISO 17025 certified and/or WHO-prequalified (n=42)



In 61 percent of countries, the NMRA conducts field surveillance monitoring to identify SF contraceptives (Exhibit 47), an increase from 32 percent in 2021. Nine new countries confirmed NMRA monitoring (Liberia, Madagascar, Mali, Nepal, Nigeria, Peru, Tanzania, DRC, and El Salvador).

EXHIBIT 47

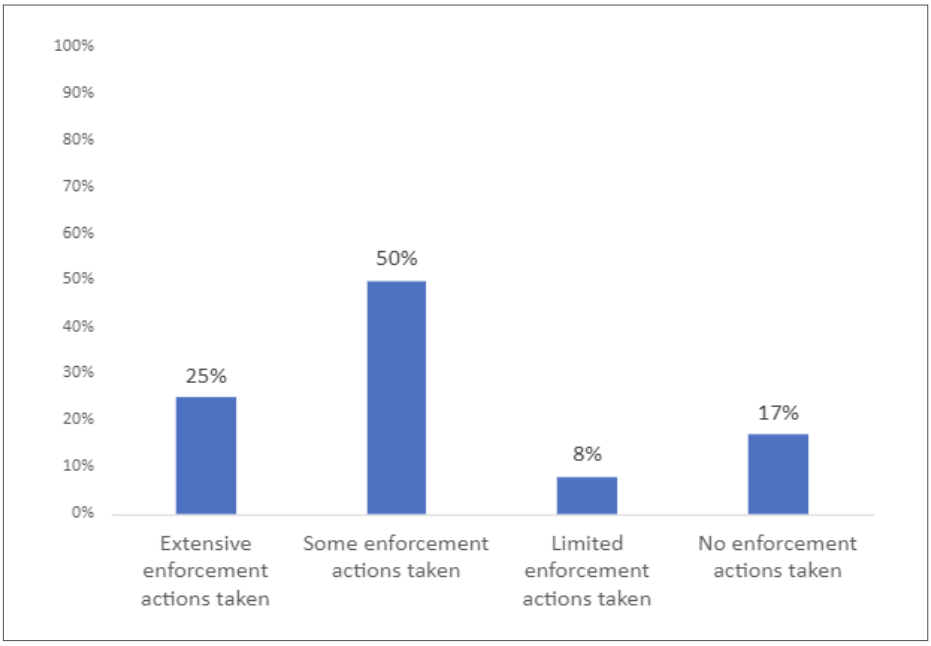
National Medical Regulatory Authority conducts field surveillance monitoring to identify SF contraceptives (n=31)



In 25 percent of countries, extensive regulatory enforcement actions are taken following field surveillance of contraceptives. In 50 percent of countries some enforcement takes place, while 8 percent of countries take limited action, and 17 percent take no action (Exhibit 48). In the 2021 report, among the 10 countries where NMRA conducted field surveillance monitoring, 50 percent took extensive enforcement actions, 20 percent took some, 10 percent took limited actions, and 20 percent took none.

EXHIBIT 48

Extent of regulatory enforcement actions taken following field surveillance of contraceptives (n=12)



II.

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Private Sector

Collaboration and coordination with the private sector give clients additional access to contraceptives, brand choice, and expanded price points to help meet the population's varied demands. The private sector—defined as all the providers, suppliers, and ancillary and support services that lie outside the public sector—is a vital partner in global efforts to provide FP/RH services and commodities. The private sector includes for-profit or commercial/private entities, NGOs, community groups, informal vendors, and private providers such as doctors, pharmacies, drugstores, and hospital staff.

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:

82%

have more than three wholesalers registered in the country to distribute FP commodities.

58%

of countries have established private-sector engagement plans to expand private-sector FP products or services. Of those, 79 percent have taken at least some actions to implement the plan.

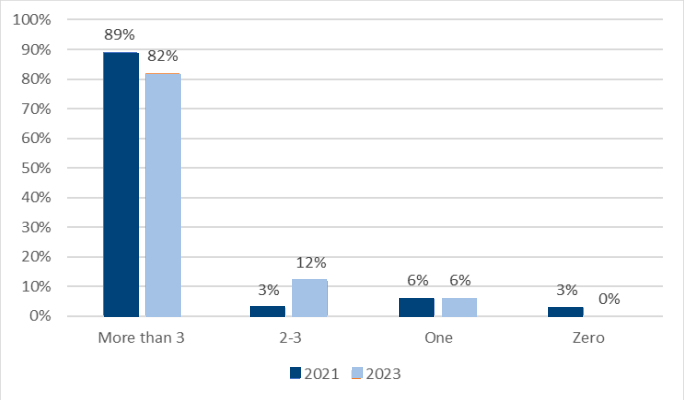
5-30%

By FP product, the percentage of countries where there were no WHO-prequalified or SRA-approved products registered for distribution ranged from 5 percent (COCs) to 30 percent (female condoms).

Most countries (82 percent) have more than three wholesalers registered for distributing FP products in the countries (Exhibit 49). Twelve percent have two to three, six percent have one, and zero countries have no wholesalers registered to distribute FP products. In 2021, 89 percent of countries had more than three wholesalers registered as FP distributors. The percentage of countries with zero wholesalers has dropped from six percent in 2019 and three percent in 2021 to zero in 2023.

EXHIBIT 49

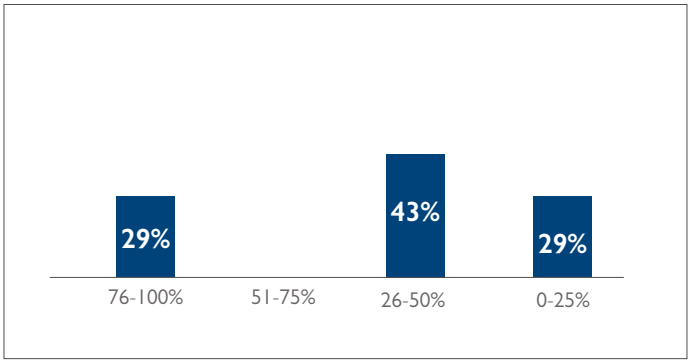
Number of wholesalers registered in the country to distribute FP commodities (n=33)



Two out of seven countries (29 percent) stated that 76–100 percent of the wholesalers in the country report to the government on their FP commodity sales and FP services (Exhibit 50), down from 42 percent in 2021. Of the remaining countries, 43 percent responded that 26–50 percent of the wholesalers report to the government, and 29 percent responded that 0–25 percent report this information.

EXHIBIT 50

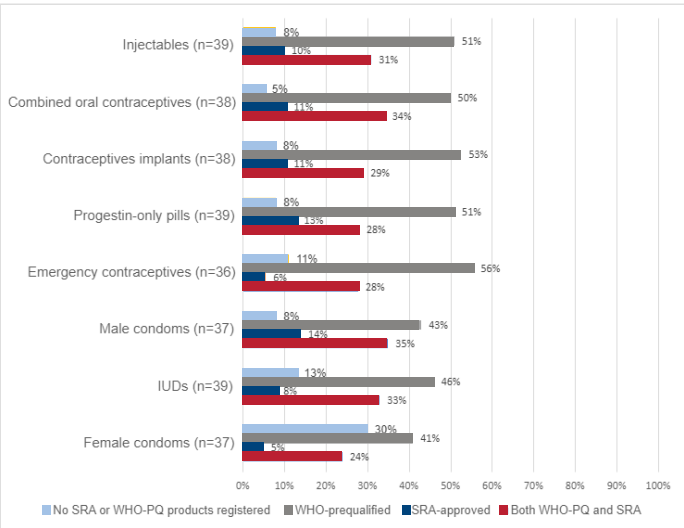
Approximate proportion of wholesalers reporting to the government on their FP commodity sales and FP services (n=7)



Countries were asked about WHO-PQ and SRA-approved products registered for distribution among the following eight FP methods: COCs, POPs, injectables, implants, IUDs, male and female condoms, and ECs. A range of 46–56 percent of countries have WHO-PQ-only implants, injectables, COCs, POPs, ECs, and IUDs for distribution in the country (Exhibit 51). WHO-PQ-only male and female condoms are registered in 43 and 41 percent, respectively. The percentage of countries with products that are both WHO-PQ and SRA-approved range from 24–35 percent across all eight methods. Those with only SRA range from 5 to 14 percent among the eight methods. Those with neither WHO-PQ or SRA range 5–30 percent among the eight methods.

