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USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM
Procurement and Supply Management

2019 CONTRACEPTIVE SECURITY INDICATORS REPORT

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CONTRACEPTIVE SECURITY INDICATORS SURVEY

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-Procurement and Supply Management
ISO	International Organization of Standards
IUD	intrauterine device
LAC	Latin America and the Caribbean
LMIS	logistics management information system
MoH	Ministry of Health
NEML	National Essential Medicines List
NGO	non-governmental organization
NMRA	national medicines regulatory authority
NQCL	national quality control laboratory
POP	progestin-only pill
PPP	public-private partnership
PSE	private-sector engagement
QA	quality assurance
QC	quality control
RH	reproductive health
SDP	service delivery point
SRA	stringent regulatory authority
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SF	substandard and falsified
SSFFC	substandard, spurious, falsely labelled, falsified, and counterfeit
USAID	United States Agency for International Development
WHO	World Health Organization
WHO-PQ	World Health Organization-prequalified
SRA	stringent regulatory authority
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SF	substandard and falsified

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Executive Summary

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

This 2019 CS Indicators report updates the 2017 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 2009 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 ninth round — to benefit the global health community. This report presents data from **43 countries,** which include updated indicators in the Leadership and Coordination, Finance and Procurement, Policy, Supply Chain, Quality, and Private Sector 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, newly collected data for select measures from the former Contraceptive Security Index can be found in Annex C of this document.

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

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

Leadership and Coordination

- 95 percent of surveyed countries have a national committee that works on CS.
- 88 percent of these CS committees have formal written terms of reference.

Finance and Procurement

- 79 percent of countries (33 of 42 reporting) spent government funds on public-sector contraceptive procurement.
- An average of 38 percent of financing comes from government sources and 62 percent from in-kind donations.
- 76 percent of respondent countries have a government budget line item specifically for contraceptives; 79 percent spent government funds on contraceptives in the most recently completed fiscal year.

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

- 51 percent have a funding gap between funding spent and estimated contraceptive need.

Commodities

- On average, countries offer eight of the 13 assessed contraceptive methods[2]; 10 in public-sector facilities, eight through the commercial sector,[3] eight in non-governmental facilities, and six through social marketing.
- 91 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector.

Policies

- All countries have either a CS or reproductive health commodity security strategy or a strategy that explicitly mentions increasing contraceptive access.
- In 50 percent of countries (21 of 42 reporting), FP commodities are subject to duties.
- 10 percent of countries (four of 39) have policies that hinder the ability of the private sector to provide contraceptives.
- 28 percent of countries have policies that restrict access to contraceptives for those between ages 15 and19 who are unmarried and 14 percent of the countries for those in the same age group who are married.
- 73 percent of countries have operational or cultural practices that increase access to FP for rural populations, minority populations (68 percent), and disadvantaged sub-regions (65 percent).

Supply Chain[4]

- 93 percent of countries (40 of 43) have a logistics management information system that includes contraceptives.
- Of the 37 countries providing information on central-level stock-outs, 11 (30 percent) report zero stock-outs at the central level of any of the following "core" FP/RH products: combined oral contraceptives, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms. Also, seven countries (19 percent) had no central-level stock-outs of any FP/RH product.

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

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

[4] Stock-out 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.

- Of the 26[5] countries providing information on service delivery point level stock-outs, none reported a zero percent stock-out rate for either core FP/RH method or other FP/RH methods.
- Average annual stock-out rates at the central medical store level for the most common FP/RH methods[6] ranged as follows among countries reporting:
    - **Combined oral contraceptives:** 78 percent of countries reporting (29 of 37 countries) had no stock-outs, eight countries had stock-out rates ranging from 8 percent (Guatemala) to 36 percent (Liberia) stocked out at the central level.
    - **Injectable contraceptives:** 73 percent (27 countries) had no stock-outs; 10 countries had stock-out rates ranging from 13 percent (Sierra Leone) to 100 percent (Angola).
    - **Implants:** 67 percent (24 countries) had no stock-outs; 12 countries had stock-out rates ranging from 3 percent (Lao PDR) to 81 percent (Bangladesh).
    - **Intrauterine devices (IUDs):** 76 percent (28 countries) had no stock-outs; the other nine countries had stock-out rates ranging from 1 percent (Bangladesh) to 83 percent (Kenya).
    - **Male condoms:** 81 percent (30 countries) had no stock-outs; seven countries had stock-out rates ranging from 8 percent (Ghana) to 42 percent (Tanzania).
- Average annual stock-out rates at the service delivery point (SDP) level for the most common FP/RH methods ranged as follows:
    - **Combined oral contraceptives:** 16 percent (four countries) had zero stock-outs of combined oral contraceptives; four countries had stock-out rates ranging from 1 percent (Haiti) to 100 percent (Nicaragua).
    - **Injectable contraceptives:** 15 percent (four countries) had no stock-outs; 23 countries had stock-out rates ranging from 2 percent (Rwanda) to 100 percent (Dominican Republic).
    - **Implants:** 4 percent (one country, Haiti) had no stock-outs; 24 countries had stock-outs ranging from 2 percent (Rwanda) to 100 percent (Dominican Republic).
    - **IUDs:** 8 percent (two countries) had no stock-outs; 24 countries had stock-out rates ranging from 1 percent (Bangladesh) to 100 percent (Dominican Republic).
    - **Male condoms:** 12 percent (three countries) had no stock-outs; 23 countries had stock-out rates ranging from 2 percent (Peru) to 100 percent (Dominican Republic).

Quality

- 98 percent (42 of 43 countries) require registration of locally manufactured or imported contraceptives by the in-country national medicines regulatory authority.
- The average lead time for registration of contraceptives is six months to a year for 50 percent of countries (18 of 36).
- 80 percent (32 of 40) require testing of contraceptives at the national quality control laboratory (NQCL).

[5] Uganda reported only on one product, depot medroxyprogesterone acetate 150 mg intramuscular, and therefore was not counted in the denominator for the number of countries having reported on stock-out rates at the SDP level. It was included only in the SDP stock-out rate reporting for injectables contraceptives.
[6] An FP/RH "method" can be comprised of multiple FP/RH products; for example, the implants 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.

- 19 percent (six of 31) of NQCLs are currently International Organization of Standards (ISO) 17025 certified/accredited and/or currently WHO-prequalified. Forty-two percent (13 of 31) of NQCLs are neither ISO 17025–certified nor WHO-prequalified.
- In 43 percent of countries (13 of 30), the NMRA conducts field surveillance monitoring to identify substandard and falsified contraceptives. In half of these countries (six of 12 reporting), extensive enforcement actions are taken.

Private Sector

- 76 percent (25 of 33 countries) have more than three wholesalers registered in the country to distribute FP commodities.
- 53 percent (18 of 34) have established or brokered public-private partnerships in the past two years to expand private-sector FP products or services.
- By FP product, the percent of countries where there were no WHO-prequalified or stringent regulatory authority approved products registered for distribution ranged from 17 percent of countries (injectables) to 46 percent of countries (female condoms).
- 63 percent (19 of 30 countries) have a private-sector engagement (PSE) plan in place with an FP/RH component. Eighty-four percent of those countries with a PSE (16 countries) have taken some action to implement the plan.

Introduction

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

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

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 a number of different areas toward improving access to contraceptives.

The CS Indicators build off the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS[7]) 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).

The CS Index, now called Contextual Measures, provided insight into a mix of higher-level indicators to help countries identify strengths and weaknesses across five components—financing, supply chain, utilization, access, and health and social environment—and 17 CS Indicators. It has guided stakeholders in determining which countries are most in need, where to focus resources, and what type of assistance is needed. Data for the CS Index were obtained from secondary sources to develop a composite index. When taken together, the two tools have enabled high-level and granular analyses of CS constituent elements and contributing factors in fixed locations and in trends over time and across countries. The data are collected at the same time as the CS Indicators.

The CS Indicators and Contextual Measures are now reported together starting in 2017 under the USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project. This report updates the 2017 report, and both can be found on the GHSC website (www.ghsupplychain.org).

Since the first CS Indicators, additional FP-related data sets have been collected, which complement the CS Indicators. For instance, Track20[8] produces annual estimates of indicators, including modern contraceptive prevalence rate, method mix, stock-out rates, FP expenditures, and many others. Performance Monitoring and Accountability 2020 (PMA2020)[9] collects a nationally representative

[7] Hare, L., et al., 2004.
[8] http://www.track20.org/
[9] https://www.pma2020.org/data

sample of data from households and service delivery points in selected sentinel sites, to estimate health indicators annually in 11 pledging FP2020 countries, including indicators on FP demand and utilization, as well as new unique measures of access, choice, and quality of family planning information and services. FPWatch[10] (no longer operational) produced a nationally representative survey to estimate key FP market indicators. Demographic and Health Survey (DHS) data have been particularly useful. GHSC-PSM contracted IQVIA (formerly QuintilesIMS), a leading global provider of advanced analytics, technology solutions, and contract research services to the life sciences industry, to provide granular data and analysis, to obtain data services aimed at allowing USAID to conduct a contraceptive procurement analysis and provide a picture of the total market contraceptive situation, with a specific focus on the method mix in Latin America and the Caribbean (LAC), Benin, Togo, Kenya, Nigeria, and South Africa.[11] 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.

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

[11] The results of these studies are available through the CS Indicators landing page: https://www.ghsupplychain.org/csi-dashboard.

Methodology

The 2019 CS Indicators methodology has been updated since the last round in 2017. Those 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

For the 2019 report, 43 countries of 54 to whom the survey was disseminated (80 percent) completed a survey:

Africa		Asia	LAC
– Angola	– Malawi	– Afghanistan	– Dominican Republic
– Benin	– Mali	– Bangladesh	– El Salvador
– Burkina Faso	– Mozambique	– India	– Guatemala
– Burundi	– Niger	– Kyrgyz Republic	– Haiti
– Cameroon	– Nigeria	– Lao PDR	– Honduras
– Cape Verde	– Rwanda	– Nepal	– Peru
– Côte d'Ivoire	– Senegal	– Pakistan	
– DRC	– Sierra Leone	– Philippines	
– Ethiopia	– South Sudan	– Vietnam	
– Ghana	– Tanzania		
– Guinea	– Togo		
– Kenya	– Uganda		
– Liberia	– Zambia		
– Madagascar	– Zimbabwe		

The following 54 countries were selected to receive the CS Indicators Survey based on several criteria. The highest priority was given to USAID FP priority countries and Ouagadougou Partnership countries. All but one of these 30 countries were selected to receive the survey,[12] and 29 of those 30 completed it. Countries that had made an FP2020 commitment were very important, particularly for those that are USAID FP graduated countries. Seven USAID FP graduated countries received the survey; however, only three completed it.

[12] Only Yemen did not receive a survey due to the challenges of the current conflict environment.

Table 1. Characteristics of selected and respondent countries

	Country	USAID FP Priority Countries	USAID FP Graduated Countries	Other USAID-assisted FP Countries	Ouagadougou Partnership Countries	FP2020 Commitment Countries	CS Indicator 2019 Respondent Countries
1	Afghanistan	✓				✓	✓
2	Angola			✓		✓	✓
3	Armenia			✓			
4	Bangladesh	✓				✓	✓
5	Benin			✓	✓	✓	✓
6	Burkina Faso			✓	✓	✓	✓
7	Burundi			✓		✓	✓
8	Cameroon					✓	✓
9	Cape Verde						✓
10	Côte d'Ivoire			✓	✓	✓	✓
11	Dominican Republic		✓				✓
12	DRC	✓				✓	✓
13	Egypt					✓	
14	El Salvador		✓				✓
15	Ethiopia	✓				✓	✓
16	Georgia			✓			
17	Ghana	✓				✓	✓
18	Guatemala			✓			✓
19	Guinea			✓	✓	✓	✓

	Country	USAID FP Priority Countries	USAID FP Graduated Countries	Other USAID-assisted FP Countries	Ouagadougou Partnership Countries	FP2020 Commitment Countries	CS Indicator 2019 Respondent Countries
20	Haiti	✓				✓	✓
21	Honduras			✓		✓	✓
22	India	✓				✓	✓
23	Indonesia		✓			✓	
24	Kenya	✓				✓	✓
25	Kyrgyz Republic					✓	✓
26	Lao PDR					✓	✓
27	Liberia	✓				✓	✓
28	Madagascar	✓				✓	✓
29	Malawi	✓				✓	✓
30	Mali	✓			✓	✓	✓
31	Mauritania			✓	✓	✓	
32	Mozambique	✓				✓	✓
33	Myanmar					✓	
34	Nepal	✓				✓	✓
35	Nicaragua		✓			✓	
36	Niger			✓	✓	✓	✓
37	Nigeria	✓				✓	✓
38	Pakistan	✓				✓	✓
39	Paraguay		✓				

	Country	USAID FP Priority Countries	USAID FP Graduated Countries	Other USAID-assisted FP Countries	Ouagadougou Partnership Countries	FP2020 Commitment Countries	CS Indicator 2019 Respondent Countries
40	Peru		✓				✓
41	Philippines	✓				✓	✓
42	Rwanda	✓				✓	✓
43	Senegal	✓			✓	✓	✓
44	Sierra Leone					✓	✓
45	South Africa		✓				
46	South Sudan	✓				✓	✓
47	Sri Lanka		✓			✓	
48	Tanzania	✓				✓	✓
49	Togo			✓	✓	✓	✓
50	Uganda	✓				✓	✓
51	Ukraine			✓			
52	Vietnam					✓	✓
53	Zambia	✓				✓	✓
54	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 through July 2019, and responses were received between August 2019 and January 2020. Validation took place between August 2019 and February 2020.

Depending on the 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 non-governmental organizations (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, 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 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 UNFPA RH Interchange database for UN and other donor procurements, and the FP2020 commitment follow-up interviews with countries.

Analysis

Responses for each section were aggregated across countries, within-country, or, where country aggregation is not meaningful, using other descriptive (non-inferential) methods. To present the commodity mix and stock-out 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 dashboard.

Quantitative data 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 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. Key qualitative themes are presented on this site as document briefs.

Changes in Methodology From Previous Report

GHSC-PSM, in close collaboration with USAID, reviewed the survey tool as well as its impact and use, and made several changes with the goal of increasing the survey's reliability and methodological rigor while also expanding the scope to increase the survey's usefulness to a wider audience. In 2017, two new sections, Quality and Private Sector, were added to the survey. To this end, the following changes have been made to the 2019 survey:

Addition of New Indicators

The following indicators have been added to existing sections:

Section A. Leadership and Coordination:

A3. Does the committee have formal legal or administrative status?

A4. Does the committee have formal written terms of reference?

Section B. Finance and Procurement

B15. At what level does government-financed procurement of public-sector contraceptives occur?

a. Regardless of centralized or decentralized procurement, what is the delivery point (i.e., to what level does the supplier deliver the commodities)?

Section C. Commodities
No changes

Section D. Policies (Commitment)

D5. Does the country have laws, regulations, or policies that increase access to effective family planning services/commodities by the following sub-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?

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)

D15. Is family planning actively promoted through any of the following channels?

D18. Are there specific FP2020 commitments?

Section E. Supply Chain

E1. Is there a national logistics management information system (LMIS) that collects data on contraceptive commodities?

a. If yes, what types of health facilities report into the system?

b. If there is a national LMIS, how is contraceptive commodity data collected at the SDP level?

Section 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)?

F2. Are drug (including contraceptives) registration requirements strictly adhered to?

F3. What is the average lead time for the registration of contraceptive products?

F4. Does the NMRA participate in WHO-prequalified (WHO-PQ) Collaborative Procedures?

F5. Is there a requirement that contraceptives, imported or locally manufactured, be tested by the in-country national quality control laboratory (NQCL)?

F6. Is the NQCL currently International Organization of Standards (ISO) 17025 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 substandard, spurious, falsely labelled, falsified, and counterfeit (SSFFC) 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?

Section G. Private Sector

G1. According to the MoH, how many wholesalers are registered in the country (for distributing FP products)?

G2. Does the MoH use market data from third-party sources (i.e., IQVIA, Nielson, Kantar, or local market research companies) to guide programming?

G3. For each of the following contraceptive methods, please provide the following information:

a. Are there any 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.)

b. 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.)

c. If there are any WHO-prequalified and/or SRA-approved contraceptive products, list one or more examples of the brand and formulation.

d. How many in-country local manufacturers exist that produce any products within the contraceptive method?

Data Source Standardization (Updated in 2017)

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

Reflecting GHSC-PSM Updates to Supply Chain–related Measures (Updates in 2017 and 2019)

Several CS indicators in the original tool were similar to indicators that GHSC-PSM is now reporting quarterly or annually. For better alignment of indicators, some of the wording has been modified and/or additional questions added to ensure that these data can be compared, and to ease the burden of reporting for those countries where GHSC-PSM is operating. These include indicators for the national committee working on contraceptive security, sources of commodity financing, and commodity stock-outs. The stock-out indicator was revised in 2017 to capture the actual average stock-out rate at the central warehouse and facility levels for specific commodities and for the group of commodities.

Revisions to Some Questions

Several survey questions have been modified from the 2017 version to elaborate more fully on the focus area or provide more clarity in interpretation, for example, questions about formal and informal policies and cultural practices that may affect access to contraceptives. Overall, these questions, in addition to the many unchanged questions, should remain comparable to previously reported CS Indicators data.

Survey Frequency

To reduce the burden of reporting, while still maintaining a data set that reflects the most recent useful data available, beginning in 2017 the survey is now implemented biennially (once every other year) instead of annually. The next survey will take place in 2021. The 2017 survey report can be found on the CS Indicators Key Initiatives landing page on the GHSC website (https://www.ghsupplychain.org/csi-dashboard).

Survey Indicators

The 2019 CS Indicators include the following questions. *Updated and new indicators are rendered in italics.* Indicators not included from the 2017 survey are also indicated.

Section A. Leadership and Coordination

- Existence of a national committee that works on contraceptive security and organizations represented
- *If the committee has formal legal or administrative status*
- *If the committee has formal written terms of reference*
- Frequency of committee meetings

- Whether the committee developed or started developing any policies, procedures, and/or action plans in the last year
- Whether there is evidence of adherence to policies and procedures, implementing action plans, and/or following up on and addressing issues raised at previous meetings
- Description of the key functions and role of the committee

Removed:

- Existence of a contraceptive security champion and the organizational affiliation of the champion

Section B. Finance and Procurement

- Estimated dollar value of contraceptives needed to be procured for the public sector for the most recently completed fiscal year
- Existence of a government budget line item specifically for the procurement of contraceptives
- Amount of government funds allocated and spent on contraceptive procurement by type of government funds in the most recently completed fiscal year
- Amount and source of contraceptive donations, cash and in-kind, for the most recently complete fiscal year
- Existence of a funding gap for public-sector contraceptives in the most recently completed fiscal year
- Government entity that conducted the procurements
- *The level at which government-financed procurement of public-sector contraceptives occurs and the final delivery point by the supplier.*

Section C. Commodities

Range of contraceptive methods offered:

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

Section D. Policies

- Existence of a national CS strategy and *objectives in the strategy*
- Policies hindering or enabling the ability of the private sector to provide contraceptive methods (both formal and informal policies and barriers)
- The lowest-level provider that is authorized to dispense each contraceptive method in the public and private sectors
- Existence of any other indirect policy barriers that make it difficult for unmarried people, young people, or other subpopulations to access effective family planning services

- *If the country has laws, regulations, or policies that increase access or make it difficult to access effective family planning services/commodities by the following sub-populations (Unmarried youth (ages 15–19), Married youth (ages 15–19), Unmarried youth (ages 20–24), Married youth (ages 20–24), Rural population, Populations in disadvantaged sub-regions (i.e., certain geographic areas), Populations with lower educational attainment, Lower-income populations, Disabled, Minority populations (e.g., ethnic or religious groups), Other (e.g., migrants, internally displaced populations)*
- *Whether the country has any operational, cultural, or other practices that may increase or make it difficult or have other barriers to access to effective family planning services/commodities by the following sub-populations (same sub-population list as previous question)*
- *If family planning commodities are subject to duties and in which sectors*
- If there are charges (formal policies) to the client in the public sector for family planning services or commodities
- Whether and what charges exist for the client in the public sector for family planning that are informal, unofficial, or are different than posted charges
- Whether there is public/government/national health insurance that covers family planning if fees are charged, and the proportion of the population it covers
- Whether there is a National Essential Medicines List (NEML), the year it was issued, inclusion of contraceptives on the NEML
- If family planning actively is promoted through social marketing, mass media, mobile outreach/education, or community mobilization/engagement channels
- *The approximate percentage of public-sector family planning providers that have been trained in implant and intrauterine device (IUD) insertion and removal*
- Country commitments to FP2020 *and the specific commitment areas*
- Partnership in the Global Financing Facility *and the provisions included*

Removed:

- Proportion of modern contraceptive use that is attributed to married women in each wealth quintile (moved to the Contextual Measures, formerly the CS Index)

Section E. Supply Chain

- *If there is a national logistics management information system that collects data on contraceptive commodities, the type of facilities that report into the system, and how data is collected at the service delivery point*
- Average annual stock-out rate by product and across products at the central level
- Average annual stock-out rate by product and across products at the SDP level.

Section F. Quality

- *Whether there is a requirement that all contraceptives that are locally manufactured or imported be registered by the in-country NMRA.*
- *If drug (including contraceptives) registration requirements are strictly adhered to.*

- *Average lead time for registration of contraceptive products.*
- *If the NMRA participates in WHO-PQ Collaborative Procedures.*
- *If there is a requirement that contraceptives, imported or locally manufactured, be tested by the in-country national quality control laboratory.*
- *If the NQCL is currently ISO 17025 certified/accredited and/or currently WHO-prequalified.*
- *In the past year, the extent to which contraceptives and condoms were tested by the NQCL post-shipment.*
- *In the past year, if the NMRA conducted field surveillance monitoring to identify SSFFC contraceptives, to protect the public from ineffective and/or harmful products, and if yes, the extent to which regulatory enforcement actions were taken.*

Removed:

- Name of the national drug regulatory authority (NRA).
- If there are quality control standards for pharmaceuticals, including contraceptives that are in line with international standards.
- If contraceptive commodities from WHO-prequalified manufacturers are available in the country. (Moved to related question on WHO-PQ registration and distribution in the Private Sector section.)
- If regular assessments are done of contraceptive products available in pharmacies, including their quality and prices (e.g., purchase of retail audit data from research firms, systematic surveys by public-sector staff).
- If standards exist for post-marketing surveillance and pharmacovigilance.

Section G. Private Sector

- According to the MoH, how many wholesalers are registered in the country (for distributing FP products).
- If the MoH uses market data from third-party sources (i.e., IQVIA, Nielson, Kantar, or local market research companies) to guide programming. If yes, how the data are used, and if no, whether they would like to build this capacity.
- For each of the following contraceptive methods, combined oral contraceptives (COCs), progestin-only pills (POPs), injectables, implants, intrauterine devices (IUDs), male and female condoms, and emergency contraceptives (ECs):
    - If there are any WHO-prequalified or SRA-approved products registered for distribution in the country.
    - How many manufacturers are registered in the country for distribution of WHO-prequalified and/or SRA-approved contraceptive products.
    - If there are any WHO-prequalified and/or SRA-approved contraceptive products.
    - How many in-country local manufacturers exist who produce any products within the contraceptive method.
- Existence and nature of public-private partnerships.
- If there are any joint ventures between multinational pharmaceutical companies and local manufacturers of contraceptives.

- If the government has developed or started developing a private-sector engagement (PSE) plan for family planning/reproductive health, or with an FP/RH component. and if yes, the extent of implementation.

Removed:

- Are private sector entities that provide FP required to report to and/or register with government agencies such as the MoH?
- Whether private-sector manufacturers are registered in the country.
- Whether routine market or syndicated survey data are available.

Overall

- Successes and challenges with stock management at any level (qualitative)
- Forecast error for the most recently completed fiscal year

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 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 commodity costs, and the inclusion of freight costs in some expenditure figures, all of which could artificially increase or decrease the FP funding gap. In some cases, a government may not have visibility into all FP commodity donations, 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, or FP forecasts that do not include condom needs that are forecast under HIV programs.

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

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

Key Findings

This section provides a summary of key findings from the 2019 CS Indicators survey.

Leadership and Coordination

- 95 percent of surveyed countries have a national committee that works on CS.
- 88 percent of these CS committees have formal written terms of reference.

Finance and Procurement

- 79 percent of countries (33 of 42 reporting) spent government funds on public-sector contraceptive procurement
- An average of 38 percent of financing comes from government sources and 62 percent from in-kind donations.
- 76 percent of respondent countries have a government budget line item specifically for contraceptives; 79 percent spent government funds on contraceptives in the most recently completed fiscal year.
- 51 percent (21 of 41 reporting) have a funding gap between funding spent and estimated contraceptive need.

Commodities

- On average, countries offer eight of the 13 assessed contraceptive methods[13]; 10 in public-sector facilities, eight through the commercial sector,[14] eight in non-governmental facilities, and six through social marketing.
- 91 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector.

Policies

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

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

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

- In 50 percent of countries (21 of 42), FP commodities are subject to duties.
- 10 percent of countries (four of 39) have policies that hinder the ability of the private sector to provide contraceptives.
- 28 percent of countries have policies that restrict access to contraceptives for those between ages 15 and 19 who are unmarried and 14 percent of the countries for those in the same age group who are married.
- 73 percent of countries have operational or cultural practices that increase access to FP for rural populations, minority populations (68 percent), and disadvantaged sub-regions (65 percent).

Supply Chain[15]

- 93 percent of countries (40 of 43) have an LMIS that includes contraceptives.
- Of the 37 countries providing information on central-level stock-outs, 11 (30 percent) report zero stock-outs at the central level of any of the following "core" FP/RH products: combined oral contraceptives, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms. Also, seven countries (19 percent) had no central-level stock-outs of any FP/RH product.
- Of the 26 countries providing information on SDP-level stock-outs, none reported a zero percent stock-out rate for either "core" FP/RH products or of all FP/RH products.
- Average annual stock-out rates at the central medical store level for the most common FP/RH methods[16] ranged as follows among countries reporting:
    - **Combined oral contraceptives:** 78 percent of countries reporting (29 of 37 countries) had no stock-outs, eight countries had stock-out rates ranging from 8 percent (Guatemala) to 36 percent (Liberia) stocked out at the central level.
    - **Injectable contraceptives:** 73 percent (27 countries) had no stock-outs; 10 countries had stock-out rates ranging from 13 percent (Sierra Leone) to 100 percent (Angola).
    - **Implants:** 67 percent (24 countries) had no stock-outs; 12 countries had stock-out rates ranging from 3 percent (Lao PDR) to 81 percent (Bangladesh).
    - **IUDs:** 76 percent (28 countries) had no stock-outs; the other nine countries had stock-out rates ranging from 1 percent (Bangladesh) to 83 percent (Kenya).
    - **Male condoms:** 81 percent (30 countries) had no stock-outs; seven countries had stock-out rates ranging from 8 percent (Ghana) to 42 percent (Tanzania).
- Average annual stock-out rates at the SDP level for the most common FP/RH methods ranged as follows:
    - **Combined oral contraceptives:** 16 percent (four countries) had zero stock-outs of COCs; four countries had stock-out rates ranging from 1 percent (Haiti) to 100 percent (Nicaragua).

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

- **Injectable contraceptives:** 15 percent (four countries) had no stock-outs; 23 countries had stock-out rates ranging from 2 percent (Rwanda) to 100 percent (Dominican Republic).
- **Implants:** 4 percent (one country, Haiti) had no stock-outs; 24 countries had stock-outs ranging from 2 percent (Rwanda) to 100 percent (Dominican Republic).
- **IUDs:** 8 percent (two countries) had no stock-outs; 24 countries had stock-out rates ranging from 1 percent (Bangladesh) to 100 percent (Dominican Republic).
- **Male condoms:** 12 percent (three countries) had no stock-outs; 23 countries had stock-out rates ranging from 2 percent (Peru) to 100 percent (Dominican Republic).

Quality

- 98 percent (42 of 43 countries) require registration of locally manufactured or imported contraceptives by the in-country national medicines regulatory authority (NMRA).
- 11 percent take one year to 18 months for registration of contraceptive products.
- 80 percent (32 of 40) require testing of contraceptives at the NQCL.
- 19 percent (six of 31) of NQCLs are currently ISO 17025 certified/accredited and/or currently WHO-prequalified. Forty-two percent (13 of 31) of NQCLs are neither ISO 17025-certified nor WHO-prequalified.
- In 43 percent of countries (13 of 30), the NMRA conducts field surveillance monitoring to identify SSFFC contraceptives. In half of these countries (six of 12 reporting), extensive enforcement actions are taken.

Private Sector

- 76 percent (25 of 33 countries) have more than three wholesalers registered in the country to distribute FP commodities.
- 53 percent (18 of 34) have established or brokered public-private partnerships in the past two years to expand private-sector FP products or services.
- By FP product, the percent of countries where there were no WHO-prequalified or SRA-approved products registered for distribution ranged from 17 percent of countries (injectables) to 46 percent of countries (female condoms).
- 63 percent of countries (19 of 30) have a private-sector engagement plan in place with an FP/RH component. Eighty-four percent of those countries with a PSE (16 countries) have taken some action to implement the plan.

Leadership and Coordination

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

Highlights

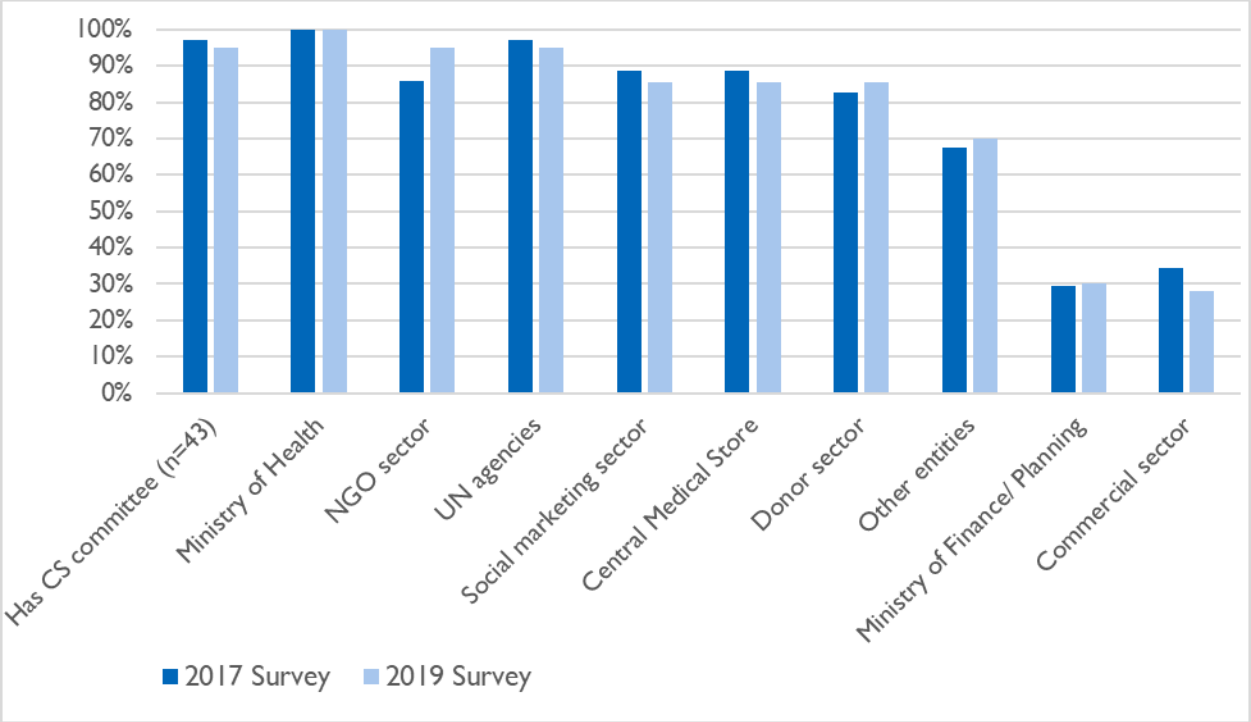
Of the countries surveyed:

- 95 percent have a national committee that works on CS.
- 88 percent have formal terms of reference.

Contraceptive Security Committee

Of 43 countries, 95 percent (41) have a committee that work on CS (Exhibit 1). In 2017 this was 97 percent (35 of 36) and 86 percent in 2015 (42 of 49). The MoH is represented in all of the countries (100 percent). NGOs and UN agencies participate in 95 percent; social marketing, central medical stores, and donors, 85 percent; other entities, 70 percent; Ministry of Finance or Planning, 30 percent; and the commercial sector, 28 percent.

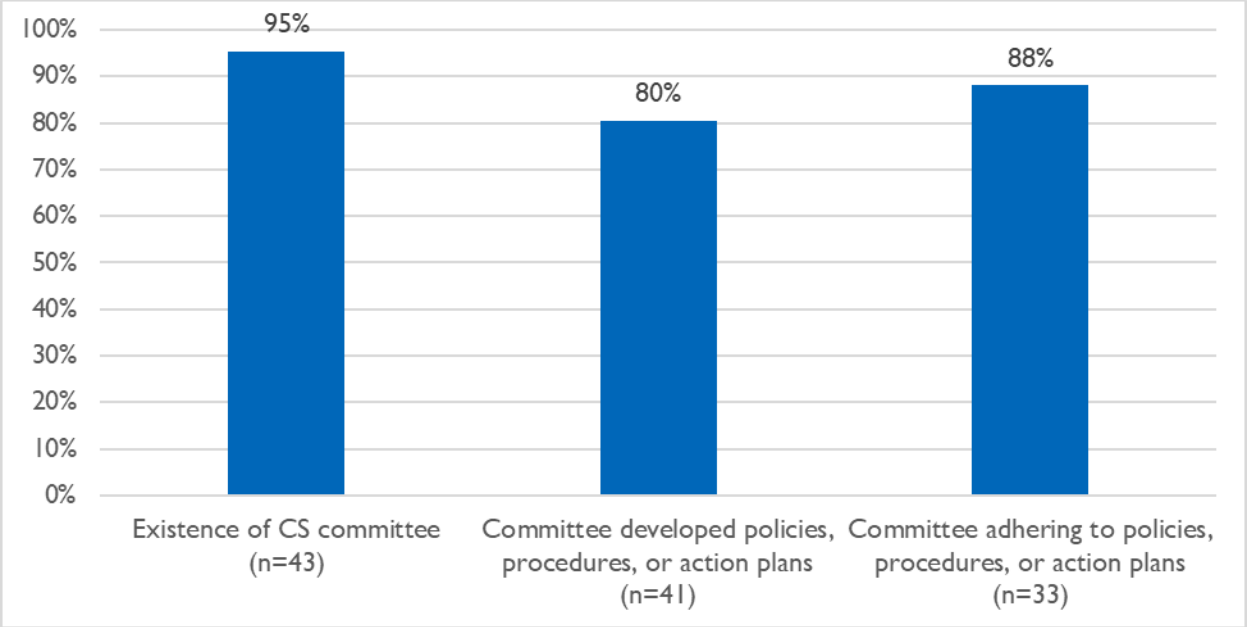
Exhibit 1. Percentage of countries that have CS committees, and their composition (n=41)



CS committees have legal or administrative status in 76 percent (31 of 41) of the countries.

