


# 2021 Contraceptive Security Indicators Survey

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## Acronyms

<b>CHW</b>	community health worker
<b>COC</b>	combined oral contraceptive
<b>CS</b>	contraceptive security
<b>CYP</b>	couple years of protection
<b>DRC</b>	Democratic Republic of the Congo
<b>EC</b>	emergency contraceptive pills
<b>FAM</b>	fertility awareness-based methods
<b>FP</b>	family planning
<b>FY</b>	fiscal year
<b>GHSC-PSM</b>	Global Health Supply Chain Program-Procurement and Supply Management
<b>ISO</b>	International Organization of Standards
<b>IUD</b>	intrauterine device
<b>LAC</b>	Latin America and the Caribbean
<b>LMIS</b>	logistics management information system
<b>MoH</b>	Ministry of Health
<b>NEML</b>	National Essential Medicines List
<b>NGO</b>	non-governmental organization
<b>NMRA</b>	national medicines regulatory authority
<b>NQCL</b>	national quality control laboratory
<b>POP</b>	progestin-only pill
<b>PPP</b>	public-private partnership
<b>PSE</b>	private-sector engagement
<b>QA</b>	quality assurance
<b>QC</b>	quality control
<b>RH</b>	reproductive health
<b>SDP</b>	service delivery point
<b>SPARHCS</b>	Strategic Pathway to Reproductive Health Commodity Security
<b>SRA</b>	stringent regulatory authority
<b>SPARHCS</b>	Strategic Pathway to Reproductive Health Commodity Security
<b>SSF</b>	substandard and falsified
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization
<b>WHO-PQ</b>	World Health Organization-prequalified



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We would also like to thank the many partner organizations that facilitated and participated in data collection in many country offices. In particular, FP2030 and UNFPA were instrumental in facilitating connections to points of contact in countries that might otherwise have been difficult to reach.

## 01.

## Executive Summary



PHOTO CREDIT: USAID GHSC-PSM

## Executive summary

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

This 2021 Contraceptive Security Indicators Report updates the 2019 report, building on the CS Indicators first developed in 2009 and presented in the USAID | DELIVER PROJECT paper, *Measuring Contraceptive Security in 36 Countries*.<sup>1</sup> Starting in 2010, CS Indicators have been collected, measured, and reported annually, and then biennially starting 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 45 countries<sup>2</sup>, including updated indicators in the Leadership and Coordination, Policy, and Supply Chain sections, as well as a new section on the impact of the COVID-19 pandemic on contraceptive security. Changes to previous questions and the addition of new questions increase the methodological rigor and relevance of the survey. A data collection and usage manual helps guide responses. To help data users 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 and procurement, policy, supply chain, quality, the private sector, and the impact of the COVID-19 pandemic on contraceptive security. Key findings include:

### Leadership and Coordination

- 96 percent of surveyed countries have a national CS committee. 44 percent of those committees meet one to three times a year; 46 percent meet four or more times per year.

<sup>1</sup> USAID | DELIVER PROJECT, Task Order 1. 2010.

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



- 93 percent of CS committees have formal, written terms of reference.
- 76 percent of CS committees developed policies, procedures, recommendations, and/or action plans, and 100 percent of those reported adhering to policies and procedures or implementing action plans.
- The commercial/private sector participates in one-third of CS committees (14 out of 43).

## Finance and Procurement

- 73 percent of respondent countries (32 out of 44) have a government budget line item specifically for contraceptives, 75 percent of countries allocated government funds for contraceptive procurement in the most recently completed fiscal year, and 70 percent spent government funds on contraceptives in the most recently completed fiscal year.
- An average of 47 percent of financing comes from government sources and 53 percent from in-kind donations.
- Expenditures on contraceptives in more than half the countries reporting (51 percent, or 21 countries) exceeded or met the country's forecasted demand. The remaining 49 percent had a funding gap between funding spent and estimated contraceptive need.

## Commodities

- Countries offer on average 8 of the 13 assessed contraceptive methods;<sup>3</sup> 10

in public-sector facilities, nine through the commercial/private sector;<sup>4</sup> eight in non-governmental facilities, and six through social marketing.

- 89 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector; and 91 percent offer the five most common methods per survey findings (male condoms, combined oral contraceptives, injectables, intrauterine devices (IUDs), and contraceptive implants).
- The commercial/private sector offers the five most common contraceptives (male condoms, combined oral contraceptives, injectables, intrauterine devices, and contraceptive implants) in 73 percent of reporting countries.

## Policies

- 96 percent of reporting countries have either a CS or reproductive health commodity security strategy or a strategy that explicitly mentions increasing contraceptive access.
- In 51 percent of countries (23 of 45 reporting), FP commodities are subject to duties.
- 18 percent of countries (seven out of 40) have policies that hinder the ability of the private sector to provide contraceptives.
- 20 percent of countries have policies that restrict access to contraceptives for those between ages 15 and 19 who are unmarried, and 16 percent of

countries have restrictive policies for those in the same age group who are married.

- 80 percent of countries have operational or cultural practices that increase access to FP for rural populations, minority populations (67 percent), and disadvantaged sub-regions (67 percent).
- 80 percent of countries have either made (42 percent) or plan to make (38 percent) an FP2030 commitment. Of those, 80 percent (33 out of 41) have committed or plan to commit to improving domestic financing for contraceptives.

## Supply Chain<sup>5</sup>

- 93 percent of countries (42 of 45) have a logistics management information system (LMIS) that includes contraceptives. Among those, 93 percent (39 out of 42) capture contraceptive stock data at the service delivery point (SDP) level.
- Of the 35 countries providing information on central level stockouts,<sup>6</sup> 12 (34 percent) reported zero stockouts at the central level of any of the following most common FP/RH products: combined oral contraceptives, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms. Also, seven countries (20 percent) had no central level stockouts of any FP/RH product.

<sup>3</sup> The assessed methods are combined oral contraceptive pills, progestin-only pills, injectables, contraceptive 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 fertility awareness-based methods (FAM).

<sup>4</sup> When responding to the question about the availability of contraceptive methods in the commercial/private, public, NGO, or social marketing sector, there is potential in some contexts for some contraceptives (especially injectables) to be perceived as commercial/private-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.

<sup>5</sup> Stockout rates are reported at the country/method level only and not aggregated across countries, as interpreting the data becomes difficult at higher levels of aggregation.

<sup>6</sup> Guatemala and the Kyrgyz Republic each reported only on one product, norethisterone enanthate and levonorgestrel/ethinyl estradiol 150/30 mcg, respectively, at the central level, and therefore were not counted in the denominator for the number of countries having reported on stockout rates at the central level. They were included only in the central stockout rate reporting for injectables and combined oral contraceptives, respectively.

- Of the 32<sup>7</sup> countries providing information on service delivery point level stockouts, one country, Cape Verde, (3 percent) reported a 0 percent stockout rate for either the most common FP/RH methods or other FP/RH methods.
- Average annual stockout rates at the central level for the most common FP/RH methods<sup>8</sup> ranged as follows among countries reporting:
  - **Combined oral contraceptives:** 76 percent of countries reporting (26 of 34 countries) had no stockouts, eight countries had stockout rates ranging from 8 percent (Ghana) to 100 percent (Sri Lanka and the Democratic Republic of the Congo [DRC]) at the central level.
  - **Injectable contraceptives:** 50 percent (18 countries) had no stockouts; 18 countries had stockout rates ranging from 8 percent (Ethiopia and Mali) to 100 percent (Angola, Guatemala, Sri Lanka).
  - **Implants:** 44 percent (15 countries) had no stockouts; 18 countries had stockout rates ranging from 8 percent (Madagascar) to 100 percent (Sri Lanka).
  - **Intrauterine devices (IUDs):** 71 percent (24 countries) had no stockouts; the other 10 countries had stockout rates ranging from 14 percent (DRC) to 100 percent (Sri Lanka).
  - **Male condoms:** 79 percent (27 countries) had no stockouts;
- 6 countries had stockout rates ranging from 8 percent (Honduras) to 100 percent (Sri Lanka).
- Average annual stockout rates at the service delivery point (SDP) level for the most common FP/RH methods ranged as follows:
  - **Combined oral contraceptives:** 7 percent (two countries) had zero stockouts of combined oral contraceptives; 27 countries had stockout rates ranging from 1 percent (Burundi, Haiti) to 100 percent (El Salvador, Sri Lanka).
  - **Injectable contraceptives:** 9 percent (three countries) had no stockouts; 30 countries had stockout rates ranging from 1 percent (Togo) to 100 percent (El Salvador and Sri Lanka).
  - **Implants:** 6 percent (two countries) had no stockouts; 31 countries had stockouts ranging from 1 percent (Togo, Bangladesh, Burundi) to 100 percent (Sri Lanka and El Salvador).
  - **IUDs:** 10 percent (three countries) had no stockouts; 25 countries had stockout rates ranging from 1 percent (Burundi) to 100 percent (El Salvador, Sri Lanka).
  - **Male condoms:** 10 percent (three countries) had no stockouts; 26 countries had stockout rates ranging from 1 percent (Burundi and Togo) to 100 percent (El Salvador and Sri Lanka).

## Quality

- 98 percent (44 of 45 countries) require registration of locally manufactured or imported contraceptives by the in-country national medicines regulatory authority (NMRA).
- The average lead time for registration of contraceptives is less than six months for 49 percent of countries (19 of 39).
- 42 percent of countries reported that at least some contraceptives were tested at the national quality control laboratory (NQCL).
- 15 percent (five of 34) of NQCLs are currently International Organization of Standards (ISO) 17025 certified/ accredited and WHO-prequalified (WHO-PQ). 56 percent (19 of 34) of NQCLs are neither ISO 17025 certified nor WHO-prequalified.
- In 32 percent of countries (11 of 34), the national medicines regulatory authority (NMRA) conducts field surveillance monitoring to identify substandard and falsified (SF) contraceptives. In half of these countries (five of 10 reporting), extensive enforcement actions are taken.

## Private Sector

- 89 percent (32 of 36 countries) have more than three wholesalers registered in the country to distribute FP commodities.
- 41 percent (15 of 37) have established or brokered public-private partnerships (PPPs) in the past two

<sup>7</sup> Guatemala and Uganda each reported on only one product, norethisterone enanthate, and depot medroxyprogesterone acetate 150 mg intramuscular, respectively, at the SDP level, and therefore were not counted in the denominator for the number of countries having reported on stockout rates at the SDP level. They were included only in the SDP stockout rate reporting for injectable and combined oral contraceptives, respectively.

<sup>8</sup> An FP/RH method can consist of multiple FP/RH products; for example, the implant method includes one-rod and two-rod implants. For this report, the term "method" refers to the group of one or more common product formulations. The term "product" will be used to refer only to a single formulation.



years to expand private-sector FP products or services.

- By FP product, the percentage of countries where there were no WHO-PQ or stringent regulatory authority-approved products registered for distribution ranged from 7 percent (combined oral contraceptives and contraceptive implants) to 36 percent (female condoms).
- 53 percent (20 of 38 countries) have a private-sector engagement (PSE) plan in place with an FP/RH component. 85 percent of those countries with a PSE (17 countries reporting) have taken some action to implement the plan.



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## Impact of COVID-19 Pandemic

- Half of the countries surveyed (21 out of 42) reported no impact of the COVID-19 pandemic on frequency of CS committee meetings in 2020. 40 percent (17 out of 42) reported reduced frequency of CS committee meetings in 2020, while 10 percent (four out of 42) reported the pandemic prevented the ability to meet.
- 63 percent of countries (26 out of 41) reported no impact of the COVID-19 pandemic on the approved budget line for contraceptives. All or most of the contraceptive budget was shifted to COVID-19 response in 12 percent (five out of 41) countries. These included Angola, DRC, Kyrgyz Republic, Madagascar, and Yemen.
- 59 percent (24 out of 41) reported no impact of the COVID-19 pandemic on the amount of government spending for contraceptives.
- 81 percent (35 out of 43) of countries reported having an emergency preparedness plan in place for pandemics that includes impact on FP. Out of 38 countries, 30 (79 percent) have an emergency preparedness plan in place for other types of emergencies that includes impact on FP.
- 18 countries did not report any evidence that COVID-19 disrupted the availability of FP/RH commodities.
- Nine countries established mobile clinics and/or community health worker (CHW) home visitations for the provision of FP services, while seven countries initiated telehealth capacities.

# 02.

## Introduction



PHOTO CREDIT: USAID GHSC-PSM

## Introduction

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

Multiple factors across several sectors contribute to the availability and accessibility of contraceptives within countries, including political commitment, financial capital, partner coordination, capacity, client demand and use, and commodity availability. As demand for family planning continues to grow (from 900 million women in 2000 to nearly 1.1 billion in 2020<sup>9</sup>), and other health challenges such as COVID-19 compete for scarce resources, the ability of governments and other stakeholders to direct resources and legislation in support of supply chains and family planning service delivery increases in importance. The CS Indicators assist national family planning programs and other stakeholders to obtain data and monitor progress in support of such initiatives as: Family

Planning 2030 (FP2030); the United Nations Sustainable Development Goals; and country-specific family planning goals.

### Background

The CS Indicators and CS Index were developed under the USAID | DELIVER PROJECT to improve access to contraceptives by helping countries, global aid managers, and decision makers measure and track country progress in several different indicators.

The CS Indicators build on the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS)<sup>10</sup> 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) now compiled as Contextual Measures.

The former CS Index, now presented as individual secondary metrics (called Contextual Measures), provides insight into a mix of higher-level indicators to help countries identify strengths and weaknesses across four components—financing, health and social environment, access, and utilization. It has guided stakeholders in determining which countries are most in need, where to focus resources, and what type of assistance is needed. Data for the Contextual Measures are obtained

<sup>9</sup> United Nations Department of Economic and Social Affairs, Population Division (2020). World Family Planning 2020 Highlights: Accelerating action to ensure universal access to family planning (ST/ESA/SER.A/450).

<sup>10</sup> Hare, L., et al., 2004.

from secondary sources such as the World Bank and UNICEF and are intended to complement the survey's findings with additional context. The data are collected at the same time as the CS Indicators and can be found on the online dashboard and in the downloadable dataset. The CS Indicators and Contextual Measures are reported together starting in 2017 under the USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project. This report updates the 2019 report, which can be found on the [GHSC website](http://www.ghsupplychain.org) ([www.ghsupplychain.org](http://www.ghsupplychain.org)).

The knowledge gleaned from the CS Indicators and similar research is intended to improve the effectiveness of public reproductive health 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.



# 03.

## Methodology



PHOTO CREDIT: USAID GHSC-PSM

## Methodology

The 2021 CS Indicators methodology has been updated since the last round in 2019. 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 (e.g., UNFPA).

In total, 42 countries (79 percent) completed the survey and agreed to share the data publicly. This included 26 countries in the Africa region, 11 in Asia and the Middle East, and five in Latin America and the Caribbean (LAC).

### Country Selection

The following 53 countries were selected to receive the CS Indicators Survey based on several criteria. The highest priority was given to USAID Family Planning Priority Countries, USAID Family Planning transitioned countries, and Ouagadougou Partnership countries. Countries that had made an FP2020 commitment, and those with current or anticipated FP2030 commitments, were very important, particularly for those that are USAID Family Planning transitioned countries.

**TABLE I.**

Characteristics of selected and respondent countries

<b>COUNTRY</b>	<b>USAID FP Priority Countries</b>	<b>USAID FP Transitioned Countries</b>	<b>Other USAID- assisted FP Countries</b>	<b>Ouagadougou Partnership Countries</b>	<b>FP2020 Commitment Countries</b>	<b>CS Indicator 2021 Respondent Countries</b>
<b>Afghanistan</b>	●				●	
<b>Angola</b>			●		●	●
<b>Armenia</b>			●			
<b>Bangladesh</b>	●				●	●
<b>Benin</b>			●		●	●
<b>Botswana</b>		●				●
<b>Burkina Faso</b>			●		●	●
<b>Burundi</b>			●		●	●
<b>Cameroon</b>					●	●
<b>Cape Verde</b>						●
<b>Côte d'Ivoire</b>			●		●	
<b>Dominican R.</b>		●				
<b>DRC</b>	●				●	●
<b>Egypt</b>					●	
<b>El Salvador</b>		●				●
<b>Ethiopia</b>	●				●	●
<b>Georgia</b>			●			
<b>Ghana</b>	●				●	●
<b>Guatemala</b>			●			●
<b>Guinea</b>			●	●	●	●
<b>Haiti</b>	●				●	●
<b>Honduras</b>			●		●	●
<b>India</b>	●				●	
<b>Indonesia</b>		●			●	
<b>Kenya</b>	●				●	●
<b>Kyrgyz Republic</b>					●	●
<b>Lao PDR</b>					●	●
<b>Liberia</b>	●				●	●
<b>Madagascar</b>	●				●	●
<b>Malawi</b>	●				●	●
<b>Mali</b>	●			●	●	●
<b>Mauritania</b>			●	●	●	●
<b>Mozambique</b>	●				●	●
<b>Nepal</b>	●				●	●

**TABLE I.**

Characteristics of selected and respondent countries

<b>COUNTRY</b>	<b>USAID FP Priority Countries</b>	<b>USAID FP Transitioned Countries</b>	<b>Other USAID- assisted FP Countries</b>	<b>Ouagadougou Partnership Countries</b>	<b>FP2020 Commitment Countries</b>	<b>CS Indicator 2021 Respondent Countries</b>
<b>Niger</b>			●	●	●	●
<b>Nigeria</b>	●				●	●
<b>Pakistan</b>	●				●	●
<b>Peru</b>		●				●
<b>Philippines</b>	●				●	●
<b>Rwanda</b>	●				●	●
<b>Senegal</b>	●			●	●	●
<b>Sierra Leone</b>					●	●
<b>South Africa</b>		●				
<b>South Sudan</b>	●				●	●
<b>Sri Lanka</b>		●			●	●
<b>Tanzania</b>	●				●	●
<b>Togo</b>					●	●
<b>Uganda</b>	●				●	●
<b>Ukraine</b>						
<b>Vietnam</b>					●	
<b>Yemen</b>	●				●	●
<b>Zambia</b>	●				●	●
<b>Zimbabwe</b>					●	●



## 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.

The survey was disseminated in June 2021, and responses were received between August and November 2021. Validation took place between August 2021 and March 2022.