EXHIBIT 51

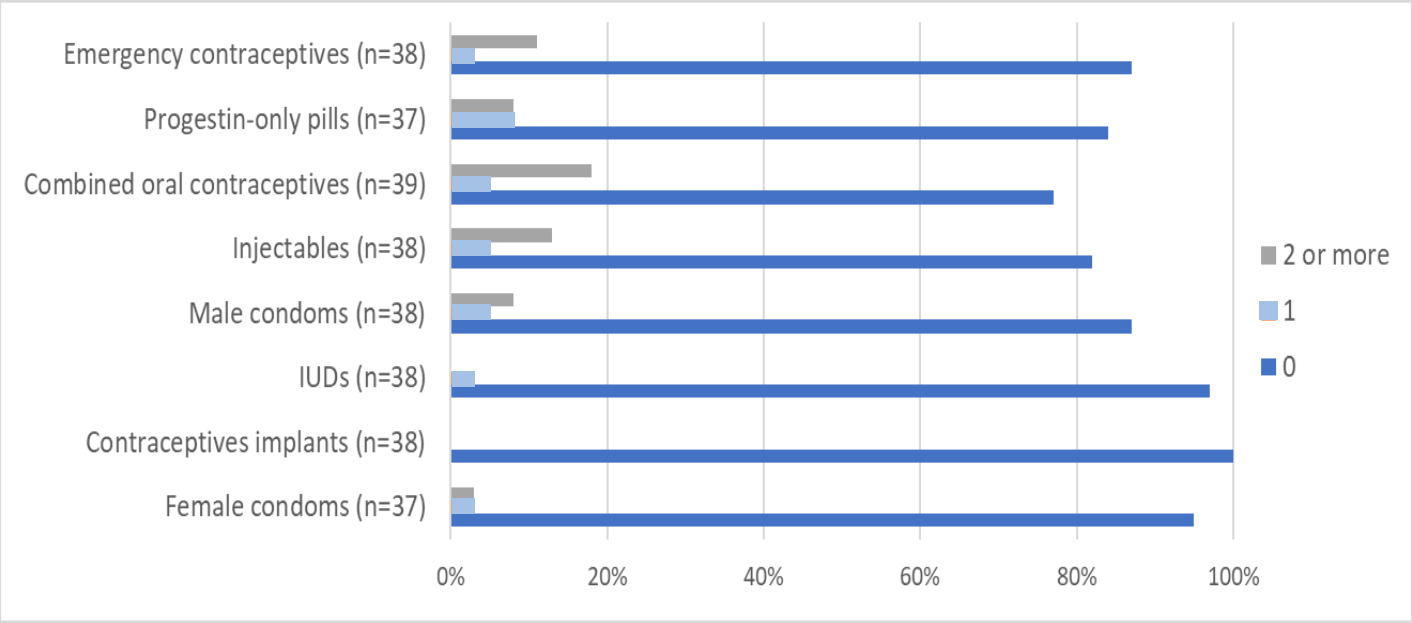
WHO-PQ and/or stringent regulatory authority-approved products registered for distribution in the country



Countries were asked how many in-country local manufacturers exist (0, 1, or 2 or more) for each of the following FP methods: COCs, POPs, injectables, implants, IUDs, male and female condoms, and ECs. Zero to 18 percent of countries reported the existence of two or more manufacturers for any of the methods, and zero to 8 percent of countries reported the existence of one manufacturer. Meanwhile, 77 to 100 percent of countries reported that there were no in-country local manufacturers for any of the eight methods (Exhibit 52).

EXHIBIT 52

Number of in-country local manufacturers that produce the FP method

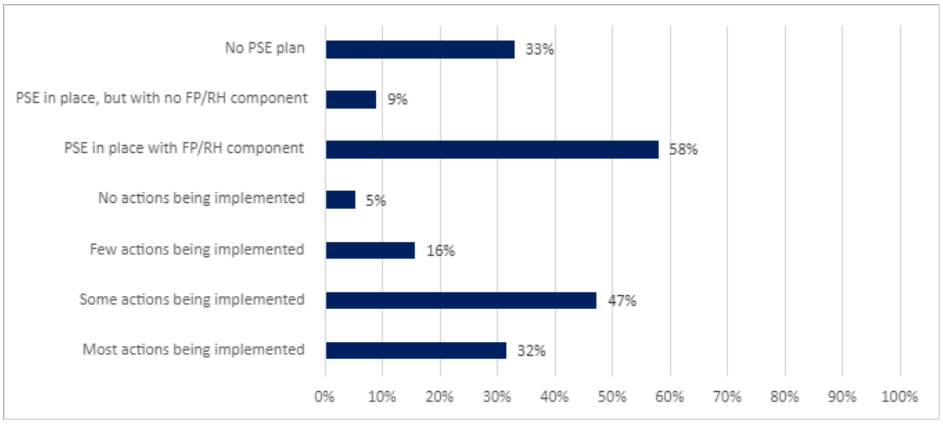


There was a notable increase in the number of countries reporting brokering public-private partnerships in the previous two years to expand private-sector FP products or services, from 41 percent of countries in 2021 to 71 percent in 2023.

The percentage of countries whose governments have developed a private-sector engagement (PSE) plan to expand private-sector FP products is 58 percent. For those countries with a PSE plan that includes a FP/RH component, 32 percent are implementing most actions, 47 percent are implementing some actions, 16 percent are implementing few actions, and 5 percent are taking no action9 percent have a PSE plan in place but it does not include a FP/RH component, and 33 do not have any PSE plan in place. (Exhibit 53).

EXHIBIT 53

FP/RH PSE plan developed by government and extent of implementation (n=33)



12.

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Impact of the COVID-19 Pandemic

In 2021, the CS Indicators Survey provided a high-level assessment of the perceived impact of the COVID-19 pandemic on a few aspects of access to contraceptives, including changes in frequency of CS committee meetings and in FP commodity budgets and expenditures, the existence of emergency plans that account for access to FP/RH, and operational practices put in place to enable continued access to FP/RH in the face of COVID-19. In 2023, the survey examined how these same dynamics have evolved since 2021.

Highlights

The COVID-19 pandemic is still having substantial residual effects on the frequency of CS committee meetings, government budgets for FP, and government spending on FP.

84%

of countries reported having an emergency preparedness plan in place for pandemics that includes impact on FP. Of the 37 reporting countries, 86 percent have an emergency preparedness plan in place for other types of emergencies that includes impact on FP.

75%

of countries reported no impact of the COVID-19 pandemic on the approved budget line for contraceptives. All or most of the contraceptive budget was shifted to COVID-19 response in 8 percent of surveyed countries (3 countries).

74%

of the countries surveyed reported no impact of the COVID-19 pandemic on frequency of CS committee meetings in 2023, 24 percent (9 countries) reported reduced frequency of CS committee meetings, and 3 percent (1 country, El Salvador) reported that the pandemic prevented their ability to meet.

62%

of countries reported no impact of the COVID-19 pandemic on the amount of government spending for contraceptives.

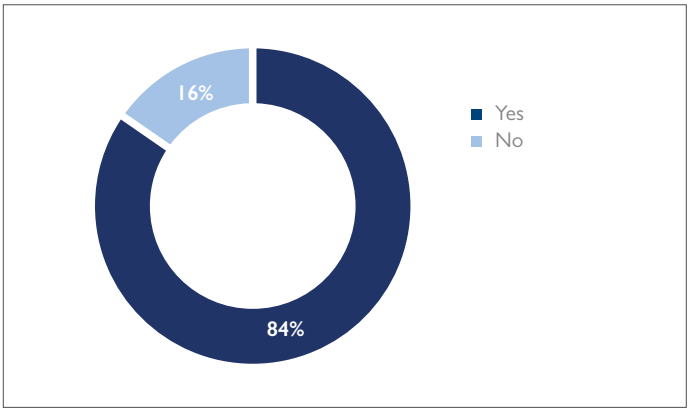
Emergency preparedness plans

Emergency preparedness plans are essential to ensure continued contraceptive access during emergencies. Eighty-four percent of countries reported having an emergency preparedness plan in place for pandemics that includes impact on FP (Exhibit 54), an increase from 76 percent in 2021. Sixteen percent did not have a pandemic emergency preparedness plan.

Most countries now also have emergency plans in place for other types of emergencies (86 percent) that take into account impact on FP, and slightly fewer countries (82 percent) had FP/RH supplies prepositioned.

EXHIBIT 54

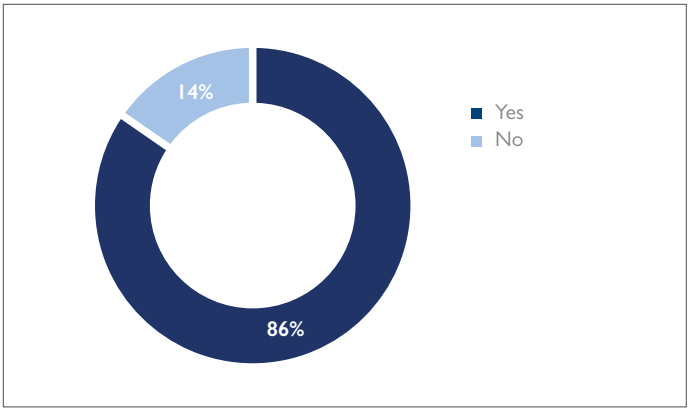
Emergency preparedness plan in place for pandemics (that includes impact on FP) (n=38)



Excluding the countries that responded "don't know," 86 percent of the 37 responding countries had an emergency preparedness plan that includes the impact on family planning for other types of emergencies, as shown in Exhibit 55. This is an increase from 76 percent in 2021.