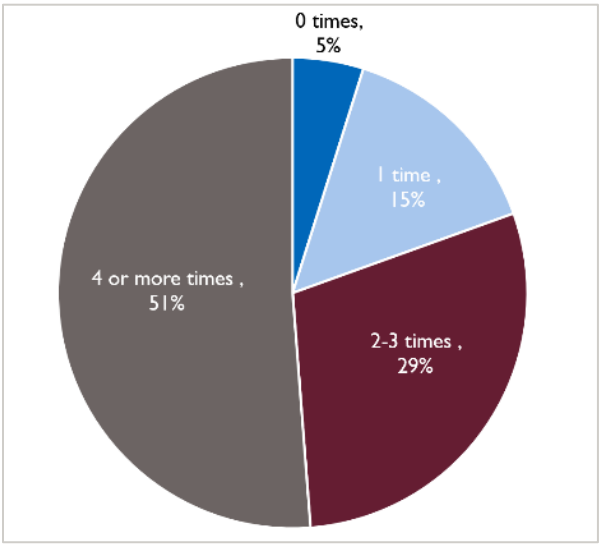
Eighty percent of the CS committees have developed policies, procedures, or action plans, while 88 percent responded there is evidence that these are taking place or being implemented (Exhibit 2).

Exhibit 2. Activity of CS committees[17]



Over half (51 percent) meet four or more times a year, while 29 percent met two to three times, 15 percent met once, and 5 percent did not meet at all (Exhibit 3).

Exhibit 3. Frequency of CS committee meetings in the previous year (n=41)



[17] Countries without CS committees were removed from the denominator for the two questions about committee activities. Countries whose committees had not developed policies, procedures, or action plans were removed from the denominator for the question on adherence to policies, procedures, or action plans. Also, one country responded "don't know" to this question but "yes" to the previous question.

The common functions of CS committees include:

- Improve and expand access to family planning services and commodities
- Forecast, monitor, quantify, and analyze national contraceptive commodity needs
- Provide technical assistance
- Review supply plans, procurement status, and distribution channels
- Monitor stock levels and mitigate stock-outs
- Ensure adequate financing
- Identify advocacy needs for additional resources and policy change
- Coordinate between government and FP stakeholders
- Strengthen M&E procedures for continuous improvement and quality services
- Ensure functioning of the LMIS system
- Share best practices

Finance and Procurement

A sufficient and reliable stream of financing for procuring contraceptives is essential to achieving CS. Tracking the different sources of financing, government, in-kind donations, and grants from year to year provides visibility into the availability of funding to cover the estimated need and if there are financing gaps. The survey collected information on the forecasted amount, whether there is a budget line item for contraceptives, amount allocated versus spent, sources of funding, and who conducts contraceptive procurement.

Highlights

- 79 percent of countries (33 of 42 reporting) spent government funds on public-sector contraceptive procurement:
    - 67 percent (28 of 42) use internally generated funds
    - 23 percent (9 of 40) use other government funds
- Of total spending, an average of 38 percent of financing comes from government sources and 62 percent from in-kind donations. In 2017, 41 percent of financing came from government sources and 59 from in-kind donations.
- 76 percent (31 of 41 reporting) of respondent countries have a government budget line item specifically for contraceptives; 33 of those countries (79 percent, 33 of 42 reporting[18]) spent government funds in the most recently completed fiscal year.
- 51 percent (21 of 41) of respondent countries had a funding gap between funding spent and estimated contraceptive need.

Financing Sources and Expenditures for Public-sector Contraceptives

Countries were asked to provide the government funding sources used toward procuring contraceptives. Internally generated funds and other funds, which can include World Bank credits or loans, basket funds, and other funds provided to the government from a donor, comprised government funding sources. Because governments count these World Bank credits, basket funds, and other funds as part of their national budget and they decide how to allocate and spend these funds, they are considered to be part of government funding. A total of 42 countries responded.

Government Expenditures

Of 42 country responses, 86 percent (36 countries) allocated funds toward public-sector contraceptive procurement and 79 percent (33 countries) spent government funds on contraceptives for the most recently completed fiscal year[19] (Exhibit 4). In 2017, 86 percent allocated funds and 76 percent spent funds on contraceptive procurement.

[18] Afghanistan did not have a budget line for contraceptives but did report spending government funds on them.
[19] One country did not know if funds were allocated or spent (Cameroon).

Exhibit 4. Government spending by source, FY19 (U.S.$) (n=43)

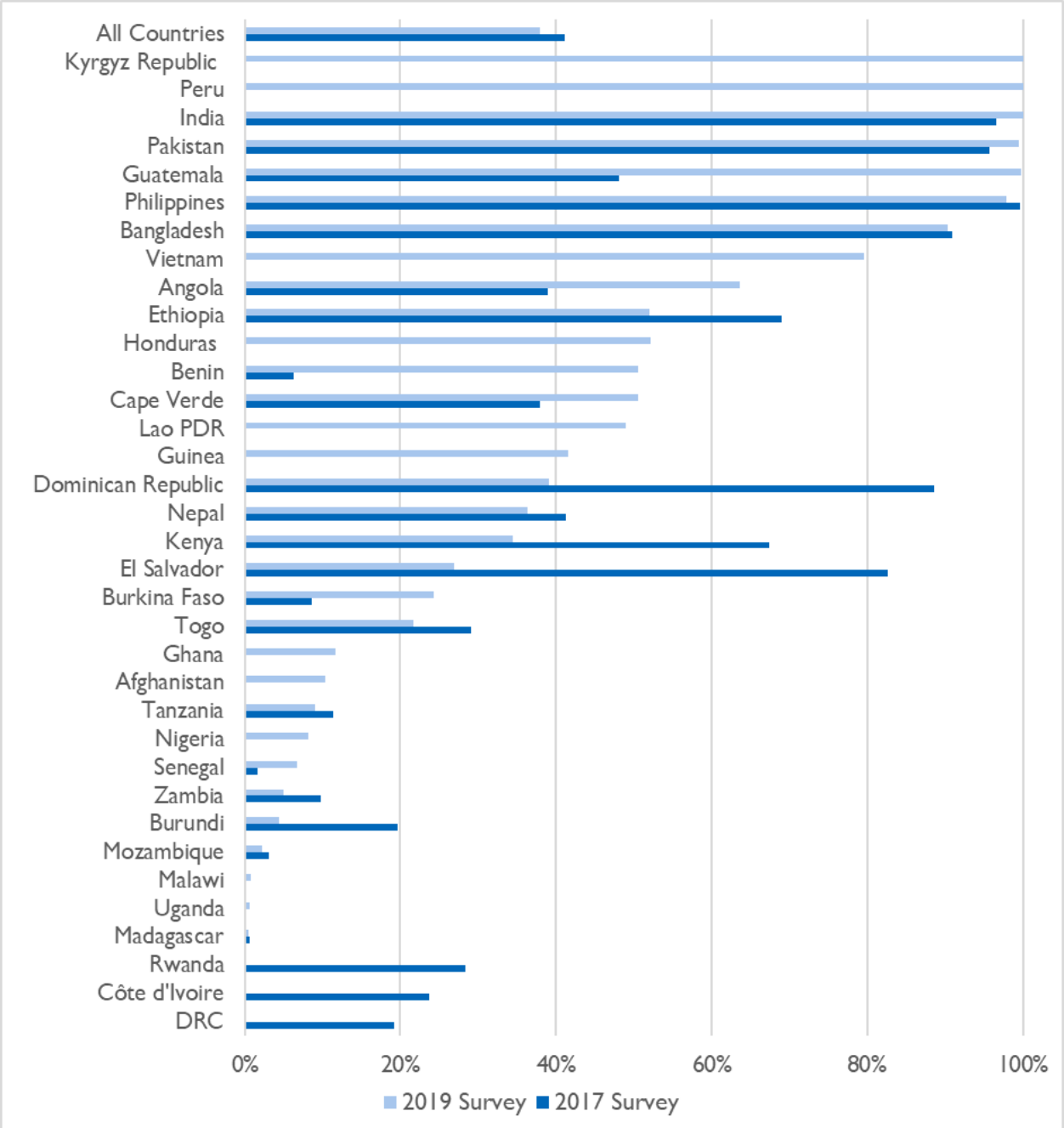
Country	Internally generated funds spent	All other government funds spent	Total government funds spent	Internally generated funds as a percent of total government funds spent
Afghanistan	$5,845	$0	$5,845	100%
Angola	$0	$1,042,062	$1,042,062	0%
Bangladesh	$9,280,120	$34,404,429	$43,684,549	21%
Benin	$339,560	$0	$339,560	100%
Burkina Faso	$1,428,571	$0	$1,428,571	100%
Burundi	$61,560	$0	$61,560	100%
Cameroon	$0	$0	$0	0%
Cape Verde	$143,467	$0	$143,467	100%
Côte d'Ivoire	$0	$0	$0	0%
Dominican Republic	$1,321,844	$0	$1,321,844	100%
DRC	$0	$0	$0	0%
El Salvador	$215,416	$0	$215,416	100%
Ethiopia	$965,517	$16,811,260	$17,776,777	5%
Ghana	$0	$809,416	$809,416	0%
Guatemala	$2,557,184	$0	$2,557,184	100%
Guinea	$1,420,765	$0	$1,420,765	100%
Haiti	$0	$0	$0	0%
Honduras	$247,649	$0	$247,649	100%
India	$10,606,487	$0	$10,606,487	100%
Kenya	$0	$3,836,186	$3,836,186	0%
Kyrgyz Republic	$24,286	$84,400	$108,686	22%
Lao PDR	$275,066	$0	$275,066	100%
Liberia	$0	$0	$0	0%
Madagascar	$33,000	$0	$33,000	100%
Malawi	$204,000	$0	$204,000	100%
Mali	$0	$0	$0	0%
Mozambique	$235,800	$0	$235,800	100%
Nepal	$11,229	$2,335,139	$2,346,368	0%

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
Niger	Unknown	Unknown	Unknown	Unknown
Nigeria	$0	$2,000,000	$2,000,000	0%
Pakistan	$26,200,000	$0	$26,200,000	100%
Peru	$9,636,311	$0	$9,636,311	100%
Philippines	$3,008,877	$0	$3,008,877	100%
Rwanda	$0	$0	$0	0%
Senegal	$201,269	N/A	$201,269	100%
Sierra Leone	$0	$0	$0	0%
South Sudan	$0	$0	$0	0%
Tanzania	$1,778,426	$0	$1,778,426	100%
Togo	$231,000	N/A	$231,000	100%
Uganda	$168,421	$0	$168,421	100%
Vietnam	$2,578,268	$0	$2,578,268	100%
Zambia	$179,712	$169,488	$349,200	51%
Zimbabwe	$0	$0	$0	0%

Of the countries that did use government funds to procure contraceptives, the proportion of government financing ranged from 1 percent or less (Madagascar, Malawi, Uganda) to 100 percent (India, Kyrgyz Republic, Peru). The government share of total spending was 38 percent (in 2017 it was 41 percent). The government share of total spending made up nearly the entire amount spent for Guatemala (99.7 percent), Pakistan (99.5 percent), the Philippines (97.9 percent), and Bangladesh (90.4 percent). Government financing made up the majority for Vietnam (79.6 percent), Ethiopia (52.1 percent), and Zambia (5 percent).

In 10 countries, no government funds were used to procure public-sector contraceptives: Cameroon, Côte d'Ivoire, DRC, Haiti, Liberia, Mali, Rwanda, Sierra Leone, South Sudan, and Zimbabwe.

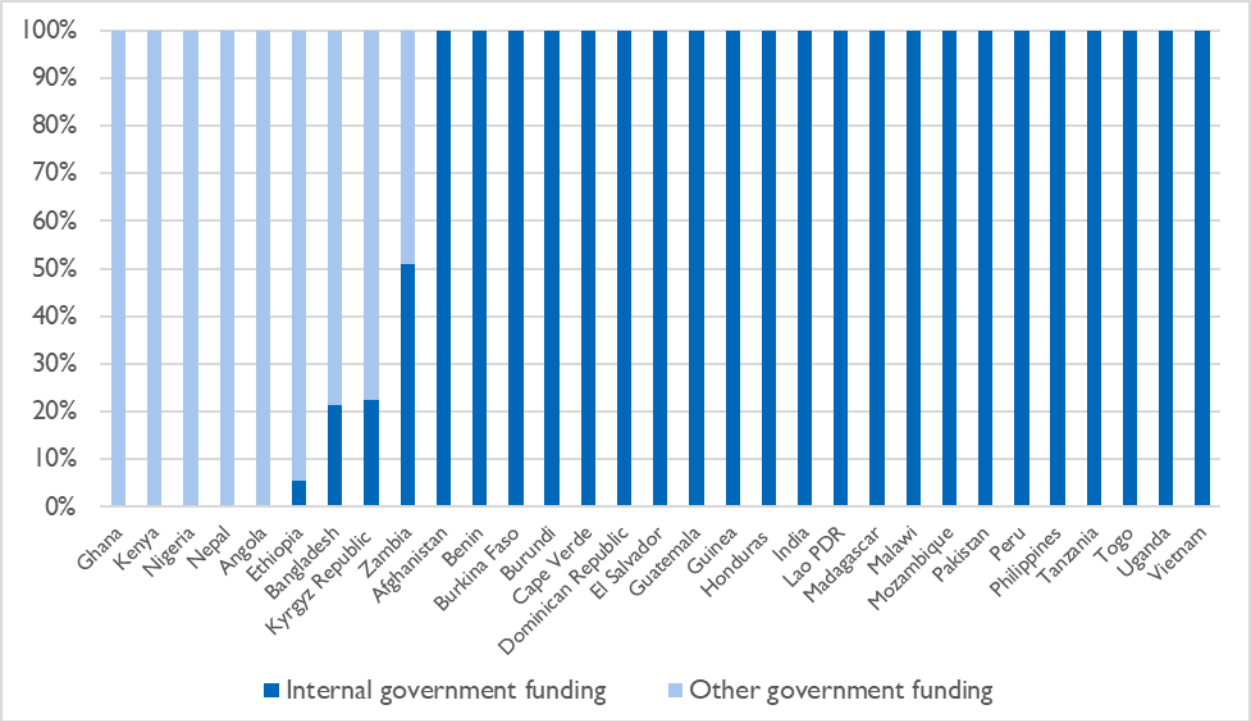
Exhibit 5. Total government spending as a share of total spending on public-sector contraceptives, 2019 and 2017 (n=42)



Of the 33 countries that used government funds on contraceptives, 85 percent (28 countries) used internally generated funds, and 27 percent (nine countries) used other government funding (Exhibit 6).[20]

[20] One country, Niger, did not know the amount or sources of government funds spent on contraceptives, and another, Senegal, did not know whether other government funds had been spent.

Exhibit 6. Share of government spending by government funding source (n=31)

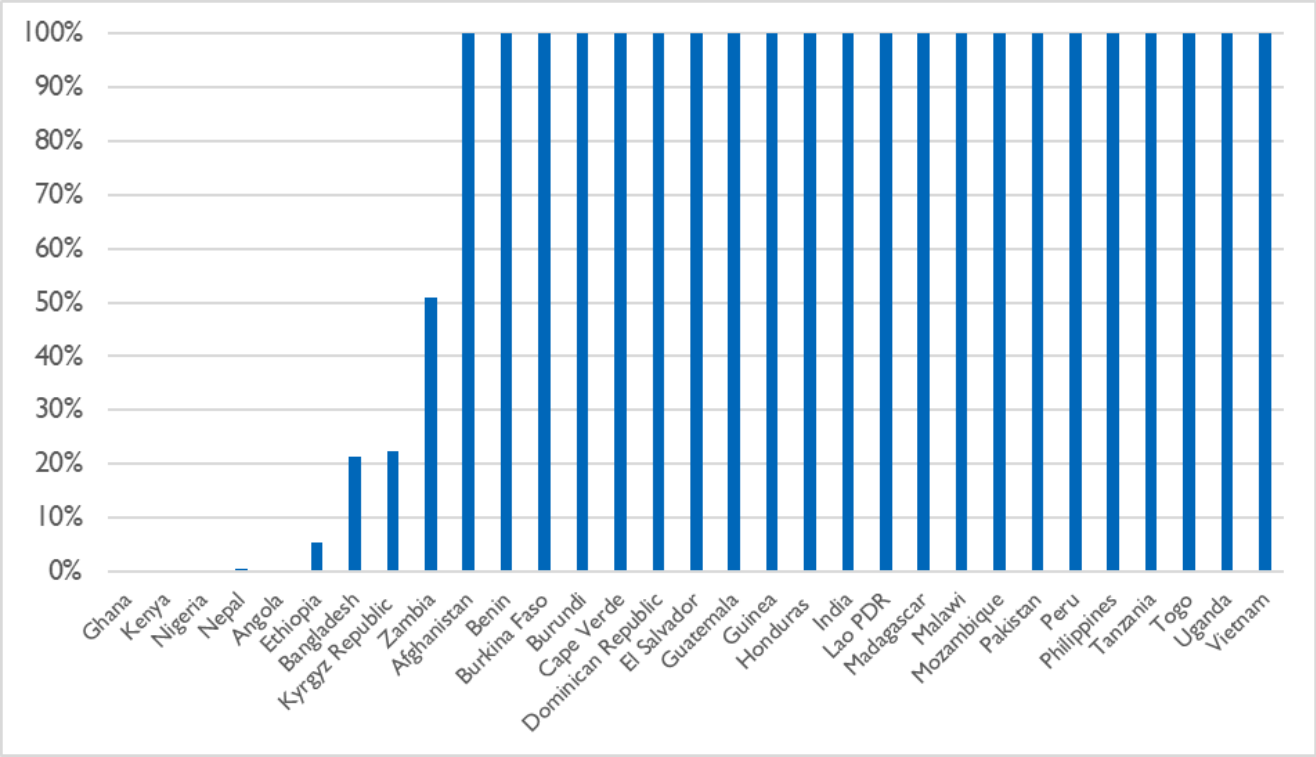


When looking at government funding sources as a total of contraceptive spending, internally generated funds made up 21 percent and other government funds made up 17 percent.

For 22 countries, internally generated funds were the only source of government funds used toward the purchase of contraceptives.

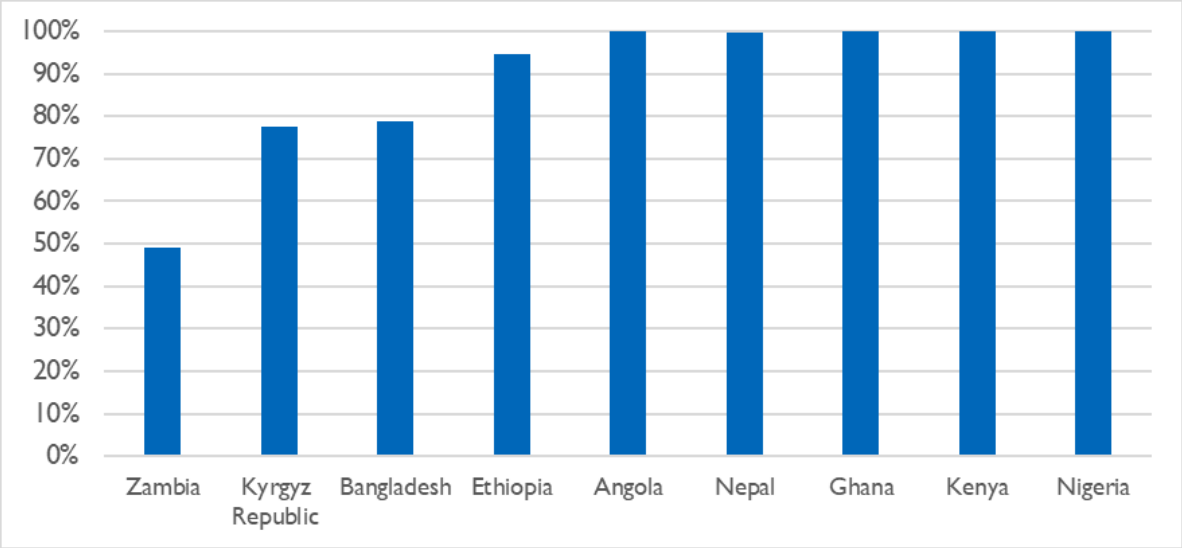
India and Peru were the only countries that solely used internally generated funds as the source of total spending toward the procurement of contraceptives.

Exhibit 7. Internally generated funds as a share of government funding for public-sector contraceptives (n=31)



For the nine 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 49 percent to 100 percent of total government funding. In other words, when countries used other government funds along with internally generated funds, other government funds were the larger financing source within total government financing. Of the nine countries, four used only other government funds and no internally generated funds to procure contraceptives (Angola, Ghana, Kenya, Nigeria).

Exhibit 8. Percentage of other government spending as a share of total government spending, non-zeros shown (n=31)

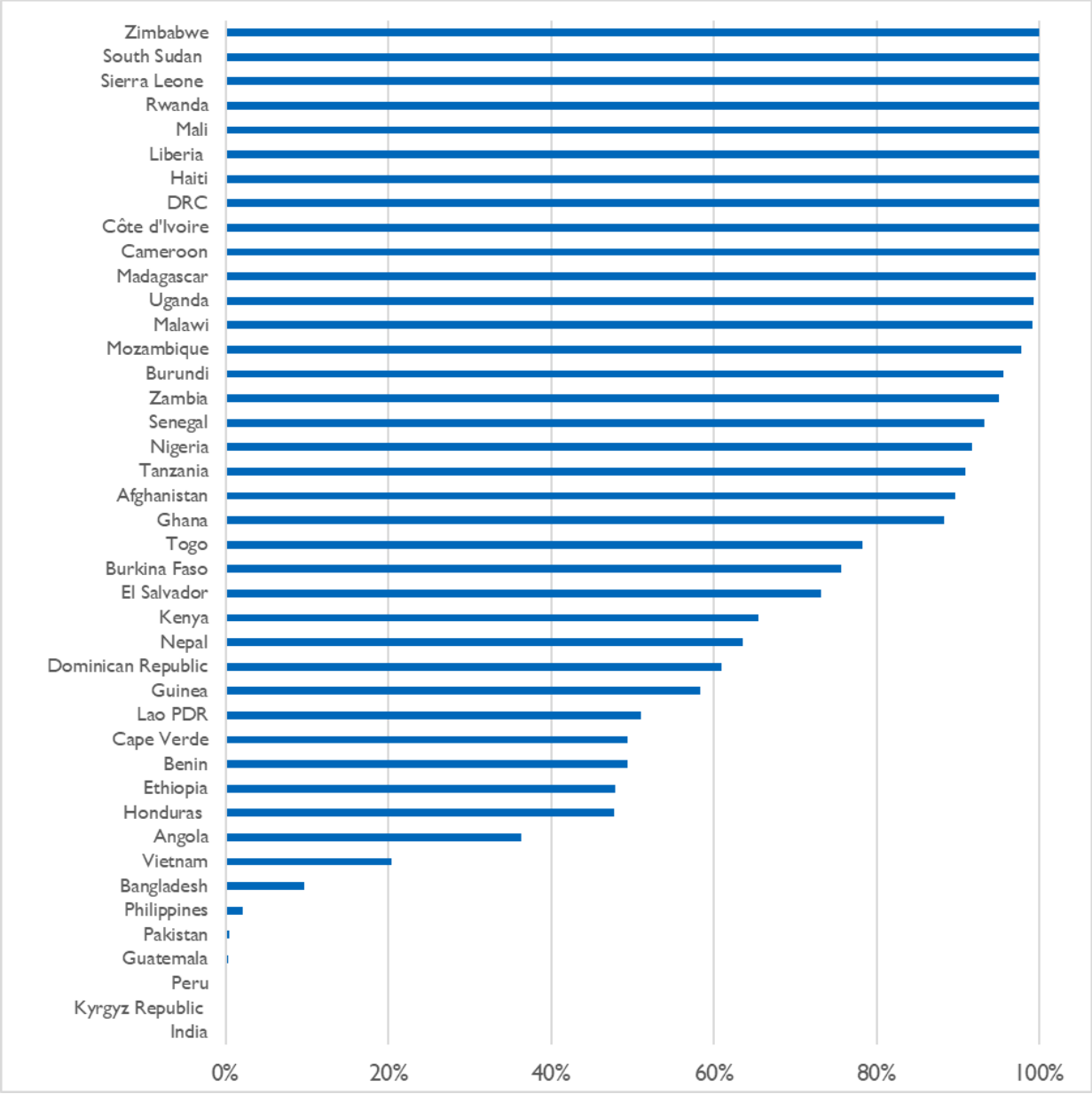


In-Kind Donations and Global Fund Grants

Of 43 countries, 40 received in-kind donations (Exhibit 9). Three countries, India, the Kyrgyz Republic, and Peru, did not receive any in-kind donations. For 10 countries, in-kind donations were the sole funding sources for procuring contraceptives (Cameroon, Côte d'Ivoire, DRC, Haiti, Liberia, Mali, Rwanda, Sierra Leone, South Sudan, and Zimbabwe). For 19 countries, in-kind donations were 51 percent to nearly 100 percent of total contraceptive funding. In the remaining 10 countries, funding from in-kind donations ranged from 0.3 percent (Guatemala) to 49 percent (Cape Verde).

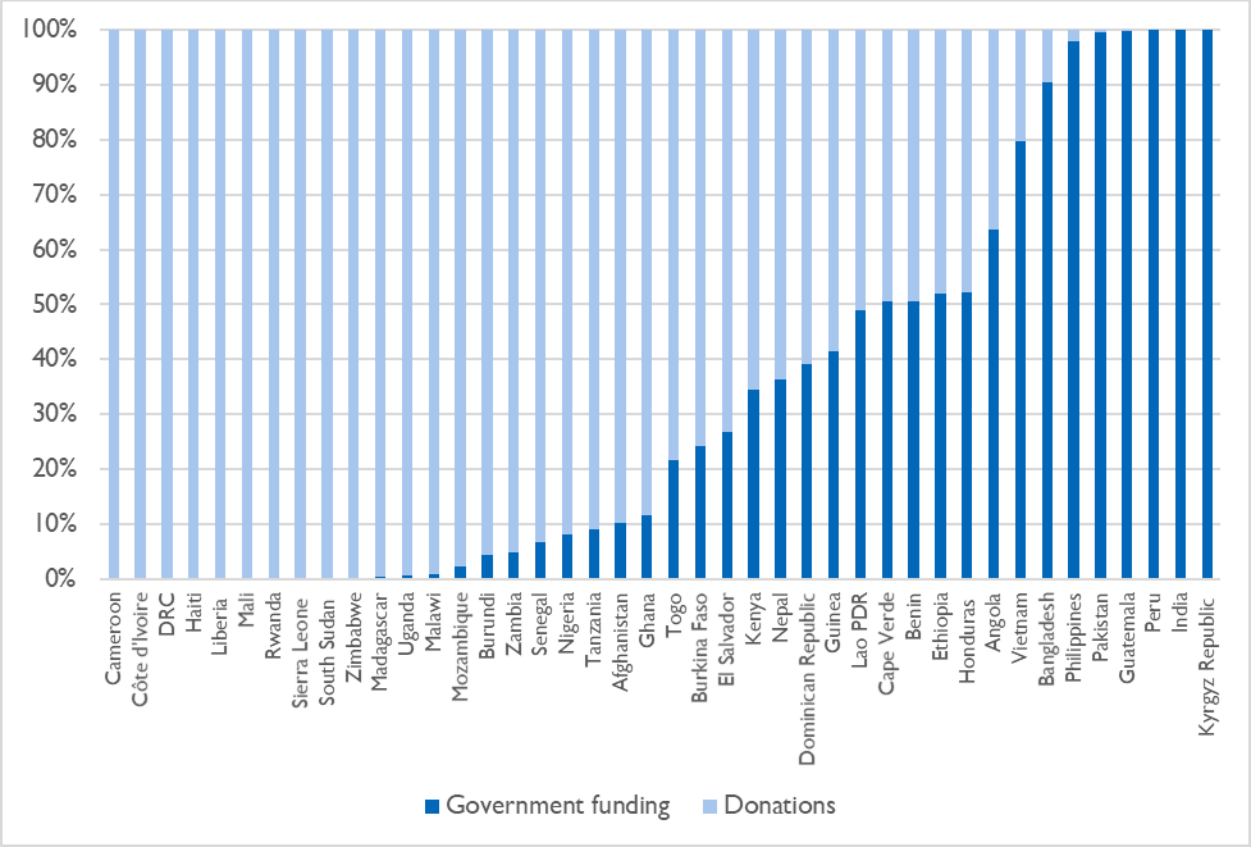
Donations from the UN accounted for the largest amount (30 percent), followed by USAID (18 percent), Other donations (6 percent), Global Fund (5 percent), and Other bilateral (3 percent).

Exhibit 9. In-kind donations and grants as a percentage of total spending on public-sector contraceptives (n=42)



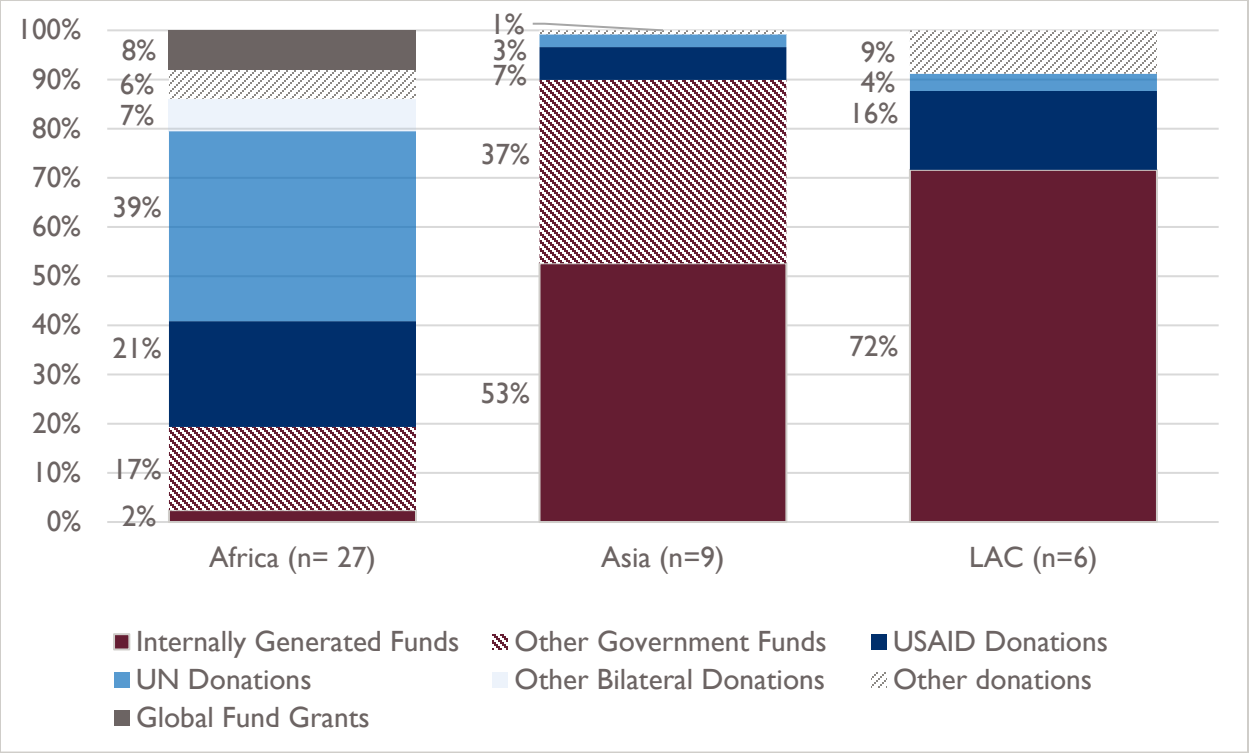
In terms of total spending, 38 percent of financing came from government sources and 62 percent from in-kind donations (Exhibit 10). In 2017 this was 41 and 59 percent, respectively.

Exhibit 10. Percentage of total spending on public-sector contraceptives by funding source (n=42)



The Asia region used the greatest amount of government spending toward procuring public-sector contraceptives (90 percent, up from 89 percent in 2017), followed by LAC (72 percent) and Africa (14 percent) (Exhibit 11). The Africa region used mainly donations (86 percent, up from 81 percent in 2017, or 87 percent up from 81 percent when comparing the same countries) while donations made up 28 percent in the LAC region (down from 60 percent in 2017, or from 60 percent up to 56 percent when comparing the same countries for 2017 and 2019, respectively).

Exhibit 11. Total contraceptive spending by source and region (n=42)



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. There were 31 of 41 countries, 76 percent, that have a budget line item. In 2017, this was 80 percent, and in 2015, 60 percent.