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

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

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

## Analysis

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

Quantitative 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 and made several changes and updates to improve the clarity and utility of the survey, including the addition of a section assessing the effects of the COVID-19 pandemic on

several aspects of contraceptive security (CS). The following changes have been made to the 2021 survey:

### Section A. Leadership and Coordination

A1, A5. Definition of a contraceptive security committee updated to include committees that provide recommendations in addition to those that have decision making powers. Clarification added that a committee does not need to have formal legal or administrative status to be considered a committee.

### Section B. Finance and Procurement

B1. Clarified that the time period assessed for the remainder of the section should stay consistent, so that the expenditures on contraceptives can be compared to the forecast.

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)

- Sub-question added (B2a) to add a new dimension to the forecast-spending comparisons and to help validate this section: Quantity of contraceptives forecast (in B2), in Couple Years of Protection (CYP)

B8. and B9. Source of government funds spent on contraceptive procurement. Source of donated funds for contraceptives for the public sector

- Added column to capture the quantity spent in Couple Years of Protection (CYPs)
- Added column, “spending type” to clarify whether the dollar amount and CYPs were calculated based on delivery dates, ship dates, purchase dates, or other/unknown
- Data source options in columns O and P updated to replace the RH Interchange database with the new Global Family Planning Visibility

and Analytics Network (GFPVAN) platform

B12. New automatically calculating indicator added for additional information: total expenditures on public sector contraceptives

B14. New automatically calculating indicator to capture the forecast-spending comparison with CYPs: Total quantity of contraceptives procured in Couple Years of Protection as a percent of the quantity that needed to be procured (forecast)

B16. New automatically calculating indicator added for additional information: Internally generated government funds as a percentage of the total value of contraceptives that needed to be procured (forecast)

### Section C. Commodities

Removed the 'not applicable' option from contraceptive method drop-down menus by sector

### Section D. Policies (Commitment)

D17. Updated the questions on an FP2020 commitment to also ask about an FP2030 commitment or anticipated FP2030 commitment

### Section E. Supply Chain

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

— Added a follow-up question (E1a) for additional clarification and detail on the LMIS: If there is a national LMIS, does it capture data down to the service delivery point (SDP) level? (At a minimum, data elements for health facilities must include stock on hand, rate of consumption, and losses and adjustments)

— Updated follow-up question (E1c) on how data is collected at the SDP level to account for the extent to which sites report electronically in a country,

instead of just whether any sites report electronically.

E3. Added a new optional question: What have been the main drivers of stockouts of contraceptives in the country during the previous year?

### Section F. Quality

F8. Updated the term SSFFC (substandard, spurious, falsely labeled, falsified and counterfeit) to SF (substandard and falsified) in accordance with updated WHO terminology.

### Section G. Private Sector

G3. Added clarifications on the definition of Stringent Regulatory Authorities (SRA)

New section added: Section H. Impact of COVID-19 Pandemic

H1. Is there an emergency preparedness plan in place for pandemics (that includes impact on family planning)?

H2. If yes, what policies are in place to alleviate impacts of pandemics on FP? (e.g., multi-month dispensing, switch to long-term methods, etc.) (Free-text response)

H3. Is there an emergency preparedness plan in place for other types of emergencies (that includes impact on FP)?

H4. How did the COVID-19 pandemic impact the frequency of CS committee meetings in 2020?

H5. To what extent did the COVID-19 pandemic affect the approved budget line for contraceptives for the current fiscal year?

H6. To what extent has the COVID-19 pandemic affected the amount of government spending for contraceptives in the most recent complete year?

H7. What, if any, operational practices were put in place to facilitate access to FP services during COVID-19? (e.g., Mobile FP clinics, telehealth, increased task sharing or task shifting, self-care interventions, no-prescription methods, etc.) This may

include both government practices and/or those of non-governmental or private entities. (Free-text response)

H8. What, if any, evidence do you have that COVID has disrupted the availability of FP/RH commodities (if applicable)? (Free-text response)

# 04.

## Limitations

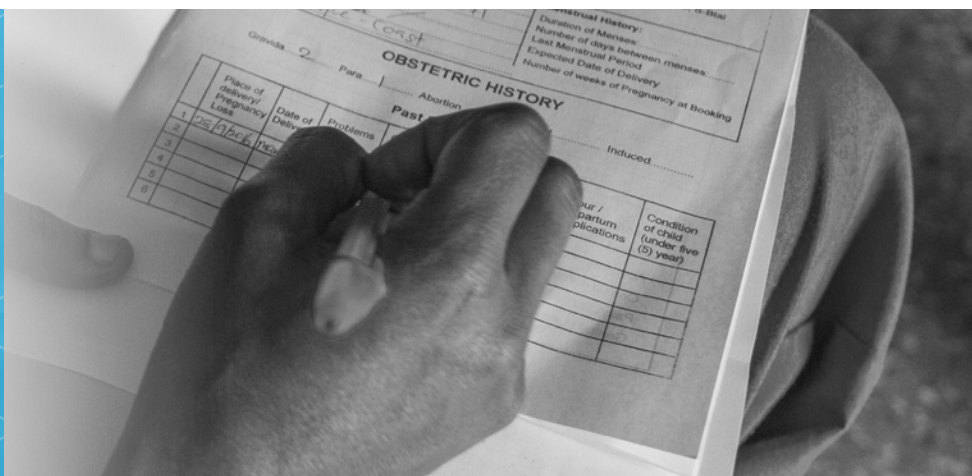


PHOTO CREDIT: USAID GHSC-PSM

## Limitations

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

Most of the data provided are from secondary sources. This is a centrally and remotely collected survey where the principal authors did not have direct access to 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, forecasts that exclude commodities currently available in the pipeline (which could mask the true annual demand for contraceptives), or FP forecasts that do not include condom needs that are forecast under HIV programs.

Regional comparisons and comparisons between countries have not been drawn in this survey, due to the limited numbers of respondent countries in several regions

and the non-random selection of the countries responding in each region.

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

Due to differences in reporting countries, revisions to some questions and the addition 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/) (<https://www.ghsupplychain.org/>), or by contacting the GHSC-PSM project.

## 05.

## Leadership and coordination



PHOTO CREDIT: USAID GH-SC-PSM

## Leadership and coordination

Effective and strong leadership is necessary for effective coordination among in-country partners in the public, NGO, social marketing, and commercial/private sectors to ensure resources, financing, and information are used to strengthen contraceptive security.

The survey collected data on the existence of a contraceptive security committee, composition of its membership, frequency of meetings, legal status, terms of reference, and whether the committee has started, developed and/or implemented family planning action plans or policies.

### Highlights

Of the countries surveyed:

- 96 percent have a national committee that works on CS.
- 93 percent have formal terms of reference.
- 76 percent of CS committees developed policies, procedures, recommendations, and/or action plans, and 100 percent of those reported adhering to policies and procedures or implementing action plans.

- The commercial/private sector participates in one-third of CS committees (14 out of 43).

### Contraceptive Security Committee

Of 45 countries, 96 percent (43) have a committee that works on CS (Exhibit 1). This number has remained relatively stable since 2017. The MoH is represented on the committee in all countries. NGOs participate in 93 percent of CS committees; UN agencies, 98 percent; the social marketing sector, 77 percent; central medical store/central warehouses, 95 percent; donors, 79 percent; other entities, 60 percent; Ministry of Finance or Planning, 29 percent; and the commercial/private sector, 33 percent.

CS committees have legal or administrative status in 79 percent (34 of 43) of the countries.

**EXHIBIT 1.**

Percentage of countries that have CS committees, and their composition

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

**EXHIBIT 2.**

Activity of CS committees<sup>11</sup>

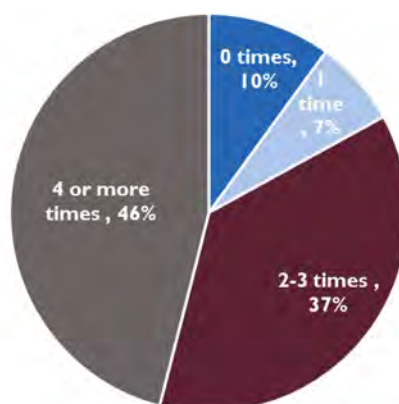
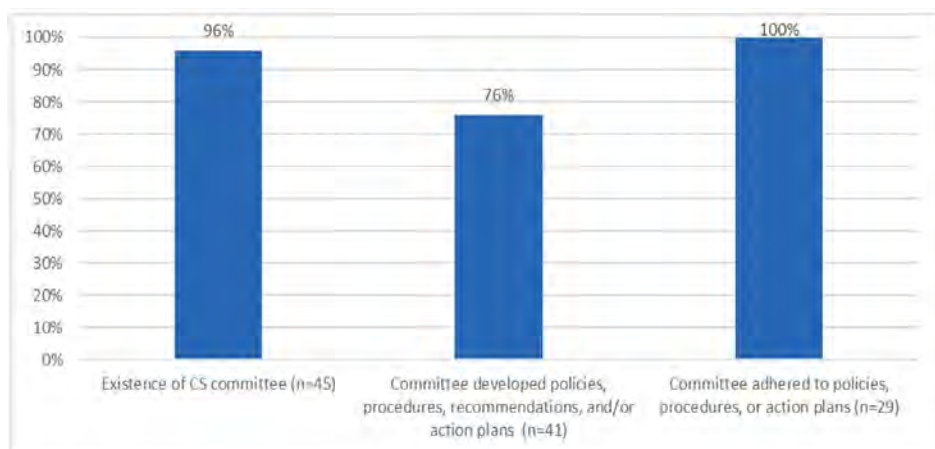
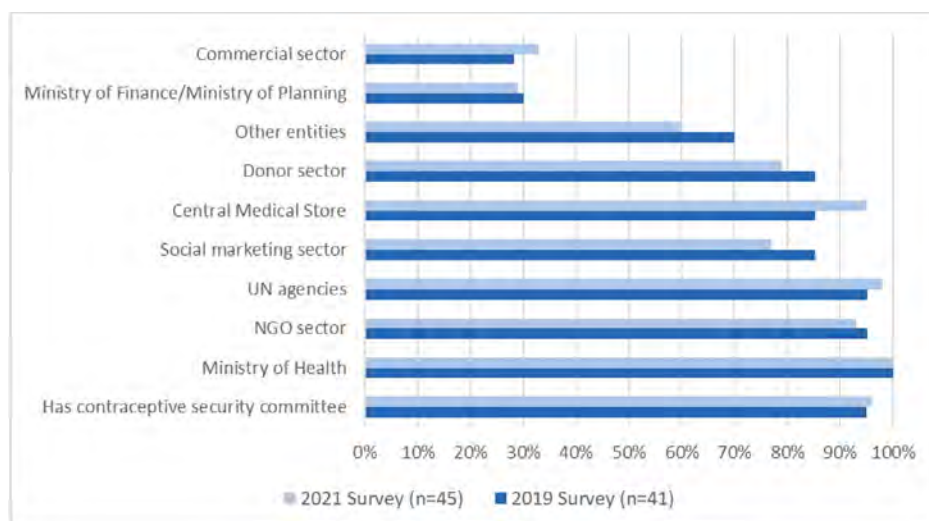
Forty-six percent of the CS committees met four or more times per year; while 37 percent met two to three times, 7 percent met once, and 10 percent did not meet at all (Exhibit 3).

**EXHIBIT 3.**

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

The common functions of CS committees among respondent countries include:

- Forecasting, monitoring, and analyzing national contraceptive commodity needs
- Making recommendations for FP sector
- Monitoring FP stock levels and coordinating supply chain
- Increasing collaboration among FP stakeholders
- Providing technical support to FP supply chain
- Ensuring adequate funding for FP
- Overseeing implementation of national FP plan



<sup>11</sup> Committees that had not developed policies, procedures, or action plans were marked as "not applicable" for this question, thereby removing them from the denominator.





PHOTO CREDIT: USAID GH-SC-PSM

## Finance and procurement

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

The survey asked whether there is a budget line item for contraceptives and, if so, the forecasted amount, amount allocated versus spent, sources of funding, and contraceptive procurement.

Total expenditures on FP commodities have trended upwards since 2010, despite stagnation in the share of government spending, which can be at least partially attributed to the COVID-19 pandemic.<sup>12</sup>

### Highlights

- 73 percent of respondent countries (32 of 44) have a government budget line item specifically for contraceptives, 75 percent of countries allocated government funds for contraceptive procurement in the most recently completed fiscal year, and 70 percent spent government funds on

contraceptives in the most recently completed fiscal year:

- An average of 47 percent of financing comes from government sources and 53 percent from in-kind donations.
- Expenditures on contraceptives in more than half the countries reporting (51 percent, or 21 countries) exceeded or met the country's forecasted demand. The remaining 49 percent 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. Government

funding sources comprise internally generated funds and other funds, which can include World Bank credits or loans, basket funds, and other funds provided to the government from a donor. Because governments count these World Bank credits, basket funds, and other funds as part of their national budget and they decide how to allocate and spend these funds, they are considered part of government funding. A total of 45 countries responded.

### Government Expenditures

Of 44 country responses, 75 percent (33 countries) allocated funds toward public-sector contraceptive procurement and 70 percent (31 countries) spent government funds on contraceptives for the most recently completed fiscal year (Exhibit 4). In 2019, 86 percent allocated funds and

<sup>12</sup> When accounting for estimated global inflation (World Bank consumer price index), the expenditure trends did not significantly change.



**EXHIBIT 4.**

Government spending by source, FY21 (U.S.\$) (n=42)

<b>COUNTRY</b>	<b>Internally generated funds spent</b>	<b>All other government funds spent</b>	<b>Total government funds spent</b>	<b>Internally generated funds as a percent of total</b>
<b>Angola</b>	\$0	\$6,727,963	\$6,727,963	0%
<b>Bangladesh</b>	\$21,606,912	\$47,614,794	\$69,221,706	31%
<b>Benin</b>	/	/	/	/
<b>Botswana</b>	\$1,017,974	\$0	\$1,017,974	100%
<b>Burkina Faso</b>	\$1,607,143	\$0	\$1,607,143	100%
<b>Burundi</b>	\$56,872	\$0	\$56,872	100%
<b>Cameroon</b>	/	/	/	/
<b>Cape Verde</b>	\$289,352	\$0	\$289,352	100%
<b>DRC</b>	/	/	/	/
<b>El Salvador</b>	\$1,979,583	\$0	\$1,979,583	100%
<b>Ethiopia</b>	\$1,030,574	\$17,691,061	\$18,721,634	6%
<b>Ghana</b>	\$0	\$2,573,715	\$2,573,715	0%
<b>Guatemala</b>	\$1,722,089	\$0	\$1,722,089	100%
<b>Guinea</b>	\$1,400,000	\$0	\$1,400,000	100%
<b>Haiti</b>	/	/	/	/
<b>Honduras</b>	\$2,215,218	\$0	\$2,215,218	100%
<b>Kenya</b>	\$2,284,810	\$5,504,569	\$7,789,379	29%
<b>Kyrgyz Republic</b>	\$65,000	\$12,000	\$77,000	84%
<b>Lao PDR</b>	\$135,000	\$0	\$135,000	100%
<b>Liberia</b>	/	/	/	/
<b>Madagascar</b>	\$0	\$0	\$0	0%
<b>Malawi</b>	\$293,333	\$6,231,640	\$6,524,974	4%
<b>Mali</b>	\$94,745	\$0	\$94,745	100%
<b>Mauritania</b>	\$27,375	\$104,307	\$131,682	21%
<b>Mozambique</b>	\$0	\$0	\$0	0%
<b>Nepal</b>	\$1,267,686	\$0	\$1,267,686	100%
<b>Niger</b>	\$327,869	\$0	\$327,869	100%
<b>Nigeria</b>	\$827,921	\$0	\$827,921	100%
<b>Pakistan</b>	\$9,241,612	\$0	\$9,241,612	100%
<b>Peru</b>	\$4,861,895	\$0	\$4,861,895	100%
<b>Philippines</b>	\$8,219,400	\$1,575,415	\$9,794,815	84%
<b>Rwanda</b>	\$0	\$0	\$0	0%
<b>Senegal</b>	\$228,982	\$0	\$228,982	100%

**EXHIBIT 4.**

Government spending by source, FY21 (U.S.\$) (n=42)

<b>COUNTRY</b>	<b>Internally generated funds spent</b>	<b>All other government funds spent</b>	<b>Total government funds spent</b>	<b>Internally generated funds as a percent of total</b>
<b>Sierra Leone</b>	\$0	\$0	\$0	0%
<b>South Sudan</b>	\$0	\$0	\$0	0%
<b>Sri Lanka</b>	\$1,204,200	\$0	\$1,204,200	100%
<b>Tanzania</b>	\$0	\$0	\$0	0%
<b>Togo</b>	\$227,727	\$0	\$227,727	100%
<b>Uganda</b>	\$354,600	/	\$354,600	100%
<b>Yemen</b>	\$0	\$0	\$0	0%
<b>Zambia</b>	\$535,680	\$0	\$535,680	100%
<b>Zimbabwe</b>	\$0	\$0	\$0	0%

79 percent spent funds on contraceptive procurement.

Of the countries that did use government funds to procure contraceptives, the proportion of government financing ranged from 2 percent (Burundi and Uganda) to 100 percent (Philippines), with the median rate being 40 percent. The government share of total spending across countries was 48 percent (in 2019 it was also 48 percent). The government share of total spending made up nearly the entire amount spent for Sri Lanka (97 percent), Bangladesh (95 percent), and Guatemala (91 percent). Government financing made up the majority for Botswana (89 percent), Peru (87 percent), Pakistan (86 percent), El Salvador (77 percent), Ethiopia (72 percent), Kyrgyz Republic (72 percent), Angola (62 percent), and Honduras (60 percent).