EXHIBIT 55

Emergency preparedness plan in place for other types of emergencies (that includes impact on FP) (n=37)

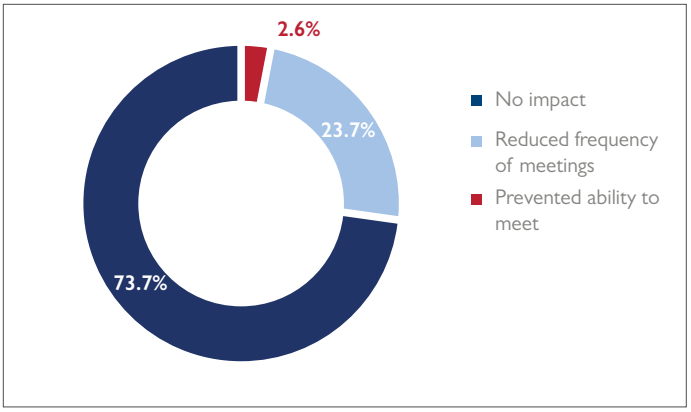


CS committees

Nearly one-quarter of countries (24 percent) reported that the COVID-19 pandemic reduced the frequency of CS committee meetings in 2023. This was down from 40 percent at the peak of the pandemic, but the impact of the pandemic is still evident (Exhibit 56). The COVID-19 pandemic did not affect the frequency of CS committee meetings in 74 percent of countries.

EXHIBIT 56

Impact of the COVID-19 pandemic on frequency of CS committee meetings in 2023 (n=38)

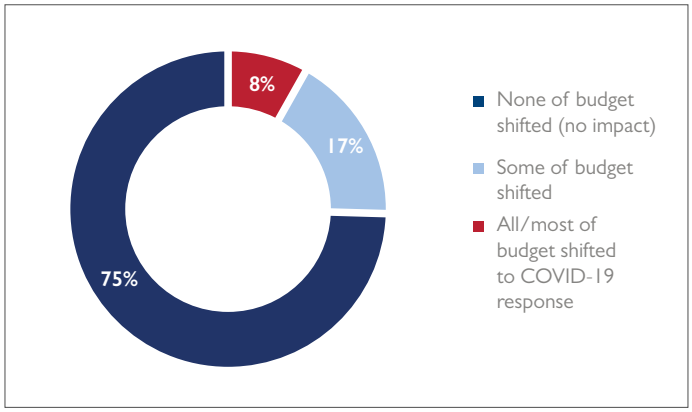


Contraceptive budgets

Of 36 reporting countries, 75 percent reported no impact on contraceptive budgets resulting from the COVID-19 pandemic (Exhibit 57). Three countries (7 percent, Angola, Côte d'Ivoire, and Liberia) reported that all or most of the budget for FP had been shifted to the COVID-19 response in the most recent year. An additional six countries (17 percent) reported some of the budget having shifted. This was a decrease from 2021 but remained high.

EXHIBIT 57

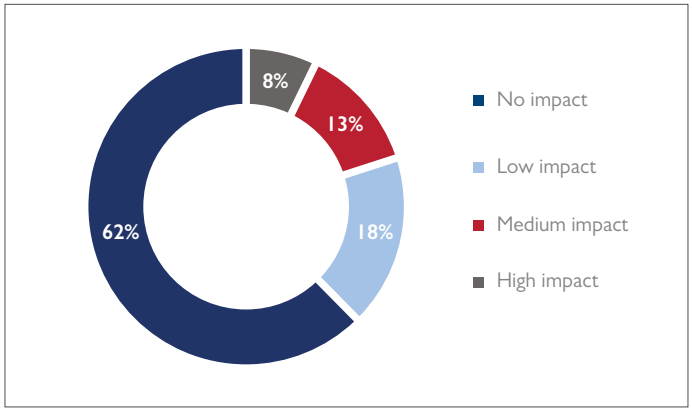
Impact of the COVID-19 pandemic on the approved budget line for contraceptives (n=36)



The COVID-19 pandemic impacted government spending for contraceptives in 38 percent of countries in 2022, the most recent complete year prior to the survey (Exhibit 58). Of the 39 reporting countries, 18 percent reported low impact on government spending for contraceptives. Three countries (7 percent, Côte d'Ivoire, DRC, and Guatemala) reported that COVID-19 had a high impact on the level of government spending on contraceptives in the most recent year, while an additional five countries reported medium impact.

EXHIBIT 58

Impact of the COVID-19 pandemic on the amount of government spending for contraceptives (n=39)



COVID-era practices to facilitate access to FP

Since 2020, most countries have maintained or scaled up their COVID-era practices, which were initially designed to provide continuity of FP services during COVID-19 but may now be helping to further expand access to FP and safeguard access in case of future emergencies. Among the 75 practices to safeguard FP services cited by 37 countries, 55 (73 percent) were maintained or scaled up in 2023, 13 (17 percent) were scaled back or eliminated, and the current status of the remaining seven practices (9 percent) is unknown. The practices most likely to be scaled back or eliminated were those directly related to preventing the spread of COVID-19. However, other practices that were scaled back or eliminated include high-cost alternative commodity distribution methods, such as house-to-house delivery in Ethiopia and Peru, distribution of free commodities (in Benin and Guatemala), or multi-month dispensing (in Guatemala). Multi-month dispensing was maintained or scaled up in three countries (Kenya, Mozambique, and Peru).

The type of practices most commonly maintained or scaled up include encouraging self-care interventions (nine countries), providing mobile family planning clinics (eight countries), and providing telehealth services (five countries). However, three countries scaled back telehealth services (Guinea, Peru, and Zambia) and one country, Guinea, scaled back the promotion of self-care.

13.

PHOTO CREDIT: GHSC-PSM

Conclusions

Consistent collection of CS data provides insight into developments across the multiple components needed to improve the availability of contraceptives at all levels of the health system. The 2023 CS Indicators Survey shows steady progress in several indicators and others that need continued investment and attention.

Leadership and Coordination

Contraceptive security committees continue to be prevalent in countries (95 percent) and remain highly active in terms of meeting frequency. In the 2023 survey, 87 percent of committees met at least twice in the previous year, and 82 percent of committees developed policies, procedures, recommendations, and/or action plans. The share of CS committees in which the commercial sector participates has been hovering at around one-third for the past several rounds of the survey. In this iteration, it reached 45 percent of countries reporting.

The primary functions of CS committees continue to be monitoring FP stock levels and coordinating supply chain interventions (24 countries), particularly forecasting and quantification, overseeing implementation of national FP strategies (23 countries), making technical or policy recommendations (17 countries), and increasing communication and collaboration among FP stakeholders (16 countries).

Finance and Procurement

Even though the number of countries with a funding gap remained the same in 2023, there was a drop in government spending, with the share of government spending falling from 47 percent in 2021 to 34 percent in 2023, while the average value of donations increased slightly. In the 2021 survey, Zambia, Kenya, Nigeria, El Salvador, and Mauritania spent government funds. For the 2023 survey, Zambia reported that the funds were allocated but the procurement process was delayed; these funds were carried over to 2023. For Kenya, Nigeria, El Salvador, and Mauritania, government funds were allocated for contraceptives but not released in time to spend them in the assessment year.

Furthermore, the reported total expenditures do not specifically account for inflation. Worldwide inflation jumped from 1.9 to 8 percent between 2020 and 2022, with many surveyed countries recording even higher rates. Some of the decrease in government spending, therefore, may have been due to inflation, exchange rate variations, or other factors.

Commodities

100 percent of reporting countries now offer combined oral contraceptives and IUDs in the public sector, while 100 offer male condoms in both the commercial and NGO sectors.

The number of countries offering vasectomy and tubal ligation in the social marketing sector has nearly tripled since 2021 (from 5 and 6 countries to 14 and 15 countries, respectively).

Policies

Most national FP/RH strategies (specifically their contraceptive security components) aim to influence overall FP outcomes, such as increasing the availability of and access to FP services and commodities; reducing unmet need; increasing demand for FP and ultimately increasing mCPR; improving maternal and child health; and reducing maternal, neonatal, and child mortality. The strategies and sub-objectives for achieving these higher-level goals are varied, but a common theme is health system strengthening, especially through capacity building. Within this overarching

theme, several countries cited objectives to improve service delivery and FP product quality, strengthen aspects of the supply chain, and improve monitoring and evaluation.