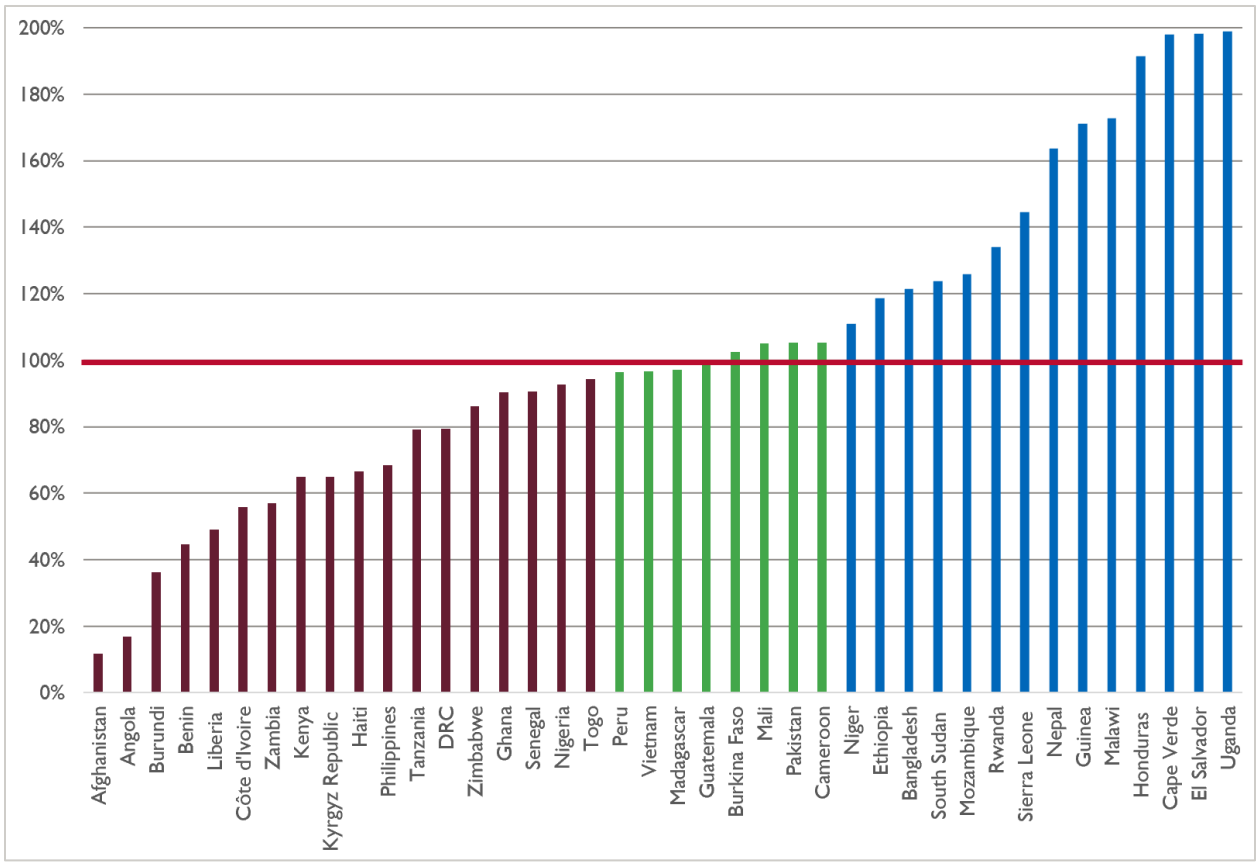
Of the 31 countries (76 percent) that have a budget line item, 87 percent (27 countries) spent government funds on contraceptives.[21] This was 82 percent in 2017. Four countries have a budget line item but did not use government funds (Côte d'Ivoire, DRC, Haiti, Rwanda). Six countries (Afghanistan, Dominican Republic, El Salvador, Ghana, Kyrgyz Republic, Vietnam) do not have a budget line item but used government funds to procure contraceptives. Five countries (Liberia, Mali, Sierra Leone, South Sudan, and Zimbabwe) do not have a budget line item and did not spend government funds.

[21] Spending on contraceptives in this survey is defined as the value in USD of contraceptives actually delivered (in cases where delivery data were available) in the country's most recently completed fiscal year, as of the date the country completed the survey. Commodities delivered in one fiscal year may have been planned for an earlier or later year. Similarly, commodities may have been planned for a fiscal year but not actually delivered in that year.

Financing Gap for Procurement of Public-sector Contraceptives

Of 41 countries, 21 (51 percent) had a funding gap between the forecasted need and available financing (Exhibit 12).[22]

Exhibit 12. Percentage of quantified need covered by any source of funding (n=41)[23]



Key:
Red = <96 percent of funding need met, Green = 96–105 percent of funding need med, Blue: >105 percent of funding need met.

[22] Outlier not shown: Dominican Republic (256 percent).

[23] The Limitations section discusses some of the explanations for the fluctuations in this indicator result.

Commodities

Having a range of contraceptive methods gives the client the ability to choose a method that best meets its needs. Respondents were asked which contraceptive methods are offered through the public, commercial, NGO, and social marketing sectors. The survey gathered information on the following 13 methods:

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

Highlights

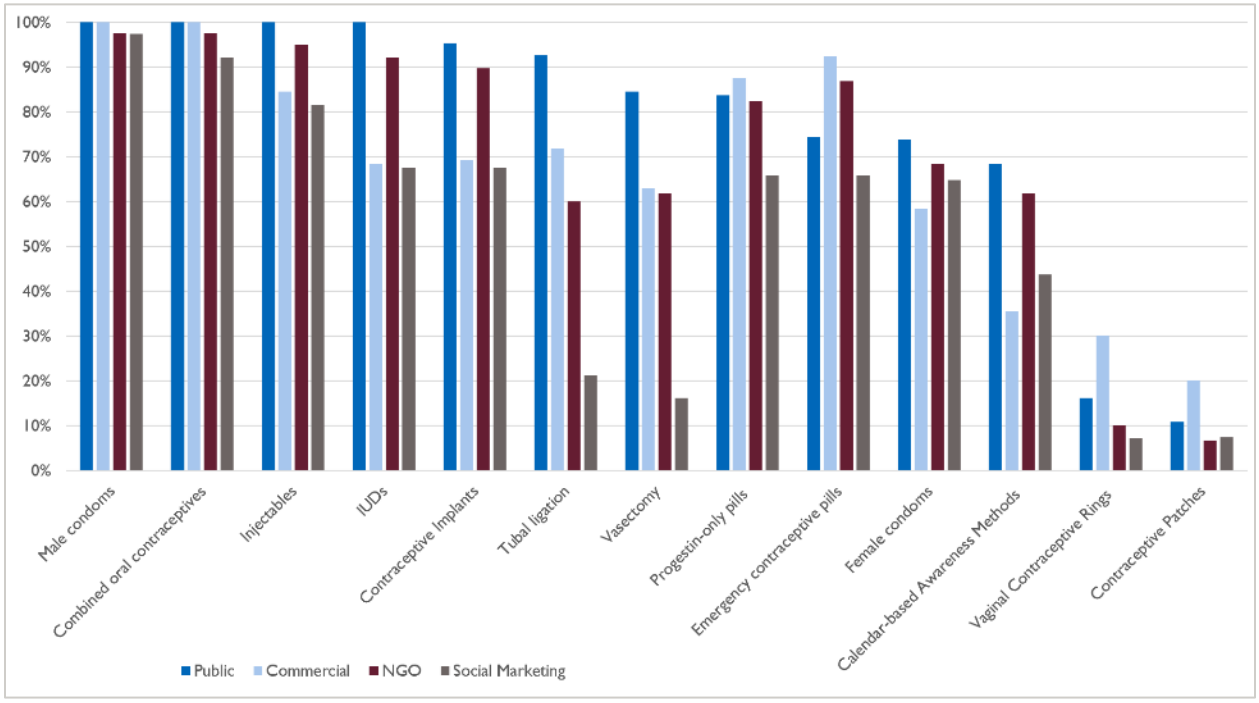
- On average, countries offer 10 of the 13 assessed contraceptive methods in public-sector facilities, eight in NGO facilities, eight through the commercial sector, and six through social marketing.
- 95 percent (41 of 43 countries) offer all the following commonly offered methods in public-sector facilities: male condoms, combined oral contraceptives, injectables, IUDs, and contraceptive implants.
- 91 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector.
- Public-sector facilities are the least likely to offer contraceptive patches and vaginal contraceptive rings.

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 all countries through the public sector and through NGOs in 98 percent of countries (Exhibit 13). Implants are offered in the public sector in 95 percent of the countries and through NGOs in 90 percent. Permanent methods, vasectomy and tubal

ligations, are more often offered through the public sector than through any other sector. Emergency contraceptives are more commonly offered in the commercial sector than in other sectors.

Exhibit 13. Percentage of contraceptive methods offered by sector



Public Sector

Of all 43 countries surveyed, 91 percent offer at least eight of the 13 assessed contraceptive methods in the public sector, and 95 percent offer all five of the most commonly offered methods in public-sector facilities (male condoms, COCs, injectables, IUDs, and implants) (Exhibit 14). In 2017, this was 89 percent and 86 percent, respectively.

All countries offer COCs, injectables, IUDs, and male condoms. Most countries offer implants (95 percent), tubal ligation (93 percent), vasectomy (85 percent), POPs (84 percent), female condoms and emergency contraceptive pills (both 74 percent), and calendar-based methods (68 percent). Only a small percentage offer vaginal contraceptive rings (16 percent) and contraceptives patches (11 percent).

Exhibit 14. Method mix by sector (percentage of countries that offer the following contraceptive methods by sector)

Product	Commercial sector	Public sector	NGOs	Social marketing
COCs	100%	100%	98%	92%
POPs	88%	84%	83%	66%
Injectables	85%	100%	95%	82%
Contraceptive implants	69%	95%	90%	68%

Product	Commercial sector	Public sector	NGOs	Social marketing
IUDs	68%	100%	92%	68%
Male condoms	100%	100%	98%	98%
Female condoms	58%	74%	68%	65%
Emergency contraceptive pills	93%	74%	87%	66%
Vasectomy	63%	85%	62%	16%
Tubal ligation	72%	93%	60%	21%
Contraceptive patches	20%	11%	7%	7%
Vaginal contraceptive rings	30%	16%	10%	7%

NGOs

The NGO sector is another good source for clients where a variety of contraceptives are offered. In most countries, COCs and male condoms (both 98 percent), injectables (95 percent), IUDs (92 percent), implants (90 percent), ECs (87 percent), and POPs (83 percent) can be found through the NGO sector. Vasectomy (62 percent) and tubal ligations (60 percent) are offered less frequently. Female condoms (68 percent), calendar-based methods (62 percent), vaginal contraceptive rings (10 percent), and contraceptive patches (7 percent) are not as commonly found at NGO facilities. An average of eight of 13 methods are available in the NGO sector, and 85 percent of NGO facilities offer five of the most common methods.

Commercial Sector

COCs, male condoms, and ECs are available through the commercial sector in almost all countries. POPs (88 percent) and injectables (85 percent) are commonly offered. Implants (69 percent), IUDs (68 percent), vasectomy (63 percent), and female condoms (58 percent) are less commonly offered. Calendar-based methods (35 percent), vaginal contraceptive rings (30 percent), and contraceptive patches (20 percent) are less likely to be found in the commercial sector. Eight of the 13 methods and five of the most common methods can be found in 60 percent of the commercial-sector facilities.

Social Marketing

Male condoms (98 percent), COCs (92 percent), and injectables (82 percent) are offered through social marketing in most countries. Implants, IUDs, POPs, ECs, and female condoms can be found in between 66 and 68 percent of countries. Calendar-based methods (44 percent), contraceptive patches, and vaginal contraceptive rings (both 7 percent) are less commonly found through social marketing. Six of the 13 methods and five of the most common methods are available in 61 percent of NGO facilities.

Policies

Policies supportive of contraceptive security are essential to provide an enabling environment for access and awareness of contraceptives for clients and to allow health workers to provide and prescribe them as needed. Supportive policies demonstrate a government commitment to strengthen contraceptive security. A strong contraceptive security (CS) environment is defined as one in which:

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

The survey collected information on:

- Whether countries had national strategies that include contraceptive security
- Any policies that hinder or enable the private sector to provide contraceptives
- The lowest-level provider that is allowed to provide particular methods
- Laws or practices that increase or are barriers to family planning access
- If there are duties on commodities or charges to clients for services or commodities
- Which contraceptives are on the National Essential Medicines List
- A country's FP2020 commitment to contraceptives, and financing from the Global Financing Facility

Highlights

In many countries, national strategic plans include a focus on FP services for youth as well as national laws and guidelines specific to FP youth needs. There is also a common sentiment that reproductive rights are linked to basic human rights. Some countries are also making efforts to increase access to FP services for rural populations and disadvantaged populations.

Short-term methods (male and female condoms) are readily available through the lowest-level provider, community health workers (CHWs). Oral contraceptives (nearly 70 percent) can be provided by CHWs in most countries. However, subcutaneous (51 percent) and intramuscular (31 percent) injectables, a popular method, are less frequently dispensed by CHWs.

Less than half of the countries (41 percent) have at least 50 percent of their providers trained to remove or insert implants and IUDs.

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

- In 50 percent of countries (21 of 42), FP commodities are subject to duties in at least one sector (public, commercial, NGO, or social marketing).
- 10 percent (four of 39 countries) have policies that hinder the ability of the private sector to provide contraceptives.
- 28 percent restrict access to contraceptives by unmarried people, and 14 percent, by married people ages 15–19.
- On average, countries included eight of 12 methods on their National Essential Medicines List.
- Community mobilization/engagement is the most popular channel for promoting family planning.

National Strategy Objectives for Contraceptive Security

The most common objectives of a CS strategy across countries are listed below.

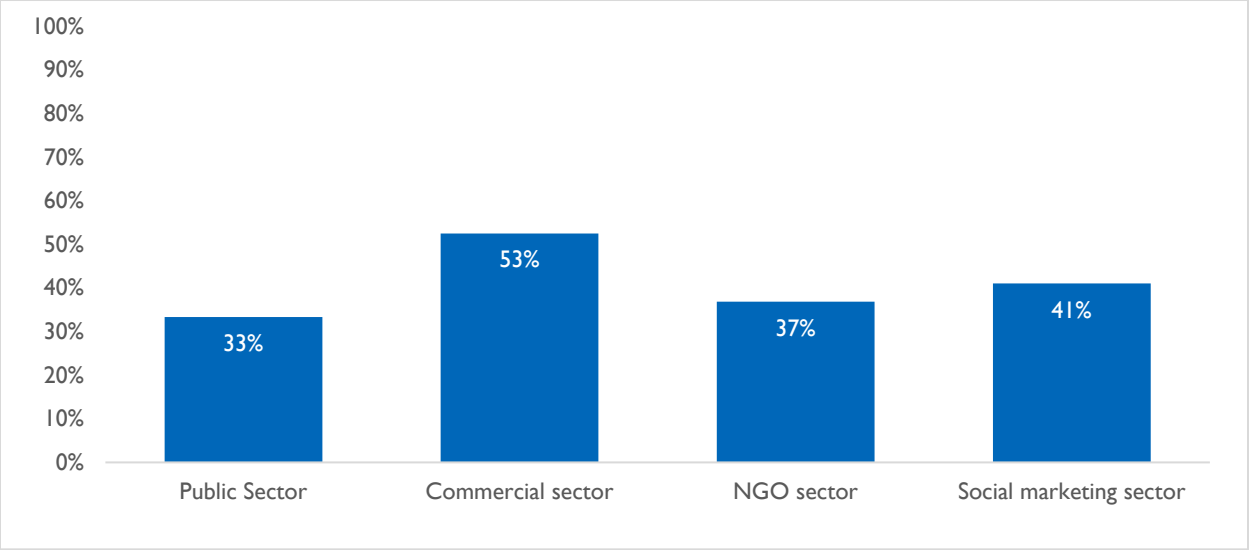
- Increase demand, availability, and quality of contraceptives and FP services
- Strengthen capacity of health service providers
- Expand contraceptive options
- Increase contraceptive prevalence
- Increase financing for FP services
- Reduce maternal and child mortality
- Bring stakeholders together and strengthen coordination mechanism
- Strengthen logistics management and M&E of FP services
- Decrease unwanted fertility
- Integrate FP services into the private sector

Policy Barriers Impacting Access or Provision to Contraceptives

Duties

On average, 50 percent of countries (21 of 42) are subject to duties in any sector (Exhibit 15). In 33 percent of countries (14 of 42) with the information, public-sector FP commodities are subject to duties. In 2017 this was 39 percent (22 of 36). Duties are applied to the NGO sector in 37 percent of the countries (14 of 38), 41 percent in the social marketing sector (16 of 39), and 53 percent in the private sector (21 of 40). Madagascar noted NGOs must pay taxes and customs duties on contraceptives. However, this policy may be eliminated pending approval by the Ministry of Economy and Finance.

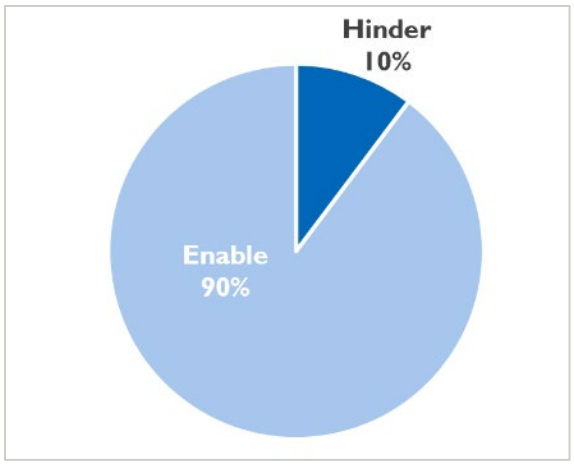
Exhibit 15. Percentage of countries where FP commodities are subject to duties by sector



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

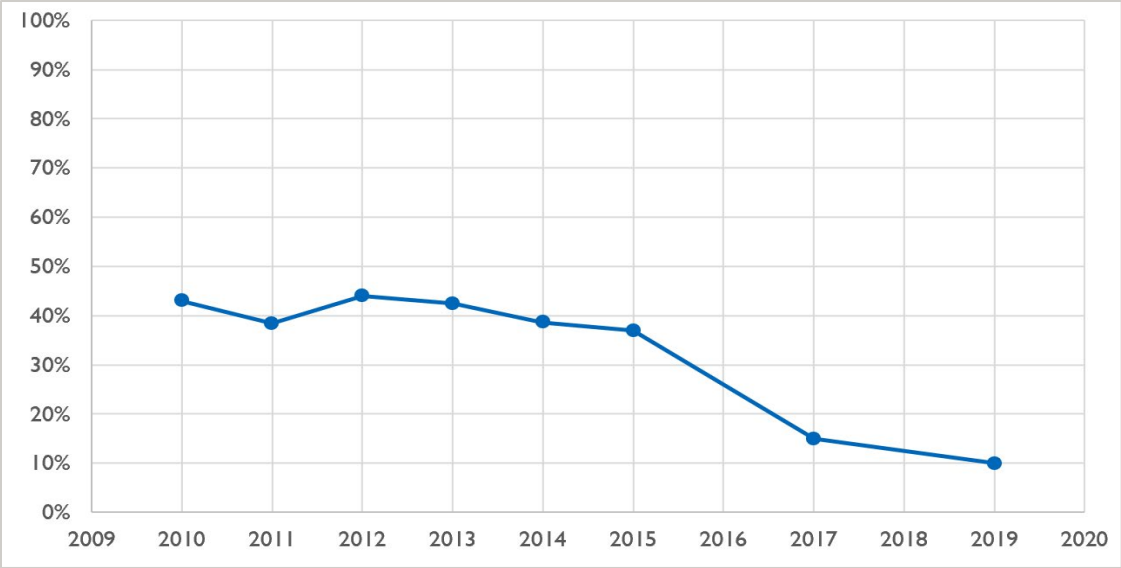
Of all country respondents, 10 percent (four of 39) reported there are policies that hinder the ability of the private sector to provide contraceptives (Exhibit 16).

Exhibit 16. Policies that enable or hinder private-sector provision of contraceptives (n=39)



This was 15 percent (five of 34) and 37 percent (17 of 46) in 2017 and 2015, respectively, and 43 percent (15 of 35) in 2010, showing a steady downward trend (Exhibit 17). Three of the four countries (Bangladesh, Ghana, and the Philippines) continue to have the same policy barriers from 2017. Four countries did not know if policies hinder the private sector.

Exhibit 17. Trend over time in policies that impact private-sector distribution of contraceptives

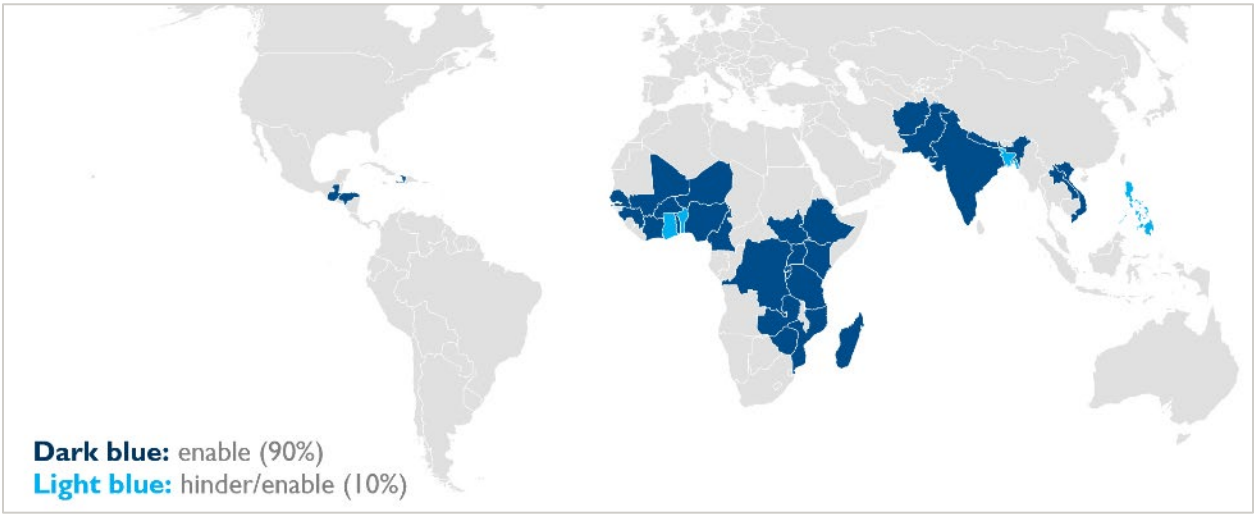


Examples of barriers are provided below.

- In Bangladesh, the private sector must receive permission from the MoH to import contraceptives.
- In Ghana, there are large taxes and lengthy registration processes.
- In the Philippines, regulated drugs, including contraceptives, cannot be advertised in mass media.
- In Benin, contraceptives are subject to customs duties.

In 90 percent of surveyed countries (35 of 39), there are policies that enable or support the private sector (Exhibit 18). This was 94 percent (30 of 32) and 73 percent (33 of 45) in 2017 and 2015, respectively.

Exhibit 18. Countries where policies enable or hinder private sector provision of contraceptives (n=39)



Examples of enabling policies toward the private sector include:

- Facilitate better coordination between the government and the private sector
- Build capacity of health care providers to deliver FP services
- Expand availability of and access to contraceptives in the private and public sectors (through social marketing especially)
- Increase variety of contraceptive methods available
- Increase access to reproductive health information for clients

Dispensing restrictions

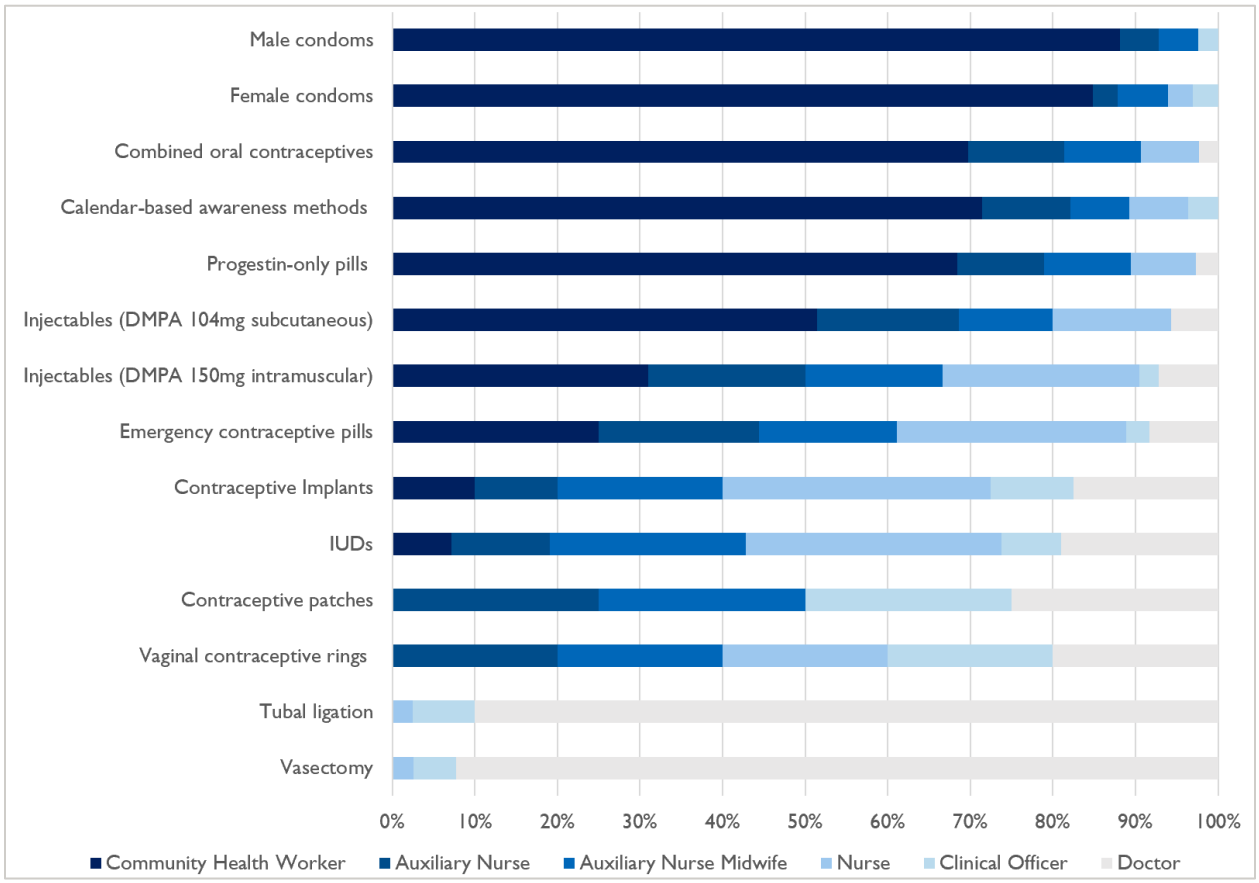
Restrictions on those who can dispense certain contraceptives can be barriers preventing clients from easily accessing the method of their choice.

For short-term methods, male and female condoms (88 and 85 percent, respectively), the community health worker is the lowest-level provider who can either sell or dispense the method in the public sector (Exhibit 19). For long-term, reversible methods—implants and IUDs—clients must go to higher-level providers to receive the method. Additional results are presented below for each method from lowest- to higher-level provider (CHW or equivalent), auxiliary nurse, auxiliary nurse midwife, nurse, clinical officer, doctor) and the percentage which clients can access the method from the provider.

- **Implants:** CHW (10 percent), auxiliary nurse (10 percent), auxiliary nurse midwife (20 percent), nurse (33 percent), clinical officer (each 10 percent), doctors (18 percent).
- **IUDs:** The CHW and the clinical officer are the lowest-level providers in 7 percent of the countries, followed by the auxiliary nurse (12 percent), auxiliary nurse midwife (24 percent), nurse (31 percent), and doctor (19 percent).
- **Injectables (subcutaneous):** In nearly half of the countries the CHW can provide this product (51 percent), 17 percent can go to the auxiliary nurse, 11 percent to the auxiliary nurse midwife, and 14 percent to nurses. Six percent must go to the doctor. The clinical officer was not a provider in any country.
- **Injectables (intramuscular):** In a third of the countries, clients can go to the CHW (31 percent) to receive this injectable, while 24 percent can go to nurses, 19 percent to the auxiliary nurse, 17 percent to the auxiliary nurse midwife. Seven percent must go to doctors, and 2 percent to clinical officers.
- **COCs:** CHW (70 percent), auxiliary nurse (12 percent), auxiliary nurse midwife (9 percent), nurse (7 percent), clinical officer (none), and doctor (2 percent). In the Kyrgyz Republic, clients must see a doctor to receive COCs.
- **POPs:** CHW (68 percent), auxiliary nurse and auxiliary nurse midwife (both (11 percent), nurse (8 percent), clinical officer (none), doctor (2 percent). In the Kyrgyz Republic, clients must see a doctor to receive POPs. In 2017 the lowest-level provider was also the CHW (53 percent), followed by the auxiliary nurse midwife (14 percent) and nurse (14 percent),
- Emergency contraceptive pill: CHW (25 percent), auxiliary nurse (19 percent), auxiliary nurse midwife (17 percent), nurse (28 percent), clinical officer (3 percent), and doctor (8 percent).

For permanent methods, vasectomy, and tubal ligations, most clients must go to a doctor (92 percent and 90 percent, respectively), or clinical officer (5 percent and 8 percent, respectively), or a nurse (3 percent for both). Neither method is accessible in any countries through a CHW, auxiliary nurse, or auxiliary nurse midwife.

Exhibit 19. Lowest-level provider allowed to dispense/sell contraceptive methods in the public sector

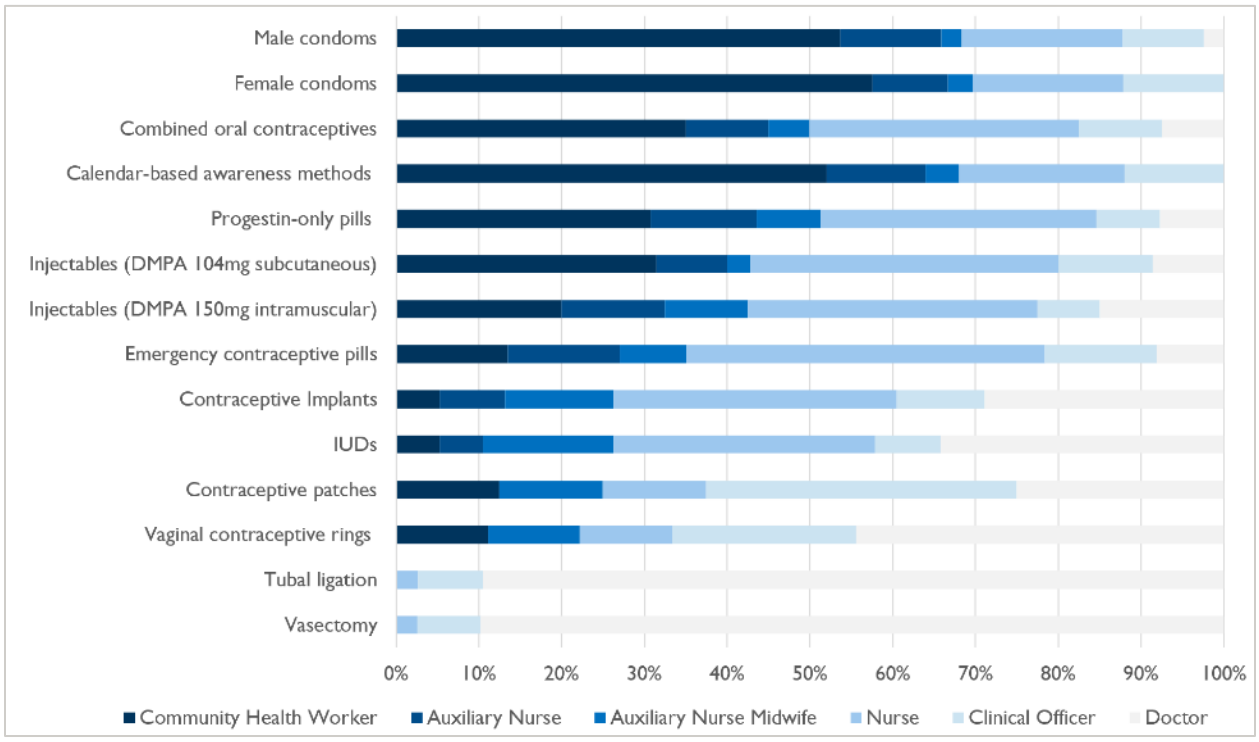


The level of provider who can sell or dispense contraceptive methods in the private sector includes the following (Exhibit 20):

- **Implants:** In most of the countries, clients must go to a nurse (34 percent) or doctor (29 percent) to access implants. They are also accessible through CHWs (5 percent), an auxiliary nurse (8 percent), an auxiliary nurse midwife (13 percent), and a clinical officer (11 percent). These results are similar to 2017 findings.
- **IUDs:** CHW (5 percent), auxiliary nurse (5 percent), auxiliary nurse midwife (16 percent), nurse (32 percent), clinical officer (8 percent), doctor (34 percent).
- **Injectable (subcutaneous):** CHW (31percent), auxiliary nurse (9 percent), auxiliary nurse midwife (3 percent), nurse (37 percent), clinical officer (11 percent), doctor (9 percent).
- **Injectable (intramuscular):** CHW (20 percent), auxiliary nurse (13 percent), auxiliary nurse midwife (10 percent), nurse (35 percent), clinical officer (8 percent), doctor (15 percent). These findings are similar to 2017 results.

- **COCs:** CHW (35 percent), auxiliary nurse (10 percent), auxiliary nurse midwife (5 percent), nurse (33 percent), clinical officer (10 percent), doctor (8 percent). The results were similar in 2017: CHW (31 percent), nurse (33 percent), auxiliary nurse (8 percent), or auxiliary nurse midwife (8 percent).
- **POPs:** CHW (31 percent), auxiliary nurse (13 percent), auxiliary nurse midwife (8 percent), nurse (33 percent), clinical officer (8 percent), doctor (8 percent). The findings were similar in 2017.
- **ECs:** CHW and auxiliary nurse (both 14 percent), auxiliary nurse midwife (8 percent), nurse (43 percent), clinical officer (14 percent), doctor (8 percent).