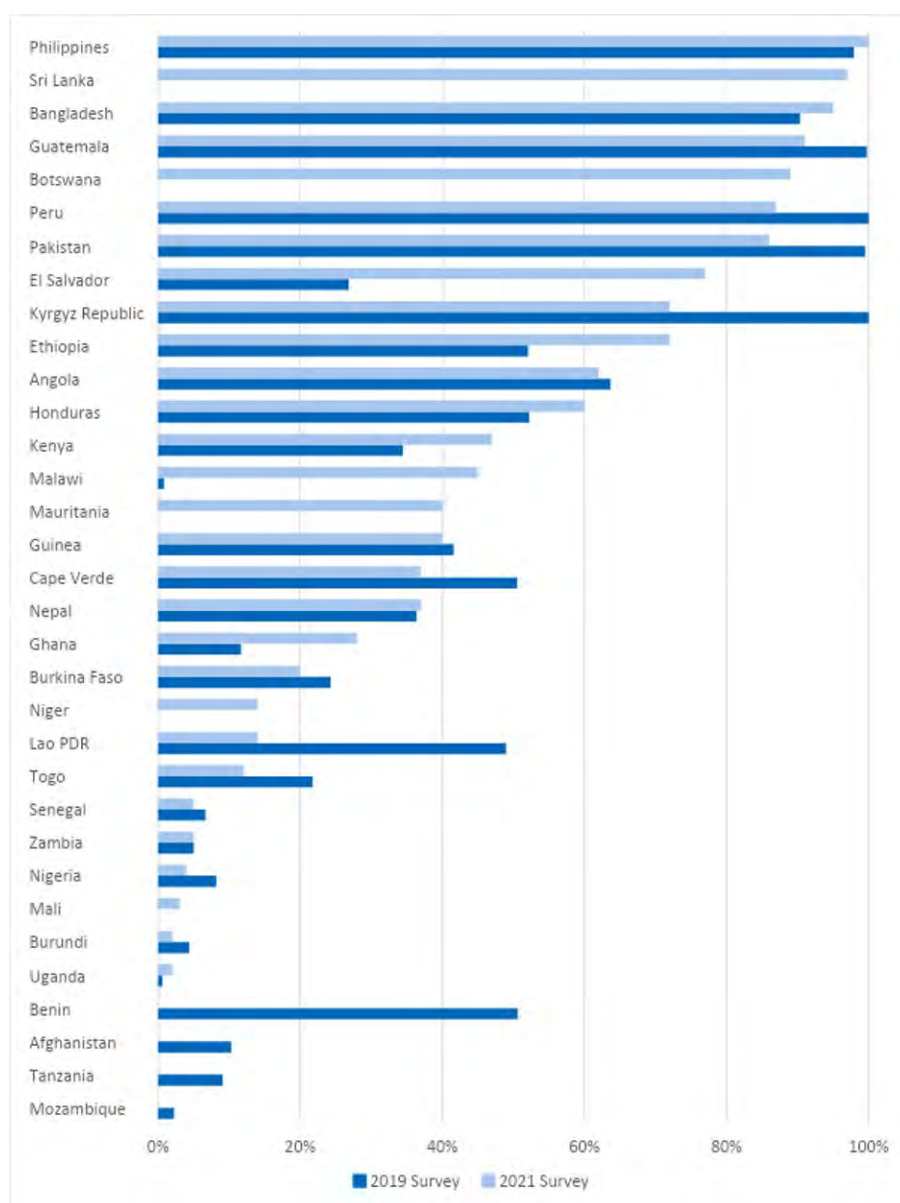
In 10 countries, no government funds were used to procure public-sector contraceptives: DRC, Haiti, Madagascar, Mozambique, Rwanda, Sierra Leone, South Sudan, Tanzania, Yemen, and Zimbabwe. Three countries did not provide any data on government spending amounts: Benin, Cameroon, and Liberia.

## EXHIBIT 5.

Total government spending as a share of total spending on public-sector contraceptives, 2021 and 2019 (n=42)<sup>13</sup>

Of the 29 countries that used government funds for contraceptives, in 19 countries (66 percent) internally generated funds were the only source of government funds used toward the purchase of contraceptives. In 2019, only two countries had this designation (India and Peru).

34 percent (10 countries) used other government funding (Exhibit 6).<sup>14</sup>

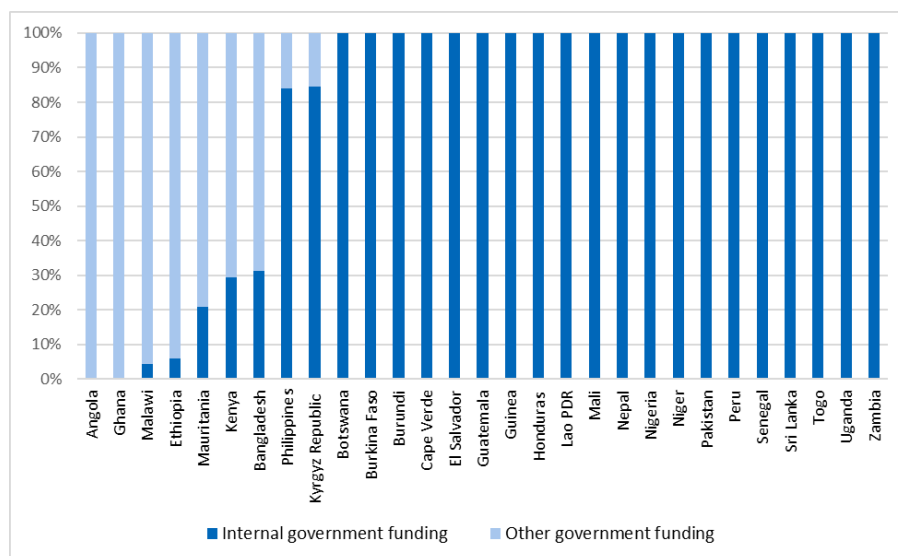


<sup>13</sup> Excludes Benin, Cameroon, DRC, Haiti, Liberia, Mozambique, Rwanda, Sierra Leone, South Sudan, Tanzania, Yemen, and Zimbabwe that spent no government funds, or where spending was unknown.

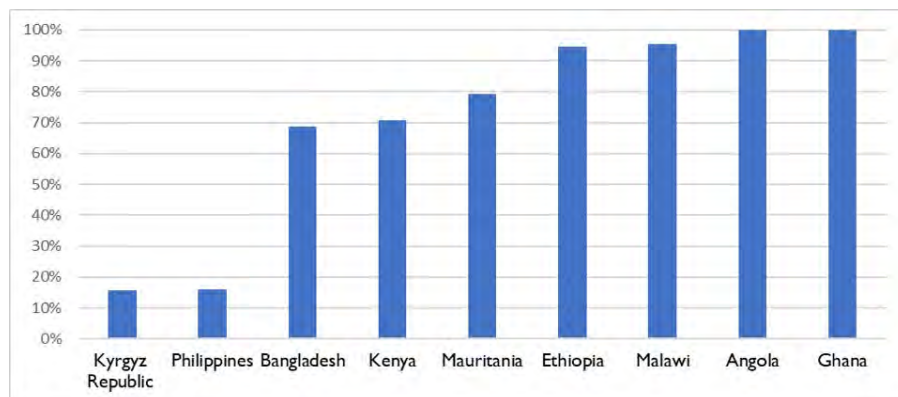
<sup>14</sup> One country, Benin, did not know whether government funds had been allocated or spent.

**EXHIBIT 6.**

Share of government spending on contraceptives by government funding source (n=29)<sup>15</sup>

**EXHIBIT 7.**

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



## In-Kind Donations and Global Fund Grants

Of 42 countries, all but one, the Philippines, received in-kind donations (Exhibit 8). For 13 countries, in-kind donations were the sole funding sources for procuring contraceptives. For 17 countries, in-kind donations were 53 percent to nearly 100 percent of total contraceptive funding. In the remaining 11 countries, funding from in-kind donations ranged from 3 percent (Sri Lanka) to 40 percent (Honduras).

Donations from the UN accounted for the largest amount (29 percent), followed by USAID (14 percent), Global Fund (5 percent), other donations (2 percent), and other bilateral (1 percent).

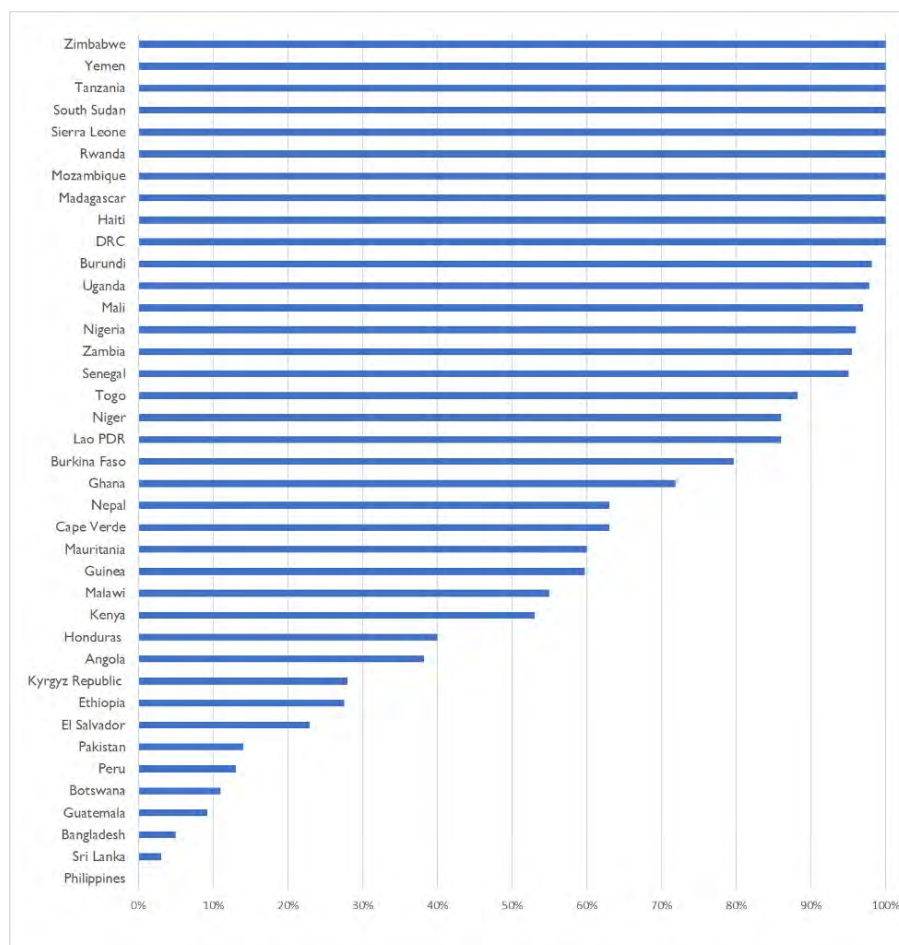
The trend over the last decade has been toward increasing donations as a share of spending on contraceptives, while government spending was also increasing, although at a slower rate.

<sup>15</sup> Excludes Afghanistan, Benin, Cameroon, Liberia, Sierra Leone, Zimbabwe, Yemen, Ukraine, Rwanda, Mozambique, Tanzania, Haiti, and DRC.

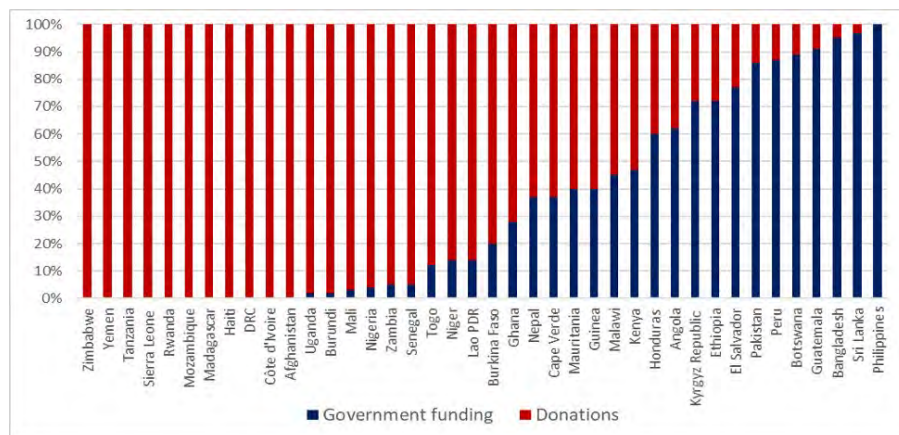
**EXHIBIT 8.**

In-kind donations and grants as a percentage of total spending on public-sector contraceptives (n=42)<sup>16</sup>

In terms of total spending, 47 percent of financing came from government sources and 53 percent from in-kind donations (Exhibits 9 and 10). In 2019 this was 38 and 62 percent, respectively.

**EXHIBIT 9.**

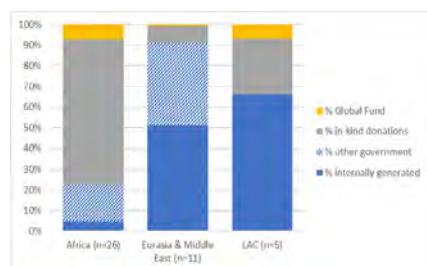
Percentage of total spending on public-sector contraceptives by funding source (n=40)



<sup>16</sup> Excludes Benin, Cameroon, and Liberia, where amounts were unknown.

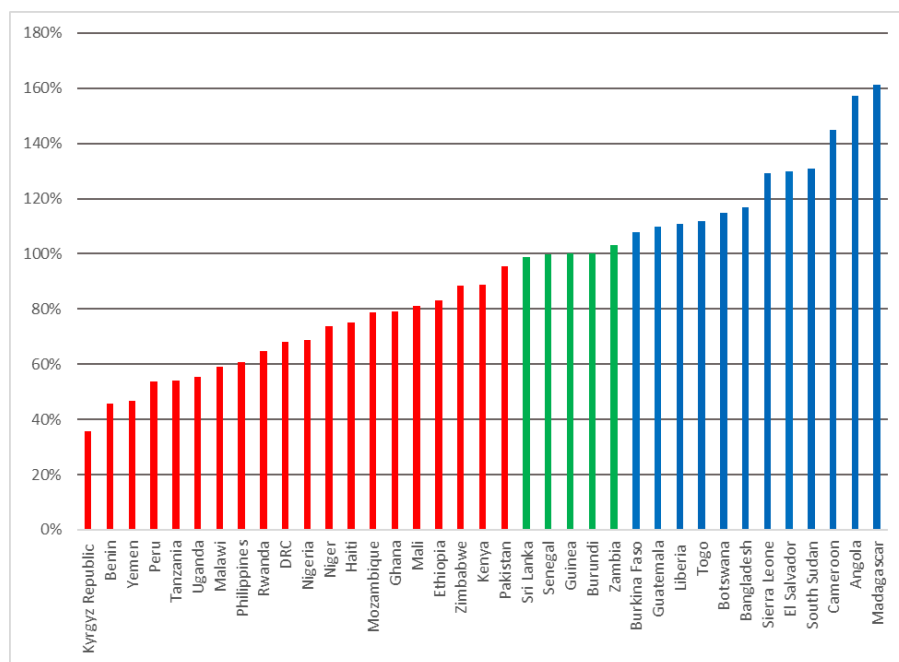
**EXHIBIT 10.**

Total contraceptive spending by source and region (n=42)<sup>17</sup>

**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 be spent on contraceptives. In 32 of 44 countries (73 percent), there is a budget line item for FP commodities. In 2019, this was 76 percent, and in 2017, 80 percent.

Of the 32 countries (73 percent) that have a budget line item, 70 percent (31 countries) spent government funds on contraceptives.<sup>18</sup> This was 87 percent in 2019. Six countries have a budget line item but did not use government funds (Cameroon, DRC, Haiti, Mozambique, Rwanda, Tanzania). Five countries (Botswana, El Salvador, Ghana, Mali, Philippines) do not have a budget line item but used government funds to procure contraceptives. One country answered “don't know” about budget line item but spent government funds (Angola). Four countries (Madagascar, Sierra Leone, Yemen, Zimbabwe) do not have a budget line item and did not spend government funds.



Key: Red = 32–96 percent of funding need met, Green = 99–103 percent of funding need met, Blue: 108–161 percent of funding need met.

**EXHIBIT 11.**

Percentage of quantified need covered by any source of funding (n=42)<sup>20</sup>

**Financing Gap for Procurement of Public-sector Contraceptives**

Of 41 countries, 20 (49 percent) had a funding gap between the forecasted need and available financing (Exhibit 11).<sup>19</sup>

<sup>17</sup> Benin, Cameroon, and Liberia were excluded from this analysis due to lack of data on the amount of government spending.

<sup>18</sup> 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 12-month period for which data were available, at the time of the survey. Commodities delivered in one year may have been planned for an earlier or later year. Similarly, commodities may have been planned for a year but not actually delivered in that year.

<sup>19</sup> The Limitations section discusses some of the explanations for the fluctuations in this indicator result.

<sup>20</sup> Outliers not shown: Nepal 232%, Cape Verde 273%, Honduras 321%, Lao PDR 722%



# 07.

## Commodities



PHOTO CREDIT: USAID GHSC-PSM

## Commodities

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

The survey gathered information on the following 13 methods:

- Combined Oral Contraceptive (COC) pills
- Progestin-Only Pills (POPs)
- Injectables
- Implants
- Intrauterine Devices (IUDs)
- Male condoms
- Female condoms
- Emergency contraceptive pills (EC)
- Long-acting permanent methods for males (vasectomy)

- Long-acting permanent methods for females (tubal ligation)
- Contraceptive patches
- Vaginal contraceptive rings
- Fertility awareness-based methods (FAM)<sup>21</sup>

### Highlights

- Countries offer on average eight of the 13 assessed contraceptive methods: 10 in public-sector facilities, nine through the commercial/private sector, eight in non-governmental facilities, and six through social marketing.
- 89 percent of countries offer at least eight of the 13 assessed contraceptive methods in the public sector.

- The commercial/private sector offers the five most common contraceptives (male condoms, combined oral contraceptives, injectables, intrauterine devices, and contraceptive implants) in 73 percent of reporting countries.

### 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 44 out of 45 countries through the public sector and through NGOs in 93 percent of countries. Implants are offered in the public sector in 91 percent of the countries and through NGOs in 93 percent. Permanent methods—vasectomy and tubal ligation—are more often offered through the public sector than any other

<sup>21</sup> Fertility-awareness based methods (FAM) is a broad and inclusive term that encompasses calendar-based FP methods, as well as symptoms-based methods such as gauging body temperature and cervical secretions. The CSI survey uses the term “calendar-based awareness methods” referring specifically to cycle beads. The GHSC-PSM project is responsible for procurement and delivery of contraceptive products (such as cycle beads) and does not conduct training on symptoms-based FP methods.

sector: Emergency contraceptives are more commonly offered in the commercial/private sector than in other sectors.