National governments continued the trend of coordinating with the private sector to expand contraceptive access. Most countries (87 percent) reported having enabling policies, while only four cited policies that hinder the private sector's distribution of contraceptives. Among some of the specific enabling policies cited include governments supporting training for private-sector providers; subsidizing contraceptives in the private sector; facilitating private imports, such as through tax exemptions; public/private provider networks and franchises; accreditation services; and regulations allowing for over-the-counter sale of contraceptives. The hindering policies cited include: specific permission needed to import contraceptives, branding or advertising restrictions, high taxes on contraceptives, price controls, and bans on mass media promotions. The number of countries that impose duties on FP commodities in the commercial sector increased in 2023.

The main cultural or operational barriers to accessing FP/RH services and commodities continue to be religious institutional barriers or beliefs (cited by 11 countries), social norms, misconceptions, or taboos (9 countries), in addition to negative perceptions specifically about youth access to FP (8 countries). Other frequently cited barriers were geographic access difficulties (7 countries), inaccessibility of services for people with disabilities (6 countries), and a lack of knowledge about FP services (4 countries).

There was a 11 percent reduction between 2021 and 2023 in the share of countries using mass media as a channel for promoting family planning. Use of all other channels remained about the same.

The majority of reporting countries (88 percent) made or plan to make an FP2030 commitment. All of the countries reporting on specific commitment areas in their existing or planned FP2030 commitment reported that improving domestic financing for contraceptives and improving access to or availability of contraceptives are key areas of their commitment.

Countries with Global Financing Facility partnerships include family planning much more frequently (83 percent) compared to the previous survey in 2021 (63 percent), as well as procurement provisions for contraceptives (67 percent, compared to 65 percent in 2021).

Supply Chain

Ninety-three percent of countries reported having an LMIS that includes data on contraceptives; of these, 95 percent track contraceptive stock data down to the SDP level. Since the previous survey, there has been a large uptick in electronic reporting at the SDP level, from 68 to 84 percent of reporting countries.

Quality

The percent of countries in which the NMRA conducts field surveillance monitoring to identify SF contraceptives rose from 32 percent to 61 percent between 2021 and 2023, with nine new countries confirming NMRA monitoring (Liberia, Madagascar, Mali, Nepal, Nigeria, Peru, Tanzania, DRC, and El Salvador).

The testing of most contraceptives (excluding condoms) nearly tripled from 17 percent in 2021 to 46 percent in 2023. The rates of NQCL testing either most or some contraceptives (excluding condoms) post-shipment rose in 2023 to 58 percent of countries, an increase from 41 percent of countries in 2021. The NQCL tested most or some condoms post-shipment in 75 percent of countries in 2023, an increase from 21 percent in 2021.

Ninety-three percent of countries reported having an LMIS that includes data on contraceptives; of these, 95 percent track contraceptive stock data down to the SDP level.

PHOTO CREDIT: GHSC-PSM

Private Sector

There was a notable increase in the number of countries reporting brokering public-private partnerships in the previous two years to expand private-sector FP products or services, from 41 percent of countries in 2021 to 71 percent in 2023.

Impact of COVID-19 Pandemic

The COVID-19 pandemic continues to have substantial residual effects on the frequency of CS committee meetings, government budgets for FP, and government spending on FP. Nearly one-quarter of countries (24 percent) reported that the COVID-19 pandemic reduced the frequency of CS committee meetings in 2023. This was down from 40 percent in the peak of the pandemic, but the influence of the pandemic is still evident.

Three countries (8 percent, Angola, Côte d'Ivoire, and Liberia) reported that all or most of the budget for FP had been shifted to the COVID-19 response in the most recent year. An additional six countries (17 percent) still reported some of the budget having shifted, a decrease from 2021, but still high.

Three countries (Côte d'Ivoire, DRC, and Guatemala) reported that COVID-19 had a high impact on the level of government spending on contraceptives in the most recent year, while an additional five countries reported medium impact.

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Annexes

ANNEX A | **Contraceptive Security Indicators Survey Questionnaire**

USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM
PROCUREMENT AND SUPPLY MANAGEMENT

Contraceptive Security (CS) Indicators Survey, 2021

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

Country: (Select from drop-down menu)

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 H. Impact of COVID-19 Pandemic

Instructions:
- Please indicate your answers in the yellow and white spaces. Most questions contain dropdown lists for your selection. Yellow cells denote required responses.
- 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.

Interviewer: *Read the following statement to the Ministry of Health representative with authority to provide agreement.*
This full survey will be published on the GHSC-PSM website (https://www.ghsupplychain.org/), and will be aggregated and summarized along with the surveys of other countries and published as an Excel database, narrative report, and interactive dashboard. In accordance with USAID policies, these data may be used in other research venues for the purpose of building the global evidence base for family planning programming.
This survey has been conducted since 2010 with more than 50 countries participating. The information collected is used to share and assess family planning policies and best practices.

Before proceeding with data collection:
Select an option from the drop-down menu to the left to confirm if a representative of the Ministry of Health has agreed to this statement.

Ministry of Health official's name:
Job title:

A. Leadership and Coordination

A1.	Is there a national committee that works on contraceptive security? Committees can range from advisory committees to those responsible for decision-making on supply management or other policies, and they do not need to have formal legal or administrative status to be considered a committee for this survey. Also, a 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:
	IF NO, SKIP TO SECTION B.		
	a. What is the name of the committee?		

		(Y/N dropdown)	
A2.	Are the following organizations represented on the committee?		
	a. Social marketing, *(for example: PSI, DKT, SFH, etc.)*		If yes, specify name(s) of organizations:
	b. NGOs *(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 *(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 *(for example: logistics, reproductive health, family planning, maternal and child health, HIV/AIDS, pharmacy units, MOH department of finance, 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 *(for example: professional associations, educational institutions, civil society)*		If yes, specify:
	i. Other *(for example: professional associations, educational institutions, civil society)*		If yes, specify:

A3.	Does the committee have formal legal or administrative status?		Please describe the key functions and role of the committee
A4.	Does the committee have formal written terms of reference?		
A5.	How many times did the committee meet during the last year?		
A6.	Has the committee developed or started development on any policies, procedures, recommendations, and/or action plans in the last year?		
a.	If yes, is there evidence that the committee has adhered to its policies and procedures, implemented its action plans, and/or followed up on and addressed issues raised at previous meetings?		

B. Finance and Procurement

B1.	What is the most recent completed 12-month period for which both contraceptive commodity **forecast data** and **expenditure data** are available for the public sector (ideally the country government's previous fiscal year)? This must be the same 12-month period used for questions B2-B17, hereinafter referred to as 'complete year'. Please explain any exceptions in the comments section.	Beginning month		Ending month		Comments
		Beginning year		Ending year		
B2.	What was the forecasted (estimated) dollar value of contraceptives needed to be procured for the public sector* for the most recent complete year (as indicated above in B1)? (in USD) *In addition to public sector needs, include any family planning commodities which the government provides to NGOs and/or social marketing organizations. This information will be used to compare with actual expenditures later in this section.					
	a. Quantity of contraceptives forecast (in B2), in Couple Years of Protection (CYP) *(See CYP Calculator tab for assistance)*					
B3.	Who conducted the forecast/quantification? (Specify organizations.)					
	a. What is the frequency of forecast updates? (Please select from drop-down menu)					
B4.	Is there a government **budget line item** specifically for the procurement of contraceptives? Please select from the drop-down menu.					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 year? This question refers to funds planned to be spent on contraceptives, whether or not they ended up being spent. (Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.) **IF NO, SKIP TO QUESTION B7.**		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) *(should be the same as indicated in B1)*	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])				

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	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 **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 procuring contraceptive commodities in the most recent complete year?* (Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.) *(Include cases where the government funded contraceptive supply for NGOs or social marketing.) **IF NO, SKIP TO QUESTION B9.**		Comments:

In the table below, the time period should reflect when the funds were spent (ideally when commodities were delivered), and should reflect the same time period as indicated in B1.