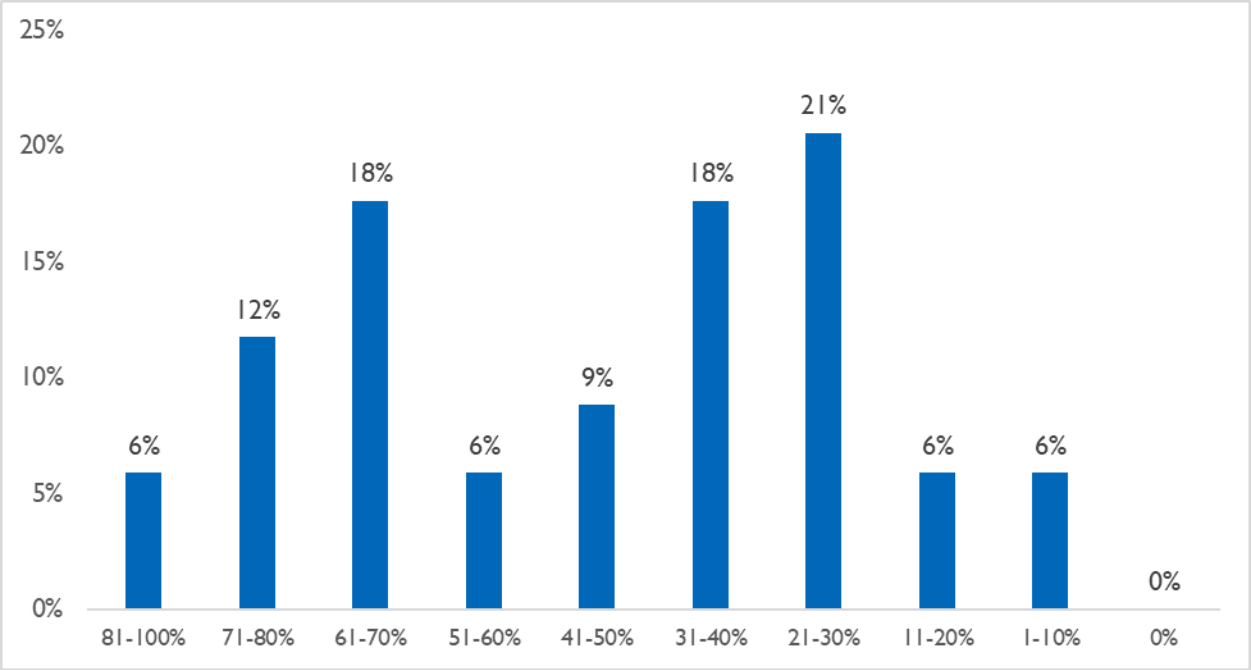
Exhibit 20. Lowest-level provider allowed to dispense/sell contraceptive methods in the private sector



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 21). Only 6 percent said 81–100 percent of providers are trained, 12 percent responded 71–80 percent are trained, 18 percent with 61–70 percent, 6 percent with 51–60 percent, 9 percent with 41–50 percent, 18 percent with 31–40 percent, 21 percent with 21–30 percent, and 6 percent with 11–20 percent and 1–10 percent.

Exhibit 21. 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 if there are laws, regulations, or policies that either increase or decrease access to family planning services and commodities for sub-populations: youth, unmarried, rural, disadvantaged sub-regions, populations with lower educational attainment, lower-income populations, disabled, minority populations (ethnic or religious groups), and other (migrants, internally displaced populations).

Most countries have supportive policies among the sub-populations (Exhibit 22). These include married youth in 79 percent (ages 15–18 years) and 81 percent (ages 20–24 years) of countries and although slightly lower, for unmarried youth with 72 percent (ages 15–18 years) and 74 percent (ages 20–24 years). Afghanistan, Bangladesh, and South Sudan promote access to FP services for married youth.

Eighty-one percent of countries have policies to increase access to FP for the rural population, 81 percent for disadvantaged sub-regions, 74 percent for those with lower education, 79 percent for those with lower incomes, 76 percent for those who are disabled, 74 percent for minority populations, and 67 percent for those who are considered migrants or internally displaced populations.

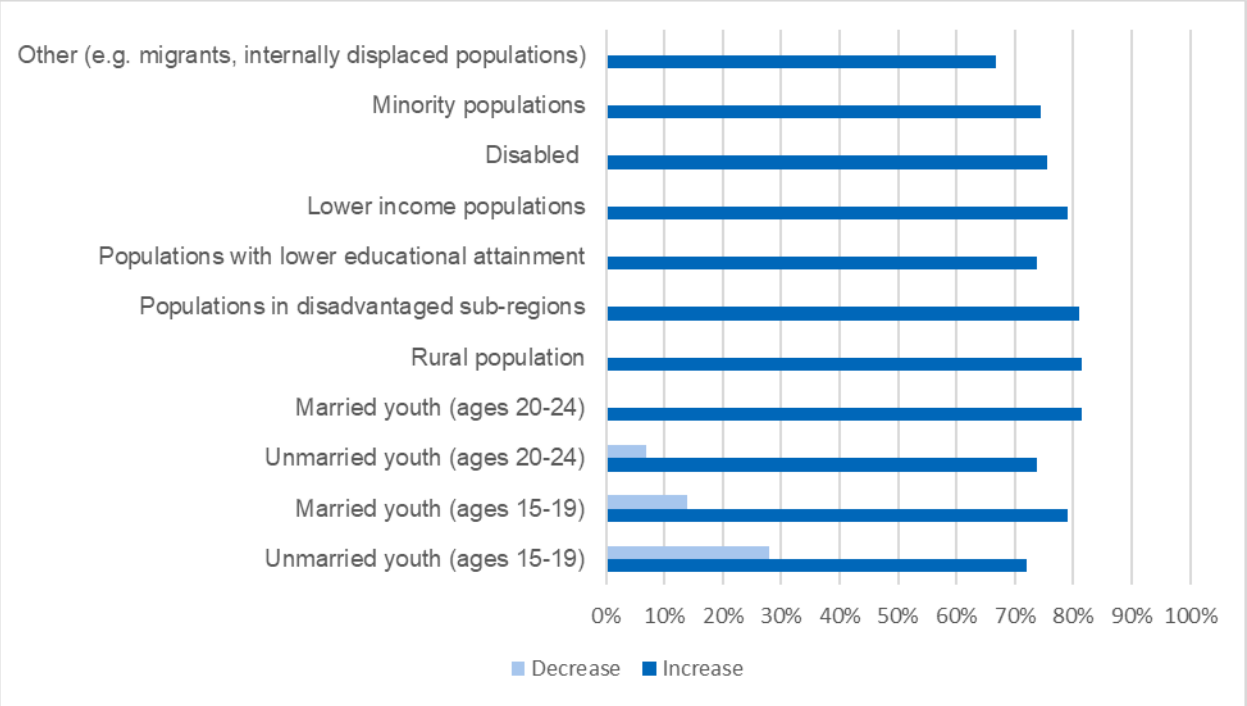
No countries have policies that decrease access based on location, income, disability, minority populations, or married youth 20–24 years of age. There are countries that have policies limiting access to FP for those between 15 and 19 who are either unmarried (26 percent or 11 of 43 countries) or married (12 percent or five of 43 countries) and those who are unmarried between the ages of 20 and 24 (7 percent, or three of 43 countries—Afghanistan, Bangladesh, and Nepal).

Examples of policy barriers include:

- Selling contraceptives to anyone under age 18 is restricted

- Any unmarried youth under 18 who obtain contraceptives must be reported to authorities
- Only married couples can receive contraceptives
- Providers must ask about marital status
- Support for adolescents is lacking
- Unmarried women are prohibited from accessing free contraceptives
- Contraceptives can be prescribed for a health condition
- Youth must obtain parental consent to receive contraceptives

Exhibit 22. Laws, regulations, or policies that increase or decrease access to FP services among sub-populations



Cultural 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 family planning services and commodities for the same sub-populations as noted in the above section.

Sixty-six percent of countries have supportive practices toward unmarried youth (ages 15–19 and 20–24), and 73 percent and 70 percent responded that supportive practices exist for married youth ages 15–19 and 20–24, respectively (Exhibit 23). Practices exist that increase access to FP for rural populations (73 percent), disadvantaged sub-regions (65 percent), lower education (63 percent), lower income (66 percent), disabled (62 percent), minority populations (68 percent), and migrants or internally displaced population (65 percent).

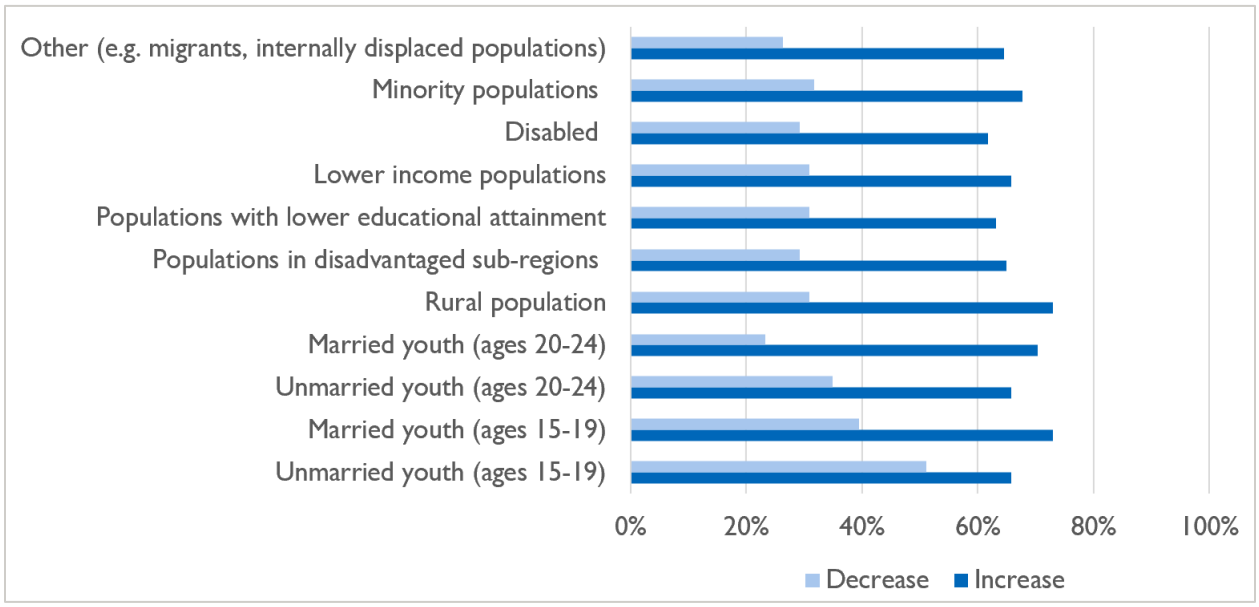
Half of the countries responded that there are cultural practices that decrease access for unmarried youth ages 15–19 (51 percent). Among those countries reporting cultural and operational barriers to unmarried youth ages 15–19, eight of 22 countries (36 percent) reported either that access to contraceptives in this group is formally prohibited, or they cited a lack of social acceptance for it. 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 35 percent for unmarried youth and 23 percent for married youth.

In 32 percent of the countries, practices decrease access for minority populations. For rural populations, those with lower education, or low income, 31 percent of countries have practices decreasing access. A similar percentage exists for disadvantaged sub-regions and disabled (both 29 percent) and migrants or internally displaced populations (26 percent).

Some country examples of cultural barriers are:

- The inability for unmarried people to access contraceptives
- Religious beliefs/practices, mentioned by 27 percent (six of 22)
- Machismo/limited male involvement, cited by 10 percent (two of 10)

Exhibit 23. Operational and cultural practices that increase or decrease access to FP services among sub-populations



Charges

Fees are charged to clients for family planning services in 13 of 42 countries (31 percent) and in 15 of 41 countries (37 percent) for commodities. In comparison, in 2017 this was 33 and 31 percent. respectively, 23 and 23 for both in 2015 (11 of 48 countries), and 15 and 24 percent in 2010 (five of 34 and eight of 33 countries).

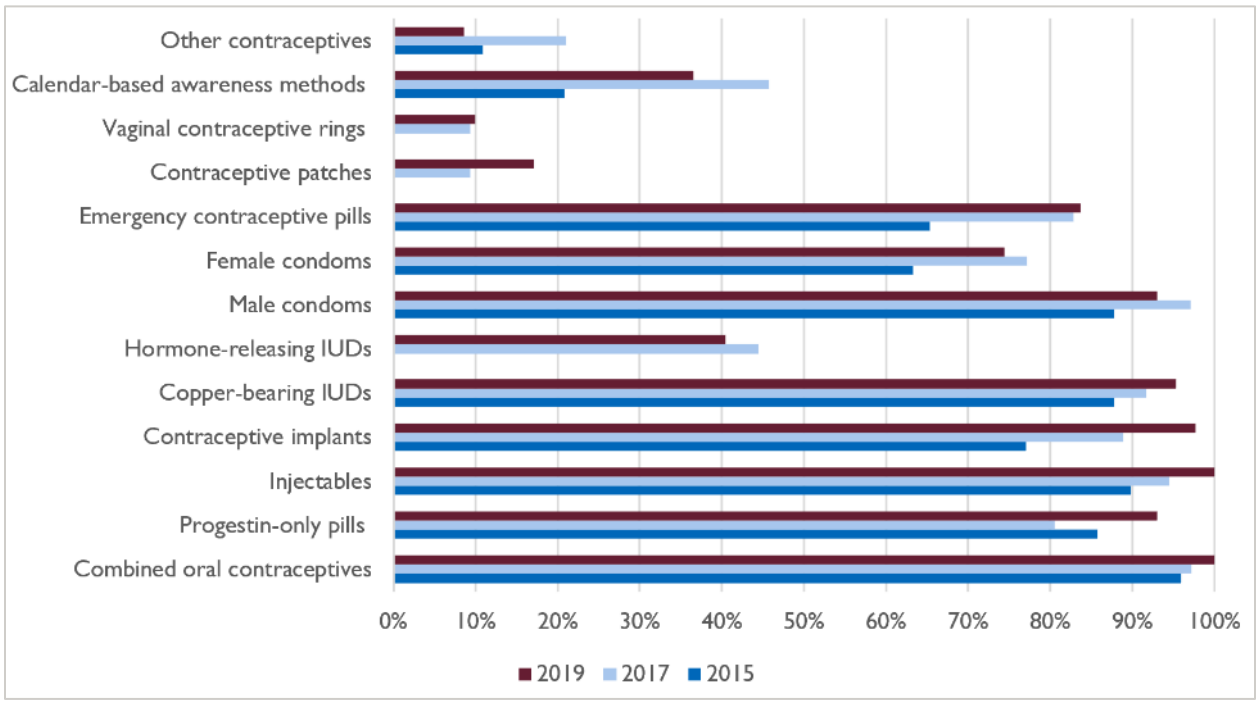
Government health insurance covers FP fees in 10 of 24 countries (42 percent). This was not applicable in 19 countries where no fees were charged.

National Essential Medicine List

An average of eight contraceptives are on the NEML. All countries have COCs and injectables on their NEML (Exhibit 24). Nearly all countries include implants (98 percent), IUDs (copper bearing) (95 percent), and POPs and male condoms (both 93 percent). Fewer countries include ECs (84 percent), female condoms (74 percent), hormone-releasing IUDs (40 percent), contraceptive patches (17 percent), vaginal contraceptive rings (17 percent), calendar-based methods (37 percent), and other contraceptives (9 percent).

The number of countries increased from 2017 for COCs (97 percent), injectables (94 percent), copper-bearing IUDs (92 percent), implants (89 percent), and POPs (81 percent). It decreased for male condoms (97 percent) and ECs (83 percent).

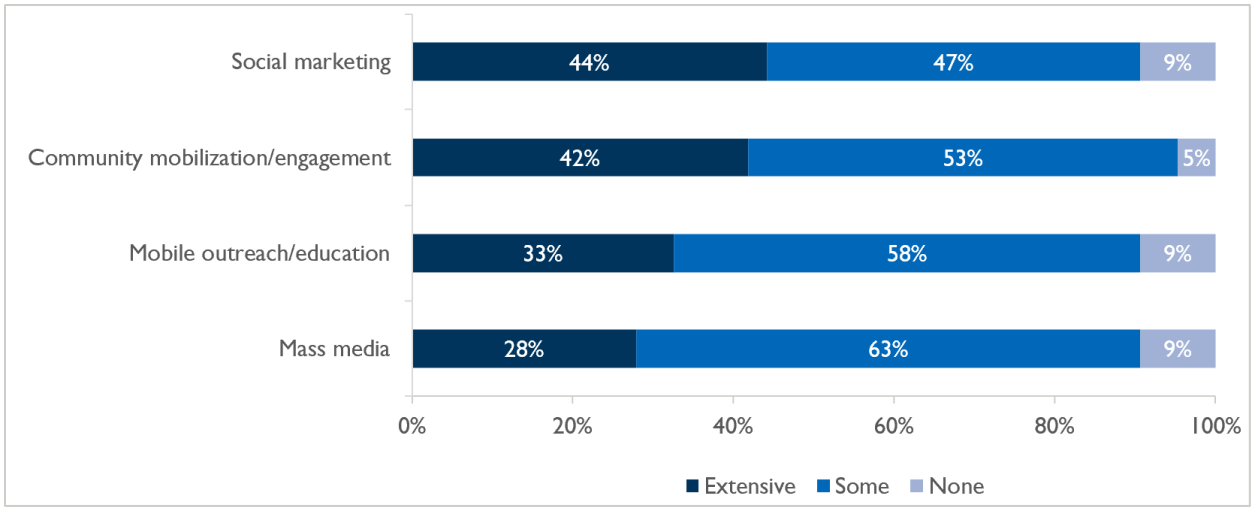
Exhibit 24. Percentage of countries with methods included in the NEML



Promotion of Family Planning

The survey asked if FP is actively promoted through social marketing, mass media, mobile outreach/education, or community mobilization/engagement channels either extensively, somewhat, or not at all (Exhibit 25). When looking at channels used either "extensively" or "some," community mobilization/engagement is the most popular channel (95 percent), followed by social marketing, mobile outreach/education, and mass media (all 91 percent). Nine percent each do not do any promotion through social marketing, mass media, or mobile outreach. and 5 percent do not promote through community mobilization. Forty-eight percent noted FP is promoted through other channels.

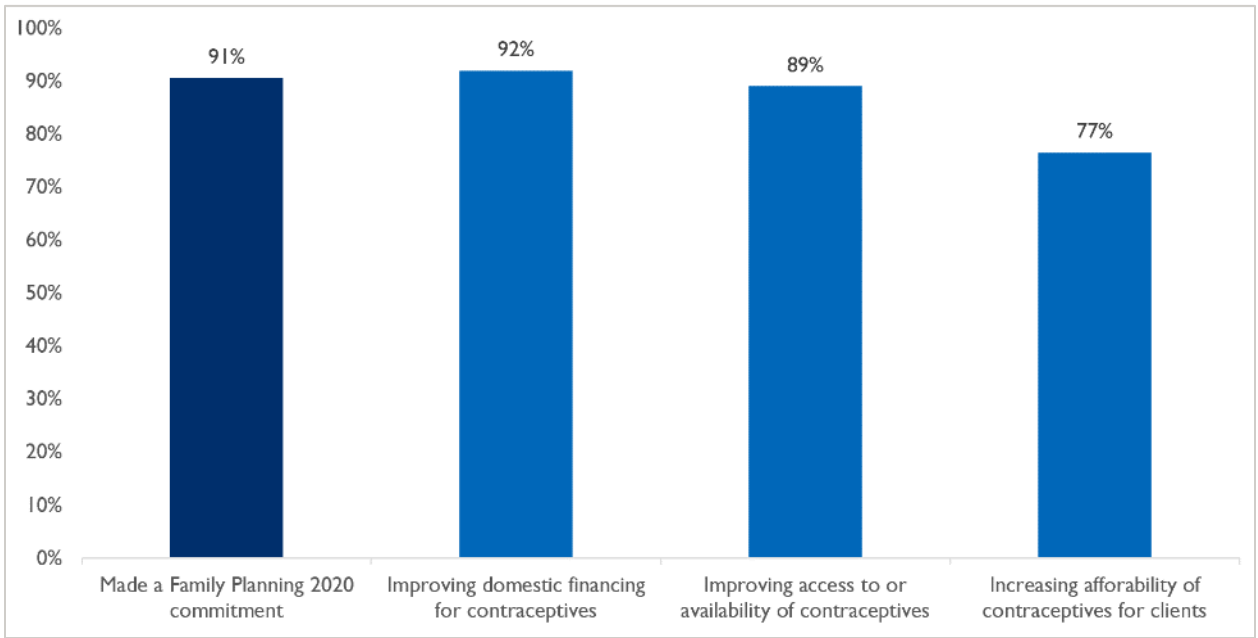
Exhibit 25. Promotion of FP by channel



FP2020 Commitment

Ninety-one percent of surveyed countries have made an FP2020 commitment (Exhibit 26) (as noted in the methodology section, this was one of the main criteria for countries to be selected for the survey). A commitment to improve domestic financing for contraceptives was made in 92 percent (35 of 38) of countries, 77 percent (23 of 30) have a made commitment for increasing affordability of contraceptives for clients, and 89 percent to improve access or availability of contraceptives.

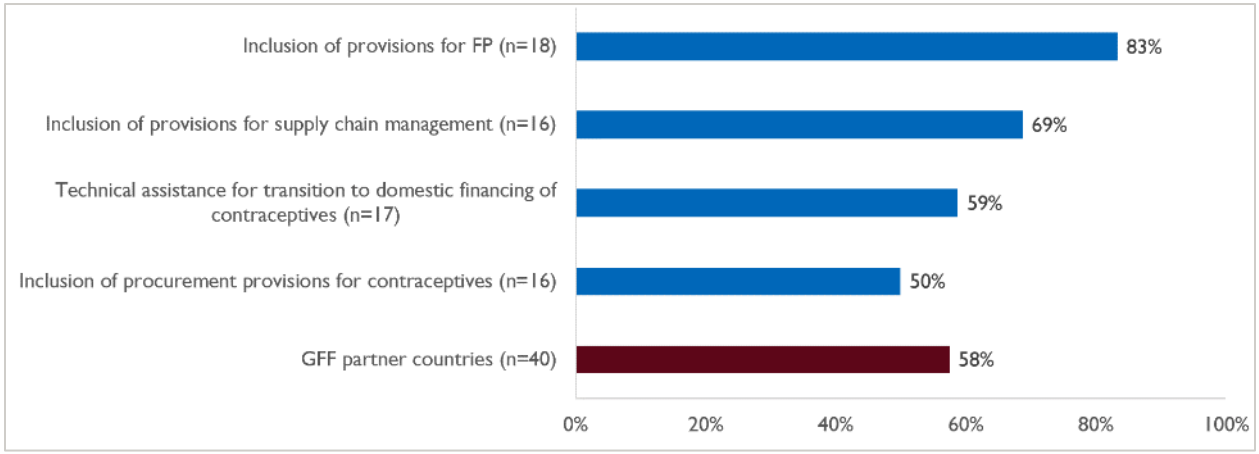
Exhibit 26. Percentage of countries with specific FP2020 commitment areas



Global Financing Facility

Fifty-eight percent (23 of 40) are Global Financing Facility partners (Exhibit 27). Eighty-three percent (15 of 18) have financing for inclusion of provisions for FP, 50 percent (eight of 16) have provisions for procuring contraceptive commodities, 69 percent (11 of 16) for supply chain management, and 59 percent (10 of 17) for technical assistance for transition to domestic financing of contraceptives.

Exhibit 27. Global Financing Facility partnership areas (n=40)



Supply Chain

Having a reliable supply chain is essential for commodities to reach the intended destination. Accurately estimating the forecasted need is key to ensuring the correct amounts of contraceptives are procured to provide a regular, uninterrupted supply of commodities. Accurate forecasting also contributes to better use of financial resources, as well as program efficiency and effectiveness.

Countries were asked to provide the number of stock-outs observed during the previous 12-month period at the central level, out of the total stock observations for each product in that time period. At the SDP level, data were collected on the percentage of facilities stocked out of each contraceptive product at a point in time for each reporting period (usually four quarterly reporting periods), which was averaged over the year (total facilities reporting a stock-out of the product out of the total facilities that reported on the product across the reporting periods). Countries were also asked if they have a LMIS that collects data on contraceptives.

Highlights

- Of the 37 countries that provided information on stock-outs at the central level, 11 (30 percent) reported zero stock-outs at the central level for any FP/RH product in the previous 12 months before the survey.
- Average annual stock-out rates at the **central medical store level** for the most common FP/RH methods ranged as follows among countries reporting:
    - **COCs:** 78 percent (29 of 37 countries) of countries with data had no stock-outs; for eight countries the stock-out rate ranged from 8 percent (Guatemala) to 36 percent (Liberia) of stock status observations reported as stocked out.
    - **Injectable contraceptives:** 73 percent (27 of 37 countries) of countries with data had no stock-outs; for 10 countries the stock-out rate ranged from 13 percent (Sierra Leone) to 100 percent (Angola).
    - **Implants:** 67 percent (24 of 36 countries) of countries with data had no stock-outs; for 12 countries the stock-out rate ranged from 3 percent (Lao PDR) to 81 percent (Bangladesh).
    - **IUDs:** 76 percent (28 of 37 countries) of countries with data had no stock-outs; the remaining nine countries ranged from 8 percent (Uganda) to 70 percent (Zambia) stocked out.
    - **Male condoms:** 81 percent (30 of 37 countries) of countries with data had no stock-outs; the remaining seven countries ranged from 8 percent (Ghana) to 42 percent (Tanzania) stocked out.
- Average annual stock-out rates at the **SDP** level for the most common FP/RH methods ranged as follows:
    - **COCs:** 16 percent (four of 25 countries) of countries with data had zero stock-outs of COCs: Bangladesh, Cape Verde, Laos, Kenya; four countries had stock-out rates ranging from 1 percent (Haiti) to 100 percent (Dominican Republic).
    - **Injectables:** 15 percent of countries with data (four of 27) had no stock-outs; for the remaining 23 countries, stock-out rates ranged from 2 percent (Rwanda) to 100 percent (Dominican Republic).

- **Implants:** 4 percent of countries with data (one of 25) had no stock-outs (Haiti); for the remaining 24 countries, stock-outs rated ranged from 2 percent (Rwanda) to 100 percent (Dominican Republic).
- **IUDs:** 7 percent of countries with data (two of 26) had no stock-outs; the remaining 24 countries ranged from 1 percent (Bangladesh) to 100 percent (Dominican Republic) stocked out.
- **Male condoms:** 12 percent of countries with data (three of 26) had no stock-outs; the remaining 23 countries ranged from 2 percent (Peru) to 100 percent (Dominican Republic) stocked out.

Forecast Error

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

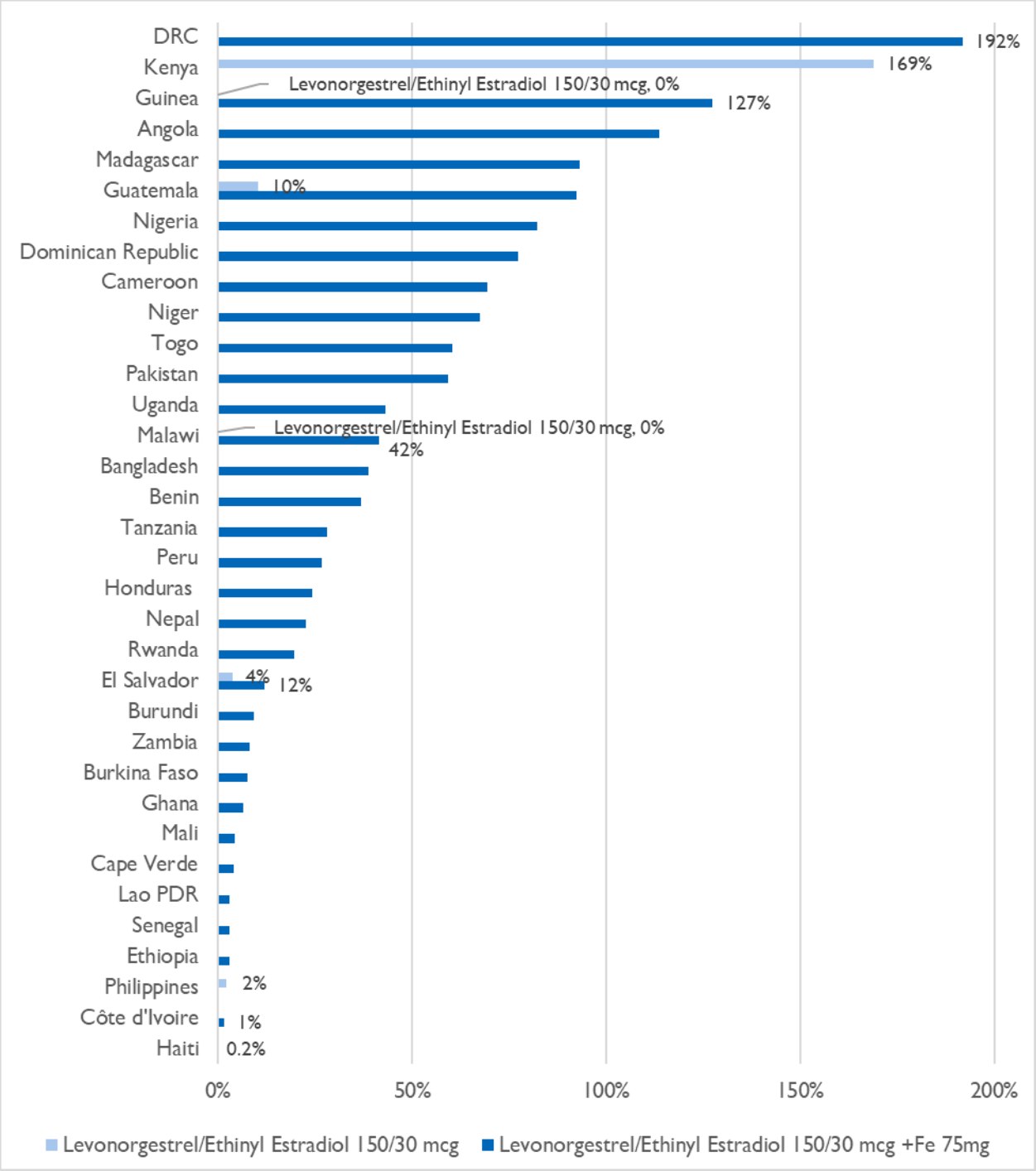
(Actual quantity consumed) – (Forecasted consumption)/Actual quantity consumed

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

Combined oral contraceptives

For the 34 countries that provided data on forecast error for COCs (Exhibit 28), the forecast error ranged from 0 percent (levonorgestrel/ethinyl estradiol 150/30 mcg in Guinea and Malawi) and 0.2 percent for levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg in Haiti to 694 percent (levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg in Afghanistan, due primarily to budget shortages).

Exhibit 28. Forecast error for COCs (n=34)24

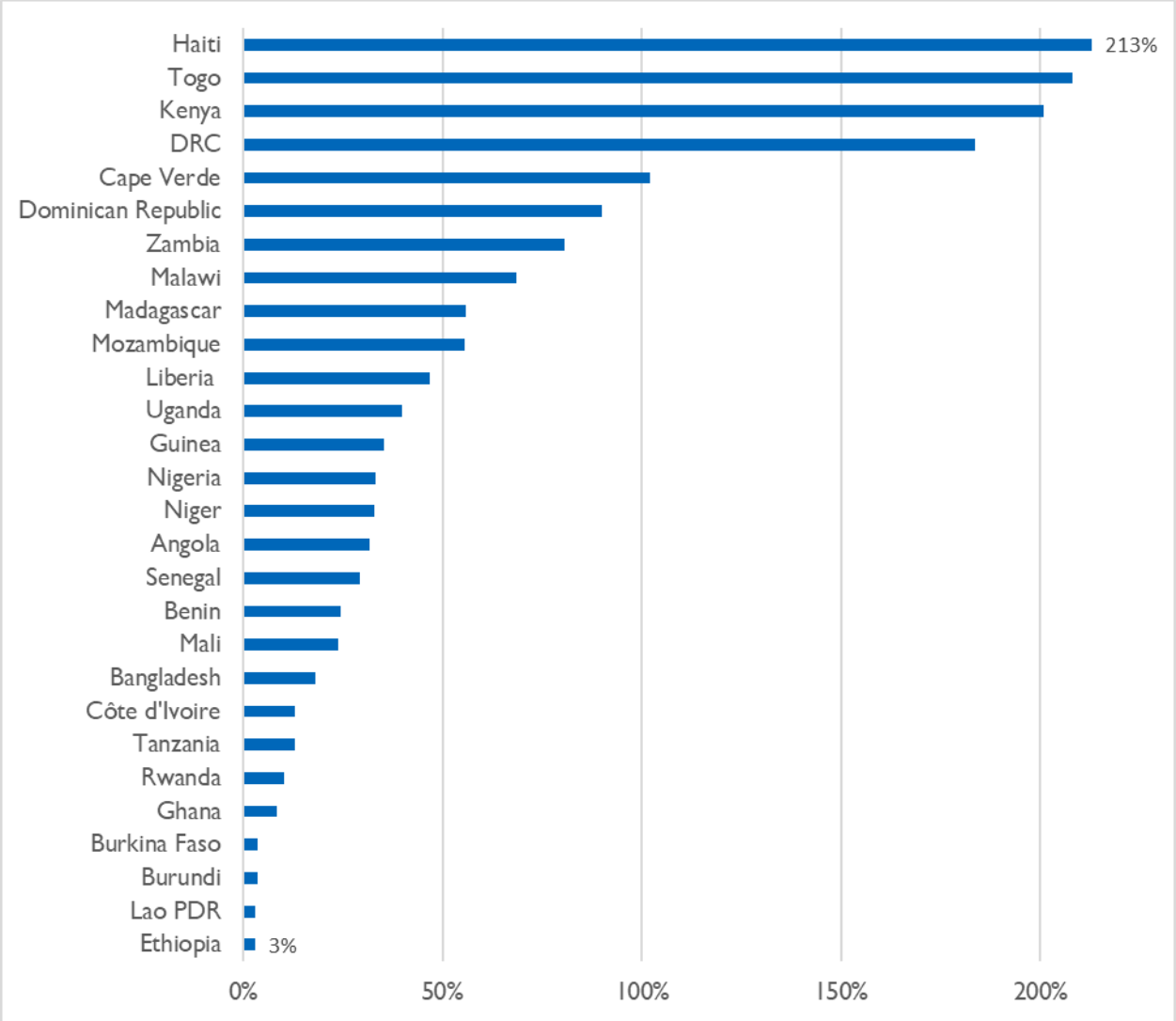


[24] Outliers not shown: Afghanistan (694 percent) and Liberia (285 percent), both for levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg.