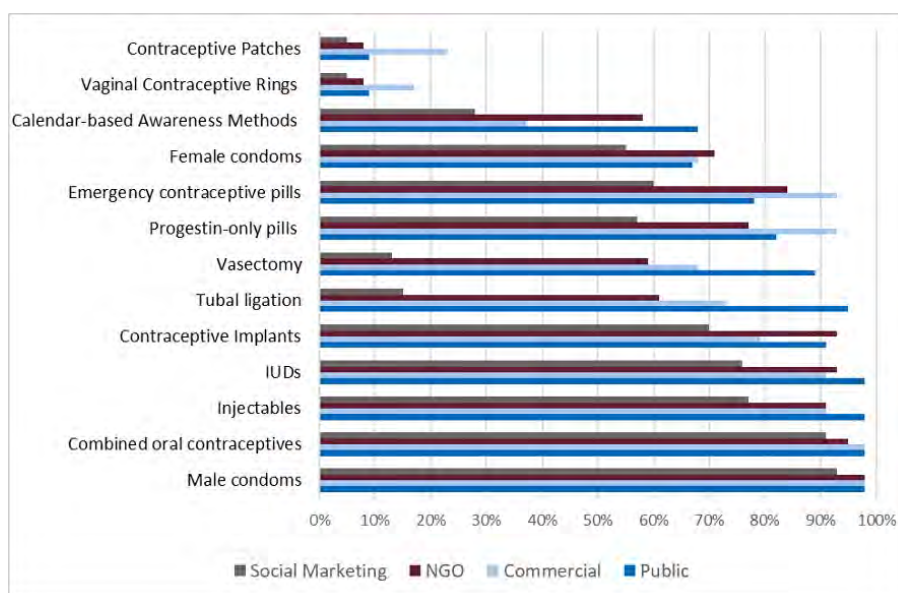
## Public Sector

Of all 45 countries surveyed, 89 percent offer at least eight of the 13 assessed contraceptive methods in the public sector, and 91 percent offer all five of the most commonly offered methods in public-sector facilities (male condoms, COCs, injectables, IUDs, and implants) (Exhibit 12). In 2019, this was 91 percent and 95 percent, respectively.

All but one country offers COCs, injectables, IUDs, and male condoms in the public sector. Most countries offer tubal ligation (95 percent), implants (91 percent), vasectomy (89 percent), POPs (82 percent), emergency contraceptive pills (78 percent), female condoms (67 percent) and fertility awareness-based methods (FAM), (68 percent). Only a small percentage offer vaginal contraceptive rings and contraceptives patches (both 9 percent).

## EXHIBIT 12.

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



## NGOs

In most countries, male condoms (98 percent), COCs (95 percent), IUDs and implants (both 93 percent), injectables (91 percent), emergency contraceptives (84 percent), and POPs (77 percent) can be found through the NGO sector. Vasectomy (59 percent) and tubal ligations (61 percent) are offered less frequently. Female condoms (71 percent), FAM (58 percent), and vaginal contraceptive rings and contraceptive patches (both 8 percent) are not as commonly found at NGO facilities. An average of eight of 13 methods are available in the NGO sector, and five of the most common methods can be found in the NGO sector in 80 percent of reporting countries. Since 2017, the availability of implants in the NGO sector has increased slightly from 88 percent in 2017 and 90 percent in 2019. Similarly, contraceptive patches have also increased from 4 percent in 2017 and 7 percent in 2019. The availability of all other methods has remained relatively stable.

## Commercial/Private Sector

COCs and male condoms are available through the commercial/private sector in almost all countries. ECs, POPs (both 93 percent), injectables and IUDs (both 91 percent) are commonly offered. Implants (79 percent), vasectomy and

female condoms (both 68 percent) are less commonly offered. FAM (37 percent), vaginal contraceptive rings (17 percent), and contraceptive patches (23 percent) are less likely to be found in the commercial/private sector. An average of 9 of 13 methods are available in the commercial/private sector, and five of the most common methods can be found in this sector in 73 percent of reporting countries. Compared with 2019, several methods offered are trending upward in the commercial/private sector: POPs (88 percent in 2019), injectables (85 percent), implants (69 percent), IUDs (68 percent), vasectomy (63 percent), and female condoms (58 percent).

## Social Marketing

Male condoms (93 percent), COCs (91 percent), injectables (77 percent) and IUDs (76 percent) are offered through social marketing in most countries. Implants, POPs, emergency contraceptives (ECs), and female condoms can be found in between 55 and 70 percent of countries. FAM (28 percent), contraceptive patches and vaginal contraceptive rings (both 5 percent) are less commonly found through social marketing. An average of six the 13 methods are available in the social marketing sector, and five of the most common methods can be found in the social marketing sector in 56 percent of reporting countries. The availability of contraceptives on offer in this sector has been relatively stable, although 2021 saw decreases in the availability of male condoms (98 percent in 2019) and injectables (82 percent in 2019). There has been a significant decline in FAM, from 44 percent in 2019.

# 08.

## Policies



PHOTO CREDIT: USAID GHSC-PSM

## Policies

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

A 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 commercial/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.
- Whether there are duties on commodities or charges to clients for services or commodities
- Whether or not national health insurance covers the cost of FP services and/or commodities
- Which contraceptives are on the National Essential Medicines List (NEML)
- The extent of promotion of family planning, by channel (social marketing, mass media, mobile outreach and education, community mobilization and engagement)

The survey collected information on:

- Whether countries have national strategies that include contraceptive security
- 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 by sub-populations

<sup>21</sup> Fertility-awareness based methods (FAM) is a broad and inclusive term that encompasses calendar-based FP methods, as well as symptoms-based methods such as gauging body temperature and cervical secretions. The CSI survey uses the term “calendar-based awareness methods” referring specifically to cycle beads. The GHSC-PSM project is responsible for procurement and delivery of contraceptive products (such as cycle beads) and does not conduct training on symptoms-based FP methods.

- The approximate proportion of FP providers trained in implant and IUD insertion and removal
- A country's FP2020 and FP2030 commitments to expand access 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 needs of young people. There is also a common sentiment that reproductive rights are linked to basic human rights. Some countries are making efforts to increase access to FP services for rural and disadvantaged populations.

Short-term methods (male and female condoms) are readily available in the public sector through the lowest-level provider; community health workers (CHWs). Oral contraceptives (71 percent) can be provided by CHWs in most countries through the public sector, although less frequently in the private sector (45 percent). However, subcutaneous (57 percent) and intramuscular (31 percent) injectables, a popular method, are less frequently dispensed by CHWs in the public sector, and even less in the private sector (29 and 21 percent, respectively). In the public sector, CHWs were the most cited, lowest level provider for half of the 14 listed FP methods. In the private sector, nurses were more frequently cited as the lowest level provider, cited most for 57 percent of the listed methods.

More than half of the countries (65 percent) have at least 50 percent of their providers trained to insert or remove implants and IUDs. This is an increase from 41 percent in 2019.

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

- In 51 percent of countries (23 of 45 reporting), FP commodities are subject to duties in at least one sector (public, commercial/private, NGO, or social marketing).
- 18 percent of countries (seven of 40) have policies that hinder the ability of the private sector to provide contraceptives, while 93 percent of countries (38 out of 41) have policies that enable the private sector
- 20 percent restrict access to contraceptives by unmarried people ages 15–19, and 16 percent by married people ages 15–19.
- On average, countries included nine of 12 methods on their National Essential Medicines List.
- Mass media is the most popular channel for promoting family planning; 96 percent of countries (43 out of 45) reported using this promotion channel at least to some extent, while 31 percent reported using it extensively.

## National Strategy Objectives for Contraceptive Security

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

- Increase availability of and access to FP services
- Increase modern method contraceptive prevalence rate (mCPR)
- Reduce or maintain stockout rates of FP products
- Ensure an adequate variety of FP methods available
- Reduce unmet need for FP services
- Coordinate with government stakeholders to maintain or increase dedicated FP budgets
- Reduce maternal, neonatal, and child mortality

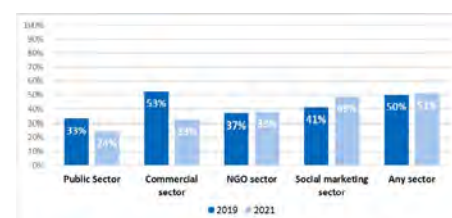
## Policy Barriers Impacting Access to or Provision of Contraceptives

### Duties

On average, 51 percent of countries (23 of 45) are subject to duties on FP commodities in any sector (Exhibit 13). In 24 percent of countries (11 of 45) with the information, public-sector FP commodities are subject to duties. In 2019 this was 33 percent. Duties are applied to the social marketing sector in 49% of the countries (21 of 43), the NGO sector in 38 percent of the countries (16 of 42), and 33 percent in the private sector (14 of 43).

### EXHIBIT 13.

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

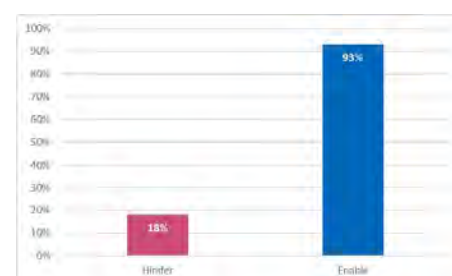


## Policies that impact the ability of the private sector to provide contraceptives

Of all country respondents, 18 percent (7 of 40) reported there are policies that hinder the ability of the private sector to provide contraceptives (Exhibit 14).

### EXHIBIT 14.

Policies that enable or hinder private-sector provision of contraceptives (n=41)

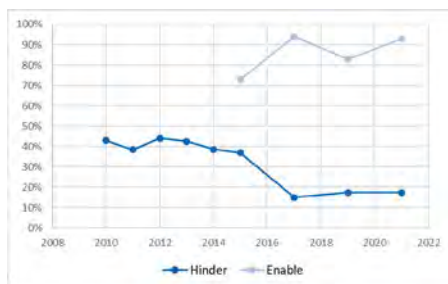




The percentage of countries reporting the existence of policies hindering the private sector's distribution of contraceptives has declined over the survey years from 43 percent of countries in 2010 (15 of 35) to 18 percent in 2021, remaining steady for the last several years. Examples of such barriers include import and other taxes, burdensome registration processes for FP commodities, branding and marketing restrictions for contraceptives, and specific permissions needed to import contraceptives.

### EXHIBIT 15.

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



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

Examples of enabling policies toward the private sector include:

- Facilitating better coordination between the government and the private sector
- Building capacity of health care providers to deliver FP services
- Expanding availability of and access to contraceptives in the private and public sectors (through social marketing in particular)

- Increasing variety of contraceptive methods available
- Increasing client access to reproductive health information

### 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, the community health worker is the lowest-level provider who can either sell or dispense male and female condoms (both 84 percent) in the public sector (Exhibit 16). For long-acting reversible methods—implants and IUDs—clients must go to higher-level providers in most countries. 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 of countries in which clients can access the method from the provider in the public sector:

- **Implants:** CHW or auxiliary nurse (both 10 percent), auxiliary nurse midwife (33 percent), nurse (33 percent), clinical officer (2 percent), doctors (12 percent).
- **IUDs:** The CHW and the clinical officer are the lowest-level providers in 4 percent of the countries, the auxiliary nurse (16 percent), auxiliary nurse midwife (38 percent), nurse (33 percent), clinical officer (2 percent), and doctor (7 percent).
- **Injectables (subcutaneous):** In more than half of the countries the CHW can provide this product (57 percent), 11 percent can go to the auxiliary nurse or auxiliary nurse midwife, and 16 percent to nurses. Five percent must go to the doctor. The clinical officer was not a provider in any country.
- **Injectables (intramuscular):** In nearly one-third of the countries,

clients can go to the CHW (31 percent) to receive this injectable, while 20 percent can go to auxiliary nurses, 22 percent to the auxiliary nurse midwife, and 24 percent to nurses. Two percent must go to doctors. The clinical officer was not a provider of intramuscular injectables in any country.

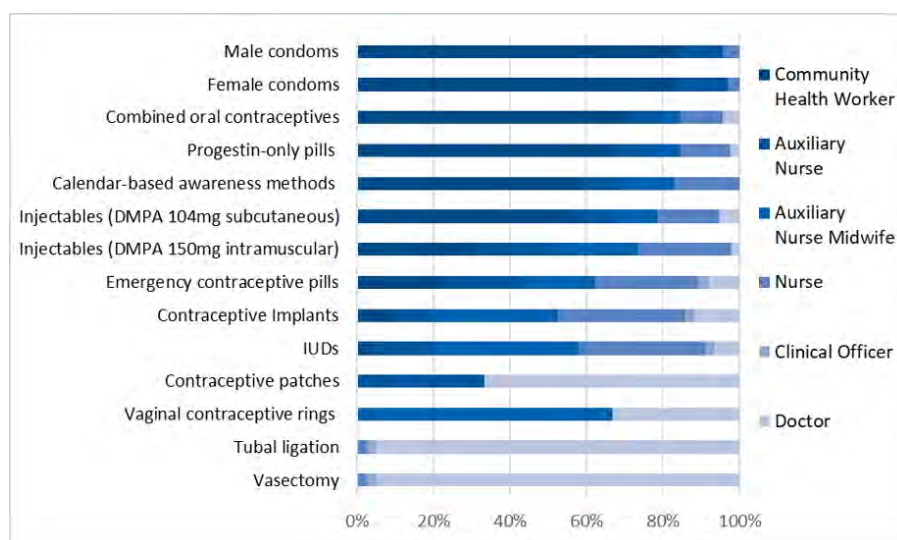
- **COCs:** CHW (71 percent), auxiliary nurse (9 percent), auxiliary nurse midwife (4 percent), nurse (11 percent), and doctor (4 percent). The clinical officer was not a provider of COCs in any country. In the Kyrgyz Republic, clients must see a doctor to receive COCs.
- **POPs:** CHW (67 percent), auxiliary nurse (10 percent), auxiliary nurse midwife (8 percent), nurse (13 percent), and doctor (3 percent). The clinical officer was not a provider in any country. In the Kyrgyz Republic, clients must see a doctor to receive POPs.
- **Emergency contraceptive pill:** CHW and auxiliary nurse (both 22 percent), auxiliary nurse midwife (19 percent), nurse (27 percent), clinical officer (3 percent), and doctor (8 percent).
- For permanent methods of vasectomy and tubal ligation, most clients must go to a doctor (both 95 percent), a clinical officer (3 percent and 2 percent, respectively), or a nurse (3 percent each). Neither method is accessible in any country through a CHW, auxiliary nurse or auxiliary nurse midwife.

## EXHIBIT 16.

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 17):

- **Implants:** In most countries, clients must go to a nurse (35 percent) or doctor (26 percent) to access implants. Contraceptive implants are also accessible through CHWs (6 percent), an auxiliary nurse (9 percent), an auxiliary nurse midwife (21 percent), and clinical officer (3 percent). Compared with 2019, there has been an increase from 13 to 21 percent for auxiliary nurse midwives, and a decrease from 11 to 3 percent for clinical officers.
- **IUDs:** To access IUDs, clients in most countries must visit an auxiliary nurse midwife (32 percent), nurse or doctor (both 29 percent). In 3 percent of reporting countries, the lowest-level providers for IUDs are clinical officers or CHWs; 5 percent are auxiliary nurse. The percentage of auxiliary nurse midwives as the lowest-level provider to dispense/sell IUDs in the private sector has doubled since 2019 (from 16 to 32 percent).
- **Injectable (subcutaneous):** CHW or nurse (both 29 percent), auxiliary nurse (20 percent), auxiliary nurse midwife or doctor (both 11 percent). The clinical officer was not a provider in any country. Auxiliary nurse and auxiliary nurse midwife saw notable increases from 2019 (from 9 to 20 percent, and from 3 to 11 percent, respectively).
- **Injectable (intramuscular):** CHW or auxiliary nurse (21 percent), auxiliary nurse midwife (13 percent), nurse (33



percent), doctor (13 percent). Clinical officers decreased from 8 percent in 2019 to 0 in 2021, while auxiliary nurse increased from 13 to 21 percent during the same period.

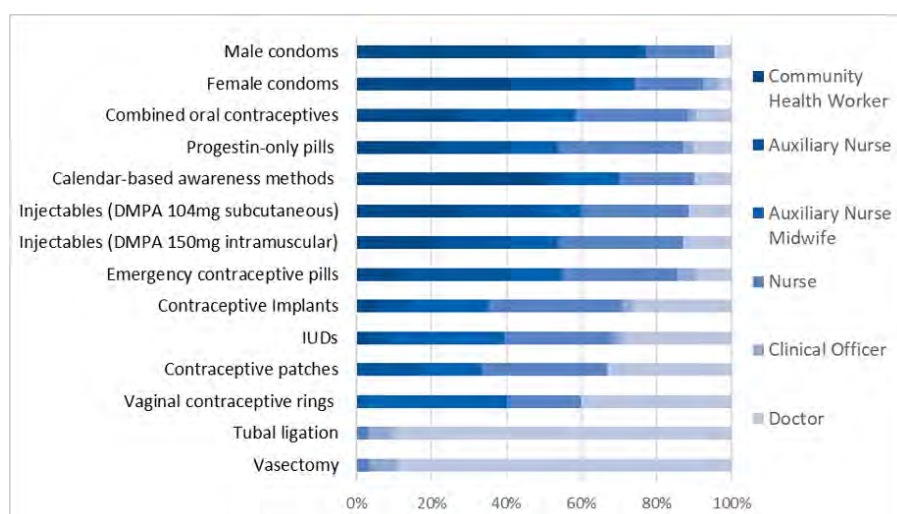
- **COCs:** CHW (28 percent), auxiliary nurse (21 percent), auxiliary nurse midwife (9 percent), nurse (30 percent), clinical officer (2 percent), doctor (9 percent). The results were similar in 2019 except for auxiliary nurse, which doubled from 10 percent to 21 percent in 2021.
- **POPs:** CHW or auxiliary nurse (both 21 percent), auxiliary nurse midwife (13 percent), nurse (33 percent),

clinical officer (3 percent), doctor (10 percent).