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) *(should be the same as indicated in B1)*	Quantity (in Couple Years Protection) *(See CYP Calculator tab for assistance)*	Spending type	Details of government procurement *(list of contraceptive methods and/or products procured, if available)*
	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 **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 year (per question B1).
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 donated funds for contraceptives for the public sector**	In-kind or cash?	Value of donation	Time period (mm/yy-mm/yy) *(should be the same as indicated in B1)*	Quantity (in Couple Years of Protection) *(See CYP Calculator tab for assistance)*	Spending type	Details of donations *(list of contraceptive methods and/or products procured, if available)*
	a. USAID						
	b. UN agencies						
	c. Global Fund						
	d. Other bilateral (specify)						
	e. Other						
	e. Other						
	f. TOTAL value of in-kind donations and grants spent on contraceptive procurement **This will auto-calculate.** *(It will sum a-e above.)*		$ -		-		

The answers to B10 - B16 should calculate automatically based on the information you provided. Please review the answers to ensure they make sense to you, and if you have explanations or additional information to add, please note it in the comment boxes provided. 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 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 total 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 year, what percent was covered by internally generated government funds?	#DIV/0!	Comments:	
B12.	**Total expenditures on public sector contraceptives** *This will automatically calculate the total amount from government expenditures (G49) and donations (G57).*	$ -	Comments:	
B13.	**Total expenditures on public sector contraceptives as percent of amount that needed to be procured (forecast) -** Of the estimated value of the contraceptives needed to be procured for the public sector for the most recent complete year, what percent was provided by any source (whether government or donor)?	#DIV/0!	Comments:	
B14.	**Total quantity of contraceptives procured in Couple Years of Protection as a percent of the quantity that needed to be procured (forecast) -** Of the estimated quantity of contraceptives needed to be procured for the public sector for the most recent complete year, what percent was provided by any source (whether government or donor)? *This will automatically calculate the quantity of contraceptives procured (K49+K57) divided by the quantity forecasted (J30).*	#DIV/0!	Comments:	
B15.	**Was there a funding gap for public sector contraceptives in the last complete year?** *(This will automatically calculate based on whether the result in B13 was at least 99 percent of the forecasted need.)*	#DIV/0!	Comments:	
B16.	**Internally generated government funds as a percentage of the total value of contraceptives that needed to be procured (forecast)**	#DIV/0!	Comments:	
B17.	If the **government financed** any contraceptive procurement in the most recent complete year, which entity(ies) conducted the procurement(s)? (Please select from the drop-down menus to indicate all that apply)			
	a. Government (e.g. Central Medical Stores/MOH logistics unit/MOH procurement unit)		Comments:	
	b. Third-party agent (e.g. UNFPA or private sector)			
	c. Parastatal (including if the government central medical store is a parastatal)			
	d. Other			
	e. Specify entity(ies):			
B18. a.	At what level(s) does **government-financed procurement** of public sector contraceptives occur? (Please use the drop-down menus to indicate all levels that apply)			
	i. Central			
	ii. Intermediate (e.g. regional, district)			
	iii. Service delivery point level			
	b. For **government-financed procurement**, regardless of centralized or decentralized procurement, what is the delivery point (i.e. to what level does the supplier deliver the commodities)?			

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b.	For **government-financed procurement**, regardless of centralized or decentralized procurement, what is the delivery point (i.e. to what level does the supplier deliver the commodities)? (Please use the drop-down menus to indicate all that apply).		Comments:
i.	Central		
ii.	Intermediate (e.g. regional, district)		
iii.	Direct to service delivery points		
iv.	Other		
v.	If other, specify:		
B19.	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**.

B20.	Have funds been **allocated** by the government for the procurement of contraceptives for the current fiscal year?		Comments:

	Source	Amount (in USD)	Comments
a. If yes, please describe the allocations (source and quantity if available).			

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 for each sector.			
	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], desogestrel 0.15mg + ethinyl estradiol 0.03mg [Enskyce, Marvelon, Exeltis], drosiperenone/ethinyl estradiol 3mg/20mcg [Yaz], norgestrel+ethinyl estradiol 0.3mg/30mcg [Cryselle, Ovral, Low-Ogestrel, LoOvral], norgestrel+ethinyl estradiol 0.5mg/50mcg [Ogestrel], 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, Azea], 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 [Depo-Provera], norethisterone enanthate [Noristerat])				
d. Contraceptive Implants (for example, levonorgestrel 75mg [Jadelle, Sino-Implant (II)/Levoplant], etonogestrel 68mg [Implanon, 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)				
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

D1.	Is there a national strategy (e.g. contraceptive security strategy or reproductive health strategy) that includes objectives for contraceptive security?		If yes, state the objectives in the strategy related to contraceptive security. (For example, does it aim to increase sustainability, meet demands, increase mCPR, etc.)	
	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.	Is there evidence of 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 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.			
D3.	Are there policies that **enable** or **support** the **private sector** (commercial sector, NGOs, or social marketing) to provide contraceptive methods? (For example: 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.			

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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, please select the closest appropriate cadre title.
(If you indicated in C1 that a method is not offered in a particular sector (public or private), select "not applicable" for that method and sector.)

D4.	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 75 mg, levonorgestrel/ethinyl estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], desogestrel 0.15 mg + ethinyl estradiol 0.03 mg [Enskyce, Marvelon, Exeltis], drosiperenone/ethinyl estradiol 3mg/20 mcg [Yaz], norgestrel+ethinyl estradiol 0.3 mg/30 mcg [Cryselle, Ovral, Low-Ogestrel, LoOvral], norgestrel+ethinyl estradiol 0.5 mg/50 mcg [Ogestrel], norethindrone acetate/ethinyl estradiol [Loestrin, Junel])			
b.	Progestin-only Oral Contraceptive Pills (for example, levonorgestrel 30 mcg [Norgeston, Microlut], norethindrone 35 mg [Micronor, Camila, Errin], desogestrel 75 mcg [Cerazette, Alzea], ethynodiol diacetate [Femulen])			
c.	i. Injectables (depot medroxyprogesterone acetate 104 mg/0.65 mL **subcutaneous** [Depo Sub-Q Provera, Sayana Press])			
	ii. Injectables (depot medroxyprogesterone acetate 150 mg **intramuscular** [Depo-Provera], norethisterone enanthate [Noristerat])			
d.	Contraceptive Implants (for example, levonorgestrel 75 mg [Jadelle, Sino-Implant (II)/Levoplant], etonogestrel 68 mg [Implanon, 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 0.75 mg, levonorgestrel 1.5 mg) [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 150/35 mcg [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. For example: SILCS diaphragm)	Type of contraceptive:		

The following questions (D5 and D6) will ask about laws and practices that may ***increase access*** by specific subpopulations to effective family planning services/commodities, while questions D7 and D8 will ask about any laws or practices that may ***prevent*** or ***reduce access*** by these subpopulations.

D5.	Does the country have laws, regulations, or policies that **increase** access to effective family planning services/commodities by the following sub-populations?	Y/N (dropdown)	If yes, describe laws/regulations/policies increasing access	Are the rules/policies implemented or enforced?
a.	Unmarried youth (ages 15-19)			
b.	Married youth (ages 15-19)			
c.	Unmarried youth (ages 20-24)			
d.	Married youth (ages 20-24)			
e.	Rural population			
f.	Populations in disadvantaged sub-regions *(i.e. certain geographic areas)*			
g.	Populations with lower educational attainment			
h.	Lower income populations			
i.	Disabled			
j.	Minority populations *(e.g. ethnic or religious groups)*			
k.	Other *(e.g. migrants, internally displaced populations)*			

D6.	Does the country have any operational, cultural, or other practices that may **increase** access to effective family planning services/commodities by the following sub-populations?	Y/N (dropdown)	If yes, describe the operational, cultural, or other practices that may increase access
a.	Unmarried youth (ages 15-19)		
b.	Married youth (ages 15-19)		
c.	Unmarried youth (ages 20-24)		
d.	Married youth (ages 20-24)		
e.	Rural population		
f.	Populations in disadvantaged sub-regions *(i.e. certain geographic areas)*		
g.	Populations with lower educational attainment		
h.	Lower income populations		
i.	Disabled		
j.	Minority populations *(e.g. ethnic or religious groups)*		
k.	Other *(e.g. migrants, internally displaced populations)*		

D7.	Does the country have laws, regulations, or policies that **make it difficult** for the following sub-populations to access effective family planning services/ commodities? (e.g. spousal approval required to access contraceptives)	Y/N (dropdown)	If yes, describe laws/regulations/policies affecting access	Are the rules/policies implemented or enforced?
a.	Unmarried youth (ages 15-19)			
b.	Married youth (ages 15-19)			
c.	Unmarried youth (ages 20-24)			
d.	Married youth (ages 20-24)			
e.	Rural population			
f.	Populations in disadvantaged sub-regions *(i.e. certain geographic areas)*			
g.	Populations with lower educational attainment			
h.	Lower income populations			
i.	Disabled			
j.	Minority populations *(e.g. ethnic or religious groups)*			
k.	Other *(e.g. migrants, internally displaced populations)*			

D8.	Does the country have any operational, cultural, or other **barriers** and practices that **make it difficult** for the following sub-populations to access effective family planning services/commodities? (for example, providers not wanting to offer services to young people)	Y/N (dropdown)	If yes, describe the operational, cultural, or other barriers and practices affecting access
a.	Unmarried youth (ages 15-19)		
b.	Married youth (ages 15-19)		
c.	Unmarried youth (ages 20-24)		
d.	Married youth (ages 20-24)		
e.	Rural population		
f.	Populations in disadvantaged sub-regions *(i.e. certain geographic areas)*		