Progestin-only pills

For the 30 countries that provided data on POPs (Exhibit 29), the forecast error ranged from 3 percent (Ethiopia and Lao PDR) to 213 percent (Haiti).

Exhibit 29. Forecast error for POPs (n=30)25

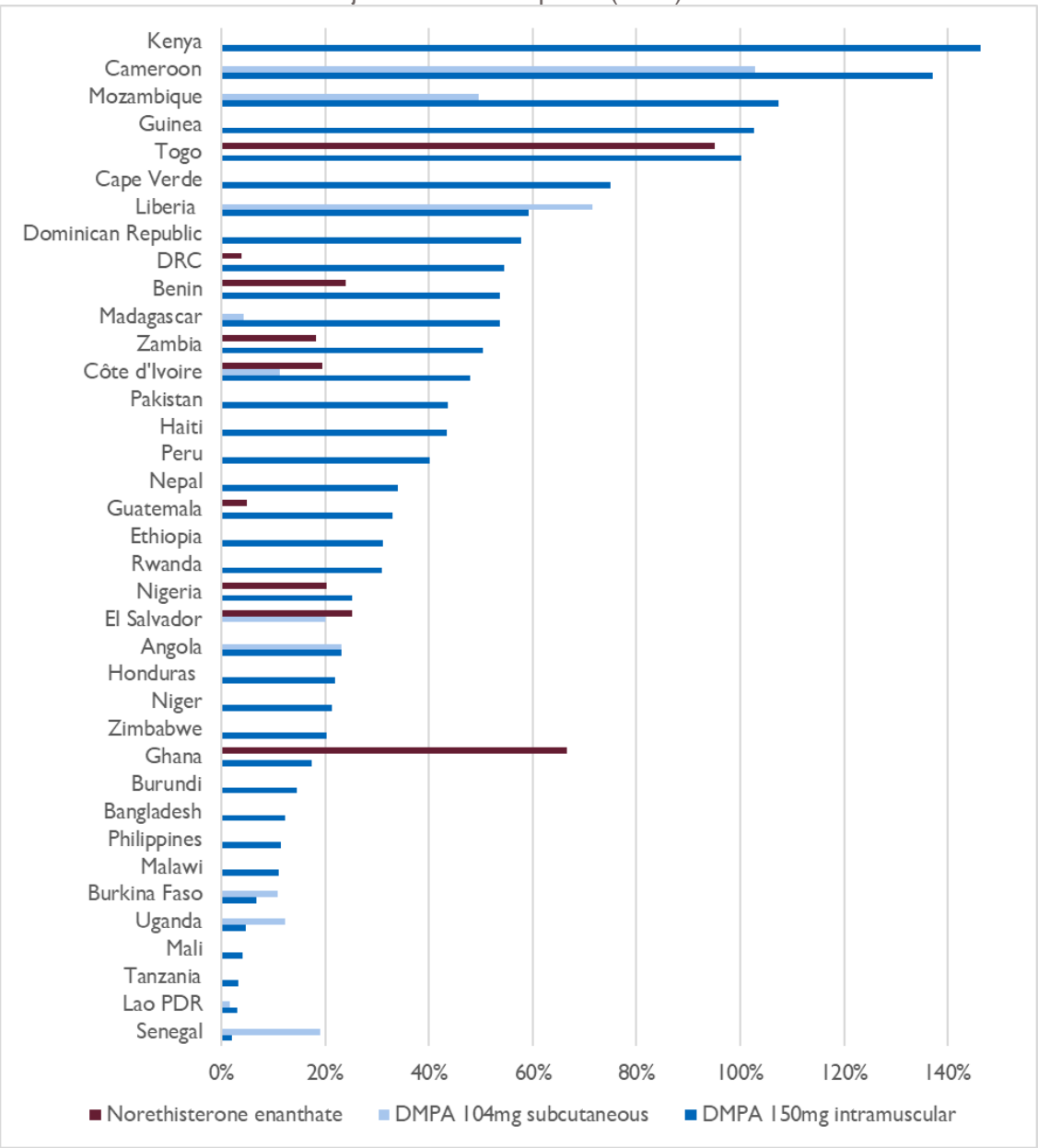


[25] Outliers not shown: Afghanistan (1,075 percent) and Pakistan (1,729 percent)

Injectable contraceptives

The forecast error range for injectables (Exhibit 30) was also wide, from 2 percent (Senegal) to 146 percent (Kenya) for DMPA 150mg intramuscular, and from 2 percent (Lao PDR) to 103 percent (Cameroon) for DMPA 104mg subcutaneous, and from 5 percent (Guatemala) to 95 percent (Togo) for norethisterone enanthate.

Exhibit 30. Forecast error for injectable contraceptives (n=39)[26]

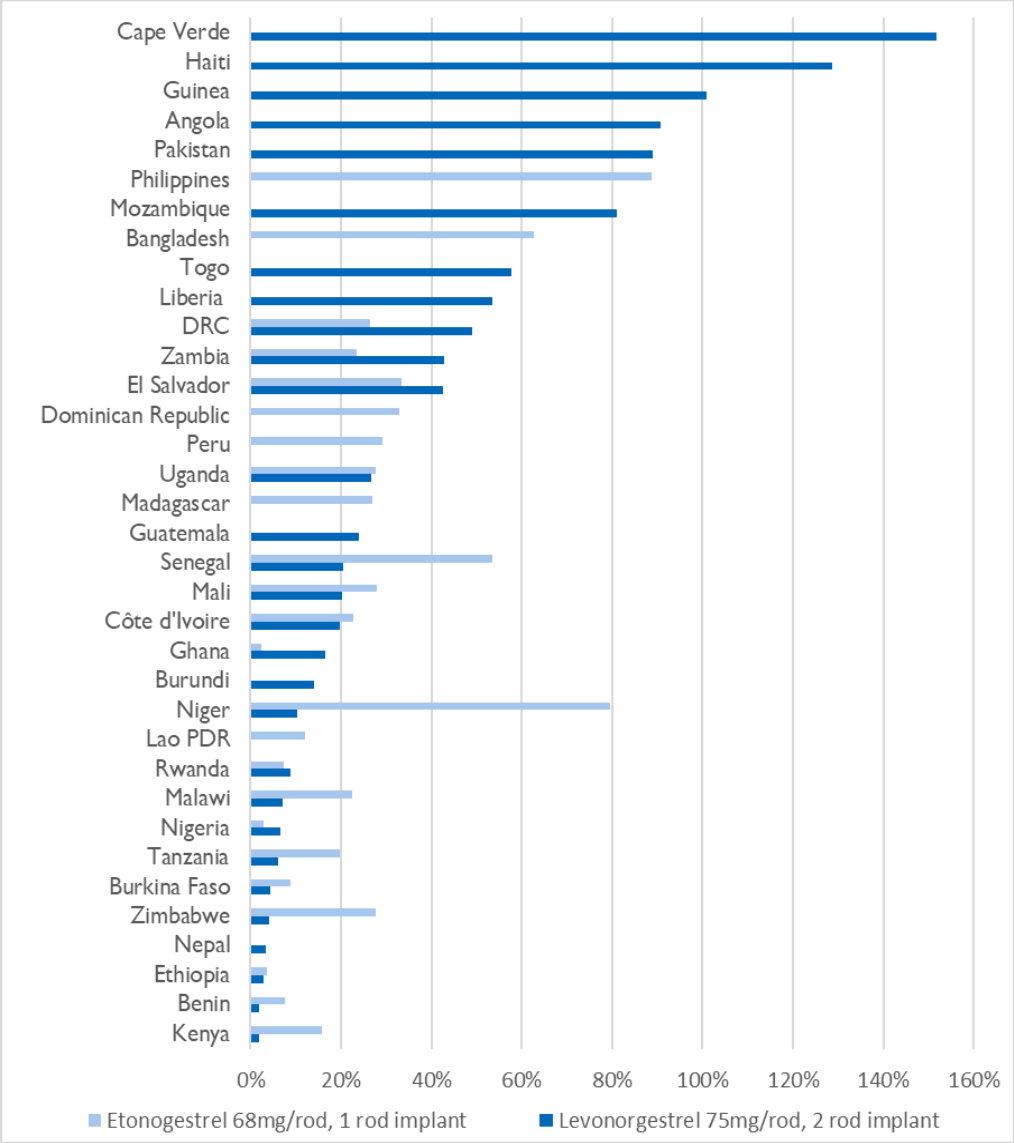


[26] Outliers not shown: Afghanistan (1,140 percent for DMPA 150mg intramuscular and 963 percent for DMPA 104mg subcutaneous), Togo (100 percent for DMPA 150mg intramuscular and 8,488 percent for DMPA 104mg subcutaneous), Nigeria (353 percent for DMPA 104mg subcutaneous), DRC (243 percent for DMPA 104mg subcutaneous), and Niger (184 percent for DMPA 104mg subcutaneous).

Contraceptive implants

The forecast error for two-rod implants (Exhibit 31) ranged from 2 percent (Kenya and Benin) to 282 percent (Bangladesh). The forecast error for one-rod implants ranged from 0.51 percent (Honduras) to 6,439 percent (Pakistan).

Exhibit 31. Forecast error for contraceptive implants (levonorgestrel 75mg/rod, two-rod and etonogestrel 68mg/rod, one-rod) (n=39)[27]

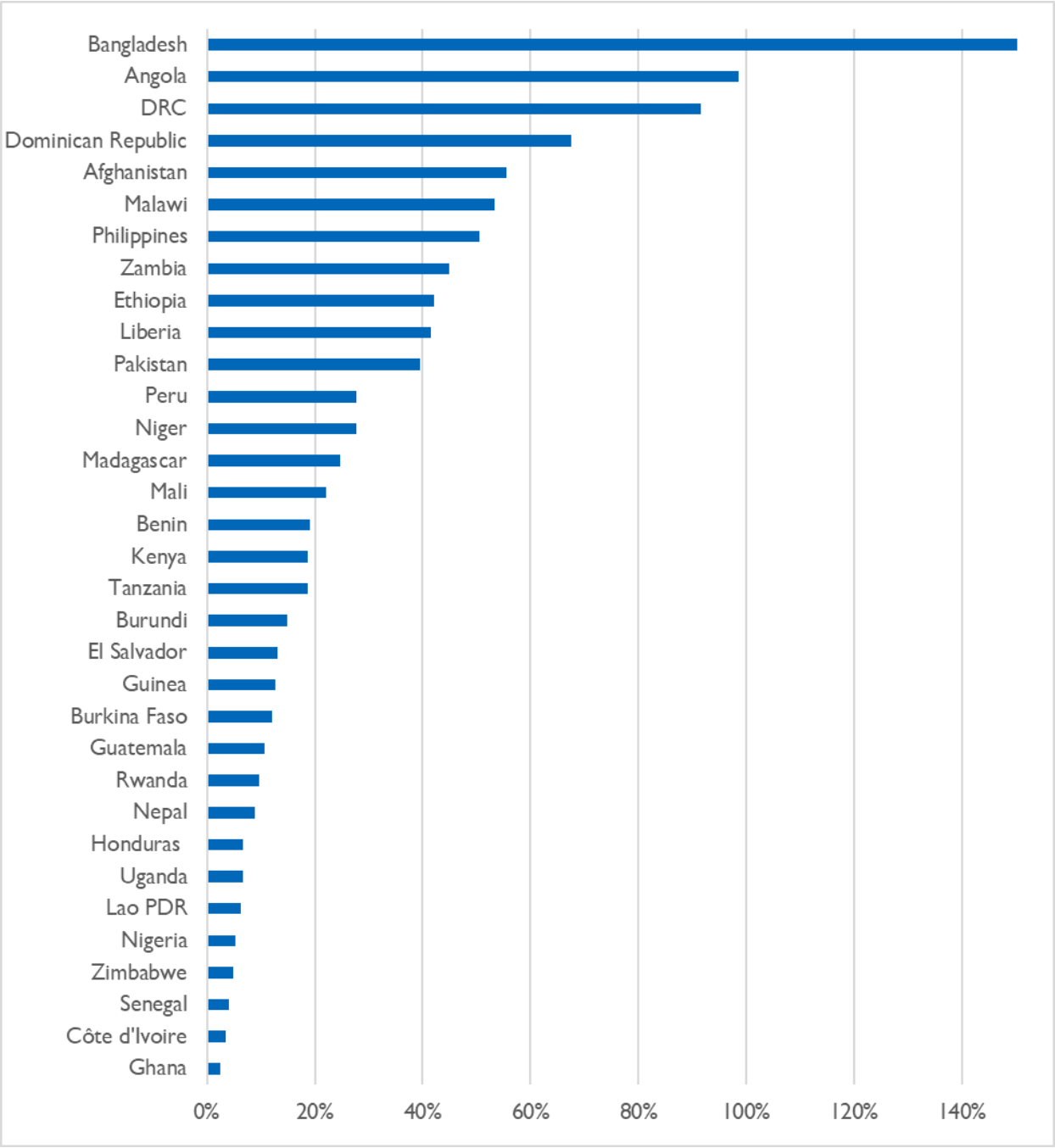


[27] Outliers not shown: Afghanistan (957 percent for levonorgestrel 75mg/rod), Bangladesh (282 percent for levonorgestrel 75mg/rod), and Pakistan (6,439 percent for etonogestrel 68mg/rod)

Copper-bearing intrauterine devices

The forecast error for IUDs (Exhibit 32) ranges from 3 percent (Ghana) to 689 percent (Haiti).

Exhibit 32. Forecast error for copper-bearing IUDs (n=37)[28]

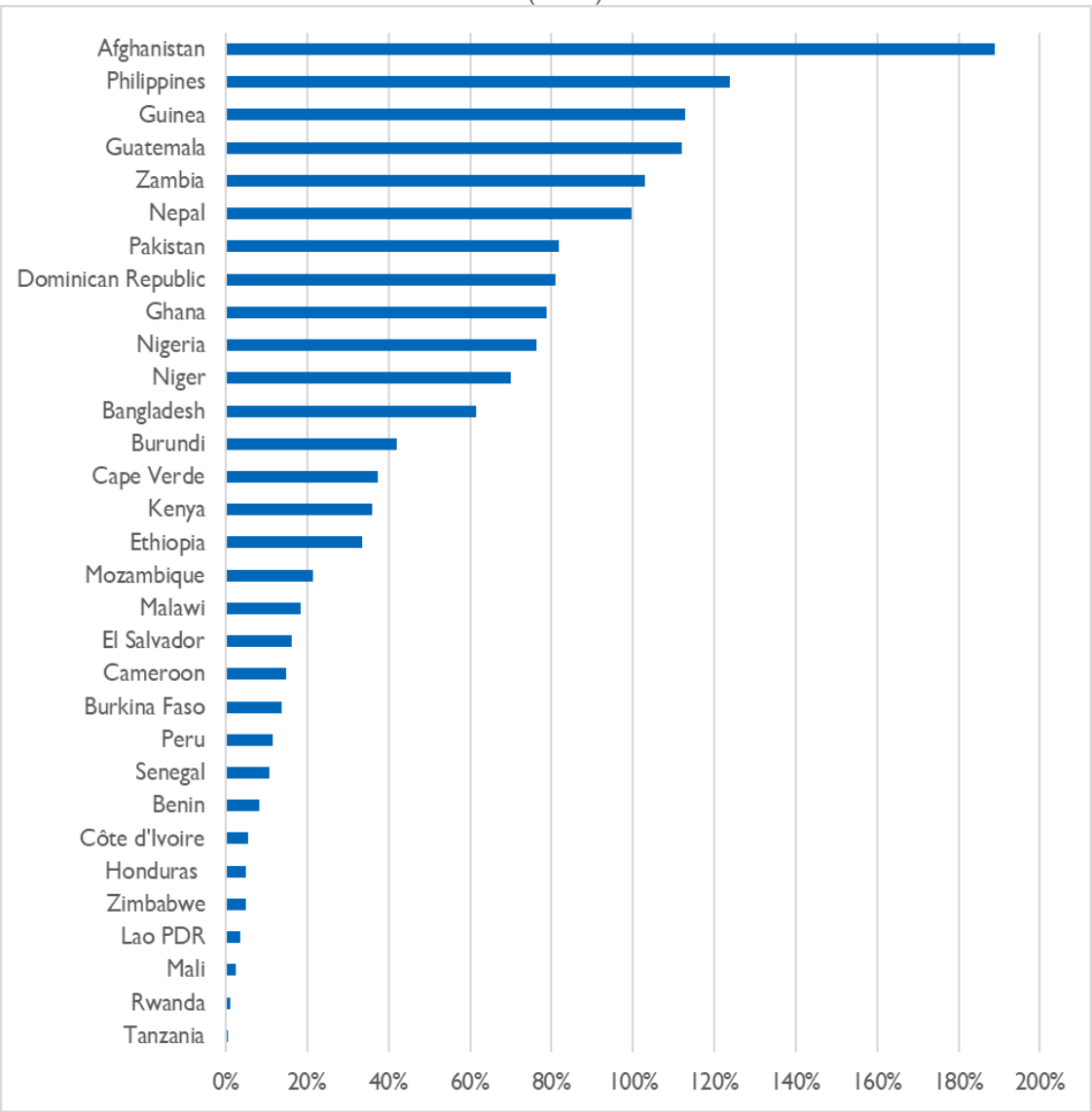


[28] Outliers not shown: Mozambique (211 percent), Togo (461 percent), Cape Verde (599 percent), and Haiti (689 percent).

Male condoms

The forecast error for male condoms (Exhibit 33) ranged from 0.5 (Tanzania) to 752 percent (Angola).

Exhibit 33. Forecast error for male condoms (n=36)[29]

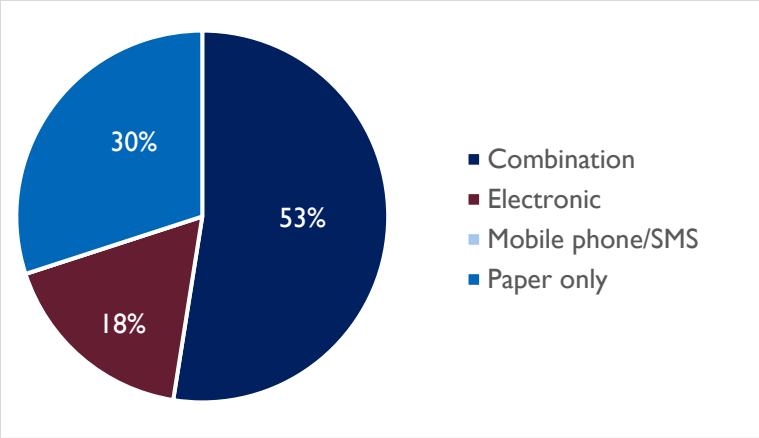


[29] Outliers not shown: Togo (206 percent), Uganda (268 percent), Haiti (288 percent), DRC (750 percent), and Angola (752 percent).

LMIS

Of 43 countries, 40 (93 percent) have an LMIS that includes contraceptives (Exhibit 34). When asked how commodity data are collected at the SDP level, 53 percent collect using a combination of either electronic, mobile phone/SMS, and/or paper, 30 percent use paper only, 18 percent collect electronically, and none uses solely mobile phone/SMS.

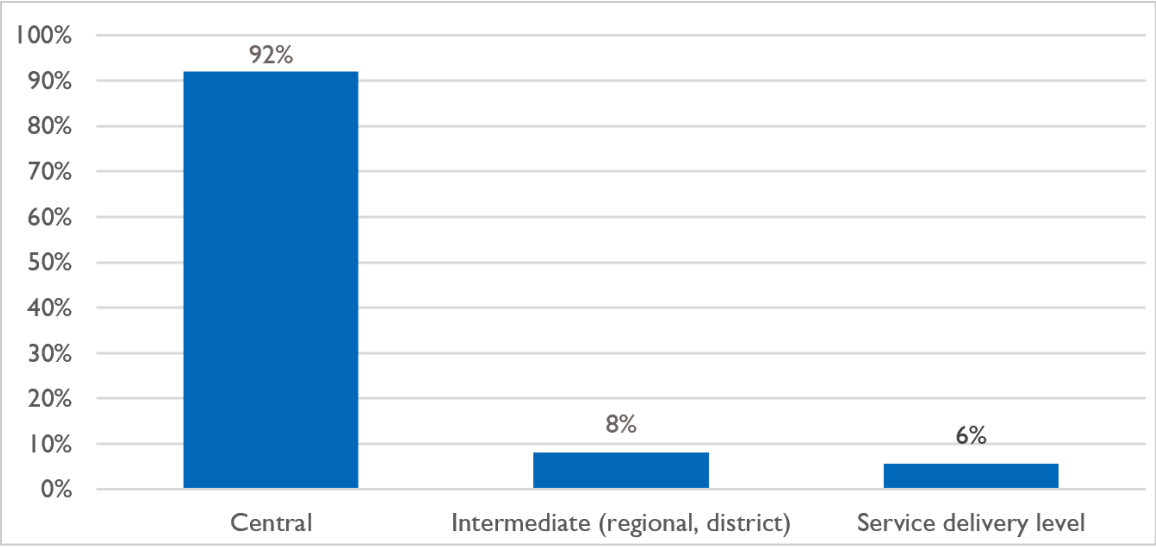
Exhibit 34. Method of data collection at the service delivery point (n=40)



Procurement

Procurement of government financed procurement takes place at the central level for 92 percent of countries (32 of 38 countries where applicable) (Exhibit 35). Only 8 percent and 6 percent responded that procurement takes place at either the intermediate (regional or district) or service delivery level, respectively. Procurement can take place in more than one location.

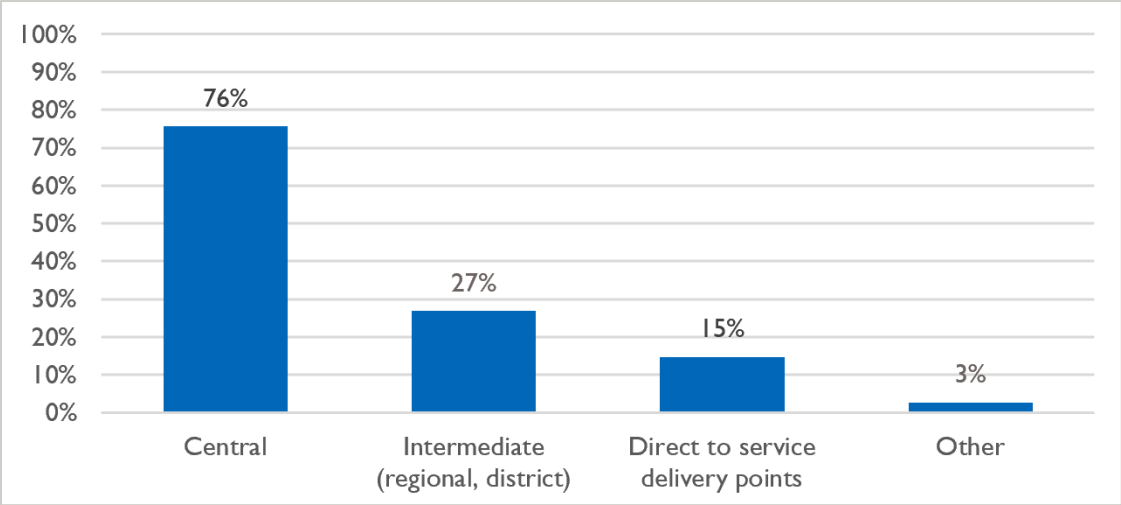
Exhibit 35. Locations of government-financed procurement (n=38)



Supplier Delivery Points

The survey asked, regardless of central or decentralized procurement, the level(s) to which the suppliers deliver commodities (for government-financed procurement only). Delivery may be to more than one level. For 76 percent of countries, the supplier delivers to the central level (31 of 41 countries) (Exhibit 36). For 27 (11 of 41) percent, the supplier also delivers to an intermediate level (regional or district), 15 percent of suppliers deliver directly to the SDP (six of 41), and 3 percent said other (one of 38). There can be more than one delivery point.

Exhibit 36. Supplier delivery points of government-procured contraceptives (n=41)



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 stock-out during the fiscal year at 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 39 countries providing information on central level stock availability, 12 (31 percent) reported zero stock-outs among all products offered within the eight methods at the central level.

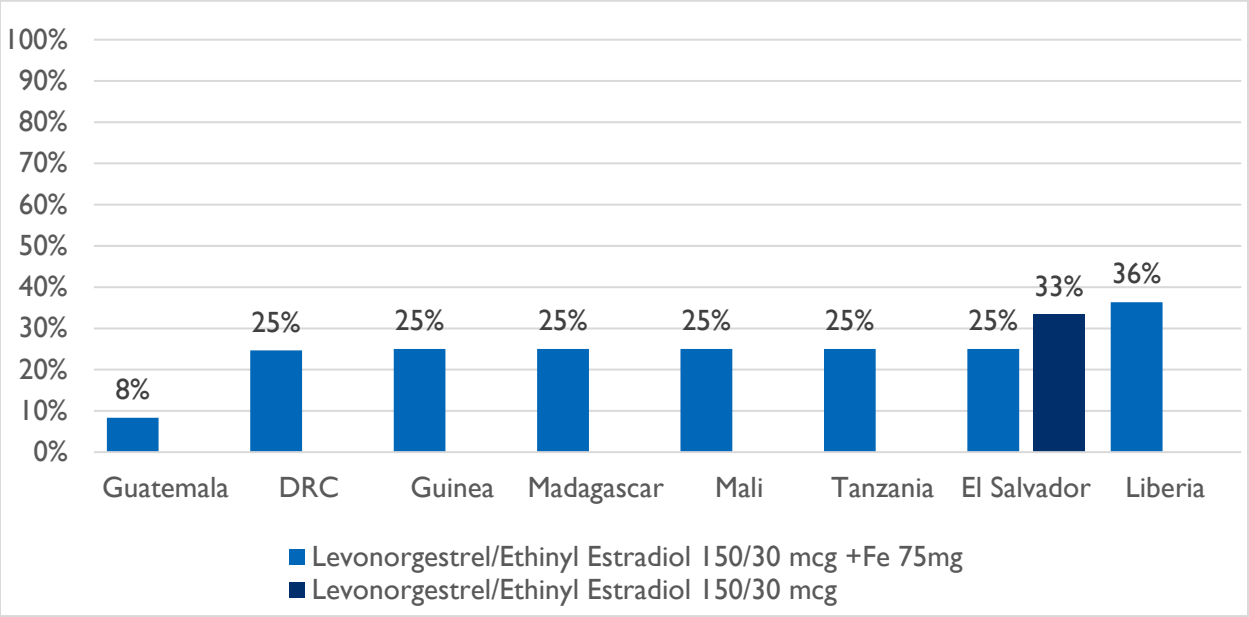
This section provides information on the average stock-out rate at the central and SDP level by contraceptive method by country.

Central-level product availability

Combined oral contraceptives

For COCs, in eight countries of 37 with data, the average stock-out rate ranged from 8 percent (Guatemala) to 36 percent (Liberia) (Exhibit 37). El Salvador had stock-outs of both formulations. For 29 countries (78 percent), there were no stock-outs of COCs (in either formulation). Six countries had no data (Afghanistan, Cameroon, India, Kyrgyz Republic, Vietnam, Zimbabwe).

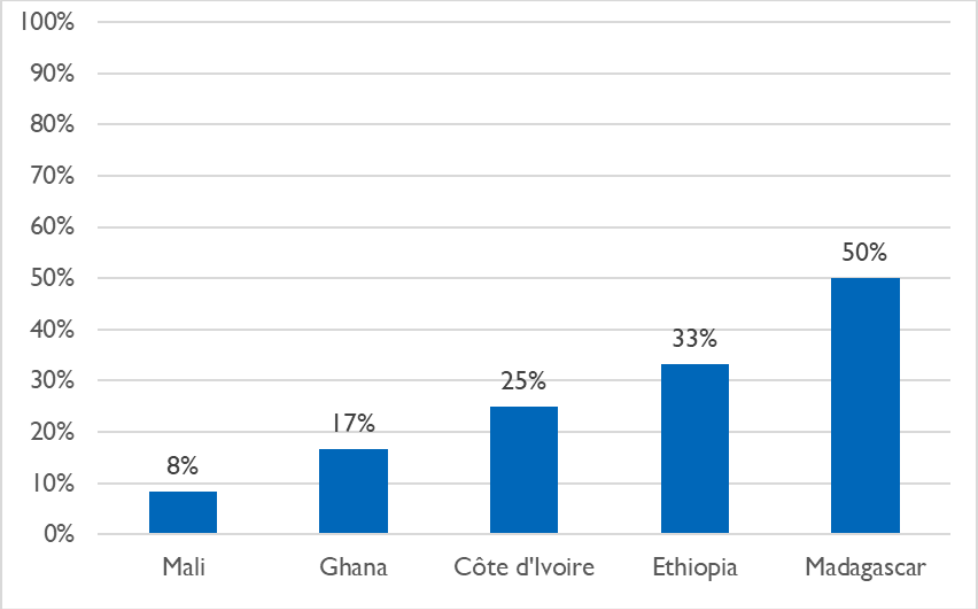
Exhibit 37. Central level stock-out rates of combined oral contraceptives, non-zero responses shown (n=37)



Progestin-only pills

Among five countries with reported average stock-out rates greater than zero, the average stock-out rate for POPs (Exhibit 38) ranged from 8 percent (Mali) to 50 percent (Madagascar). The remaining 22 reporting countries (81 percent) reported an average stock-out rate of zero percentage for POPs at the central level: Angola, Benin, Burkina Faso, Burundi, Cape Verde, Dominican Republic, DRC, Guinea, Kenya, Lao PDR, Liberia, Malawi, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Tanzania, Zambia, Zimbabwe.

Exhibit 38. Average stock-out rate for progestin-only pills (levonorgestrel 30 mcg) at the central level, non-zero responses shown (n=27)

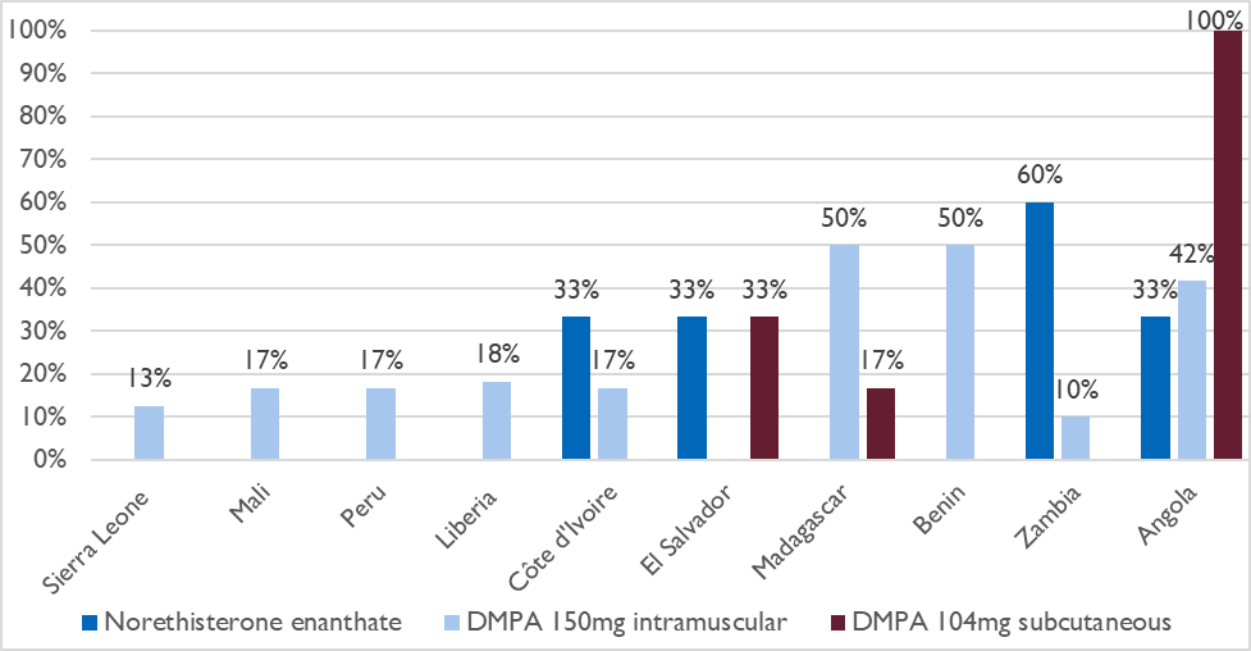


Injectable contraceptives

For injectables among the three formulations, 10 countries of 37 with data (Sierra Leona, Mali, Peru, Liberia, Côte d'Ivoire, El Salvador, Madagascar, Benin, Zambia, Angola) reported stock-outs (Exhibit 39) with the average annual stock-out rate ranging from 13 percent (Sierra Leone [DMPA 150mg intramuscular]) to 100 percent (Angola [DMPA 104mg subcutaneous]).

Côte d'Ivoire and Zambia had stock-outs of both norethisterone enanthate and DMPA 150mg intramuscular. El Salvador had stock-outs of both norethisterone enanthate and DMPA 104mg intramuscular. Madagascar had stock-outs of DMPA 150mg intramuscular and 104mg subcutaneous. Angola had stock-outs of all three formulations. A total of 27 countries (73 percent) did not have any stock-outs of injectables. Seven countries did not have data (Afghanistan, Cameroon, Honduras, India, Kyrgyz Republic, Pakistan, Vietnam).