- **ECs:** CHW (12 percent), auxiliary nurse (29 percent), auxiliary nurse midwife (14 percent), nurse (31 percent), clinical officer (5 percent), doctor (10 percent). Auxiliary nurses and auxiliary nurse midwives both increased from 14 and 8 percent, respectively, in 2019; while clinical officers decreased from 14 percent in 2019 to 5 percent in 2021.

## EXHIBIT 17.

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





## EXHIBIT 18.

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

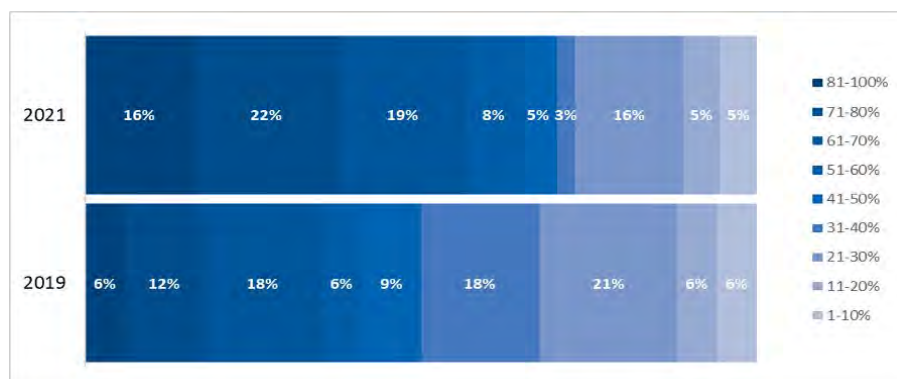
### Provider skills in implant and IUD insertion and removal

The survey asked the approximate percentage of public-sector FP providers trained in implant and IUD insertion and removal (Exhibit 18). Sixteen percent said 81–100 percent of providers are trained, 22 percent responded 71–80 percent are trained, 19 percent with 61–70 percent, 8 percent with 51–60 percent, 5 percent with 41–50 percent, 3 percent with 31–40 percent, 16 percent with 21–30 percent, and 5 percent with 11–20 percent and 1–10 percent. In 2019, 36 percent of countries had at least 71 percent of public sector FP providers who could place and remove implants and IUDs. In 2021, that percentage increased to more than half of reporting countries (57 percent).

### 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: unmarried youth, married youth, rural, disadvantaged sub-regions, populations with lower educational attainment, lower-income populations, disabled, minority populations (ethnic or religious groups), and other (migrants, internally displaced populations).

Most countries have supportive policies among the sub-populations (Exhibit 19). These include married youth in 89 percent (ages 15–19 years) and 80 percent (ages 20–24 years) of countries, and for unmarried youth with 76 percent (ages 15–19 years) and 80 percent (ages 20–24 years).



Ninety-one percent of countries have policies to enable access to FP for the rural population, 86 percent for those in disadvantaged sub-regions, 84 percent for those with lower education, 89 percent for those with lower incomes, 86 percent for those who are disabled, 82 percent for minority populations, and 83 percent for those who are considered migrants or internally displaced populations. Compared with 2019, there is a higher percentage of countries with laws, regulations, or policies that enable access to FP services among all sub-populations. The most notable increase is in policies for migrant and internally displaced populations, which rose from 67 to 83 percent.

There are countries that have policies hindering access to FP for those between 15 and 19 who are either unmarried (20 percent, or 9 of 45 countries) or married (16 percent, or 7 of 45 countries) and those who are unmarried between the ages of 20 and 24 (7 percent, or three of 45 countries)—Bangladesh, Honduras, and Yemen).

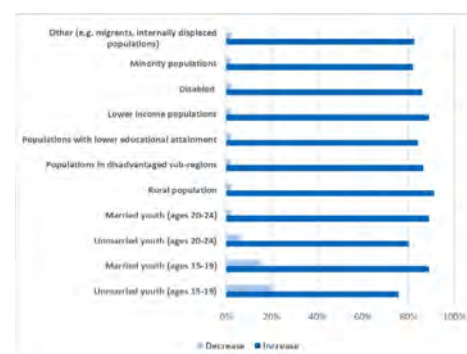
Examples of policy barriers include:

- Restrictions on selling contraceptives to anyone under age 18
- Unmarried youths 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 19.

Laws, regulations, or policies that enable or hinder access to FP services among sub-populations



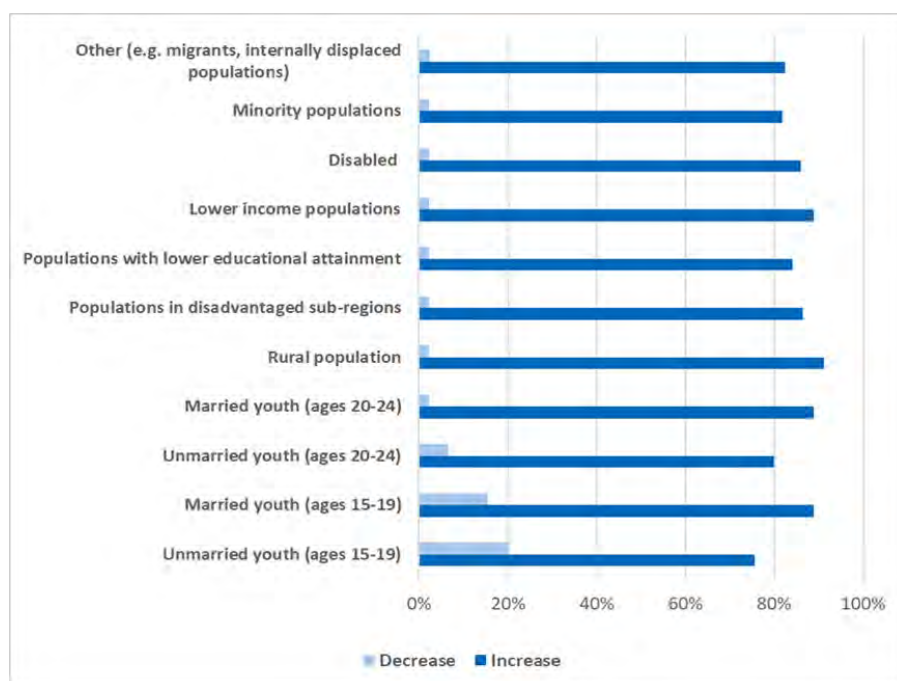
## Cultural practices that impact the ability of sub-populations to access family planning services and contraceptives

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

Seventy-three percent of countries have supportive practices toward unmarried youth (ages 15–19) and 71 percent for unmarried youth ages 20–24. Supportive practices exist for married youth ages 15–19 and ages 20–24 in 78 percent of responding countries (Exhibit 20). Practices exist that increase access to FP for rural populations (80 percent), disadvantaged sub-regions (67 percent), lower education (75 percent), lower income (71 percent), disabled (66 percent), minority populations (67 percent), and migrants or internally displaced populations (65 percent).

Less than half of the countries responded that there are cultural practices that hinder access for unmarried youth ages 15–19 (40 percent). These cultural and operational barriers were also noted in 27 percent of the countries for married youth in the same age group. For the 20–24 age group it is 20 percent for unmarried youth, and 11 percent for married youth.

In 26 percent of the countries, practices hinder access for minority populations. For rural populations, those with lower education, low income or disabled, 20 percent of countries have practices hindering access. A similar percentage exists for disadvantaged sub-regions (23 percent) and migrants or internally displaced populations (22 percent).



### EXHIBIT 20.

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

## Charges to Clients

Fees are charged to clients for family planning services in 14 of 45 countries (31 percent) and in 11 of 45 countries (24 percent) for commodities. In comparison, in 2019 this was 31 and 37 percent, respectively; in 2017 this was 33 and 31 percent, respectively; 23 for both in 2015, and 15 and 24 percent, respectively, in 2010.

Government health insurance covers FP fees in 6 of 18 countries (33 percent). This was not applicable in 14 countries where no fees were charged.

## National Essential Medicines List

An average of nine contraceptives are on the National Essential Medicines List (NEML) of reporting countries. All countries have COCs and injectables on their NEML (Exhibit 21). Nearly all countries include implants and IUDs (copper bearing) (both 96 percent), POPs (93 percent), and male condoms and ECs (both 91 percent). Fewer countries include female condoms (71 percent), hormone-releasing IUDs (61 percent), contraceptive patches (19 percent), vaginal contraceptive rings (21 percent), FAM (47 percent), and other contraceptives (10 percent).

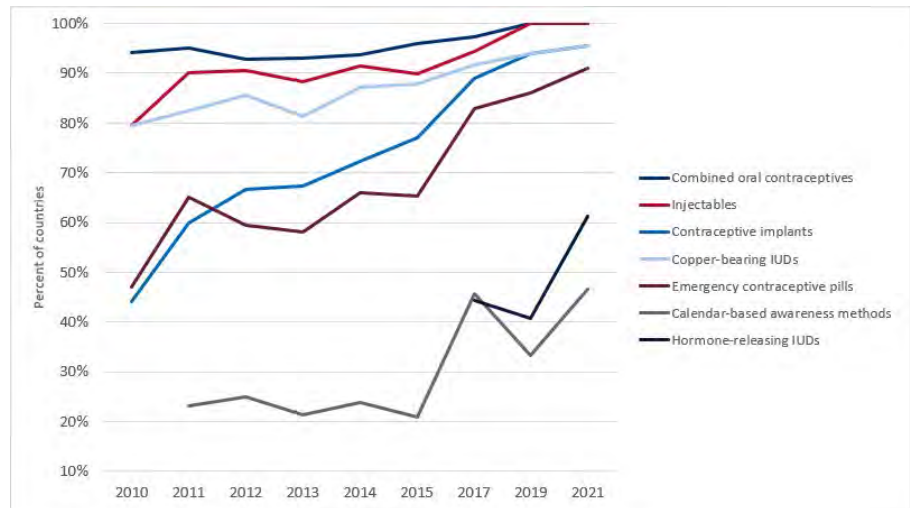
The percentage of countries increased from 2019 for copper-bearing IUDs (95 percent), ECs (84 percent), hormone-releasing IUDs (40 percent), contraceptive patches and vaginal contraceptive rings (both 17 percent), and FAM (37 percent). It decreased for implants (98 percent), male condoms (93 percent), and female condoms (74 percent).

**EXHIBIT 21.**

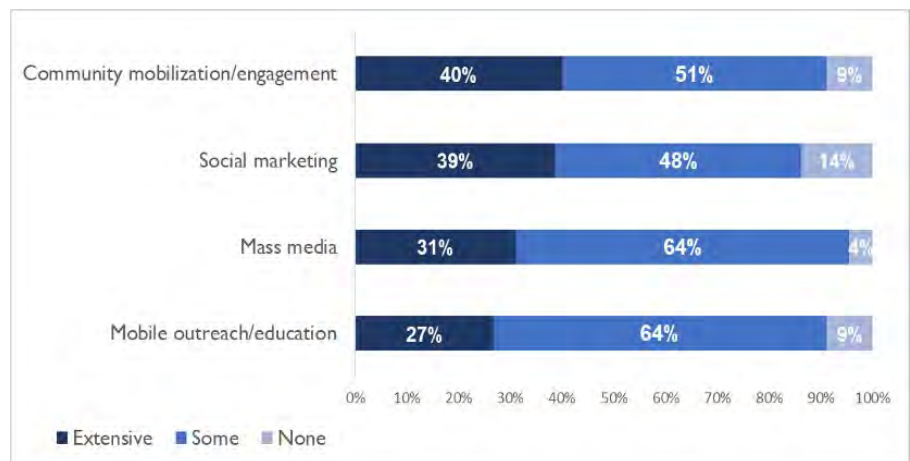
Percentage of countries with methods included in the NEML, 2015-2021 surveys

**Promotion of Family Planning**

The survey asked if family planning is actively promoted through social marketing, mass media, mobile outreach/education, or community mobilization/engagement channels either extensively, somewhat, or not at all (Exhibit 22). When looking at channels used either “extensively” or “some,” mass media is the most popular channel (96 percent), followed by community mobilization/engagement and mobile outreach/education (both 91 percent), and social marketing (86 percent). Fourteen percent do not do any promotion through social marketing, 9 percent each do not do any promotion through community mobilization/engagement or mobile outreach, and 4 percent do not promote through mass media. Forty-four percent noted FP is promoted through other channels. Respondents could indicate multiple channels.

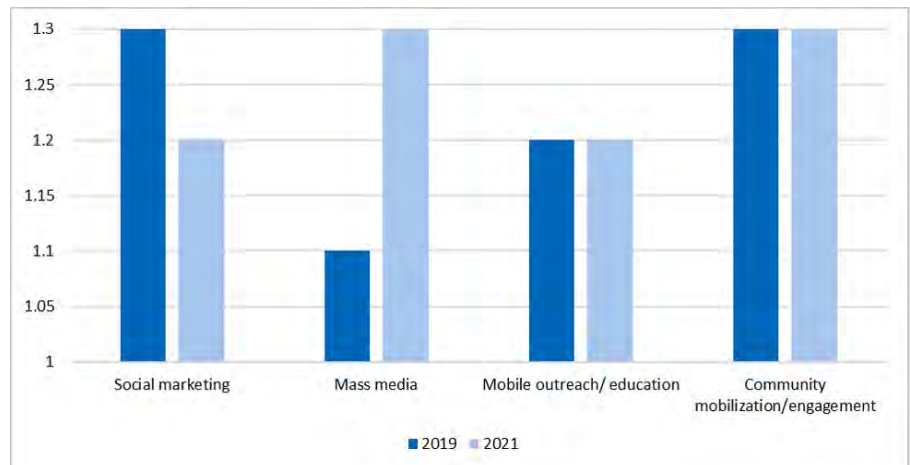
**EXHIBIT 22.**

Promotion of FP by channel

**EXHIBIT 23.**

Promotion by FP channel – change since 2019

In 2021, as shown in Exhibit 23 above, there was a shift toward greater use of mass media and a small corresponding shift away from social marketing. Mobile outreach/education and community mobilization/engagement did not show any change.



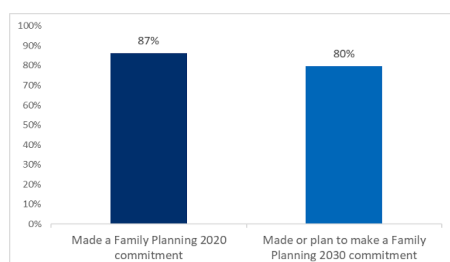
0 = None 1 = Some 2 = Extensive

## FP2020 and FP2030 Commitments

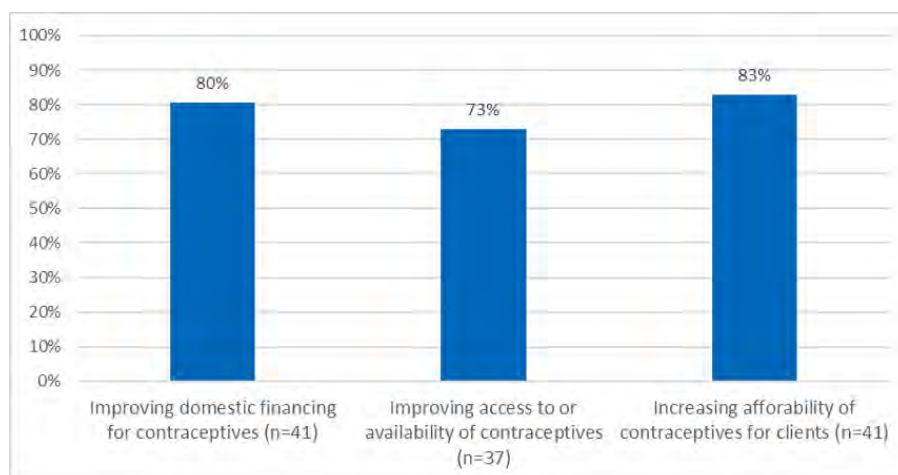
Eighty-seven percent of surveyed countries made a Family Planning 2020 commitment, while 80 percent (36 countries) have made or plan to make a Family Planning 2030 commitment (Exhibit 24). An additional 5 countries (11 percent) were uncommitted at the time of the survey. As noted in the methodology section, this was one of the main criteria for countries to be selected for the survey.

### EXHIBIT 24.

Percentage of countries with FP2020 and FP2030 commitments



Among countries that either made (42 percent) or plan to make (38 percent) an FP2030 commitment, 80 percent (33 of 41 countries) committed or plan to commit to improve domestic financing for contraceptives, 73 percent (27 of 37) committed or plan to commit to increasing affordability of contraceptives for clients, and 83 percent (34 of 41) committed or plan to commit to improve access or availability of contraceptives (see Exhibit 25). Four countries that already provide free or highly subsidized contraceptives to clients (Mauritania, Niger, Pakistan, and Sierra Leone) were excluded from the denominator for the commitment to increase affordability of contraceptives. Other countries reported that they were unsure about one or more of these commitment areas.



### EXHIBIT 25.

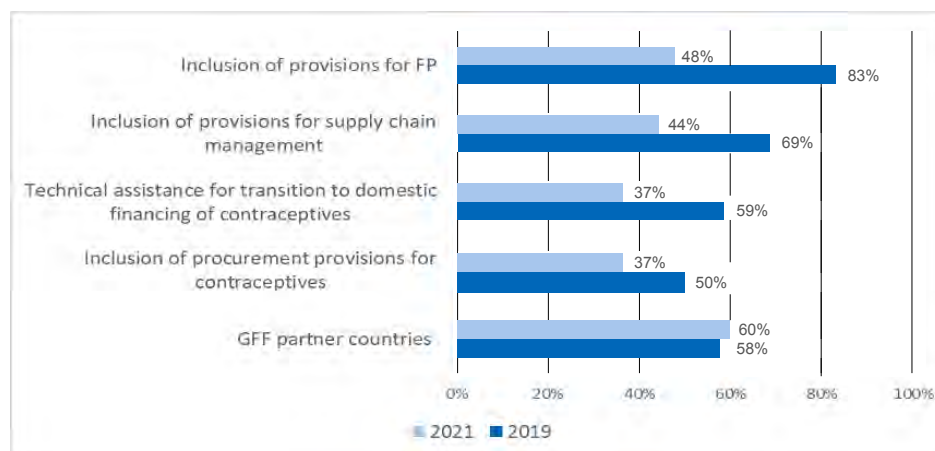
Areas of FP2030 commitments among countries that made or plan to make an FP2030 commitment

## Global Financing Facility

Sixty percent (27 of 45) are Global Financing Facility partners (Exhibit 26). Forty eight percent of these (13 of 27) have financing for inclusion of provisions for FP, 37 percent (10 of 27) have provisions for procuring contraceptive commodities, 44 percent (12 of 27) have funding for supply chain management, and 37 percent (10 of 27) have provisions for technical assistance for transition to domestic financing of contraceptives.