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	f. Populations in disadvantaged sub-regions *(i.e. certain geographic areas)*			
	g. Populations with lower educational attainment			
	h. Lower income populations			
	i. Disabled			
	j. Minority populations *(e.g. ethnic or religious groups)*			
	k. Other *(e.g. migrants, internally displaced populations)*			
D9.	Are any family planning commodities subject to duties?		Comments:	
	a. If yes, for which sectors? (Please use the dropdown menus to indicate all that apply)			
	i. Public sector health facilities			
	ii. NGO Sector			
	iii. Social Marketing Sector			
	iv. Commercial Sector			
	b. If yes, how much are the duties? (In USD or percentage of commodity value)			
D10.	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.			
D11.	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?			
D12.	Are the following contraceptives included in the country's National Essential Medicines 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 75 mg, levonorgestrel/ethinyl estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], desogestrel 0.15 mg + ethinyl estradiol 0.03 mg [Enskyce, Marvelon, Exeltis], drosiperenone/ethinyl estradiol 3 mg/20 mcg [Yaz], norgestrel+ethinyl estradiol 0.3 mg/30 mcg [Cryselle, Ovral, Low-Ogestrel, LoOvral], norgestrel+ethinyl estradiol 0.5mg/50 mcg [Ogestrel], norethindrone acetate/ethinyl estradiol [Loestrin, Junel])		Comments:	
	b. Progestin-only Oral Contraceptive Pills (for example, levonorgestrel 30 mcg [Norgeston, Microlut], norethindrone 35 mg [Micronor, Camila, Errin], desogestrel 75 mcg [Cerazette, Aizea], ethynodiol diacetate [Femulen])			
	c. Injectables (for example, depot medroxyprogesterone acetate 104 mg/0.65 mL subcutaneous [Depo Sub-Q Provera, Sayana Press], depot medroxyprogesterone acetate 150 mg intramuscular [Depo-Provera], norethisterone enanthate [Noristerat])			
	d. Contraceptive Implants (for example, levonorgestrel 75 mg [Jadelle, Sino-Implant (II)/Levoplant], etonogestrel 68 mg [Implanon, 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 0.75 mg, levonorgestrel 1.5 mg)			
	j. Contraceptive Patches (for example, norelgestromin/ethinyl estradiol 150/35 mcg [Xulane, Evra])			
	k. Vaginal Contraceptive Rings (for example, etonogestrel/ethinyl estradiol 120/15 mcg [NuvaRing], progesterone-releasing [Progering])			
	l. Calendar-based Awareness Methods (for example, CycleBeads)			
	m. Any other contraceptive(s)? (e.g. SILCS diaphragm)			
	i. If yes, name(s) of other contraceptive(s) on the list(s)			
D13.	What year(s) was the NEML/list(s) issued?			
D14.	Name of the list(s)			
D15.	Is family planning actively promoted through any of the following channels? (use the drop-down menus to select all that apply)			
	a. Social marketing		Comments:	
	b. Mass media			
	c. Mobile outreach/education			
	d. Community mobilization/engagement			
	e. Other			
	f. If other, please specify:			
D16.	Approximately what percentage of public sector family planning providers have been trained in implant and IUD insertion and removal? (Select the percentage range that is the closest approximation.)		Comments:	
	Question **D17** concerns the FP2020 partnership in its previous iteration through the year 2020. Questions **D17a through D18c** concern the new **FP2030** partnership, "A Collective Vision for Family Planning Post-2020".			
D17.	Looking back to the period of FamilyPlanning2020, did the country make an **FP2020** commitment?		Comments:	
	a. Has the country made an **FP2030** commitment?		Comments:	
	b. If not, does the country anticipate making an **FP2030** commitment?		Comments:	
D18.	If the country has or plans to make an **FP2030** commitment, which of the following components will be included? *(Indicate 'yes', 'no', 'don't know', or 'not applicable' for each component)*		Comments:	
	a. Improving domestic financing for contraceptives		Comments:	
	b. Increasing affordability of contraceptives for clients		Comments:	
	c. Improving access to or availability of contraceptives (beyond any commitments for domestic financing or affordability)		Comments:	
D19.	Is the country a Global Financing Facility (GFF) partner?			
	a. If yes, does the financing include provisions for family planning?			
	b. Does it include provisions for procurement of contraceptive commodities?		Comments:	
	c. Does the financing include provisions for supply chain management?			

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	b. Does it include provisions for procurement of contraceptive commodities?		Comments:								
	c. Does the financing include provisions for supply chain management?										
	d. Does technical assistance support a transition to domestic financing of contraceptives?										
E. Supply Chain											
E1.	Is there a national logistics management information system (LMIS) that collects data on contraceptive commodities?	Yes	Comments:								
	IF NO, SKIP TO QUESTION E2.										
	a. If there is a national LMIS, does it capture stock data down to the individual service delivery point (SDP) level? *(At a minimum, data elements reported for health facilities must include: stock on hand/ending balance, rate of consumption, losses and adjustments)*		Comments:								
	b. If yes, what types of health facilities report into the system? (Use the dropdown menus to select all that apply)										
	i. Public sector health facilities										
	ii. Private sector health facilities										
	iii. NGO health facilities										
	iv. Social marketing sites										
	c. If there is a national LMIS that captures stock data at the service delivery point (SDP) level, please select the option that best describes how data is reported at the SDP level. *(At a minimum, data elements reported for health facilities must include: stock on hand/ending balance, rate of consumption, losses and adjustments. Otherwise, please select "not applicable" for this question.)*		Comments:								
E2.	Please provide the public sector **stockout rates** for contraceptive commodities for the most recent available 12-month period for the central and service delivery point levels for the following product categories. For products that are not offered in the public sector in the country, please type in 'N/A' (not applicable) in the comments box. If the product is offered but data is not available, please also type in 'N/A' and explain why the data is not available in the comments section.			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 **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 **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:				#DIV/0!			#DIV/0!	
	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 [Depo-Provera]					#DIV/0!			#DIV/0!	
	iii. Norethisterone enanthate [Noristerat]					#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 [Implanon, 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 0.75 mg, 2 tablets					#DIV/0!			#DIV/0!	
	ii. Levonorgestrel 1.5 mg, 1 tablet					#DIV/0!			#DIV/0!	
	j. Calendar-based awareness methods (for example, CycleBeads)					#DIV/0!			#DIV/0!	
	k. Total stockout 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!	
	E3. (Optional): What have been the main drivers of stockouts of contraceptives in the country during the previous year?										
F. Quality											
F1.	Is there a requirement that all contraceptives that are locally manufactured or imported be registered by the in-country national medicines regulatory authority (NMRA)?						Comments:				
F2.	Are drug (including contraceptives) registration requirements strictly adhered to?						Comments:				
	a. If yes, are there exceptions?										
	b. Please explain any exceptions										
F3.	What is the average lead time for the registration of contraceptive products?						Comments:				
F4.	Does the NMRA participate in WHO-prequalified (WHO-PQ) Collaborative Procedures?						Comments:				
F5.	Is there a requirement that contraceptives, imported or locally manufactured, be tested by the in-country national quality control laboratory (NQCL)?						Comments:				
F6.	Is the NQCL currently ISO 17025 (International Organization of Standards) certified/accredited and/or currently WHO-prequalified?										
F7.	In the past year, to what extent were contraceptives, *excluding condoms*, tested by the NQCL post-shipment ?										
	a. In the past year, to what extent were condoms tested by the NQCL post-shipment ?										
F8.	In the past year, did the NMRA conduct field surveillance monitoring to identify SF (substandard and falsified) contraceptives, to protect the public from ineffective and/or harmful products?										
	a. If yes, to what extent were regulatory enforcement actions taken following field surveillance of contraceptives?										

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	a. If yes, to what extent were regulatory enforcement actions taken following field surveillance of contraceptives?			
G. Private Sector				
G1.	According to the MoH, how many wholesalers are registered in the country (for distributing FP products)?		Comments:	
	a. Are wholesalers required to report to the government their sales and services?			
	b. If yes, in the past year, approximately what proportion of wholesalers reported to the government on their sales and services?			
G2.	Does the MoH use market data from third party sources (i.e., IQVIA, Nielson, Kantar, or local market research companies) to guide programming?			
	a. If yes, how is the data used? (e.g. understanding commodity pricing, strategic planning, resource allocation, distribution, etc.)		Comments:	
	b. If no, would they like to build this capacity?			