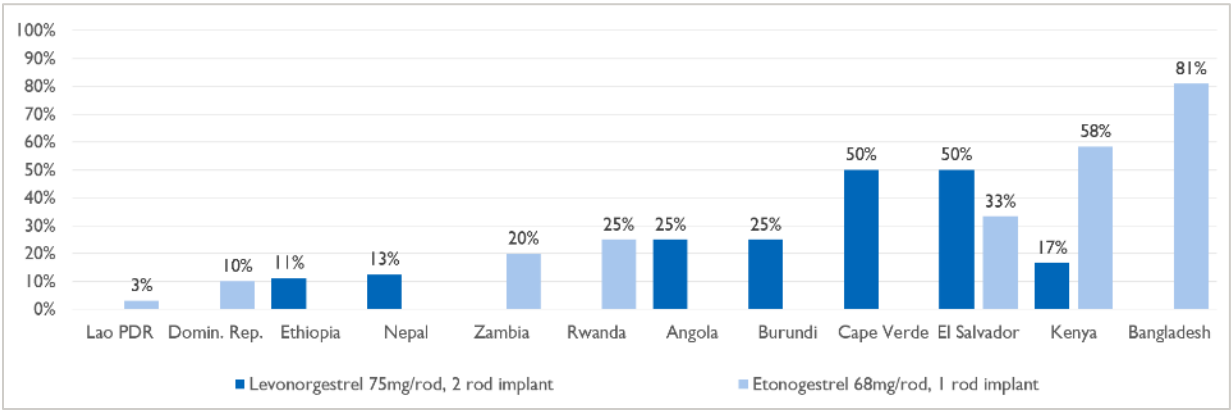
Exhibit 39. Central stock-out rates of injectable contraceptives, non-zero values shown (n=37)



Contraceptive implants

For 12 countries of 36 that had data, the average annual stock-out rate for implants (Exhibit 40) ranged from 3 percent (Lao PDR) to 81 percent (Bangladesh). Thirteen countries that offer two formulations of implants had no stock-outs of either (Benin, Burkina Faso, Côte d'Ivoire, DRC, Ghana, Malawi, Niger, Nigeria, Senegal, South Sudan, Tanzania, Togo, Zimbabwe). Twelve countries had stock-outs; of the six countries that offer both formulations, four had stock-outs of one (Bangladesh, Ethiopia, Rwanda, Zambia) and two had stock-outs of both (El Salvador and Kenya). In total, 24 countries (67 percent) did not have stock-outs of implants. Seven countries did not have data (Afghanistan, Cameroon, Honduras, India, Kyrgyz Republic, Pakistan, Vietnam).

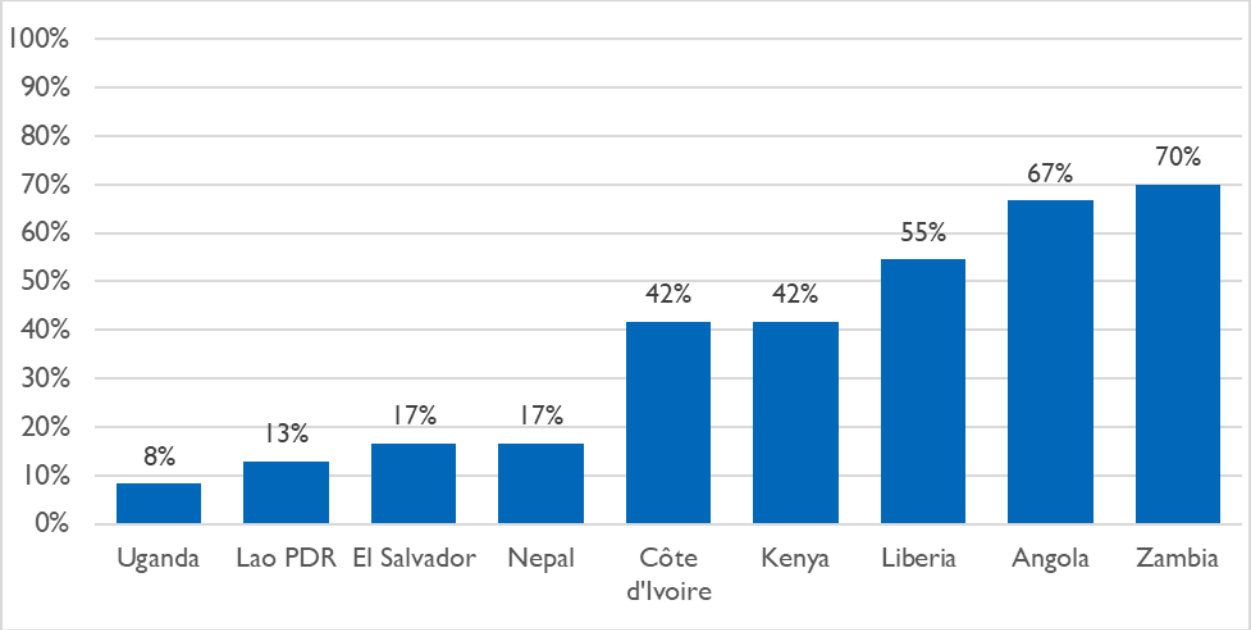
Exhibit 40. Central stock-out rates of contraceptive implants, non-zero responses shown (n=36)



Copper-bearing intrauterine devices

For nine countries of 37 that had data, the average stock-out rate for IUDs (Exhibit 41) ranged from 8 percent (Uganda) to 70 percent (Zambia). A total of 28 countries (76 percent) reported no stock-outs of IUDs. Six countries did not have data (Afghanistan, Cameroon, Honduras, India, Kyrgyz Republic, Vietnam).

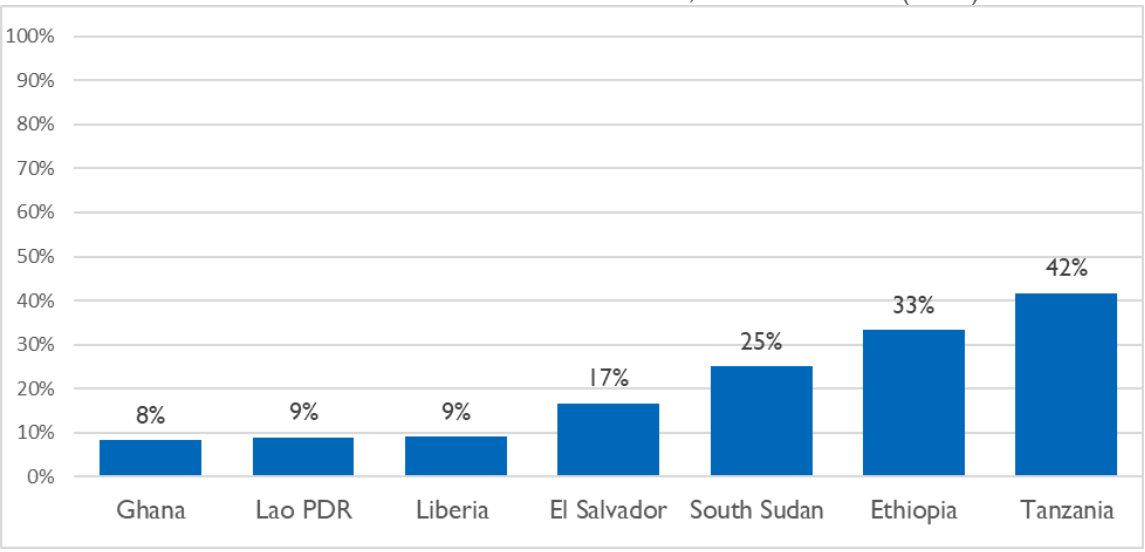
Exhibit 41. Central stock-out rates of copper-bearing intrauterine devices, non-zero values shown (n=38)



Condoms

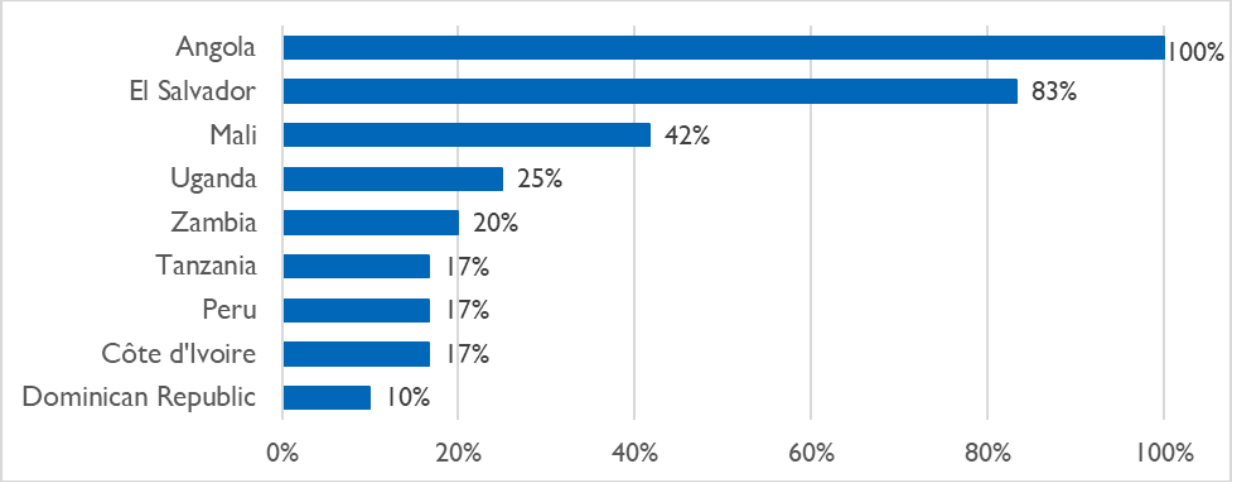
Thirty of 37 countries (81 percent) with data had zero stock-outs in the last 12-month period. The male condom stock-out rate (Exhibit 42) for the other seven countries ranged from 8 percent (Ghana) to 42 percent (Tanzania). Six countries did not have available data (Afghanistan, Cameroon, Honduras, India, Kyrgyz Republic, Vietnam).

Exhibit 42. Central-level stock-out rate for male condoms, non-zero values (n=38)



For female condoms, the average stock-out rate (Exhibit 43) ranged from 10 percent (Dominican Republic) to 100 percent (Angola). A total of 19 countries had an average stock-out rate of zero percent for female condoms: Benin, Burkina Faso, Burundi, Cape Verde, DRC, Ghana, Kenya, Liberia, Madagascar, Malawi, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Togo, and Zimbabwe.

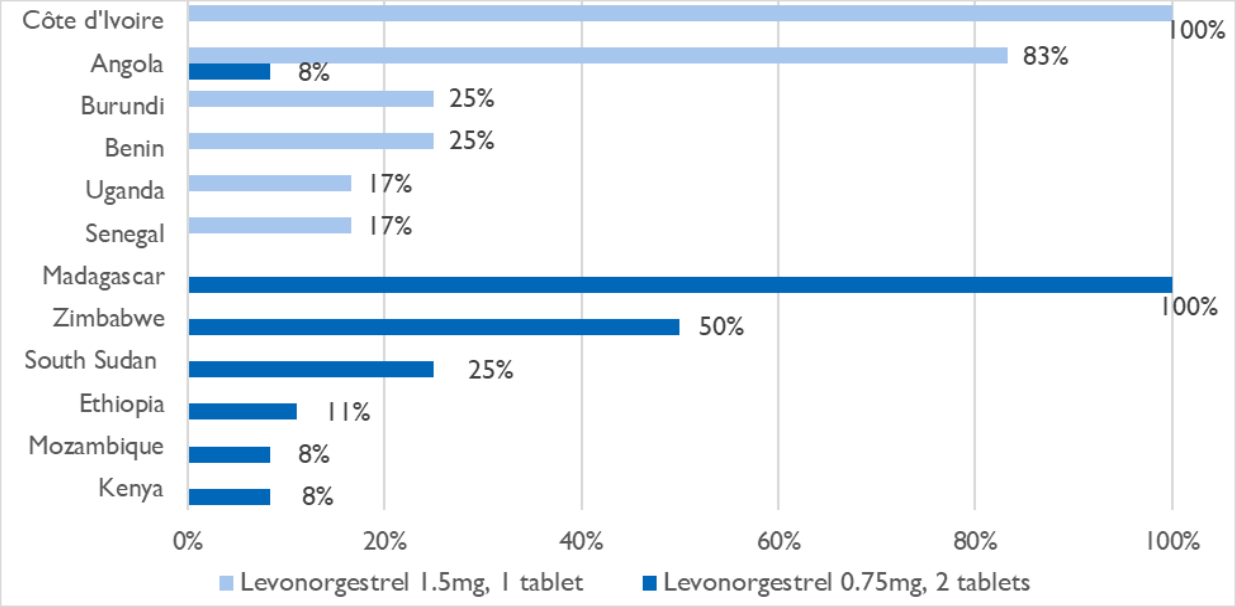
Exhibit 43. Average stock-out rate for female condoms at the central level, non-zero values shown (n=28)



Emergency contraceptives

In 12 countries of 22 reporting, the average stock-out rate for emergency contraceptives at the central level (Exhibit 44) ranged from 8 percent (Angola, Kenya, and Mozambique) to 100 percent (Côte d'Ivoire and Madagascar). Angola reported stock-outs of both products. A total of five countries had an average stock-out rate of zero percent for levonorgestrel 1.5mg, one tablet, while eight countries had an average stock-out rate of zero percent for levonorgestrel 0.75mg, two tablets.

Exhibit 44. Average stock-out rate for emergency contraceptives at the central level, non-zero values shown (n=22)



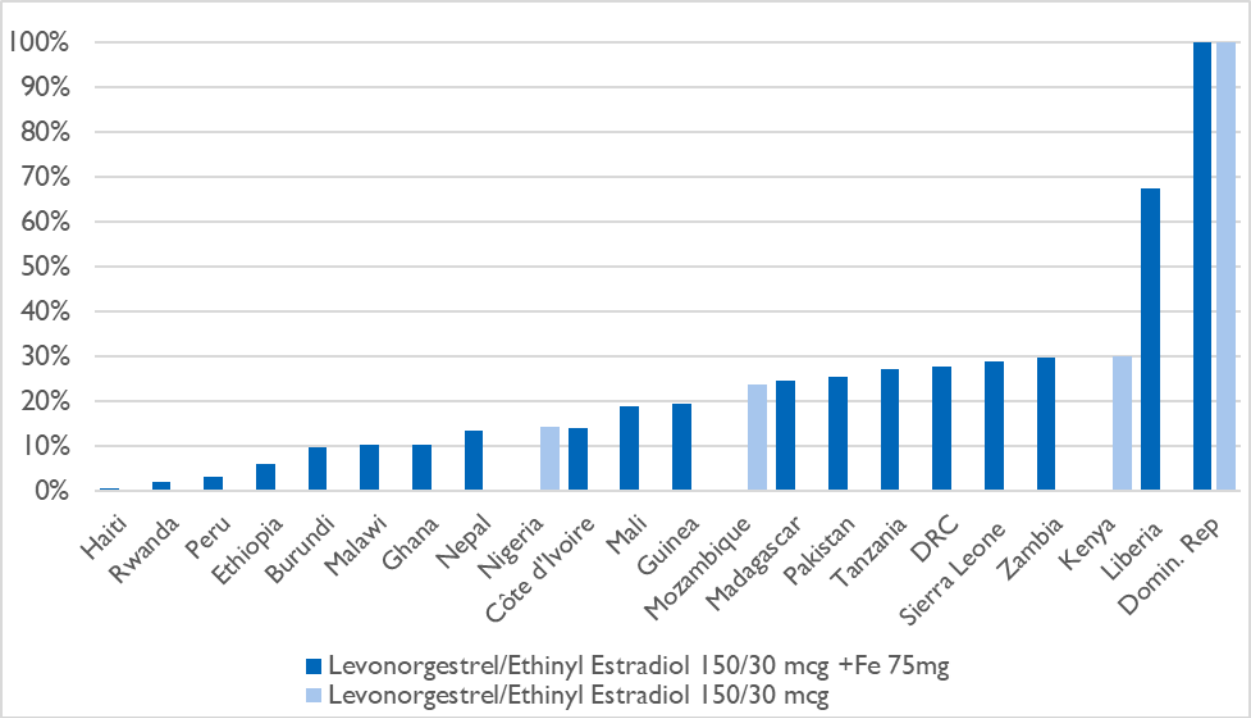
Service Delivery Point Product Availability

Countries provided stock-out data for the SDP level for the most recently completed twelve-month period, where available. This section provides average stock-out data for COCs, injectables, implants, IUDs, and male condoms. Data for female condoms, emergency contraceptives, and calendar-based awareness methods can be found in Annex A.

Combined oral contraceptives

Of 25 countries with data, four (16 percent) had zero stock-outs of COCs (Exhibit 45): Bangladesh, Cape Verde, Laos, Kenya. Stock-out rates for the other 21 countries ranged from 1 percent (Haiti) to 100 percent (Dominican Republic). Eighteen countries did not have data.

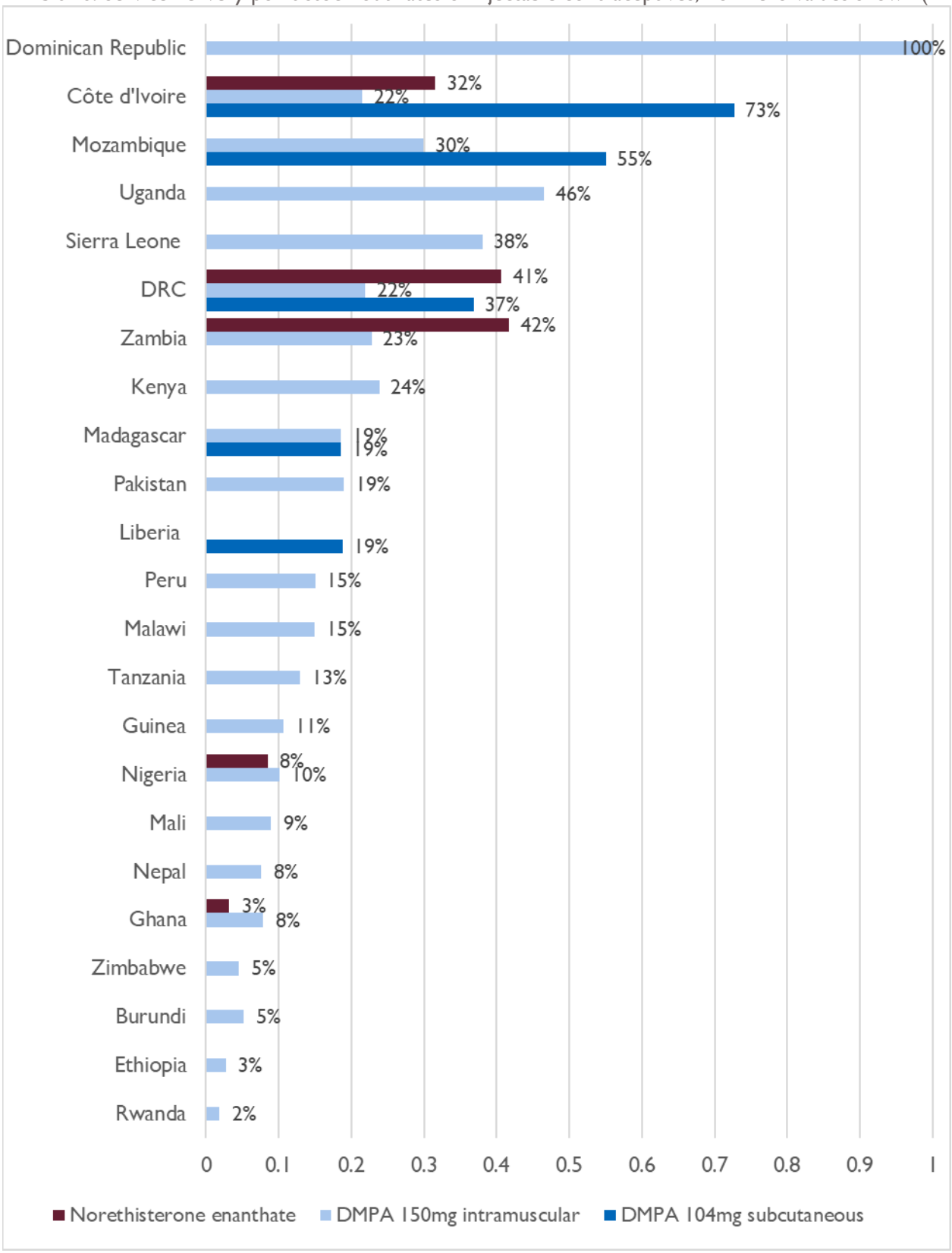
Exhibit 45. Service delivery point stock-out rates of combined oral contraceptives, non-zero values shown (n=25)



Injectable contraceptives

For 23 of the 27 countries with data, the injectable stock-out rates at the SDP level (Exhibit 46) ranged from 2 percent (Rwanda) to 100 percent (Dominican Republic). Four countries (15 percent) did not have any stock-outs (Bangladesh, Cape Verde, Haiti, and Lao PDR). All five countries that offer two formulations had stock-outs of both during the last 12 months. Kenya and Côte d'Ivoire offer three formulations. Kenya stocked out of one and Côte d'Ivoire stocked out of all three. Sixteen countries did not have data.

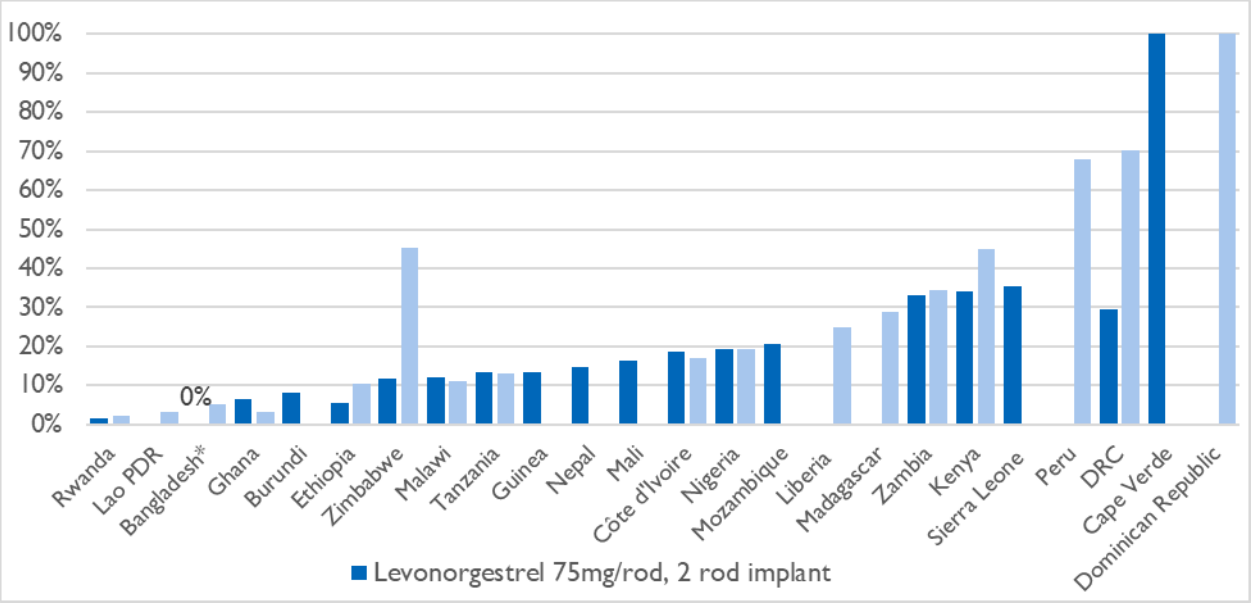
Exhibit 46. Service delivery point stock-out rates of injectable contraceptives, non-zero values shown (n=27)



Contraceptive implants

Of the 25 countries that offer implants, Haiti was the only one (4 percent) that did not have any stock-outs of implants (Exhibit 47). For the other 24 countries, the average stock-out rates ranged from 2 percent (Rwanda) to 100 percent (Dominican Republic). All but one (Bangladesh) of the 12 countries that offer two formulations stocked out of both. Eighteen countries did not have data.

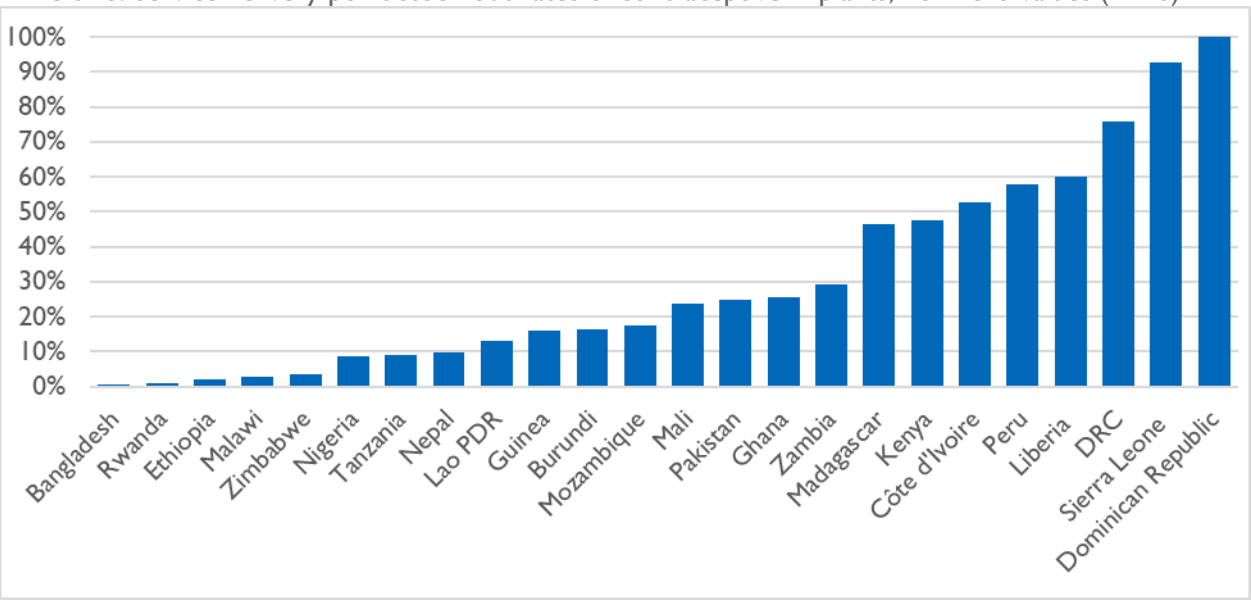
Exhibit 47. Service delivery point stock-out rates of contraceptive implants, non-zero values (n=25)



Copper-bearing intrauterine devices

For 24 out 26 countries with data, the average stock-out rate for IUDs (Exhibit 48) spanned from 1 percent (Bangladesh) to 100 percent (Dominican Republic). Cape Verde and Haiti did not have any IUD stock-outs (7 percent) at the SDP level. Seventeen countries did not have data.

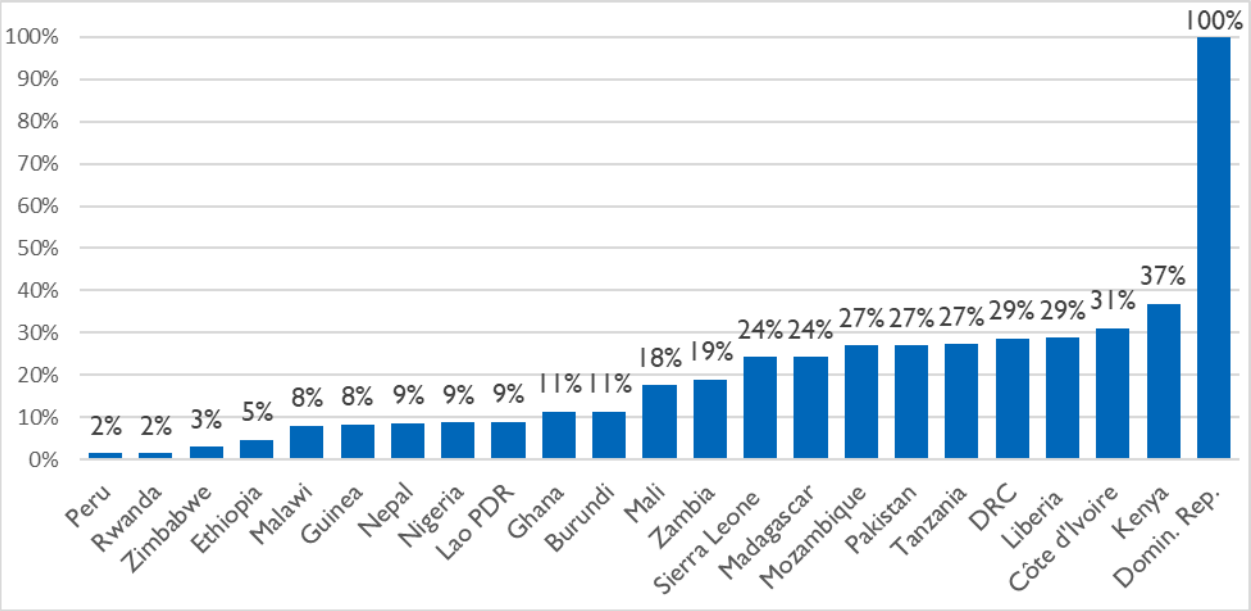
Exhibit 48. Service delivery point stock-out rates of contraceptive implants, non-zero values (n=26)



Condoms

For male condoms (Exhibit 49), average stock-out rates ranged from 2 percent (Peru) to 100 percent (Dominican Republic) among the 23 of 26 countries that had data and reported stock-outs. Three countries (12 percent) reported zero stock-outs for male condoms: Bangladesh, Cape Verde, and Haiti. Seventeen countries did not have available data.

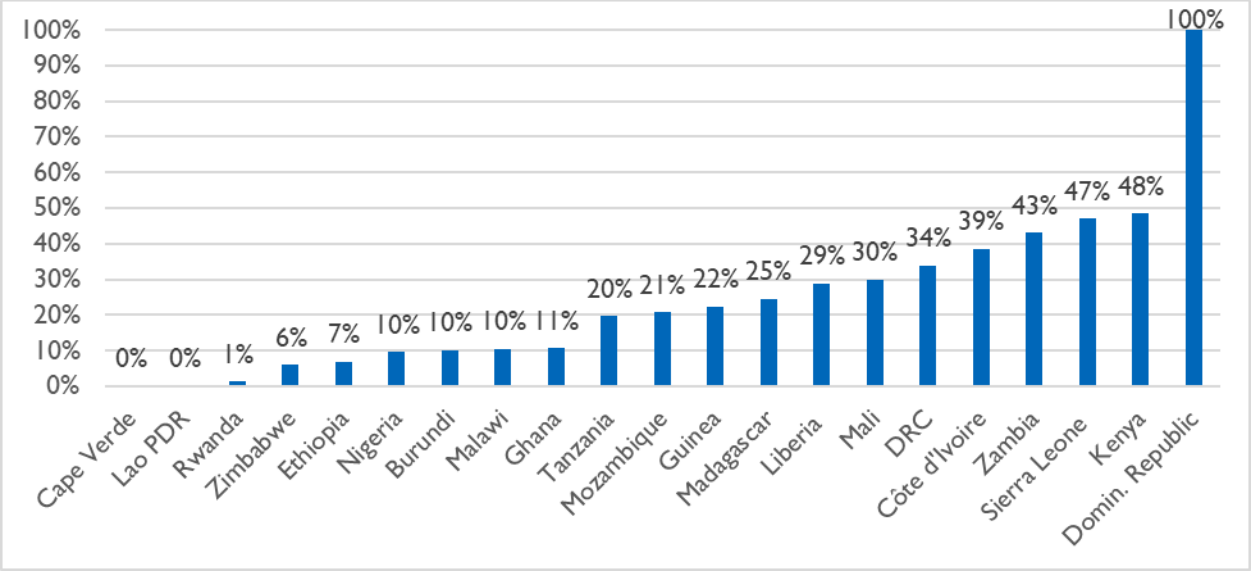
Exhibit 49. Service delivery point stock-out rates for male condoms, non-zero rates (n=27)



Progestin-only pills

For progestin-only pills (Exhibit 50), average stock-out rates ranged from zero percent (Cape Verde, Lao PDR) to 100 percent (Dominican Republic).

Exhibit 50. Average stock-out rate for progestin-only pills (levonorgestrel 30mcg) at service delivery points (n=21)



These data should be interpreted with care for several reasons:

- The duration of the stock-out is uncertain.
- A stock-out could be recurrent for a particular method.
- A stock-out at the central level does not necessarily mean a stock-out 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.

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

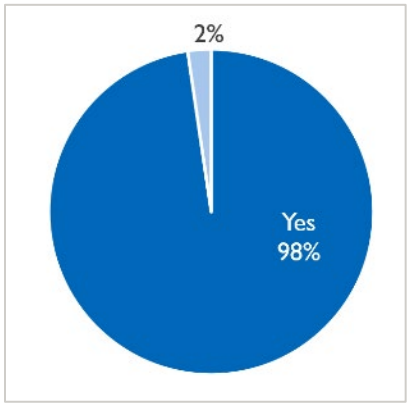
Of the countries providing information on quality:

- 98 percent (42 of 43) require registration of locally manufactured or imported contraceptives be registered by the in-country national medicines regulatory authority (NMRA)
- 95 percent (40 of 42) strictly adhere to drug registration requirements
- The average lead time for registration of contraceptives is six months to a year for 50 percent of countries (18 of 36).
- 80 percent (32 of 40) require testing of contraceptives at the NQCL.
- 19 percent (six of 31) of NQCLs are currently ISO 17025 certified/accredited and/or currently WHO-prequalified. Forty-two percent (13 of 31) of NQCLs are neither ISO 17025-certified nor WHO-prequalified.
- In 43 percent of countries (13 of 30), the NMRA conducts field surveillance monitoring to identify SF contraceptives. In half of these countries (six of 12 reporting), extensive enforcement actions are taken.