### EXHIBIT 26.

Global Financing Facility partnership areas among GFF partner countries (n=27)



Note: Among the 27 GFF partner countries, the percentages for each partnership area are based on countries that had information to report on those areas.



# 09.

## Supply Chain



PHOTO CREDIT: USAID GHSC-PSM

## Supply Chain

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

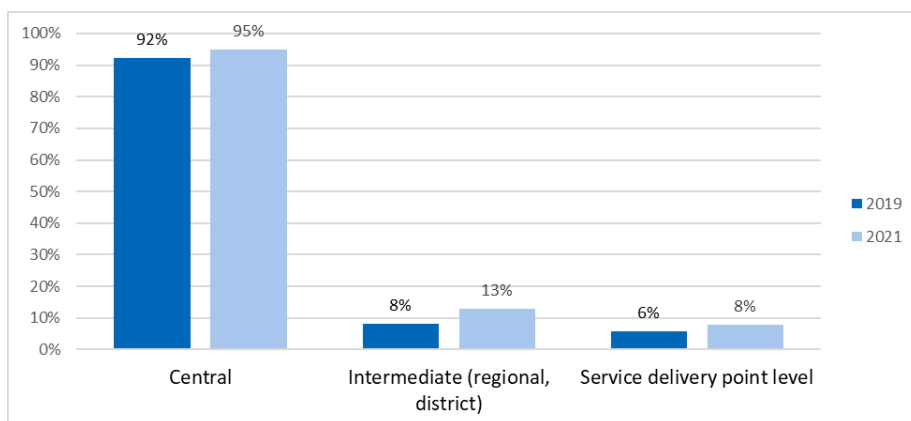
Countries were asked to provide the number of stockouts observed during the previous 12-month period at the central level, out of the total stock observations for each product in that time period. At the SDP level, data were collected on the percentage of facilities stocked out of each contraceptive 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 stockout of the product out of the total facilities that reported on the product across the reporting periods). Countries were also asked whether they have an LMIS that collects data on contraceptives, whether the LMIS captures stock status data at the SDP level, and to what extent that data is reported electronically at the SDP level.

### Highlights

- 93 percent of countries (42 of 45) have a logistics management information system (LMIS) that includes contraceptives. Among those, 93 percent capture contraceptive stock data at the service delivery point (SDP) level.
- Of the 35 countries providing information on central level stockouts, 12 (34 percent) report zero stockouts at the central level of any of the following most common FP/RH products: combined oral contraceptives, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms. Also, seven countries (20 percent) had no central level stockouts of any FP/RH product.
- Of the 32 countries providing information on service delivery point level stockouts, one country (3 percent) reported a zero percent stockout rate for either most common FP/RH methods or other FP/RH methods.
- Average annual stockout rates at the **central medical store level** for the most common FP/RH methods ranged as follows among countries reporting:
  - **COCs:** 76 percent (26 of 34 countries) of countries with data had no stockouts; for eight countries the stockout rate ranged from 8 percent (Ghana) to 100 percent (Sri Lanka and DRC) of stock status observations reported as stocked out.
  - **Injectable contraceptives:** 50 percent (18 of 36) countries

with data had no stockouts; for 18 countries the stockout rate ranged from 8 percent (Ethiopia and Mali) to 100 percent (Angola, Guatemala, Sri Lanka).

- **Implants:** 47 percent (16 out of 34) of countries with data had no stockouts; for 18 countries the stockout rate ranged from 8 percent (Madagascar, for 1-rod implants) to 100 percent (Sri Lanka, for 2-rod implants).
- **IUDs:** 71 percent (24 of 34 countries) of countries with data had no stockouts; the remaining 10 countries ranged from 14 percent (DRC) to 100 percent (Sri Lanka) stocked out.
- **Male condoms:** 79 percent (27 of 34 countries) had no stockouts; the remaining six countries ranged from 4 percent (El Salvador) to 100 percent (Sri Lanka) stocked out.
- Average annual stockout rates at the **SDP** level for the most common FP/RH methods ranged as follows:
  - **COCs:** 7 percent (two) countries with data had zero stockouts of COCs (Cape Verde and Haiti); 27 countries had stockout rates ranging from 1 percent (Burundi, Haiti) to 100 percent (El Salvador, Sri Lanka).
  - **Injectables:** 9 percent of countries with data (three countries) had no stockouts (Bangladesh, Cape Verde, and Haiti); for the remaining 30 countries, stockout rates ranged from 1 percent (Togo) to 100 percent (El Salvador;<sup>23</sup> Sri Lanka).
  - **Implants:** 6 percent of countries with data (two countries) had no



stockouts (Cape Verde and Haiti); for the remaining 29 countries, stockouts ranged from 1 percent (Bangladesh, Burundi, and Togo) to 100 percent (Sri Lanka, El Salvador).

- **IUDs:** 10 percent of countries with data (three countries) had no stockouts (Bangladesh, Cape Verde, and Haiti); the remaining 25 countries ranged from 1 percent (Burundi) to 100 percent (El Salvador; Sri Lanka) stocked out.
- **Male condoms:** 10 percent of countries with data (three countries) had no stockouts (Bangladesh, Cape Verde, and Haiti); the remaining 26 countries ranged from 1 percent (Burundi and Togo) to 100 percent (El Salvador; Sri Lanka) stocked out.

## LMIS

Of 45 countries, 42 (93 percent) have an LMIS that includes contraceptives. When asked how commodity data are collected at the SDP level, 61 percent (23 out of 38) reported that at least some sites report electronically. In seven countries (18 percent), few sites report electronically, while in eight countries (21 percent), no sites report electronically.

## EXHIBIT 27.

Locations of government-financed procurement (n=39)

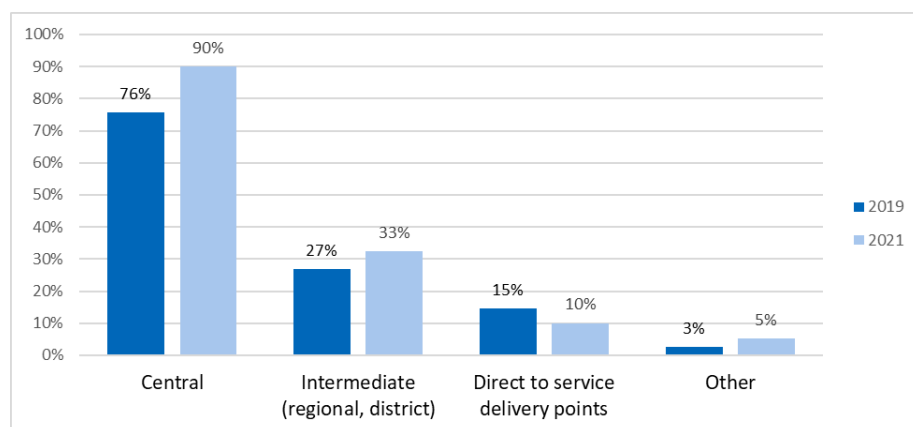
## Procurement

Procurement of government-financed contraceptives takes place at the central level for 95 percent of countries (37 of 39 countries where applicable) (Exhibit 27). Only 13 percent and 8 percent (five out of 39 and three out of 39, respectively) 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.

## 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 90 percent of countries, the supplier delivers to the central level (36 of 40 countries) (Exhibit 28). For 33 percent (13 of 40), the supplier also delivers to an intermediate level (regional or district), 10 percent of suppliers deliver directly to the SDP (4 of 40), and 5 percent reported other (two of 38).

<sup>23</sup> Only five sites are represented here for the year 2020 due to pandemic-related limitations.



### EXHIBIT 28.

Supplier delivery points for government-procured contraceptives (n=40)

### Product Availability

Having products available is essential to meeting client needs. Respondents were asked to report on the number of stock status observations where there was a stockout during the most recent year when data was available, at both the central and SDP levels, for the following contraceptive methods:

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

Of the 35 countries providing information on central level stock availability, 12 (34 percent) reported zero stockouts among all products offered within the eight methods at the central level.

This section provides information on the average stockout rate at the central and

SDP level by contraceptive method by country.

### Central level product availability

#### Combined oral contraceptives

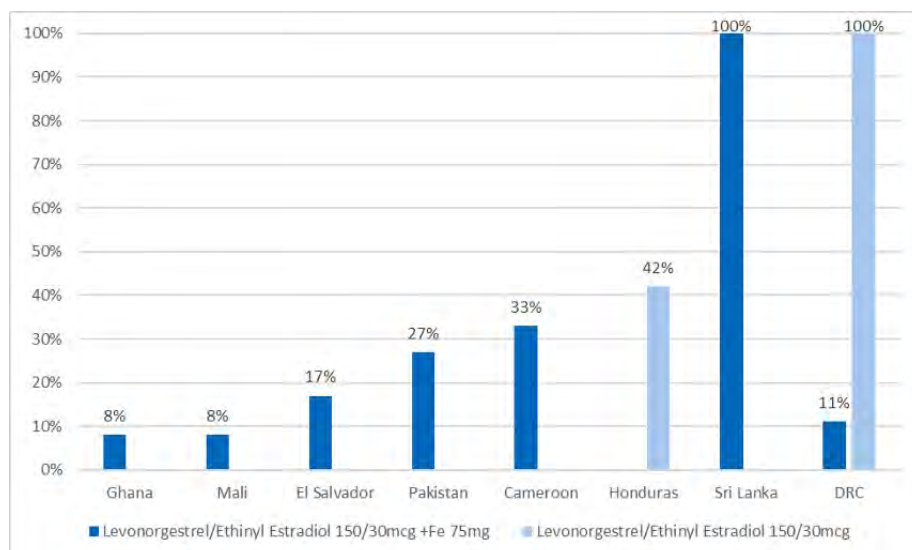
For COCs, in 34 countries with data, the average stockout rate of two formulations of combined oral contraceptives (levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg and levonorgestrel/ethinyl estradiol 150/30 mcg) ranged from 8 percent (Ghana, Mali) to 100 percent (Sri Lanka and DRC) (Exhibit 29). Honduras and DRC had stockouts of both formulations. For 26 countries (76 percent), there were no stockouts of COCs in either formulation. Eleven countries had no data.

### Progestin-only pills

Among eight countries with reported average stockout rates greater than zero, the average stockout rate for POPs (Exhibit 30) ranged from 7 percent (DRC) to 83 percent (Kenya). The remaining 20 reporting countries (56 percent) reported an average stockout rate of zero for POPs at the central level: Angola, Benin, Burundi, Cape Verde, Ghana, Guinea, Liberia, Madagascar, Mali, Mozambique, Niger, Nigeria, Peru, Rwanda, Sierra Leone, Tanzania, Togo, Uganda, Zambia, Zimbabwe.

### EXHIBIT 29.

Central level stockout rates of combined oral contraceptives, non-zero responses shown (n=34)





**EXHIBIT 30.**

Central level stockout rates for progestin-only pills (levonorgestrel 30 mcg), non-zero values shown (n=28)

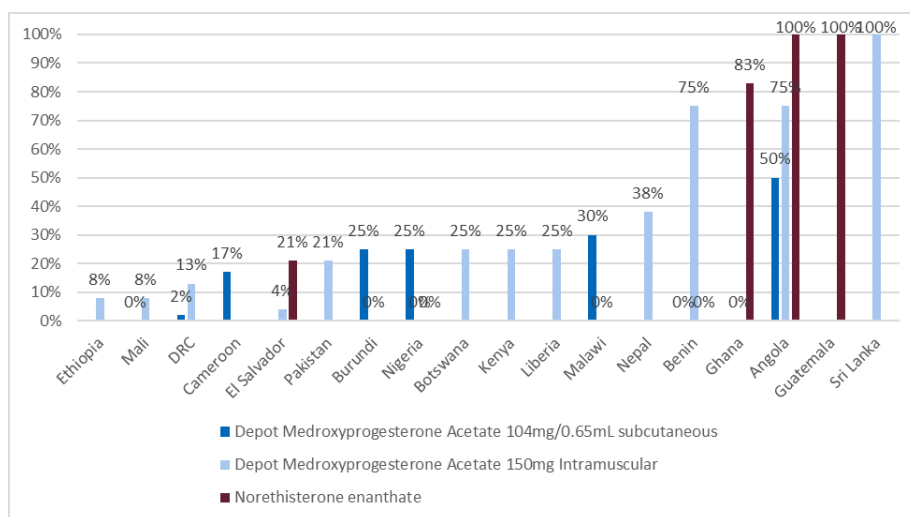
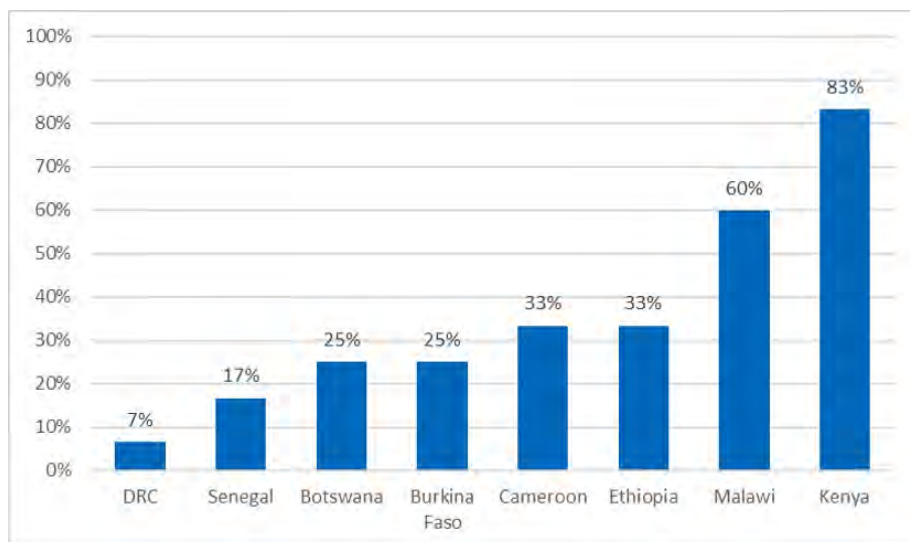
**Injectable contraceptives**

For injectables among the three formulations (DMPA 104mg subcutaneous, DMPA 150mg intramuscular, and norethisterone enanthate), 18 countries of 36 with data (Ethiopia, Mali, DRC, Cameroon, El Salvador, Pakistan, Burundi, Nigeria, Botswana, Kenya, Liberia, Malawi, Nepal, Benin, Ghana, Angola, Guatemala, Sri Lanka) reported stockouts (Exhibit 31), with the average annual stockout rate ranging from 8 percent (Ethiopia and Mali [DMPA 150mg intramuscular]) to 100 percent (Angola and Guatemala [DMPA 104mg subcutaneous], Sri Lanka [norethisterone enanthate]).

DRC had stockouts of both DMPA 104mg subcutaneous and DMPA 150mg intramuscular. El Salvador had stockouts of both norethisterone enanthate and DMPA 150mg intramuscular. Angola had stockouts of all three formulations. A total of 18 countries (50 percent) did not have any stockouts of injectables at the central level. Six countries did not report data.

**EXHIBIT 31.**

Central level stockout rates of injectable contraceptives, non-zero values shown (n=36)

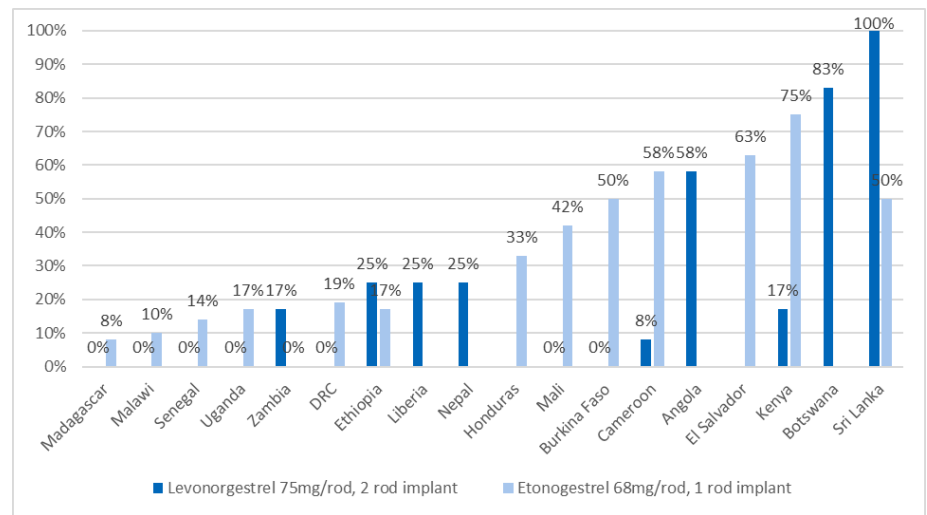


**EXHIBIT 32.**

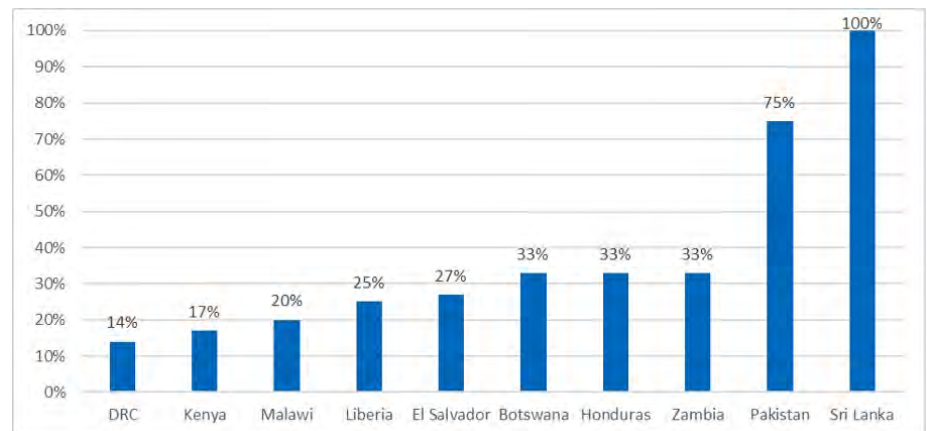
Central level stockout rates of contraceptive implants, non-zero values shown (n=34)

**Contraceptive implants**

For 18 countries of 34 that had data, the average annual stockout rate for implants (Exhibit 32) ranged from 8 percent (Madagascar, 1-rod implants) to 100 percent (Sri Lanka, 2-rod implants). Eight countries that offer two formulations of implants (levonorgestrel 75mg/rod, 2-rod implant; etonogestrel 68mg/rod, 1-rod implant) had no stockouts of either (Benin, Ghana, Niger, Nigeria, Rwanda, Tanzania, Togo, and Zimbabwe). Eighteen countries had stockouts; of the 20 countries that offer both formulations, eight had stockouts of one (Burkina Faso, DRC, Madagascar, Malawi, Mali, Senegal, Uganda, and Zambia), and three had stockouts of both (Cameroon, Ethiopia, and Sri Lanka). In total, 16 countries (47 percent) did not have stockouts of implants. Eleven countries did not have data.