The International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) aims to ensure that safe, effective and high quality medicines are developed, registered, and maintained in the most resource efficient manner whilst meeting high standards. The national drug regulatory authorities which are members, observers, or associates of the ICH are considered as **Stringent Regulatory Authorities (SRA)**, including: European Union member states, the United Kingdom, the United States, Canada, and Japan.

G3.	For each of the following contraceptive methods, please provide the following information: i. Are there any WHO-prequalified (WHO-PQ) or Stringent Regulatory Authority (SRA) approved products registered for distribution in the country? (Use the dropdown menu to indicate WHO-PQ, SRA, both, neither, or don't know) ii. How many manufacturers are registered in the country for distribution of WHO-prequalified and/or SRA-approved contraceptive products? (Use the dropdown menu to indicate 0, 1, 2-3, more than 3, or don't know) iii. If there are any WHO-prequalified and/or SRA-approved contraceptive products, list one or more examples of the brand and formulation. iv. How many in-country local manufacturers exist who produce any products within the contraceptive method.			
	a. Combined Oral Contraceptive Pills *(for example, levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75 mg, levonorgestrel/ethinyl estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], drosiperenone/ethinyl estradiol 3mg/20mcg [Yaz], norethindrone acetate/ethinyl estradiol [Loestrin, Junell)*			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-prequalified and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any combined oral contraceptives?			
	b. Progestin-only Oral Contraceptive Pills *(for example, levonorgestrel 30 mcg [Norgeston, Microlut], norethindrone 35 mg [Micronor, Camila, Errin], desogestrel 75 mcg [Cerazette, Aizea], ethynodiol diacetate [Femulen])*			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any progestin-only contraceptives pills?			
	c. Injectables *(for example, depot medroxyprogesterone acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press], depot medroxyprogesterone acetate 150 mg intramuscular [Depo-Provera], norethisterone enanthate [Noristerat])*			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any injectable contraceptives?			
	d. Contraceptive Implants *(for example, levonorgestrel 75 mg [Jadelle, Sino-Implant (II)/Levoplant], etonogestrel 68 mg [Implanon, Nexplanon])*			
	d. Contraceptive Implants *(for example, levonorgestrel 75 mg [Jadelle, Sino-Implant (II)/Levoplant], etonogestrel 68 mg [Implanon, Nexplanon])*			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any contraceptive implants?		Comments:	
	e. Intrauterine devices (IUDs) *(for example, copper-bearing [Optima Copper T], levonorgestrel-releasing [Mirena])*			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any contraceptive implants?			
	f. Male condoms			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any male condoms?			
	g. Female condoms			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any female condoms?			
	h. Emergency contraceptive pills *(for example, levonorgestrel 0.75 mg, levonorgestrel 1.5 mg [Postinor])*			
	i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?			
	ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?			
	iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation			
	iv. How many in-country local manufacturers exist who produce any emergency contraceptive pills?			
G4.	Are there any joint ventures between multinational pharmaceutical companies and local manufacturers of contraceptives?		If yes, please describe:	
G5.	Have any public/private partnerships been established or brokered in the last two years 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.			
G6.	Has the government developed or started developing a private sector engagement (PSE) plan for family planning/reproductive health, or with an FP/RH component?		Comments:	

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a.	If the government has developed a private sector engagement plan with an FP/RH component, to what extent has it implemented aspects of the plan related to FP/RH?			
Please note any overall comments about challenges and/or successes with contraceptive security in your country				
H. Impact of COVID-19 Pandemic				
H1.	Is there an emergency preparedness plan in place for pandemics (that includes impact on family planning)?		Comments:	
H2.	If yes, what policies are in place to alleviate impacts of pandemics on FP? *(e.g., multi-month dispensing, switch to long-term methods, etc.)*		Comments:	
H3.	Is there an emergency preparedness plan in place for other types of emergencies (that includes impact on FP)?		Comments:	
H4.	How did the COVID-19 pandemic impact the frequency of the CS committee meetings in 2020? *(Please select an option from the drop-down menu)*		Comments:	
H5.	To what extent did the COVID-19 pandemic affect the approved **budget line** for contraceptives for the current fiscal year? *(Please select an option from the drop-down menu)*		Comments:	
H6.	To what extent has the COVID-19 pandemic affected the amount of **government spending** for contraceptives in the most recent complete year? *(Please select an option from the drop-down menu)*		Comments:	
H7.	What, if any, operational practices were put in place to facilitate access to FP services during COVID-19? *(e.g., Mobile FP clinics, telehealth, increased task sharing or task shifting, self-care interventions, no-prescription methods, etc.)* *This may include both government practices and/or those of non-governmental or private entities.*		Comments:	
H8.	What, if any, evidence do you have that COVID-19 has disrupted the availability of FP/RH commodities (if applicable)?		Comments:	
Thank you for completing the survey!				

ANNEX B | **Annex B. Contextual Reference Measures**

(Formerly from the Contraceptive Security Index)

	Indicator	Description	Angola	Bangladesh	Benin	Botswana	Burkina Faso	Burundi	Cameroon	Cape Verde	DRC	El Salvador	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Honduras	India	Kenya	Kyrgyz Republic	Lao PDR	Liberia
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 livelihood that those most in need will be covered by health services, including FP/RH. *Source: World Bank World Development Indicators, 2018. (https://databank.worldbank.org/reports.aspx?source=2&series=SH.XPD.GHED.GE.ZS)	5,4%	3,0%	3,0%	14,3%	8,8%	8,5%	1,1%	10,4%	4,5%	18,8%	4,8%	6,4%	16,7%	4,1%	4,8%	10,7%	3,4%	8,6%	8,4%	4,4%	5,2%
2	Per Capita Gross National Income (GNI), purchasing power parity (PPP) *(constant 2017 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 World Development Indicators. Data was available for the years 2017 to 2020. (https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.KD?name_desc=false)	$ 5 593	$ 5 108	$ 3 288	$14 696	$ 2 055	$ 736	$ 3 586	$ 5 898	$1 051	$ 7 559	$ 2 280	$ 5 601	$ 8 241	$ 2 577	$ 2 940	$ 4 792	$ 6 107	$ 4 267	$ 4 495	$ 6 875	$ 1 424
	Source year of per capita GNI data		2020	2020	2020	2020	2019	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2017	2017
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 World Development Indicators. Data was available for years ranging from 2009 to 2020. (https://data.worldbank.org/indicator/SI.POV.NAHC?view=chart)	32,3%	24,3%	38,5%	19,3%	41,4%	64,5%	37,5%	35,0%	63,9%	26,2%	23,5%	23,4%	59,3%	43,7%	58,5%	48,0%	21,9%	36,1%	25,3%	18,3%	50,9%
	Source year of poverty level data		2018	2016	2019	2009	2018	2013	2014	2015	2012	2020	2015	2016	2014	2018	2012	2019	2011	2015	2020	2018	2016
Health & Social Environment																							
4	Governance																						
	Regulatory Quality *(Percentile rank: 0 to 100)*	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, 1996-2020). 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 Wordlwide Governance Indicators, 2020. (http://info.worldbank.org/governance/wgi/#reports)	15,87	16,35	38,94	65,38	37,50	12,50	19,71	50,48	5,29	50,96	14,42	52,40	44,71	19,23	10,10	34,13	47,60	35,58	37,98	21,15	13,46
5	Women's education (% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio) http://data.uis.unesco.org/#	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 was available for years ranging from 2013 to 2018. (http://data.uis.unesco.org/)	39,74%	81,49%	42,44%	83,52%	41,78%	52,25%	55,44%	92,69%	35,98%	68,97%	34,25%	77,84%	49,91%	31,04%	...	62,93%	75,28%	53,66%	98,08%	60,96%	32,91%
	Source year of gross enrollment ratio data		2016	2020	2020	2008	2020	2021	2016	2019	2015	2019	2015	2020	2020	2014	...	2020	2020	2009	2020	2020	2015
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 programs. 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 mid-2019. *Source: UNAIDS, 2020. (http://aidsinfo.unaids.org/)	1,8%	...	0,9%	19,9%	0,7%	1,0%	3,0%	0,5%	0,7%	0,5%	0,9%	1,7%	0,2%	1,4%	1,9%	0,2%	...	4,2%	0,2%	0,3%	1,1%
Access																							
7	Access to FP Methods																						
7a	Access to long-acting and permanent methods (LAPMs)	Defined as the extent to which the entire population has ready access to LAPMs (average of female sterilization, male sterilization, IUDs, and implants), this indicator is a measure under FP2020's National Composite Index on Family Planning. *Source: Track20, 2017 NCIFP (http://www.track20.org/pages/data_analysis/policy/NCIFP.php)	N/A	47,1%	N/A	N/A	47,2%	57,3%	40,5%	N/A	41,4%	59,2%	35,7%	54,4%	36,4%	45,0%	23,6%	59,0%	60,5%	56,0%	41,9%	48,7%	30,4%
7b	Access to short-term methods (STMs)	Defined as the extent to which the entire population has ready access to STMs (average of condoms, pills, injectables), this indicator is a measure under FP2020's National Composite Index on Family Planning. *Source: Track20, 2017 NCIFP (http://www.track20.org/pages/data_analysis/policy/NCIFP.php)	N/A	76,8%	N/A	N/A	83,8%	80,7%	73,2%	N/A	75,9%	82,6%	78,0%	86,2%	70,4%	75,1%	71,6%	86,4%	71,4%	85,5%	60,4%	77,4%	64,6%
Utilization																							
8	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. *Source: Track20's Family Planning Estimation Tool (FPET) and DHS Final Reports (https://dhsprogram.com/Where-We-Work/Country-List.cfm)	37,1%	19,9%	34,6%	10,8%	25,0%	31,9%	26,9%	17,4%	39,2%	14,6%	21,6%	31,4%	22,9%	23,4%	37,7%	17,4%	18,5%	17,9%	20,0%	21,0%	32,9%
9	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. *Source: Track20's Family Planning Estimation Tool (FPET), DHS Final Reports (https://dhsprogram.com/Where-We-Work/Country-List.cfm), and the 2017 United Nations report on World Family Planning (https://www.un.org/en/development/desa/population/publications/pdf/family/WFP2017_Highlights.pdf).	15,2%	54,5%	14,4%	68,8%	30,6%	27,4%	16,6%	56,2%	15,2%	68,6%	40,5%	30,6%	53,2%	12,1%	34,7%	67,3%	50,3%	58,2%	38,9%	53,0%	25,5%