Registration Requirements

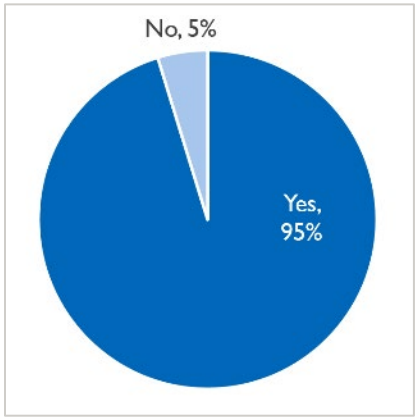
Most countries (98 percent, or 42 of 43) require registration of locally manufactured or imported contraceptives by the in-country NMRA (Exhibit 51). South Sudan is the only country that currently does not have registration requirements for contraceptives.

Exhibit 51. Percentage of countries with contraceptive registration requirements (n=43)



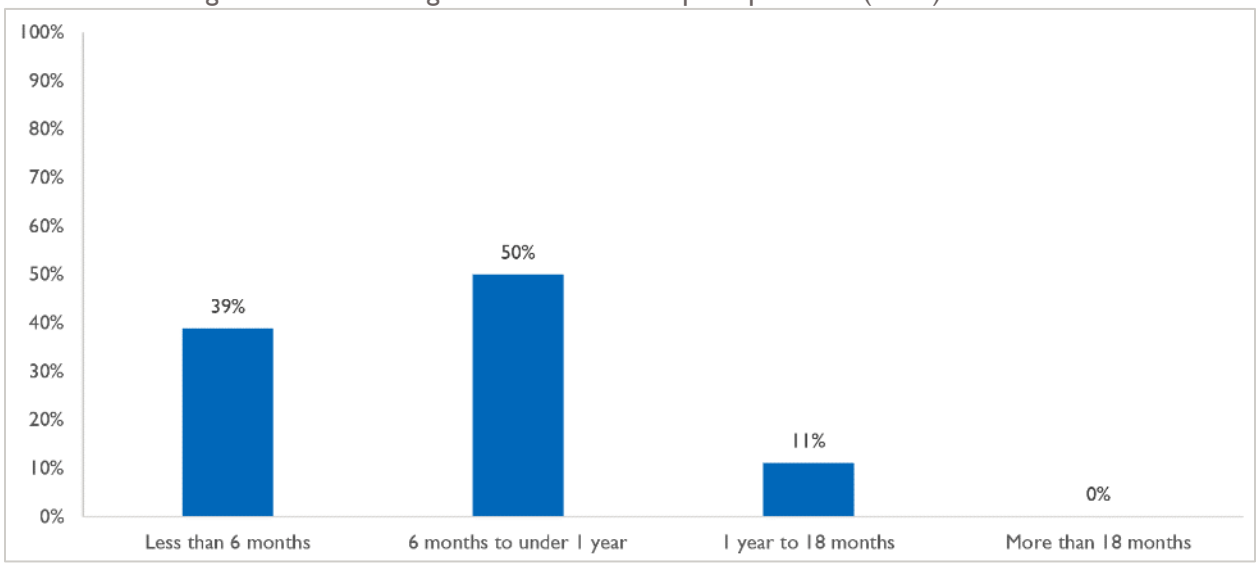
Similarly, 95 percent (40 of 42) strictly adhere to drug registration requirements (Exhibit 52). Lao PDR and Burundi do not adhere to registration requirements.

Exhibit 52. Drug registration requirements are strictly adhered to (n=42)



The average registration lead time is six months to a year for 50 percent of countries (18 of 36), while 39 percent (14 of 36) take less than six months, 11 percent take one year to 18 months, and none take more than 18 months (Exhibit 53).

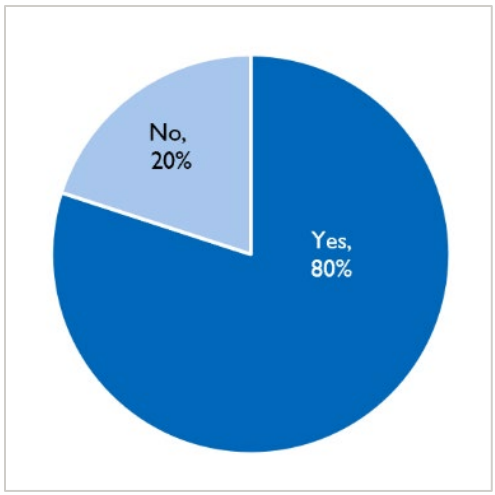
Exhibit 53. Average lead time for registration of contraceptive products (n=36)



Quality Control

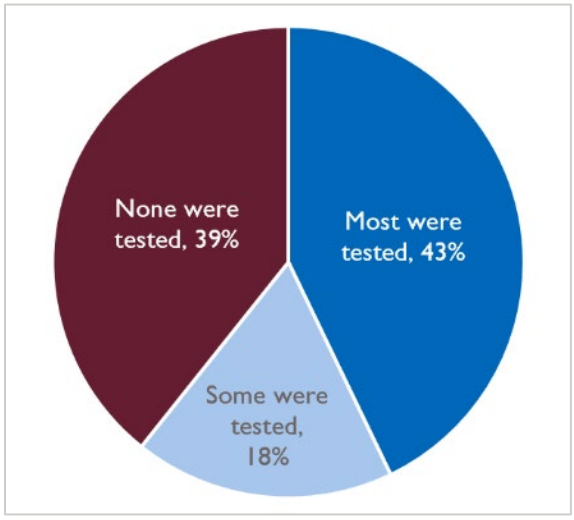
The requirement for contraceptives, whether imported or locally manufactured, to be tested by the in-country NQCL is in place for 80 percent of countries (32 of 40) (Exhibit 54).

Exhibit 54. Requirement to test contraceptives at the national quality control laboratory (n=40)



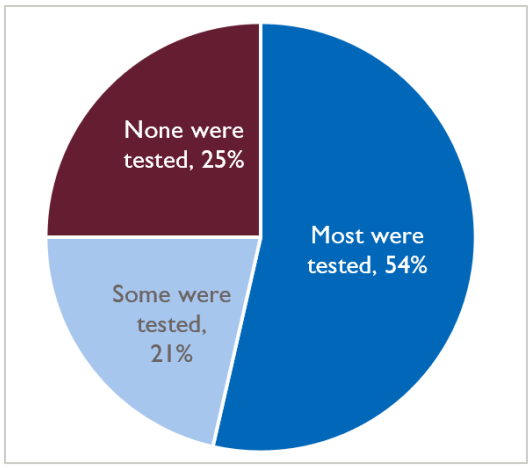
In 43 percent of the countries, most contraceptives were tested, 18 percent tested some, and 39 percent tested no contraceptives post-shipment by the NQCL (Exhibit 55).

Exhibit 55. Extent to which contraceptives, excluding condoms, were tested by the NQCL post-shipment in the past year (n=28)



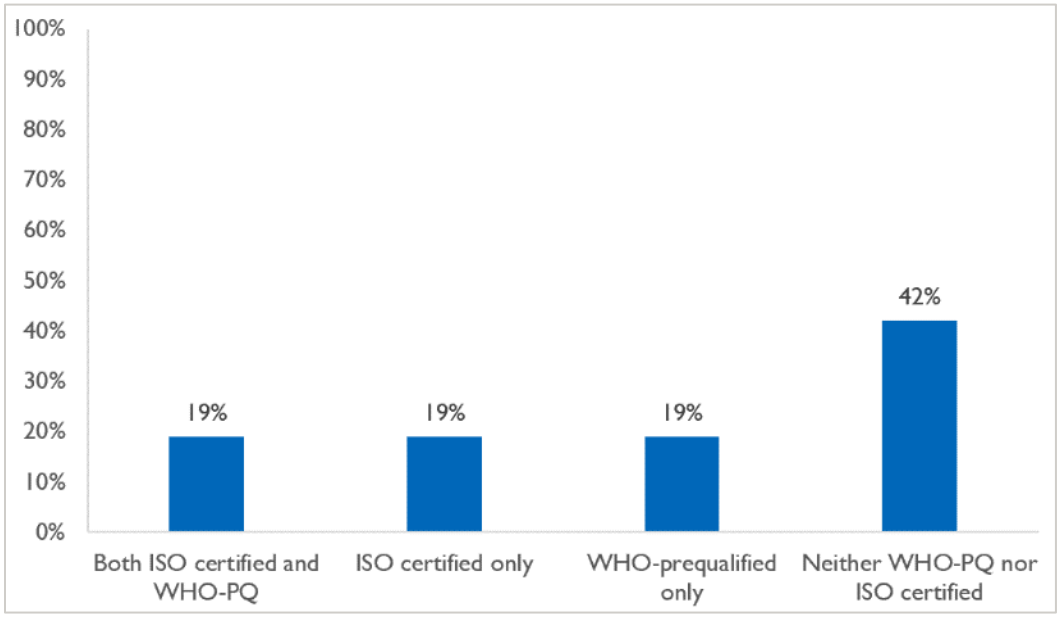
For condoms, most testing took place in over half of the countries (54 percent), while some (21 percent) were tested and none (25 percent) were tested less frequently (Exhibit 56).

Exhibit 56. Extent to which condoms were tested by the NQCL post-shipment in the past year



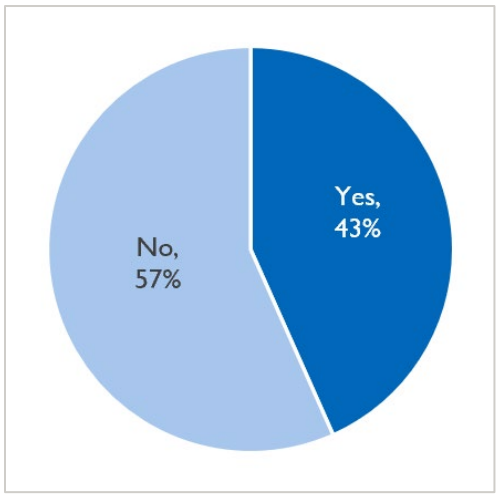
The NQCL is ISO certified and WHO-prequalified in 19 percent of the countries (six of 31) (Exhibit 57). Nineteen percent are ISO certified only, 19 percent are WHO-PQ, and 42 percent do not have either.

Exhibit 57. National quality control laboratory ISO 17025 certified/accredited and/or WHO-prequalified (n=31)



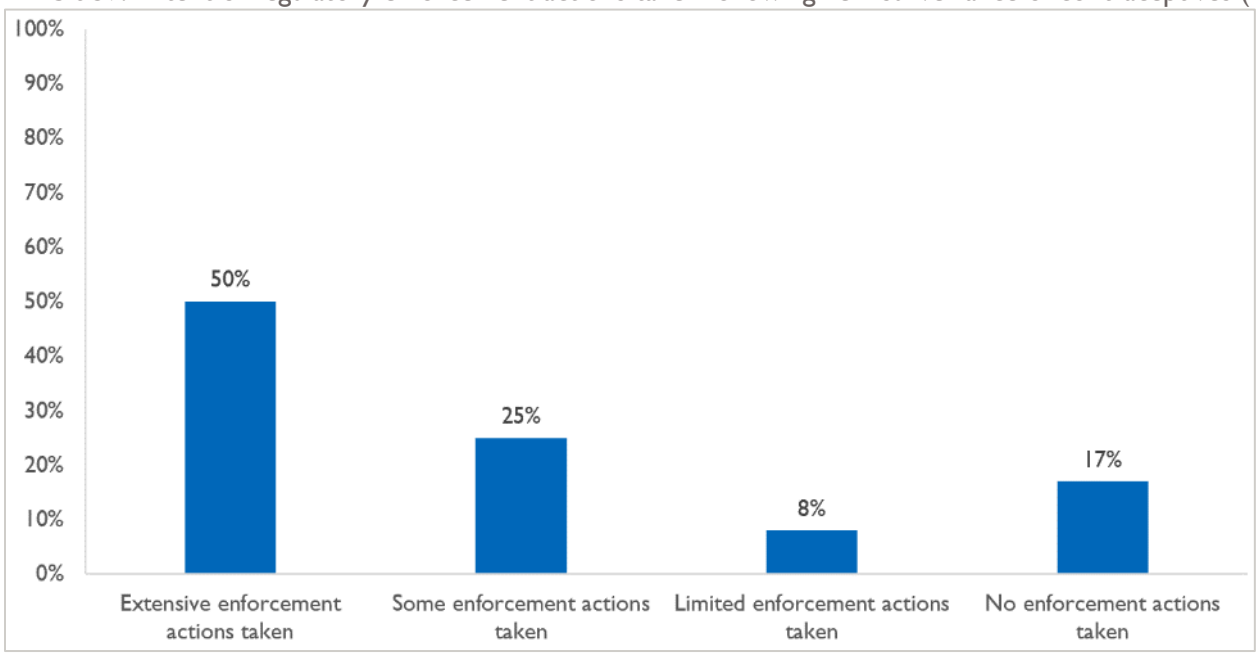
In 13 of 30 countries (43 percent), field surveillance monitoring to identify SF contraceptives is conducted by the NMRA (Exhibit 58).

Exhibit 58. NMRA conducts field surveillance monitoring to identify SF contraceptives (n=30)



In half of the countries (six of 12), extensive enforcement actions are taken. In 25 percent of the countries, some enforcement takes place, 8 percent take limited action, and 17 percent take no action (Exhibit 59).

Exhibit 59. Extent of regulatory enforcement actions taken following field surveillance of contraceptives (n=12)



Private Sector

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

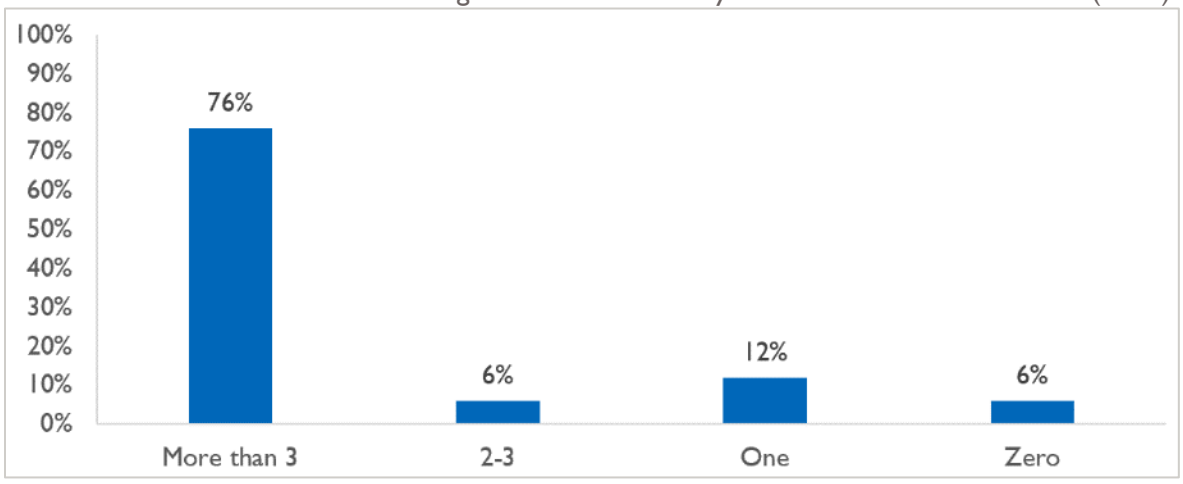
Highlights

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

- 76 percent (25 of 33) have more than three wholesalers registered in the country to distribute FP commodities
- Nearly half have WHO-PQ or SRA-approved implants, COCs, injectables, and ECs for distribution in the country.
- 53 percent (18 of 34) have established or brokered public-private partnerships in the past two years to expand private-sector FP products or services.
- By FP product, the percent of countries where there were no WHO-prequalified or SRA-approved products registered for distribution ranged from 17 percent of countries (injectables) to 46 percent of countries (female condoms).
- In 79 percent of countries (23 of 29), the government has a PSE plan in place.
- 38 percent have taken some action to implement the FP/RH PSE plan developed by the government.

Most countries (76 percent) have more than three wholesalers registered for distributing FP products in the countries (Exhibit 60). Six percent have 2–3, 12 percent have one, and 6 percent have none registered.

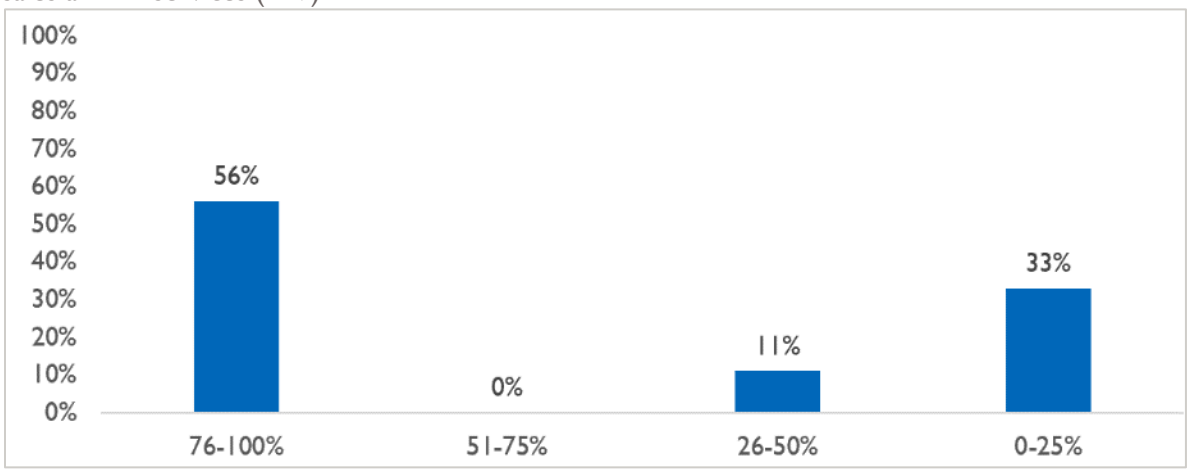
Exhibit 60. Number of wholesalers registered in the country to distribute FP commodities (n=33)



Countries where 76–100 percent of the wholesalers in the country report to the government on their FP commodity sales and FP services is 56 percent (Exhibit 61). Eleven percent responded 26–50 percent

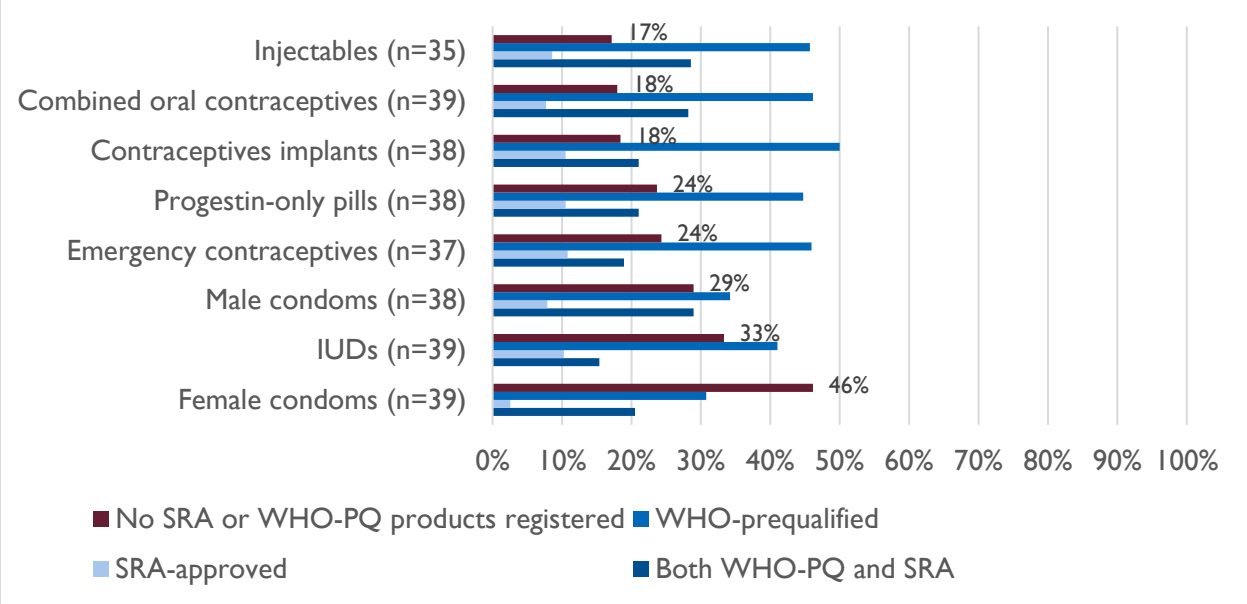
of the wholesalers report to the government and 33 percent report 0–25 percent report this information. Forty-one percent of countries require wholesalers to report sales and services data to the government.

Exhibit 61. Approximate proportion of wholesalers reporting to the government on their FP commodity sales and FP services (n=9)



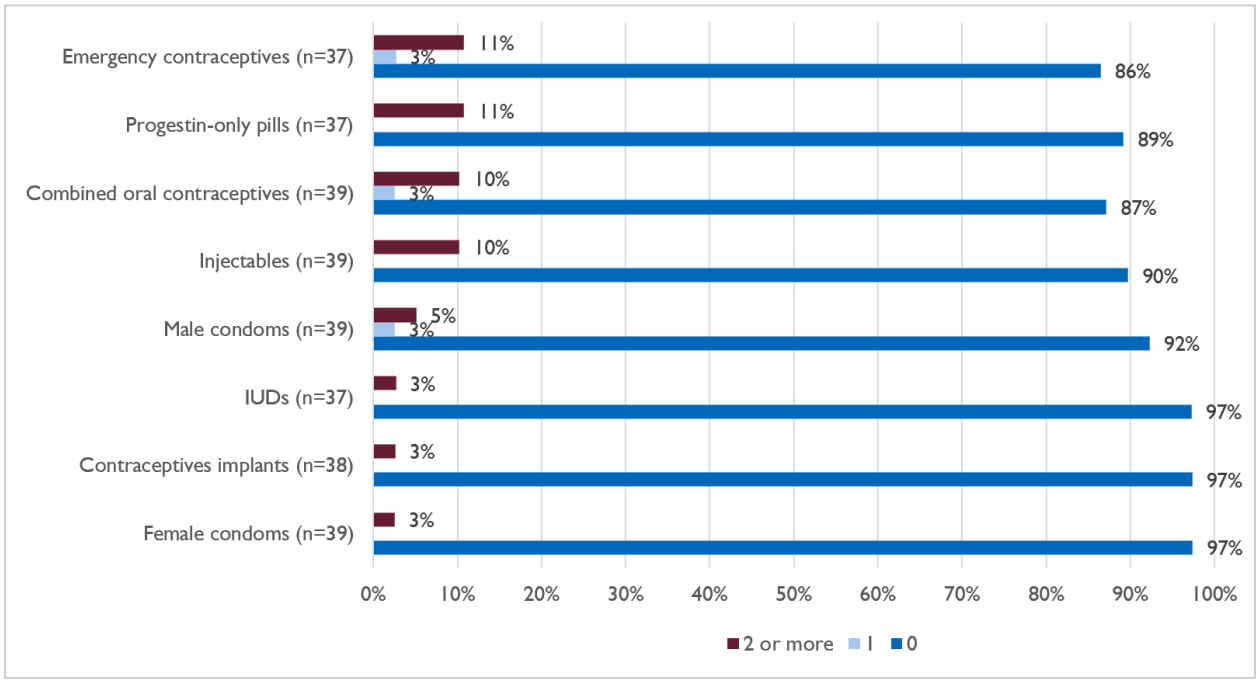
Countries were asked about WHO-PQ and SRA on the following eight methods: COCs, POPs, injectables, implants, IUDs, male and female condoms, and ECs. A range of 45–50 percent have WHO-PQ implants, injectables, COCs, POPs, ECs and IUDs for distribution in the country (Exhibit 62). UNFPA-PQ male and female condoms is 34 and 31 percent, respectively. The range is 15–29 percent that have WHO-PQ and SRA for all eight methods. Those with only SRA range from 3 to 11 percent among the eight methods. Those with neither WHO-PQ or SRA range from 24–46 percent among the eight methods.

Exhibit 62. Any WHO-PQ/UNFPA-PQ and/or stringent regulatory authority (SRA)-approved products registered for distribution in the country



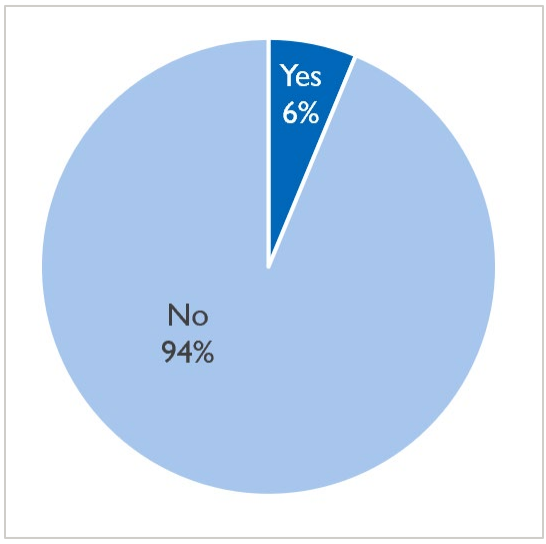
Countries were asked, for each of the following FP methods, how many in-country local manufacturers exist (0, 1, or 2 or more): COCs, POPs, injectables, implants, IUDs, male and female condoms, and ECs. A range of 0–11 percent of countries reported the existence of two or more manufactures for any of the methods and a range of 0–3 percent of countries reported the existence of one manufacturer. Meanwhile, 86 to 97 percent of countries reported for each method that there were no in-country local manufacturers (Exhibit 63).

Exhibit 63. Number of in-country local manufacturers that produce the FP method



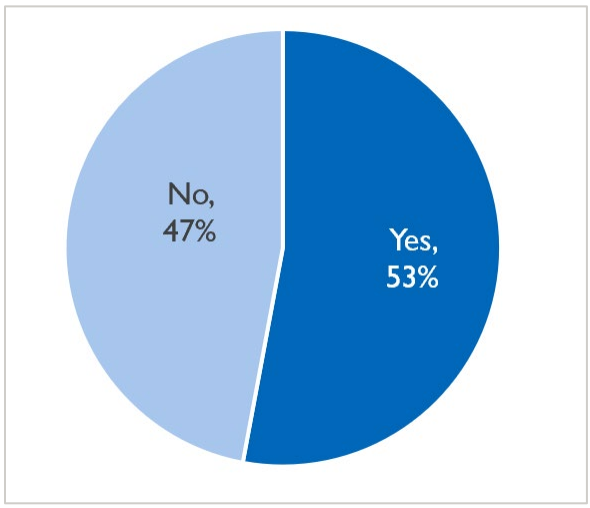
Only 2 percent of countries (two of 32) have joint ventures between multinational pharmaceutical companies and local manufactures, Vietnam and Zambia (Exhibit 64).

Exhibit 64. Joint ventures between multinational pharmaceutical companies and local contraceptive manufacturers (n=32)



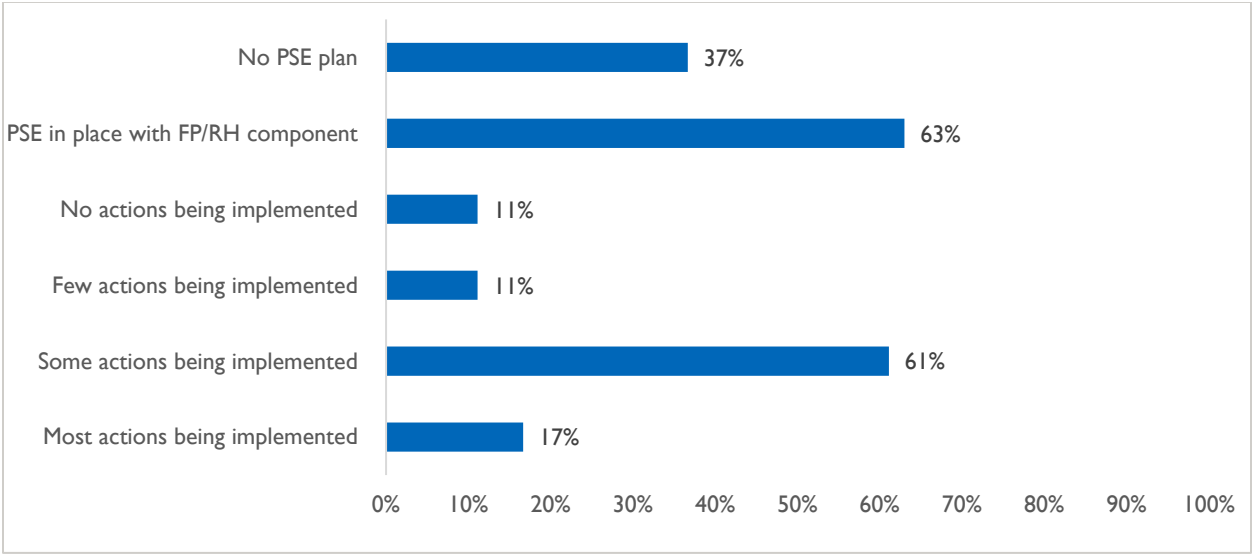
The percent of countries that have established public-private partnerships (PPPs) within the last two years to expand private-sector FP products is 53 percent (18 of 34). In 2017, this was 47 percent (16 of 34) (Exhibit 65).

Exhibit 65. PPPs established/brokered in past two years to expand private sector FP products/services (n=34)



Sixty-three percent of countries (19 of 30) reported having a government PSE plan with an FP/RH component. For those countries with a PSE plan, 61 percent (11 countries) have implemented some actions, most actions are being implemented in 17 percent (three countries), few actions are being taken in 11 percent (two countries), no action is being taken in 11 percent (two countries) and 37 percent (11 of 30 countries that responded) do not have a PSE in place, or the PSE does not have a FP/RH component. One country, India, reported having a PSE with an FP/RH component, but did not know to what extent actions had been implemented (Exhibit 66).

Exhibit 66. FP/RH PSE plan developed by government and extent of implementation (n=30)



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 2019, CS indicators show steady progress in several indicators and others that need continued investment and attention.

Leadership and Coordination

- CS committees are widespread and largely active (80 percent meet two or more times; 51 percent meet the recommended four or more times).
- While 80 percent of CS committees have developed policies, procedures, or action plans, 88 percent of those countries noted these are taking place or being implemented.
- The commercial sector is still participating in only under a third of CS committees, despite the increasing popularity of the "Total Market Approach" in the donor community.

Financing

- Governments are chiefly responsible for conducting procurement.
- Donors typically finance procurement. This is nearly unchanged from 2017, when the survey reported that 41 percent of financing came from government sources and 59 from in-kind donations.

Policies

- Of all 43 countries surveyed, 95 percent offer all five of the most commonly offered methods in public-sector facilities (male condoms, COCs, injectables, IUDs, and implants). In 2017, this was 86 percent.
- Fewer countries have policies that hinder the ability of the private sector to distribute contraceptives. These have been steadily declining since 2010.
- Culture is slowly shifting in favor of greater acceptance of contraceptive use; however, there are still significant barriers for unmarried youth, and also societal pressure for women to have children soon after marriage.
- Nearly 30 percent of the countries have policies that limit access to FP for those between 15 and 19 years of age and/or those who are unmarried.
- More countries are enacting policies that establish FP/RH as a human right for all.
- In most countries, clients must go to a nurse (34 percent) or doctor (29 percent) to access implants, similar to 2017 findings.
- In most countries, an estimation was made that fewer than half of FP providers have been trained in implant and IUD insertion and removal.
- Promotion of family planning is widespread: 95 percent of countries (41 of 43) use community mobilization/engagement to promote family planning; 42 percent (18) say they use this approach "extensively." Ninety-one percent of countries (39) reported using social marketing, mass

media, and/or mobile outreach/education either somewhat or extensively to promote family planning.

- Although 92 percent of surveyed countries with FP2020 commitments (35 of 38) have committed to increase domestic financing for contraceptives, the proportion of government spending to total spending on FP commodities has not changed since 2017. In Asia, government share of spending is increasing; however, in LAC it appears to be decreasing. Ten of the 23 surveyed countries that are receiving GFF financing reported that their financing includes technical assistance for transition to domestic financing of contraceptives.

Supply Chain

- Most countries (93 percent) have an LMIS that includes contraceptives. A little over half collect SDP-level commodity data using a combination of either electronic, mobile phone/SMS, or paper.
- A third (31 percent) of reporting countries had zero stock-outs among the eight methods at the central level.

Quality

- Most countries (98 percent) require the registration of locally manufactured or imported contraceptives by the in-country NMRA.
- However, in less than half of the countries (43 percent), the NMRA conducts field surveillance monitoring to identify SSFFC contraceptives. Of the 12 countries that conduct field surveillance and reported on the extent of enforcement actions taken, six (50 percent) reported that they take extensive actions, while three (63 percent) report that they take limited or no actions.
- Over a third of the National Quality Control Laboratories in the 31 countries that reported (42 percent, 13 of 31) are neither ISO 17025-certified nor WHO-prequalified.

Private Sector

- 53 percent (18 of 34) have established or brokered public-private partnerships in the past two years to expand private-sector FP products or services.
- 63 percent of countries (19 of 30) have a PSE plan in place with an FP/RH component. Eighty-four percent of those countries with a PSE (16 countries) have taken some action to implement the plan.