**Copper-bearing intrauterine devices**

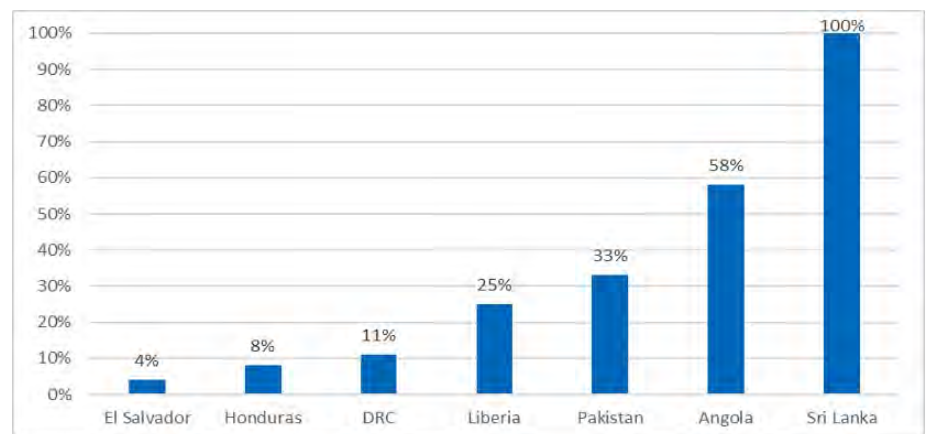
For 10 countries of 34 that had data and a non-zero stockout rate, the average stockout rate for IUDs (Exhibit 33) ranged from 4 percent (DRC) to 100 percent (Sri Lanka). A total of 24 countries (71 percent) reported no stockouts of IUDs. Eleven countries did not have data.

**EXHIBIT 33.**

Central level stockout rates of copper-bearing intrauterine devices, non-zero values shown (n=34)

**Condoms**

Twenty-seven of 34 countries (79 percent) with data had zero central level stockouts in the last 12-month period. The male condom stockout rate (Exhibit 34) for the other six countries ranged from 4 percent (El Salvador) to 100 percent (Sri Lanka). Eleven countries did not have available data.

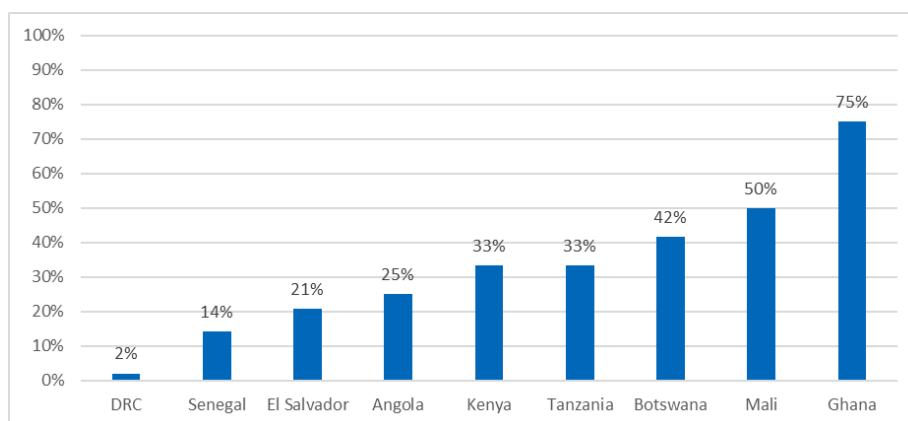
**EXHIBIT 34.**

Central level stockout rate of male condoms, non-zero values shown (n=34)

For female condoms, the average stockout rate (Exhibit 35) ranged from 2 percent (DRC) to 75 percent (Ghana). A total of 16 countries had an average stockout rate of zero percent for female condoms: Benin, Burkina Faso, Burundi, Cape Verde, Liberia, Madagascar, Malawi, Mozambique, Niger, Nigeria, Peru, Rwanda, Sierra Leone, Togo, Zambia, and Zimbabwe. Twenty countries did not report on this method.

### EXHIBIT 35.

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

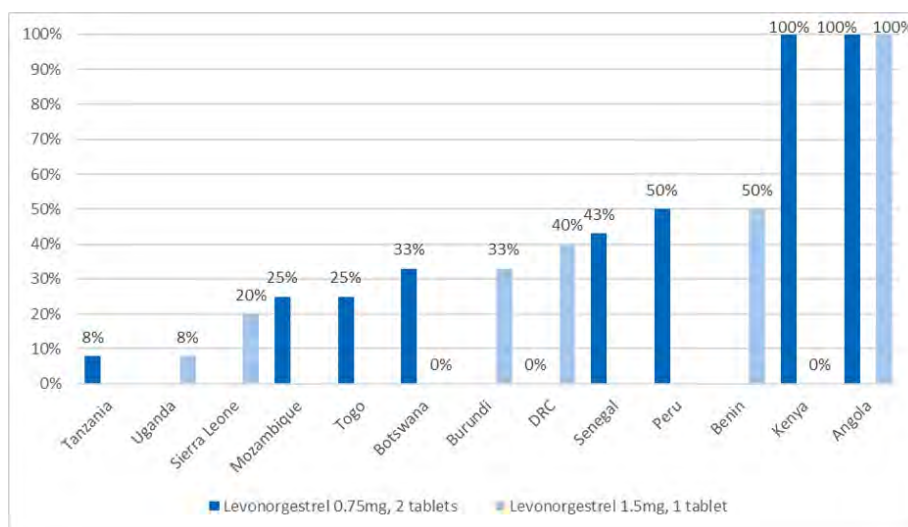


### Emergency contraceptives

In 13 of 17 countries reporting, the average stockout rate for emergency contraceptives at the central level (Exhibit 36) ranged from 8 percent (Tanzania and Uganda) to 100 percent (Kenya and Angola). Angola reported 100 percent stockouts of both products. A total of four countries had an average stockout rate of zero percent for levonorgestrel 0.75mg, two tablets.

### EXHIBIT 36.

Central level stockout rates for emergency contraceptives, non-zero values shown (n=17)



### Service Delivery Point Product Availability

Countries provided stockout data for the SDP level for the most recently completed twelve-month period, where available. This section provides average stockout data for COCs, injectables, implants, IUDs, and male condoms. Data for female condoms, emergency contraceptives, and FAM can be found in Annex A. These data should be interpreted with care for several reasons:

- The duration of the stockout is uncertain.
- A stockout could be recurrent for a particular method.

- A stockout at the central level does not necessarily mean a stockout at the SDP level, and vice versa.
- 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.

Bangladesh and Cape Verde. Stockout rates for the other 27 countries ranged from 1 percent (Burundi, Haiti) to 100 percent (El Salvador, Sri Lanka). Sixteen countries did not provide data.

### Combined oral contraceptives

Of 29 countries with data, two (7 percent) had zero stockouts of COCs (levonorgestrel/ethinyl estradiol 150/30 mcg +Fe 75mg and levonorgestrel/ethinyl estradiol 150/30 mcg) (Exhibit 37):

**EXHIBIT 37.**

Service delivery point stockout rates of combined oral contraceptives, non-zero values shown (n=29)

**Injectable contraceptives**

For 30 of the 33 countries with data, the injectable stockout rates at the SDP level (Exhibit 38) ranged from 1 percent (Togo) to 100 percent (El Salvador; Sri Lanka). Three countries (9 percent) did not have any stockouts (Bangladesh, Cape Verde, and Haiti). All 13 countries that offer two formulations had stockouts of both during the last 12 months. Benin, Nigeria, and Zambia offer three formulations (DMPA 104mg subcutaneous, DMPA 150mg intramuscular, and norethisterone enanthate), all of which reported stockouts of all three contraceptives. Twelve countries did not have data.

**EXHIBIT 38.**

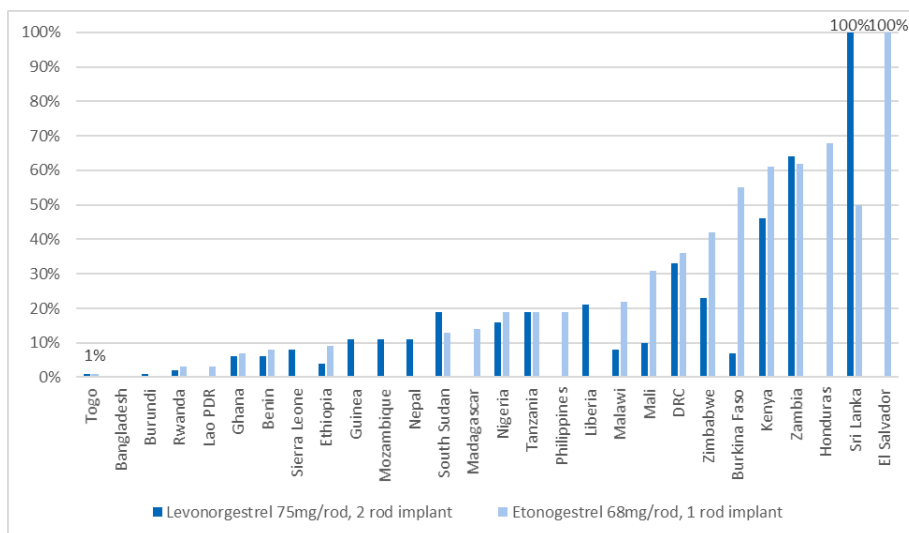
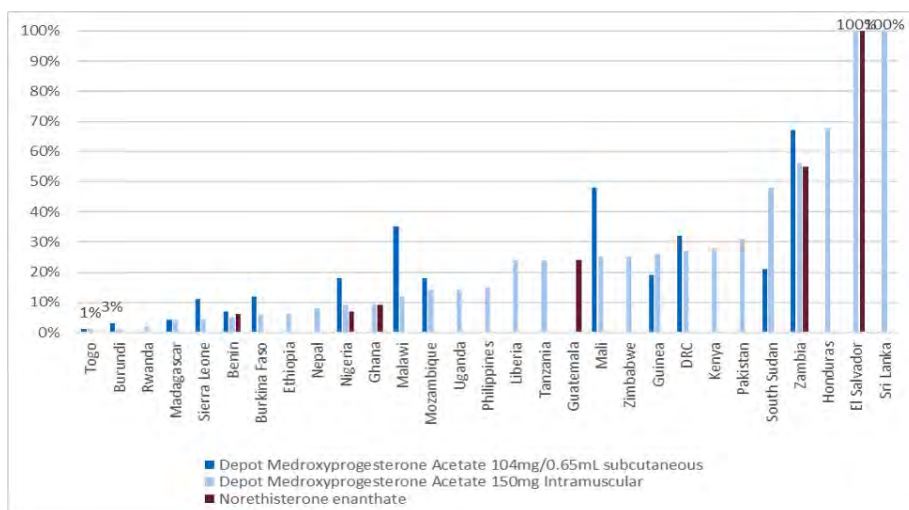
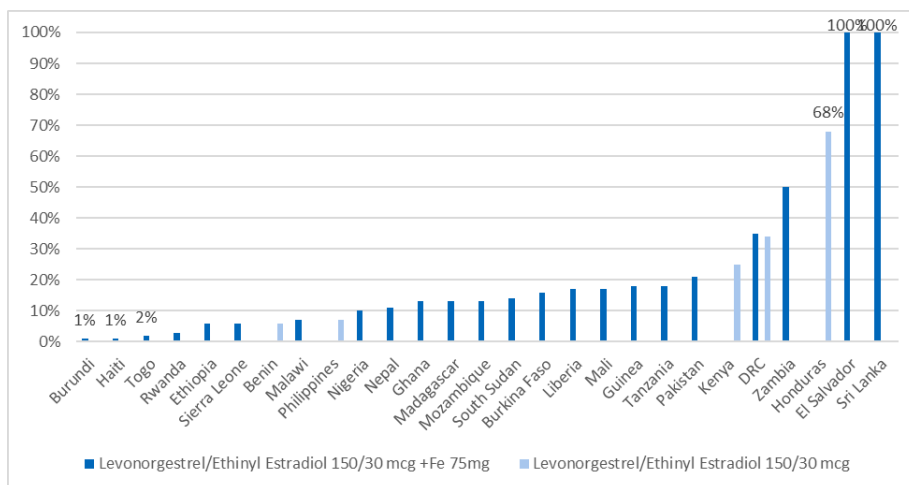
Service delivery point stockout rates of injectable contraceptives, non-zero values shown (n=33)

**Contraceptive implants**

Of the 31 countries that offer and reported on implants, Cape Verde and Haiti were the only ones (6 percent) that did not have any stockouts of implants (Exhibit 39). For the other 29 countries, the average stockout rates ranged from 1 percent (Togo, both products; Bangladesh, 2-rod implants; and Burundi, 2-rod implants) to 100 percent (Sri Lanka, 2-rod implants; and El Salvador, 1-rod implants). Fourteen countries did not have data.

**EXHIBIT 39.**

Service delivery point stockout rates of contraceptive implants, non-zero values (n=31)

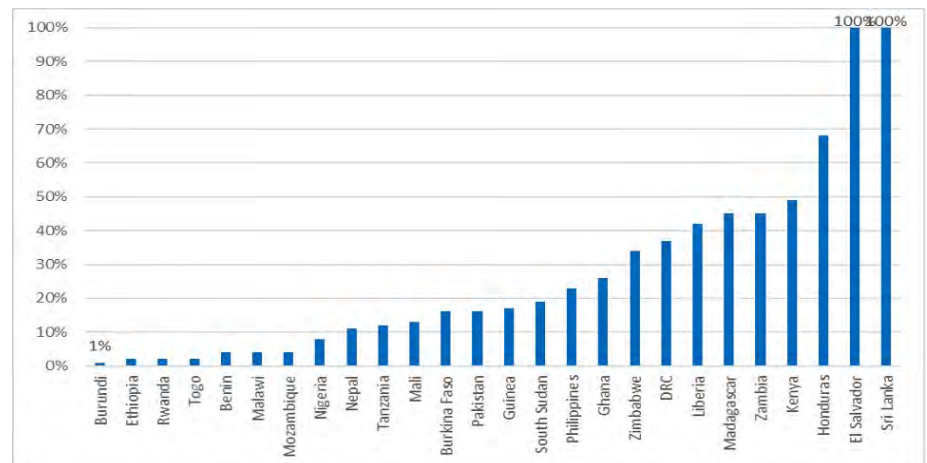


### Copper-bearing intrauterine devices

For 27 out of 30 countries with data, the average stockout rate for IUDs (Exhibit 40) spanned from 1 percent (Burundi) to 100 percent (El Salvador and Sri Lanka). Bangladesh, Cape Verde, and Haiti did not have any IUD stockouts (0 percent) at the SDP level. Fifteen countries did not have data.

#### EXHIBIT 40.

Service delivery point stockout rates of copper-bearing intrauterine devices, non-zero values (n=30)

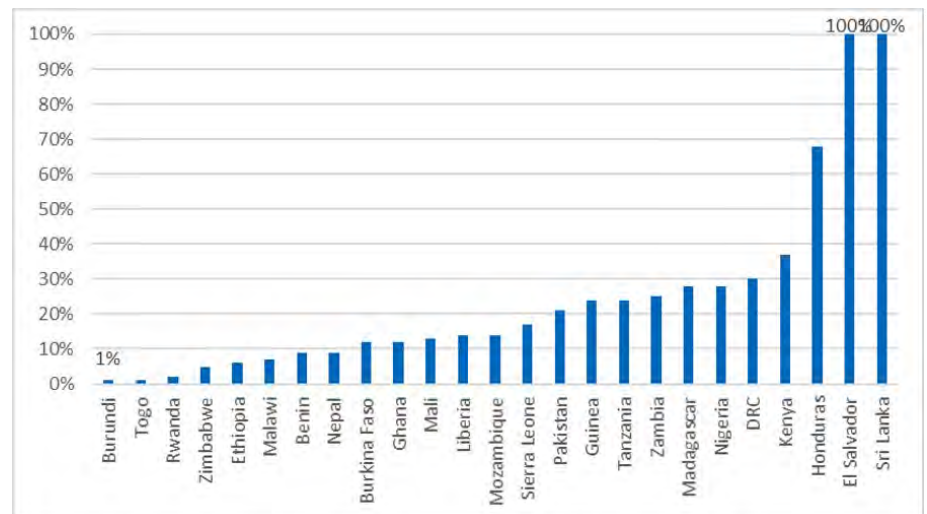


### Condoms

For male condoms (Exhibit 41), average stockout rates ranged from 1 percent (Burundi and Togo) to 100 percent (El Salvador and Sri Lanka) among the 26 of 29 countries that had data and reported stockouts. Three countries (10 percent) reported zero stockouts for male condoms: Bangladesh, Cape Verde, and Haiti. Sixteen countries did not have available data.