ANNEX B | **Annex B. Contextual Reference Measures**

(Formerly from the Contraceptive Security Index)

	Indicator	Madagascar	Malawi	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Pakistan	Peru	Philippines	Rwanda	Senegal	Sierra Leone	South Sudan	Sri Lanka	Tanzania	Togo	Uganda	Yemen	Zambia	Zimbabwe
Finance																							
1	Domestic general government health expenditure *(% of general government expenditure)*	10,5%	9,8%	5,4%	6,1%	5,6%	4,6%	8,4%	4,4%	5,3%	15,3%	6,6%	8,9%	4,3%	7,3%	2,1%	8,3%	9,4%	4,3%	5,1%	N/A	7,0%	7,6%
2	Per Capita Gross National Income (GNI), purchasing power parity (PPP) *(constant 2017 international $)*	$1 420	$1 440	$2 132	$5 039	$1 258	$3 844	$1 279	$4 740	$4 467	$10 917	$8 559	$2 052	$3 240	$1 604	N/A	$12 208	$2 616	$2 113	$2 138	N/A	$3 331	$3 864
	Source year of per capita GNI data	2020	2017	2020	2020	2019	2020	2019	2020	2020	2020	2020	2020	2020	2020	N/A	2020	2020	2020	2020	N/A	2017	2018
3	Poverty level *(Percentage of the national population living below the nationally defined poverty line)*	70,7%	51,5%	41,9%	31,0%	46,1%	25,2%	40,8%	40,1%	21,9%	20,2%	16,7%	38,2%	46,7%	56,8%	76,4%	4,1%	26,4%	55,1%	20,3%	48,6%	54,4%	38,3%
	Source year of poverty level data	2012	2016	2020	2014	2014	2010	2018	2018	2018	2019	2018	2016	2011	2018	2016	2016	2017	2015	2018	2014	2010	2019
Health & Social Environment																							
4	Governance																						
	Regulatory Quality *(Percentile rank: 0 to 100)*	22,60	23,56	30,29	20,67	25,00	24,52	23,08	13,94	24,04	70,19	53,37	58,17	42,79	18,27	1,92	44,23	27,40	30,77	36,54	3,85	29,33	7,69
5	Women's education (% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio) http://data.uis.unesco.org/#	35,24%	33,65%	37,00%	40,45%	31,95%	86,90%	20,70%	42,41%	41,59%	106,91%	93,91%	47,05%	50,09%	41,06%	7,67%	102,63%	32,89%	52,06%	21,84%	43,26%	...	51,35%
	Source year of gross enrollment ratio data	2019	2019	2018	2019	2015	2020	2017	2018	2019	2020	2019	2019	2020	2017	2015	2018	2020	2017	2007	2016	...	2013
6	Adult HIV Prevalence	0,3%	8,1%	0,9%	0,3%	11,5%	0,1%	0,2%	1,3%	0,2%	0,3%	0,2%	2,5%	0,3%	1,5%	2,3%	<0.1	4,7%	2,0%	5,4%	<0.1	11,1%	11,9%
Access																							
7	Access to FP Methods																						
7a	Access to long-acting and permanent methods (LAPMs)	39,9%	50,4%	46,1%	24,2%	35,0%	58,2%	42,5%	45,1%	36,1%	41,9%	43,1%	79,4%	40,3%	48,1%	23,4%	57,4%	44,4%	53,2%	40,0%	N/A	38,0%	36,8%
7b	Access to short-term methods (STMs)	71,9%	81,2%	84,3%	66,5%	82,2%	86,4%	84,4%	86,5%	68,6%	81,5%	67,0%	86,7%	84,4%	92,8%	55,2%	87,4%	74,1%	86,4%	69,0%	N/A	76,9%	85,9%
Utilization																							
8	Percent unmet need for family planning	21,5%	16,3%	24,3%	30,2%	23,2%	28,3%	18,9%	24,2%	26,6%	26,0%	30,1%	21,1%	22,9%	24,6%	29,7%	19,6%	25,3%	32,7%	28,9%	35,0%	21,1%	10,2%
o	Modern Contraceptive Prevalence Rate (mCPR)	44,2%	63,1%	18,8%	19,1%	27,8%	46,7%	17,7%	14,6%	28,0%	57,0%	42,3%	53,1%	27,3%	23,6%	6,9%	54,9%	38,7%	23,9%	40,5%	31,7%	49,5%	68,3%

ANNEX C | **Table of Inflation Rates**

World Development Indicators, Inflation, consumer prices (annual %)					
https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG					
March 2024					
Country Name	**2018**	**2019**	**2020**	**2021**	**2022**
Zimbabwe	10.62	255.30	557.20	98.55	104.71
Haiti	12.48	18.70	22.80	16.84	33.98
Ethiopia	13.83	15.81	20.36	26.84	33.89
Ghana	7.81	7.14	9.89	9.97	31.26
Sierra Leone	16.03	14.80	13.45	11.87	27.21
Angola	19.63	17.08	22.27	25.75	
Liberia	23.56				
Malawi	12.42	9.37	8.63	9.33	20.95
Pakistan	5.08	10.58	9.74	9.50	19.87
Nigeria	12.10	11.40	13.25	16.95	18.85
Burundi	-2.81	-0.69	7.32	8.40	18.80
Rwanda	-0.31	3.35	9.85	-0.39	17.69
Burkina Faso	1.96	-3.23	1.88	3.65	14.29
Kyrgyz Republic	1.54	1.13	6.33	11.91	13.92
Botswana	3.24	2.77	1.89	7.24	11.67
Zambia	7.49	9.15	15.73	22.02	10.99
Guinea	9.83	9.47	10.60	12.60	10.49
Mozambique	3.91	2.80	3.48	6.41	10.28
Senegal	0.46	1.76	2.54	2.18	9.70
Mali	0.30	-1.66	0.44	3.93	9.62
Mauritania	3.07	2.30	2.39	3.57	9.53
Honduras	4.35	4.37	3.47	4.48	9.09
Dominican Republic	3.56	1.81	3.78	8.24	8.81
Peru	1.51	2.25	2.00	4.27	8.33
Madagascar	8.59	5.61	4.20	5.81	8.16
Togo	0.93	0.67	1.70	4.19	7.97
Cabo Verde	1.26	1.11	0.61	1.86	7.93
Bangladesh	5.54	5.59	5.69	5.55	7.70
Kenya	4.69	5.24	5.40	6.11	7.66
Nepal	4.06	5.57	5.05	4.15	7.65
El Salvador	1.09	0.08	-0.37	3.47	7.20
Uganda	2.62	2.87	3.31	2.20	7.20
Guatemala	3.75	3.70	3.21	4.26	6.89
India	3.94	3.73	6.62	5.13	6.70
Philippines	5.31	2.39	2.39	3.93	5.82
Cote d'Ivoire	0.36	-1.11	2.43	4.09	5.28
Tanzania	3.49	3.46	3.29	3.69	4.35
Afghanistan	0.63	2.30			
Benin	0.64	-0.71	3.02	1.73	1.35
South Sudan	83.50	87.24	29.68	10.52	-6.69
Congo, Dem. Rep.					
Yemen, Rep.					