References

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

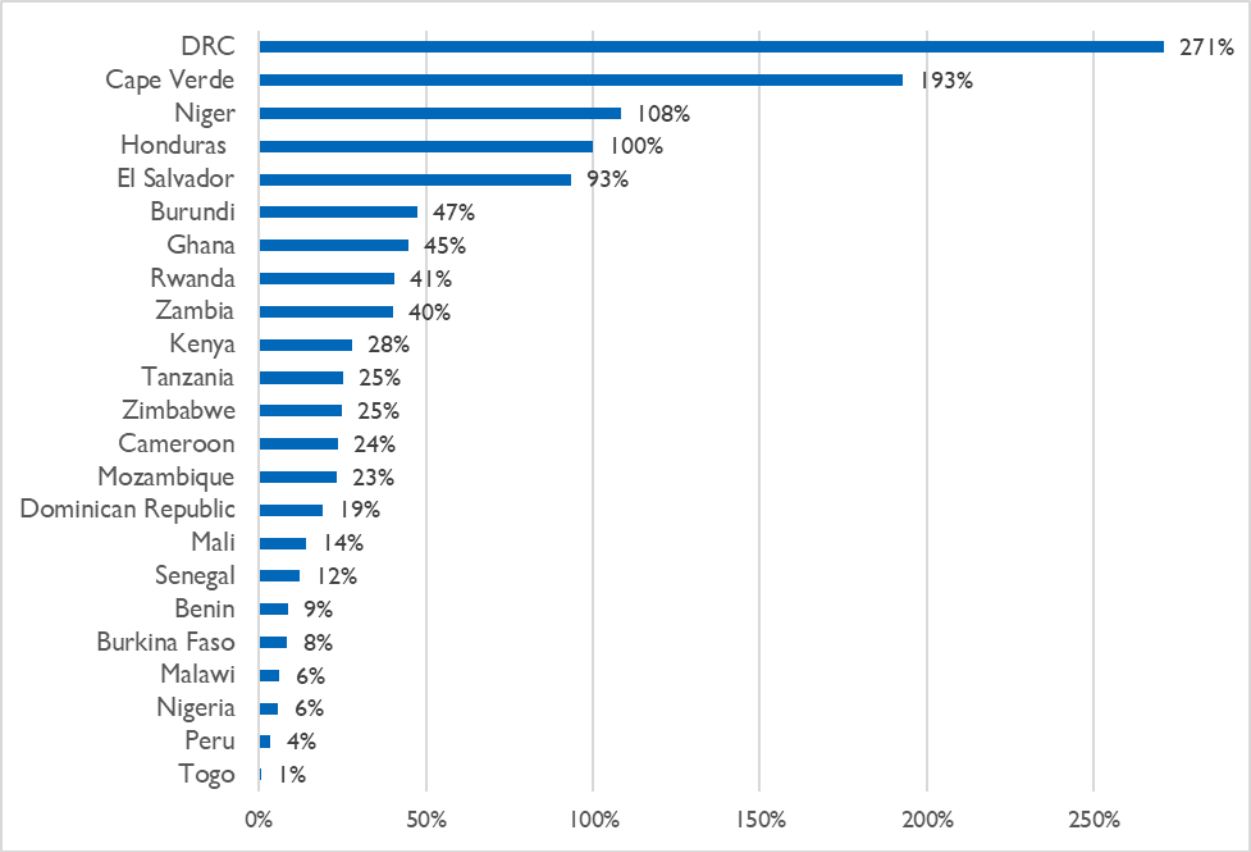
USAID Global Health Supply Chain Program-Procurement and Supply Management Single Award IDIQ. 2017. Contraceptive Security Indicators Data Collection and Usage Manual. Washington, D.C.: Chemonics International Inc.

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

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

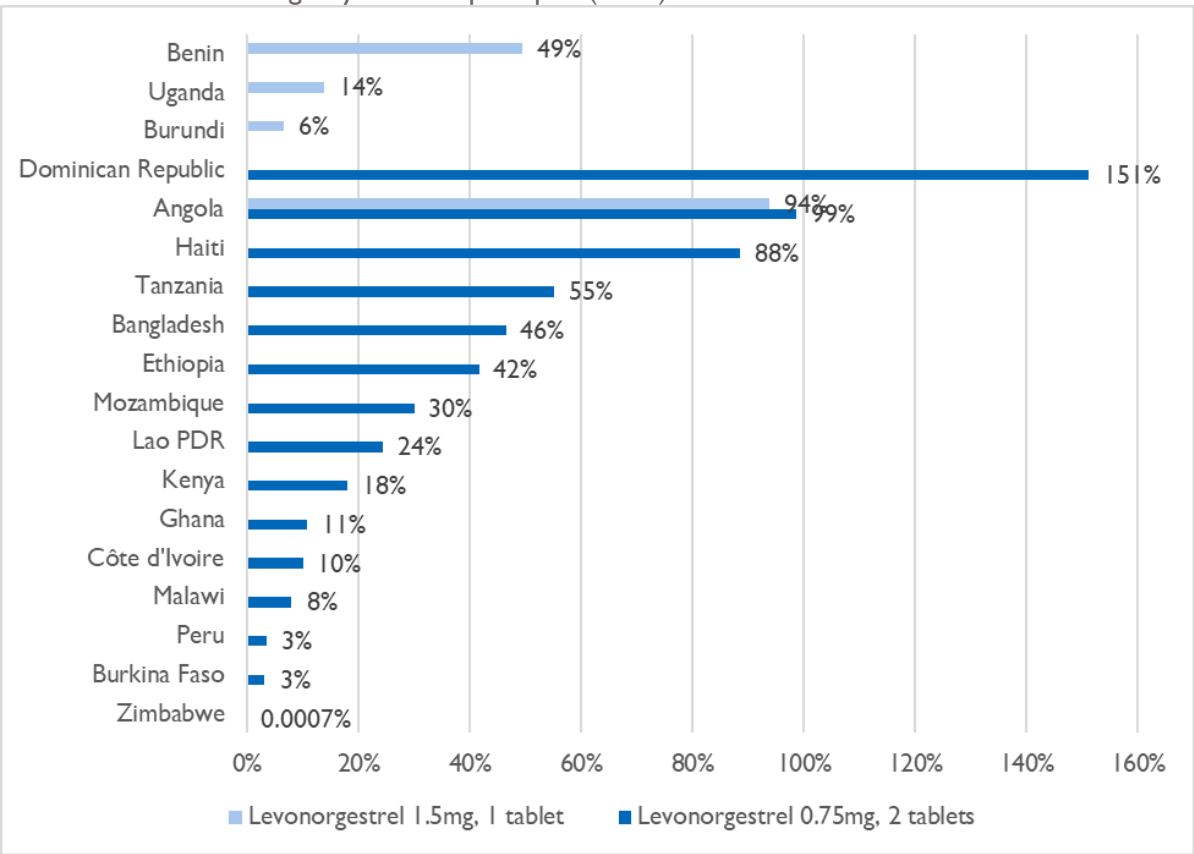
Annex A. Additional Supply Chain Data

Forecast error for female condoms (n=26)[30]

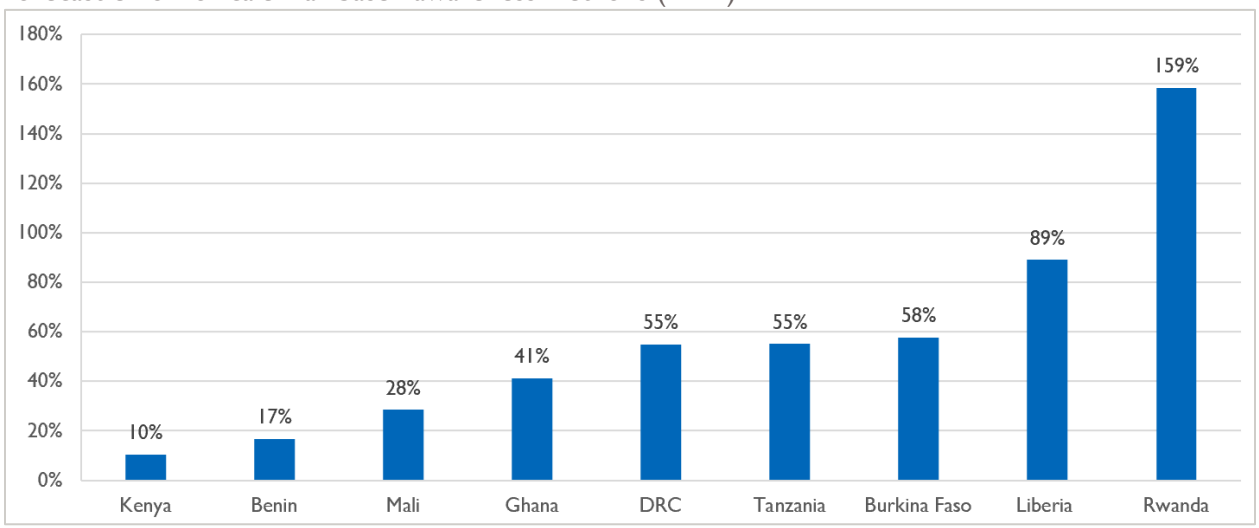


[30] Outliers not shown: Angola (622 percent), Uganda (840 percent), and Côte d'Ivoire (2,480 percent)

Forecast error for emergency contraceptive pills (n=21)[31]



Forecast error for calendar-based awareness methods (n=11)[32]



[31] Outliers not shown: Pakistan (447 percent) for levonorgestrel 0.75mg, two tablets and Togo (746 percent) and DRC (2,651 percent) for levonorgestrel 1.5mg, one tablet

[32] Outliers not shown for Togo (283 percent) and Nigeria (610 percent)

Annex B. Contraceptive Security Indicators Survey Questionnaire

USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM

PROCUREMENT AND SUPPLY MANAGEMENT

Contraceptive Security (CS) Indicators Survey, 2019

Country: (Select from dropdown menu)

Respondent's name (survey point person):
Job title:
Organization:
E-mail:
Telephone:

The CS Indicators are presented in the following sections:

A. Leadership & Coordination B. Finance & Procurement C. Commodities D. Policies E. Supply chain F. Quality G. Private Sector

Instructions:

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

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

A. Leadership and Coordination					
A1.	Is there a national committee that works on contraceptive security? 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,			Comments:	
a.	What is the name of the committee?				
A2.	Are the following organizations represented on the committee?	(Y/N dropdown)			
a.	Social marketing, (*for example: PSI, DKT, SFH, etc.)*		If yes, specify name(s) of organizations:		
b.	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: partners)*		If yes, specify:		
A3.	Does the committee have formal legal or administrative status?				
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, and/or action plans in the last year?				
a.	If yes, is there evidence of adherence to its policies and procedures, implementing its action plans, and/or following up on and addressing issues raised at previous meetings?				

B. Finance and Procurement

B1.	What is the timeline of the country government's fiscal year?	Beginning month		Ending month		Comments
B2.	What was the forecasted (estimated) dollar value of contraceptives needed to be procured for the public sector* for the most recent complete fiscal year? (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.					
B3.	One-year time period covered by the forecast/quantification amount noted in B2	Beginning month		Ending month		
		Beginning year		Ending year		
a.	Who conducted the forecast/quantification? (Specify organizations.)					
b.	Frequency of forecast update					

c. Forecast accuracy for the most recent complete fiscal year (using fiscal year stated above in B3).
For each of the following products offered by the public sector in the country where public sector forecast and consumption data are available, please enter the actual quantity consumed (in units) in column J, and the forecasted consumption (in units) for the most recently completed fiscal year in column K. The forecast accuracy will automatically calculate in column LMN. For products not offered in the country or for which data are not available, enter 'N/A' in columns J and K.

(Formula: |(Actual quantity consumed) - (Forecasted consumption)/ Actual quantity consumed |)			Actual quantity consumed	Forecasted consumption	Forecast Accuracy (Mean absolute percent consumption forecast error)
i. Combined oral contraceptive pills					
Levonorgestrel/Ethinyl Estradiol 150/30 mcg +Fe 75mg [Microgynon]					#DIV/0!
Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Seasonale, Levora, Jolessa]					#DIV/0!
Other combined oral contraceptive pills	Specify product:				#DIV/0!
ii. Progestin-only oral contraceptive pills					
Levonorgestrel 30 mcg [Norgeston, Microlut]					#DIV/0!
Progestin-only oral contraceptive pills: Other	Specify product:				#DIV/0!
iii. Injectable contraceptives					
Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press]					#DIV/0!
Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera]					#DIV/0!
Norethisterone enanthate [Noristerat]					#DIV/0!
Other injectable contraceptives	Specify product:				#DIV/0!
iv. Contraceptive implants					
Levonorgestrel 75mg/rod, 2 rod implant [Jadelle, Sino-Implant (II)/Levoplant]					#DIV/0!
Etonogestrel 68mg/rod, 1 rod implant [Implanon, Nexplanon]					#DIV/0!
Other contraceptive implants	Specify product:				#DIV/0!
v. Copper-bearing intrauterine devices (IUDs) (for example, Optima Copper T)					#DIV/0!
vi. Hormone-releasing intrauterine devices (IUDs) (for example levonorgestrel-releasing [Mirena])					#DIV/0!
vii. Male condoms					#DIV/0!
viii. Female condoms					#DIV/0!
ix. Emergency oral contraceptive pills					
Levonorgestrel 0.75mg, 2 tablets					#DIV/0!
Levonorgestrel 1.5mg, 1 tablet					#DIV/0!
x. Calendar-based awareness methods (for example, CycleBeads)					#DIV/0!

B4.	Is there a government **budget line item** specifically for the procurement of contraceptives? Please select from the dropdown list.		Comments:	

	Please complete the questions below regarding **government allocations** for contraceptive procurement. Allocated funds are those originally designated for contraceptives, *whether or not* they ended up being spent on contraceptives.				
B5.	Were government funds **allocated** (i.e., committed) for contraceptive procurement in the most recent complete fiscal year? 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.)			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	Data source (for example: Ministry records)	Comments
a.	Internally generated funds **allocated** for contraceptive procurement				
b.	Total of all other government funds **allocated** for contraceptive procurement. (For example, these other government funds could include basket funds, World Bank credits or loans, and other funds donors give to the government [e.g., direct budget support])				
c.	TOTAL government funds **allocated** for contraceptive procurement **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 fiscal 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.)		Comments:	

	In the table below, the time period should reflect when the funds were spent, and will ideally be the most recent complete fiscal year.				
B8.	**Source of government funds spent on contraceptive procurement**	Was this a source? *(Y/N)*	Amount spent (in USD)	Time period (mm/yy-mm/yy)	Details of government procurement (Note whether the amount spent in the fiscal year was determined by purchase order date or actual delivery date. Actual delivery date is preferred. You may also note what
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 fiscal year.
The time period should be the same for all sources of funding.
*This can include cases where donors provided products to the Ministry for NGOs or social marketing.

B9. **Source of donated funds for contraceptives for the public sector**	In-kind or cash?	Value of donation	Time period (mm/yy-mm/yy)	Details of donations (List commodities procured and quantities if available, and note whether the amount spent in the fiscal year was determined by purchase order date or actual delivery date. Actual delivery date
a. USAID				
b. UN agencies				
c. Global Fund				
d. Other bilateral				
e. Other				
f. TOTAL value of in-kind donations and grants spent on contraceptive procurement **This will auto-calculate.** *(It will sum a-e above.)*		$ -		

The answers to B10 - B12 should calculate automatically based on the information you provide. Please review the answers to ensure they make sense to you, and if you have additional information to add, please note it in the comment boxes provided.
The values will auto-calculate and the formulas used can be seen by selecting that cell. If the answers do not calculate automatically, please provide relevant information in the comments boxes.

B10.	**Government share of funds spent on contraceptive procurement for the public sector -** Of the total amount spent on contraceptives for the public sector in the most recent complete fiscal year (including government and donor funds), what percent was covered by government funds (including internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government)?	***#DIV/0!***	Comments:	
B11.	**Internally generated share of the government funds spent on contraceptive procurement for the public sector -** Of the total amount of government funds spent on contraceptives for the public sector in the most recent complete fiscal year, what percent was covered by internally generated government funds?	***#DIV/0!***	Comments:	
B12.	**Total expenditures on public sector contraceptives as percent of amount that needed to be procured -** Of the estimated value of the contraceptives needed to be procured for the public sector for the most recent complete fiscal year, what percent was provided by any source (whether government or donor)?	***#DIV/0!***	Comments:	
B13.	**Was there a funding gap for public sector contraceptives in the last complete fiscal year?** (This will automatically calculate by comparing the forecast in B2 to total expenditures in B12)	**#DIV/0!**	Comments:	
B14.	If the government financed any contraceptive procurement in the most recent complete fiscal 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):			

B15.	At what level does government-financed procurement of public sector contraceptives occur? (Indicate using the drop-down menu for each level)		
	Central		Comments:
	Intermediate (e.g. regional, district)		
	Service delivery level		
a.	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).		
	Central		
	Intermediate (e.g. regional, district)		
	Direct to service delivery points		
	Other		
	If other, specify:		
B16.	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**.

B17.	Have funds been **allocated** by the government for the procurement of contraceptives for the current fiscal year?		Comments:	
a.	If yes, please describe the allocations (source and quantity if available).	Source	Amount (in USD)	Comments

C. Commodities

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

Contraceptive Method	Please select from the dropdown list 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				
b. Progestin-only Oral Contraceptive Pills (for example, Levonorgestrel 30 mcg [Norgeston, Microlut], Norethindrone 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [Cerazette, Aizea], Ethynodiol Diacetate [Femulen])				
c. Injectables (for example, Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press], Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera], Norethisterone enanthate [Noristerat])				
d. Contraceptive Implants (for example, Levonorgestrel 75mg [Jadelle, Sino-Implant (II)/Levoplant], Etonogestrel 68mg [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)				
j. Long-acting permanent method for females (tubal ligation)				
k. Contraceptive Patches (for example, Norelgestromin/Ethinyl Estradiol 150/35mcg [Xulane,				
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.				

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

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 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					
b. Progestin-only Oral Contraceptive Pills (for example, Levonorgestrel 30 mcg [Norgeston, Microlut], Norethindrone 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [Cerazette, Aizea], Ethynodiol Diacetate [Femulen])					
c. i. Injectables (Depot Medroxyprogesterone Acetate 104mg/0.65mL **subcutaneous** [Depo Sub-Q Provera, Sayana Press])					
ii. Injectables (Depot Medroxyprogesterone Acetate 150 mg **Intramuscular** [DepoProvera], 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)					
j. Long-acting permanent method for females (tubal ligation)					
k. Contraceptive Patches (for example, Norelgestromin/Ethinyl Estradiol 150/35mcg [Xulane, Evra])					
l. Vaginal Contraceptive Rings (for example, Etonogestrel/Ethinyl Estradiol 120/15mcg [NuvaRing], progesterone-releasing [Progering])					
m. Calendar-based Awareness Methods (for example, CycleBeads)					
n. Other contraceptive methods - specify (Please provide the name of the other contraceptive(s) offered, and the lowest level cadre that can provide it, by sector. For example: SILCS	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	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)*		
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 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])	Comments:	
b.	Progestin-only Oral Contraceptive Pills (for example, Levonorgestrel 30 mcg [Norgeston, Microlut], Norethindrone 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [Cerazette, Aizea], Ethynodiol Diacetate		
c.	Injectables (for example, Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press], Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera], Norethisterone enantate [Noristerat])		
d.	Contraceptive Implants (for example, Levonorgestrel 75mg [Jadelle, Sino-Implant (II)/Levoplant], Etonogestrel 68mg [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 0.75mg, levonorgestrel 1.5mg)		
j.	Contraceptive Patches (for example, Norelgestromin/Ethinyl Estradiol 150/35mcg [Xulane, Evra])		
k.	Vaginal Contraceptive Rings (for example, Etonogestrel/ Ethinyl Estradiol 120/15mcg [NuvaRing], progesterone-releasing [Progering])		
l.	Calendar-based Awareness Methods (for example, CycleBeads)		
m.	Any other contraceptive(s)? (e.g. SILCS diaphram)		
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 dropdown menus to select all that apply)?			
a.	Social marketing		Comments:	
b.	Mass media			
c.	Mobile outreach/education			
d.	Community mobilization/engagement			
e.	Other			
	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:	
D17.	Has the country made an FP2020 commitment?		Comments:	
D18.	Is there a specific FP2020 commitment for:			
a.	Improving domestic financing for contraceptives?		Comments:	
i.	If yes, please describe this commitment			
b.	Increasing affordability of contraceptives for clients?		Comments:	
i.	If yes, please describe this commitment			
c.	Improving access to or availability of contraceptives (beyond any commitments described above for domestic financing or affordability)? [Do not include commitments for increasing CPR or number of FP users unless		Comments:	
i.	If yes, please describe this commitment			
D19.	Is the country a Global Financing Facility (GFF) partner?		Comments:	
a.	If yes, does the financing include provisions for family planning?			
b.	Does it include provisions for procurement of contraceptive commodities?			
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?		Comments:					
a.	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							
b.	If there is a national LMIS, how is contraceptive commodity data collected at the service delivery point level?		Comments:					
E2.	Please provide the **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:								
b.	Progestin-only oral contraceptive pills (Levonorgestrel 30 mcg [Norgeston, Microlut])				#DIV/0!			#DIV/0!	
c.	Injectable contraceptives								
i.	Depot Medroxyprogesterone Acetate 104mg/0.65mL subcutaneous [Depo Sub-Q Provera, Sayana Press]				#DIV/0!			#DIV/0!	
ii.	Depot Medroxyprogesterone Acetate 150 mg Intramuscular [DepoProvera]				#DIV/0!			#DIV/0!	
iii.	Norethisterone enanthate [Noristerat]				#DIV/0!			#DIV/0!	
d.	Contraceptive implants								
i.	Levonorgestrel 75mg/rod, 2 rod implant [Jadelle, Sino-Implant (II)/Levoplant]				#DIV/0!			#DIV/0!	
ii.	Etonogestrel 68mg/rod, 1 rod implant [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 0.75mg, 2 tablets				#DIV/0!			#DIV/0!	
ii.	Levonorgestrel 1.5mg, 1 tablet				#DIV/0!			#DIV/0!	
j.	Calendar-based awareness methods (for example, CycleBeads)				#DIV/0!			#DIV/0!	
k.	Total stock out rate for all commodities **This will auto-calculate.** (It will sum H and I and divide H by I, and will sum K and L and divide by L)		0	0	#DIV/0!	0	0	#DIV/0!	

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 SSFFC (substandard, spurious, falsely labelled, falsified and counterfeit) 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?			

G. Private Sector			
G1.	According to the MoH, how many wholesalers are registered in the country (for distributing FP products)?		
a.	Are wholesalers required to report to the government their sales and services?		Comments:
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?		
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 75mg, Levonorgestrel/Ethinyl Estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jolessa], drosiperenone/Ethinyl Estradiol 3mg/20mcg [Yaz], Norethindrone Acetate/Ethinyl Estradiol [Loestrin, Junel])*		
	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 35mg [Micronor, Camila, Errin], Desogestrel 75mcg [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 [DepoProvera], 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 75mg [Jadelle, Sino-Implant (II)/Levoplant], Etonogestrel 68mg [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 0.75mg, Levonorgestrel 1.5mg [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:	
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				

Thank you for completing the survey!

Annex C. Contextual Reference Measures (Formerly from the Contraceptive Security Index)

	Indicator	Description	Afghanistan	Angola	Bangladesh	Benin	Burkina Faso	Burundi	Cameroon	Cape Verde	Cote d'Ivoire	Dominican Republic	DRC	El Salvador	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Honduras	India	Kenya
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, 2017. (https://databank.worldbank.org/reports.aspx?source=2&series=SH.XPD.GHED.GE.ZS)	2.3%	5.4%	3.0%	4.6%	10.0%	8.5%	3.1%	9.9%	5.1%	15.6%	3.3%	19.2%	4.8%	6.1%	17.2%	4.1%	5.2%	11.7%	3.4%	8.0%
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 2017 international dollars and purchasing power parity, which adjusts for the different market prices for goods in each country.	$ 2,213	$ 7,087	$ 4,643	$ 3,129	$ 1,852	$ 763	$ 3,526	$ 6,738	$ 3,575	$ 16,927	$ 1,047	$ 8,132	$ 2,089	$ 4,864	$ 8,302	$ 2,456	$ 1,776	$ 5,241	$ 6,471	$ 4,158
	Source year of per capita GNI data	*Source: World Bank World Development Indicators. Data was available for the years 2017 and 2018. (https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.KD?name_desc=false)	2017	2017	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2017	2018	2018	2018	2018	2018	2018
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.	54.5%	36.6%	24.3%	40.1%	40.1%	64.9%	37.5%	35.0%	46.3%	22.8%	63.9%	29.2%	23.5%	23.4%	59.3%	55.2%	58.5%	48.3%	21.9%	36.1%
	Source year of poverty level data	*Source: World Bank World Development Indicators. Data was available for years ranging from 2008 to 2018. (https://data.worldbank.org/indicator/SI.POV.NAHC?view=chart)	2016	2008	2016	2015	2014	2013	2014	2015	2015	2018	2012	2017	2015	2016	2014	2012	2012	2018	2011	2015

	Indicator	Description	Kyrgyz Republic	Lao PDR	Liberia	Madagascar	Malawi	Mali	Mozambique	Nepal	Niger	Nigeria	Pakistan	Peru	Philippines	Rwanda	Senegal	Sierra Leone	South Sudan	Tanzania	Togo	Uganda	Vietnam
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, 2017. (https://databank.worldbank.org/reports.aspx?source=2&series=SH.XPD.GHED.GE.ZS)	6.2%	4.0%	4.2%	15.0%	9.8%	5.8%	4.7%	4.5%	9.7%	4.6%	4.3%	14.9%	7.1%	8.9%	3.9%	7.9%	2.1%	9.5%	5.1%	5.1%	9.5%
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 2017 international dollars and purchasing power parity, which adjusts for the different market prices for goods in each country.	$4,972	$6,875	$1,319	$1,569	$1,034	$2,233	$1,265	$3,275	$848	$4,973	$4,992	$12,155	$9,738	$2,021	$3,252	$1,594	N/A	$2,743	$1,559	$1,738	$7,051
	Source year of per capita GNI data	*Source: World Bank World Development Indicators. Data was available for the years 2017 and 2018. (https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.KD?name_desc=false)	2018	2017	2018	2018	2017	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2017	N/A	2017	2018	2018	2018
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.	22.4%	23.4%	50.9%	70.7%	51.5%	41.1%	46.1%	25.2%	44.5%	46.0%	24.3%	20.5%	21.6%	38.2%	46.7%	52.9%	82.3%	26.4%	55.1%	21.4%	6.7%
	Source year of poverty level data	*Source: World Bank World Development Indicators. Data was available for years ranging from 2008 to 2018. (https://data.worldbank.org/indicator/SI.POV.NAHC?view=chart)	2018	2012	2016	2012	2016	2009	2014	2010	2014	2009	2015	2018	2015	2016	2011	2011	2016	2018	2015	2016	2018

Indicator	Description	Afghanistan	Angola	Bangladesh	Benin	Burkina Faso	Burundi	Cameroon	Cape Verde	Cote d'Ivoire	Dominican Republic	DRC	El Salvador	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Honduras	India	Kenya
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, 1996-2016). Countries with a strong regulatory environment are more likely to attract international financing, and the private sector is more likely to invest in creating or expanding the market for contraceptives. This indicator assigns countries a percentile rank from 0 to 100, where 100 is the strongest regulatory quality. *Source: World Bank Worldwide Governance Indicators, 2018. (http://info.worldbank.org/governance/wgi/#reports)	10.58	12.98	19.23	38.94	36.06	13.46	20.19	43.27	46.15	50.48	5.77	53.85	13.94	50	45.67	21.63	8.65	34.62	46.63	43.75
5 Women's education *(% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio)*	Women's education is measured by the percent of females enrolled in secondary school out of the applicable age group, also known as the gross enrollment ratio. Women who are educated beyond the primary level are more likely to use contraceptives, and more likely to advocate for the protection of family planning/reproductive health programs. *("Gross" enrollment includes students of all ages. In other words, it includes students whose age exceeds the official age group (e.g. repeaters). Thus, if there is late enrollment, early enrollment, or repetition, the total enrollment can exceed the population of the age group that officially corresponds to the level of education – leading to ratios greater than 100 percent.)*	40.0%	39.7%	78.3%	50.7%	40.7%	51.1%	55.4%	92.5%	44.4%	83.0%	36.0%	71.4%	34.3%	64.5%	51.4%	31.0%	N/A	55.9%	76.6%	N/A
Source year of gross enrollment ratio data	*Source: UNESCO's Institute for Statistics UIS.STAT Database. Data was available for years ranging from 2013 to 2018. (http://data.uis.unesco.org/)	2018	2016	2018	2016	2018	2018	2016	2018	2018	2018	2015	2018	2015	2019	2018	2014	N/A	2017	2018	N/A
6 Adult HIV Prevalence	This measure has a complex relationship with contraceptive security. Higher burdens of HIV can put greater strains on the health system, leaving fewer health resources available for FP/RH 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, 2018. (http://aidsinfo.unaids.org/)	0.1%	2.0%	0.1%	1.0%	0.7%	1.0%	3.6%	0.6%	2.6%	0.9%	0.8%	0.6%	1.0%	1.7%	0.4%	1.4%	2.0%	0.3%	N/A	4.7%

Indicator	Description	Kyrgyz Republic	Lao PDR	Liberia	Madagascar	Malawi	Mali	Mozambique	Nepal	Niger	Nigeria	Pakistan	Peru	Philippines	Rwanda	Senegal	Sierra Leone	South Sudan	Tanzania	Togo	Uganda	Vietnam
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, 1996-2016). Countries with a strong regulatory environment are more likely to attract international financing, and the private sector is more likely to invest in creating or expanding the market for contraceptives. This indicator assigns countries a percentile rank from 0 to 100, where 100 is the strongest regulatory quality. *Source: World Bank Worldwide Governance Indicators, 2018. (http://info.worldbank.org/governance/wgi/#reports)	37.98	20.67	14.42	23.56	25.48	30.77	24.04	23.08	27.88	17.31	27.4	71.15	56.73	59.13	49.52	15.38	2.404	29.33	26.92	41.83	36.54
5 Women's education *(% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio)*	Women's education is measured by the percent of females enrolled in secondary school out of the applicable age group, also known as the gross enrollment ratio. Women who are educated beyond the primary level are more likely to use contraceptives, and more likely to advocate for the protection of family planning/reproductive health programs. *("Gross" enrollment includes students of all ages. In other words, it includes students whose age exceeds the official age group (e.g. repeaters). Thus, if there is late enrollment, early enrollment, or repetition, the total enrollment can exceed the population of the age group that officially corresponds to the level of education – leading to ratios greater than 100 percent.)*	95.1%	65.0%	32.9%	37.1%	39.9%	37.0%	33.5%	83.0%	20.7%	39.8%	39.2%	103.6%	90.7%	43.3%	45.8%	41.1%	7.7%	N/A	52.1%	N/A	N/A
Source year of gross enrollment ratio data	*Source: UNESCO's Institute for Statistics UIS.STAT Database. Data was available for years ranging from 2013 to 2018. (http://data.uis.unesco.org/)	2018	2018	2015	2018	2018	2018	2017	2019	2017	2016	2018	2018	2017	2018	2018	2017	2015	N/A	2017	N/A	N/A
6 Adult HIV Prevalence	This measure has a complex relationship with contraceptive security. Higher burdens of HIV can put greater strains on the health system, leaving fewer health resources available for FP/RH 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, 2018. (http://aidsinfo.unaids.org/)	0.2%	0.3%	1.3%	0.3%	9.2%	1.4%	12.6%	0.1%	0.3%	1.5%	0.1%	0.3%	0.1%	2.5%	0.4%	1.5%	2.5%	N/A	2.3%	5.7%	0.3%

	Indicator	Description	Afghanistan	Angola	Bangladesh	Benin	Burkina Faso	Burundi	Cameroon	Cape Verde	Cote d'Ivoire	Dominican Republic	DRC	El Salvador	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Honduras	India	Kenya
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)	36.6%	N/A	47.1%	N/A	47.2%	57.3%	40.5%	N/A	25.7%	50.4%	41.4%	59.2%	35.7%	54.4%	36.4%	45.0%	23.6%	59.0%	60.5%	56.0%
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)	75.4%	N/A	76.8%	N/A	83.8%	80.7%	73.2%	N/A	73.1%	76.2%	75.9%	82.6%	78.0%	86.2%	70.4%	75.1%	71.6%	86.4%	71.4%	85.5%
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)	28.0%	28.5%	18.9%	35.6%	26.5%	34.6%	32.5%	16.7%	30.9%	8.5%	40.6%	18.4%	23.7%	32.9%	13.9%	23.4%	42.1%	17.9%	18.9%	16.9%
9	Modern Contraceptive Prevalence Rate (mCPR)	Contraceptive prevalence rate, the percentage of married women of reproductive age currently using a modern method of familiy 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).	15.9%	12.5%	46.3%	12.4%	26.9%	17.1%	29.1%	41.6%	21.1%	52.6%	11.2%	66.5%	25.7%	22.2%	32.2%	11.5%	23.4%	44.3%	40.2%	45.1%

Indicator		Description	Kyrgyz Republic	Lao PDR	Liberia	Madagascar	Malawi	Mali	Mozambique	Nepal	Niger	Nigeria	Pakistan	Peru	Philippines	Rwanda	Senegal	Sierra Leone	South Sudan	Tanzania	Togo	Uganda	Vietnam
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)	41.9%	48.7%	30.4%	39.9%	50.4%	46.1%	35.0%	58.2%	42.5%	45.1%	36.1%	41.9%	43.1%	79.4%	40.3%	48.1%	23.4%	44.4%	53.2%	40.0%	71.5%
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)	60.4%	77.4%	64.6%	71.9%	81.2%	84.3%	82.2%	86.4%	84.4%	86.5%	68.6%	81.5%	67.0%	86.7%	84.4%	92.8%	55.2%	74.1%	86.4%	69.0%	75.3%
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)	20.5%	21.2%	29.7%	24.0%	17.1%	25.2%	22.8%	29.4%	20.7%	23.7%	27.1%	9.0%	33.9%	22.8%	26.2%	27.0%	30.6%	26.3%	34.5%	32.5%	18.1%
9	Modern Contraceptive Prevalence Rate (mCPR)	Contraceptive prevalence rate, the percentage of married women of reproductive age currently using a modern method of familiy 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).	28.0%	41.1%	30.6%	35.7%	48.3%	16.1%	35.6%	36.1%	15.5%	14.2%	17.7%	36.4%	25.6%	30.4%	20.5%	28.1%	3.9%	33.3%	20.3%	29.2%	47.6%

*Gross enrollment includes students of all ages even those students whose age exceeds the official age group (e.g., repeaters). If there is late enrollment, early enrollment, or repetition, the total enrollment can exceed the population of the age group that officially corresponds to the level of education. This can lead to ratios greater than 100 percent, as seen in the case of Peru.