#### EXHIBIT 41.

Service delivery point stockout rates of male condoms, non-zero values shown (n=29)

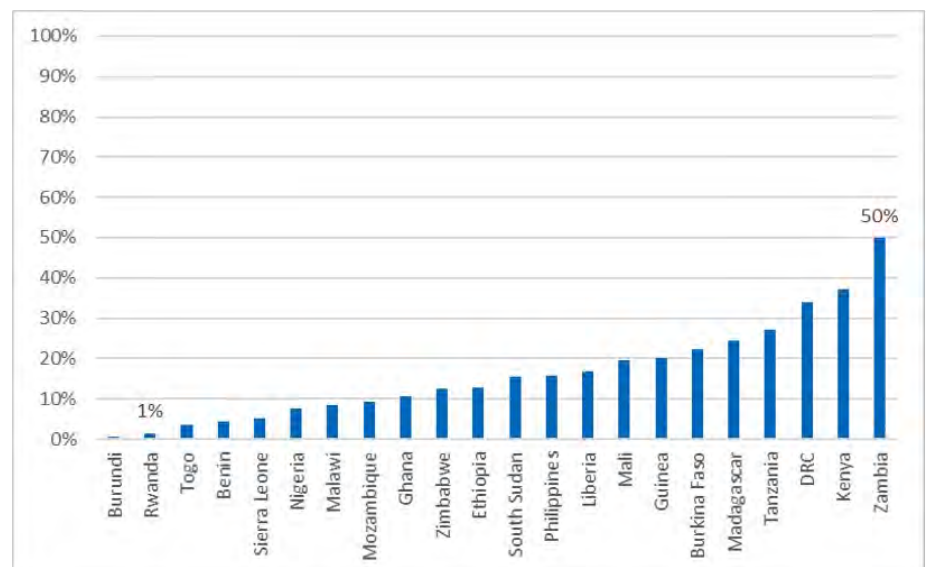


### Progestin-only pills

For progestin-only pills (Exhibit 42), average stockout rates ranged from 1 percent (Burundi and Rwanda) to 50 percent (Zambia) among the 23 countries that offer this product and reported stockout data. Cape Verde reported zero instances of a stockout of progestin-only pills at the SDP level. Twenty-two countries did not have data available.

#### EXHIBIT 42.

Service delivery point stockout rates of progestin-only pills (levonorgestrel 30mcg), non-zero values shown (n=23)





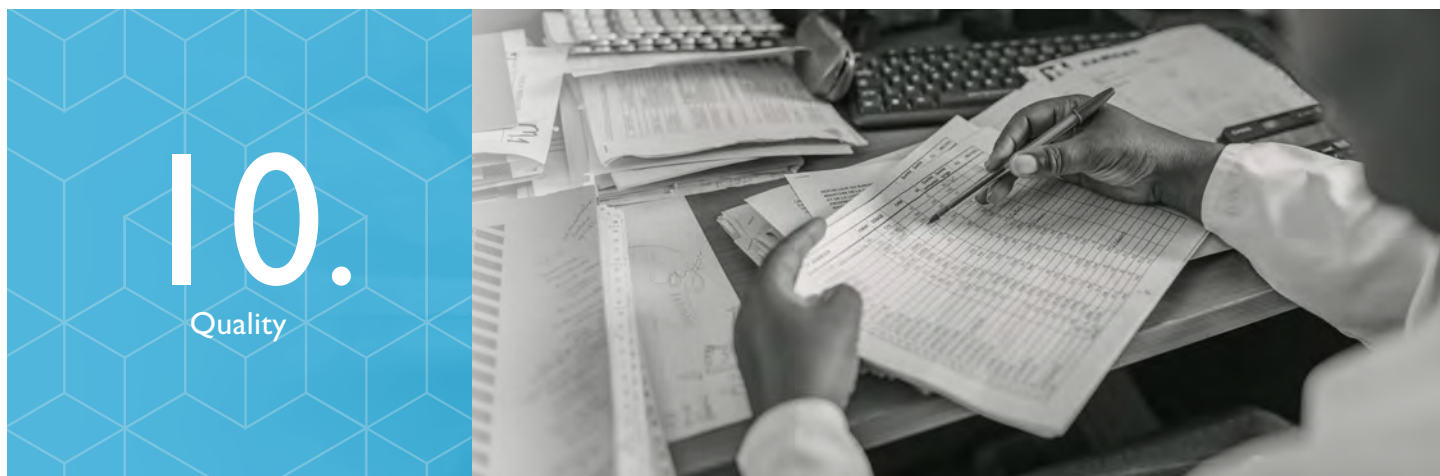


PHOTO CREDIT: USAID GHSC-PSM

## Quality

Closely monitoring contraceptive quality ensures that the products provided by all sectors meet specific standards. By ensuring that FP commodities are consistently produced and monitored, quality assurance (QA) of FP commodities protects patient safety and helps achieve reliable results and maximum benefits.

QA includes registering drug manufacturers, QA testing of commodities post-shipment, conducting field surveillance to identify substandard and falsified 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 (44 of 45) countries require locally manufactured or imported contraceptives be registered by the in-country national medicines regulatory authority (NMRA).
- The average lead time for registration of contraceptives is less than six months for 49 percent of countries (19 of 39). This is a significant improvement from 2019, when the average lead time

for 50 percent of countries was six months to one year:

- 77 percent (33 of 43) require testing of contraceptives at the NQCL. In eight countries (Burundi, DRC, Lao PDR, Mali, Mozambique, Niger, Togo, and Yemen), there is a requirement to test contraceptives post-shipment, but neither contraceptives (excluding condoms), nor condoms were tested in the year preceding the survey.
- 44 percent (15 of 34) of NQCLs are currently either ISO 17025 certified/accredited and/or currently WHO-prequalified. The remaining 56 percent (19 of 34) are neither ISO 17025-certified nor WHO-prequalified.
- In 32 percent of countries (11 of 34), the NMRA conducts field surveillance monitoring to identify substandard and falsified contraceptives. In half of

these countries (five of 10 reporting), extensive enforcement actions are taken.

### Registration Requirements

Most countries (98 percent, or 44 of 45) require registration of locally manufactured or imported contraceptives by the in-country NMRA). South Sudan is the only country that currently does not have registration requirements for contraceptives.

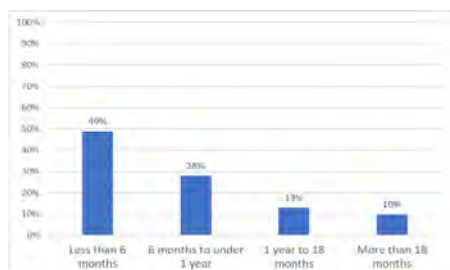
Similarly, 98 percent (43 of 44) strictly adhere to drug registration requirements. Burundi does not adhere to registration requirements.

The average registration lead time is less than six months for 49 percent of countries (19 of 39), while 28 percent (11 of 39) take six months to one year; 13 percent take one year to 18 months, and

10 percent take more than 18 months (Exhibit 43).

#### EXHIBIT 43.

Average lead time for registration of contraceptive products (n=39)

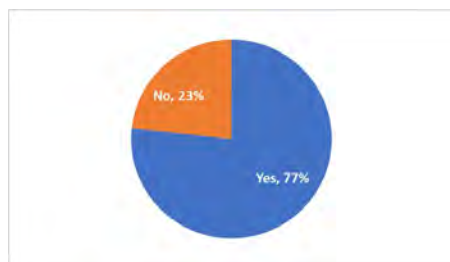


### Quality Control

The requirement for contraceptives, whether imported or locally manufactured, to be tested by the in-country NQCL is in place for 77 percent of countries (33 of 43) (Exhibit 44).

#### EXHIBIT 44.

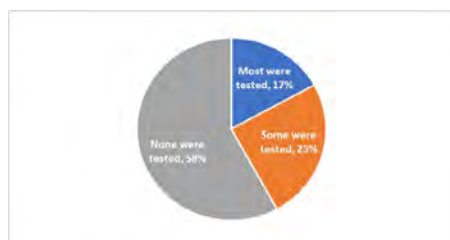
Requirement to test contraceptives at the national quality control laboratory (n=43)



In 17 percent of the countries, most contraceptives (excluding condoms) were tested, 25 percent tested some, and 58 percent tested no contraceptives post-shipment by the NQCL (Exhibit 45).

#### EXHIBIT 45.

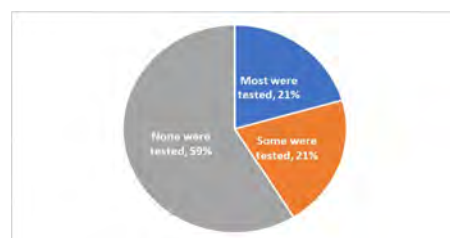
Extent to which contraceptives, excluding condoms, were tested by the NQCL post-shipment in the past year (n=36)



The NQCL tested most condoms post-shipment in 21 percent of countries, while 21 percent also tested some, and 59 percent tested none (Exhibit 46). In eight countries (Burundi, DRC, Lao PDR, Mali, Mozambique, Niger, Togo, and Yemen), there is a requirement to test contraceptives post-shipment, but neither contraceptives (excluding condoms), nor condoms were tested in the year preceding the survey.

#### EXHIBIT 46.

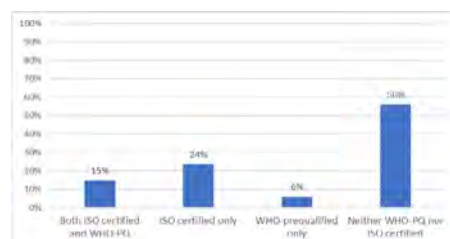
Extent to which condoms were tested by the NQCL post-shipment in the past year (n=34)



The NQCL is ISO 17025 certified and WHO-prequalified in 15 percent of the countries (5 of 34) (Exhibit 47). Twenty-four percent are ISO certified only, 6 percent are WHO-prequalified only, and 56 percent do not have either.

#### EXHIBIT 47.

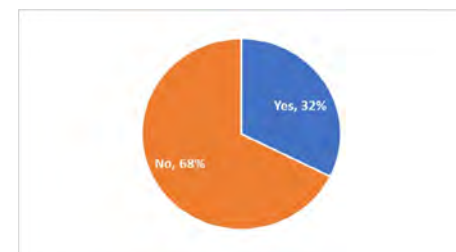
National quality control laboratory ISO 17025 certified/accredited and/or WHO-prequalified (n=34)



In 11 of 34 countries (32 percent), field surveillance monitoring to identify substandard and falsified (SF) contraceptives is conducted by the NMRA (Exhibit 48).

#### EXHIBIT 48.

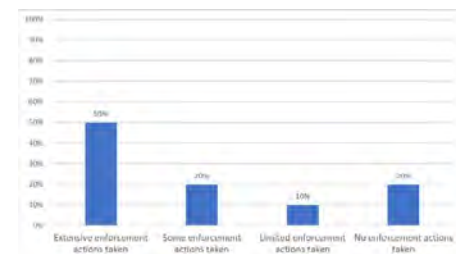
National Medical Regulatory Authority conducts field surveillance monitoring to identify SF contraceptives (n=34)



In half of the countries (5 of 10), extensive enforcement actions are taken. In 20 percent of the countries, some enforcement takes place, 10 percent take limited action, and 20 percent take no action (Exhibit 49).

#### EXHIBIT 49.

Extent of regulatory enforcement actions taken following field surveillance of contraceptives (n=10)





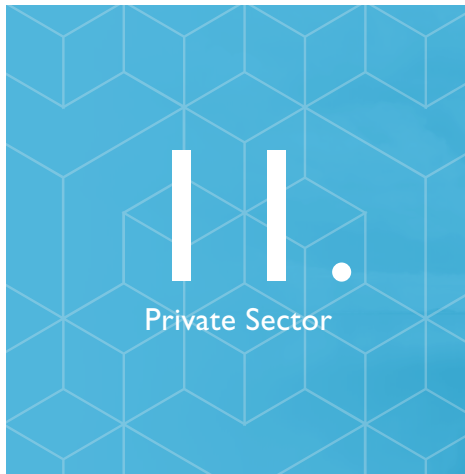


PHOTO CREDIT: USAID GH-SC-PSM

## Private Sector

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

The private sector includes for-profit or commercial entities, nonprofit organizations, community groups, informal vendors, and private providers such as doctors, pharmacies, drugstores, and hospital staff.

### Highlights

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

- 89 percent (32 of 36 countries) have more than three wholesalers registered in the country to distribute FP commodities.
- More than half of countries have WHO-prequalified (WHO-PQ) or stringent regulatory authority (SRA)-approved contraceptives registered

(injectables, COCs, implants, POP, ECs, male condoms, IUDs, and female condoms) for private-sector distribution. This is an increase since 2019, when less than half of countries had WHO-PQ or SRA-approved contraceptives registered.

- 41 percent (15 of 37) have established or brokered public-private partnerships (PPPs) 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 7 percent of countries (combined oral contraceptives and contraceptive implants) to 36 percent of countries (female condoms).

- 53 percent (20 of 38 countries) have a private-sector engagement (PSE) plan in place with an FP/RH component. Of those, 85 percent (17 countries) have taken some action to implement the plan.

Most countries (89 percent) have more than three wholesalers registered for distributing FP products in the countries (Exhibit 50). Three percent have two to three, 6 percent have one, and 3 percent have none registered. In 2019, 76 percent of countries had more than three wholesalers registered as FP distributors. The percentage of countries with zero wholesalers has dropped from 6 percent in 2019 to 3 percent in 2021.

**EXHIBIT 50.**

Number of wholesalers registered in the country to distribute FP commodities (n=36)

Countries where 76–100 percent of the wholesalers in the country report to the government on their FP commodity sales and FP services is 42 percent (Exhibit 51). Eight percent responded 26–50 percent of the wholesalers report to the government, and 50 percent responded 0–25 percent report this information. Forty-seven percent of countries reporting (17 out of 36) require wholesalers to report sales and services data to the government.

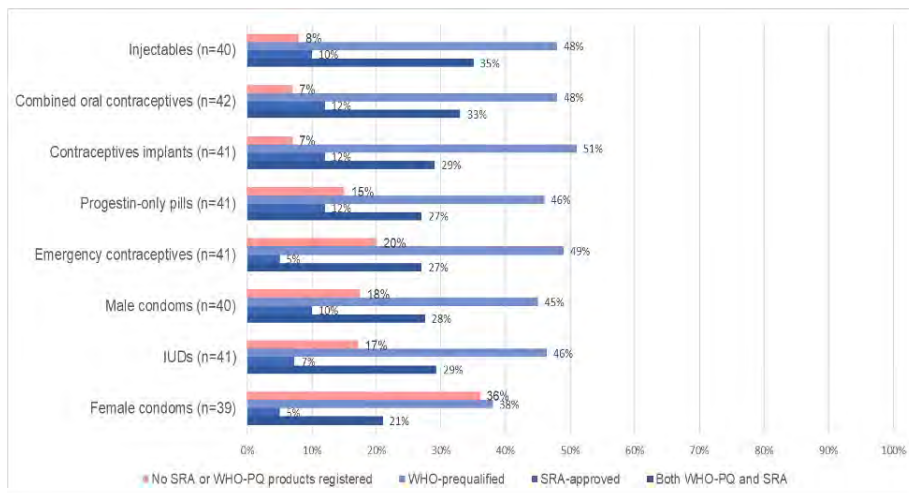
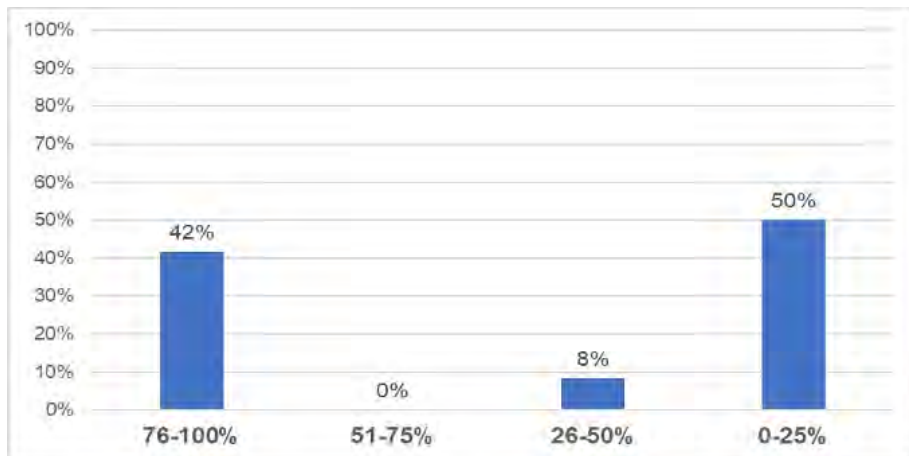
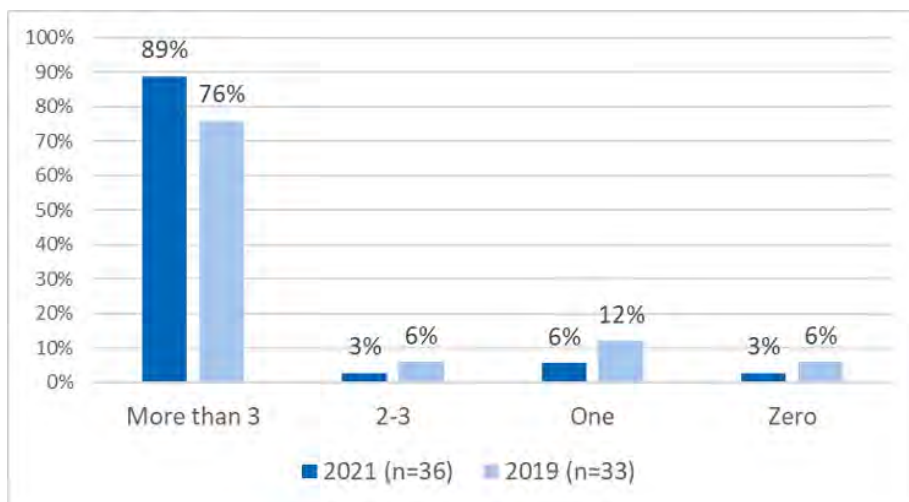
**EXHIBIT 51.**

Approximate proportion of wholesalers reporting to the government on their FP commodity sales and FP services (n=12)

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 45–51 percent have WHO-PQ implants, injectables, COCs, POPs, ECs, and IUDs for private-sector distribution in the country (Exhibit 52). WHO-PQ male and female condoms are 45 and 38 percent, respectively. The range is 21–35 percent that have WHO-PQ and SRA for all eight methods. Those with only SRA range from 5 to 12 percent among the eight methods. Those with neither WHO-PQ or SRA range 7–36 percent among the eight methods.

**EXHIBIT 52.**

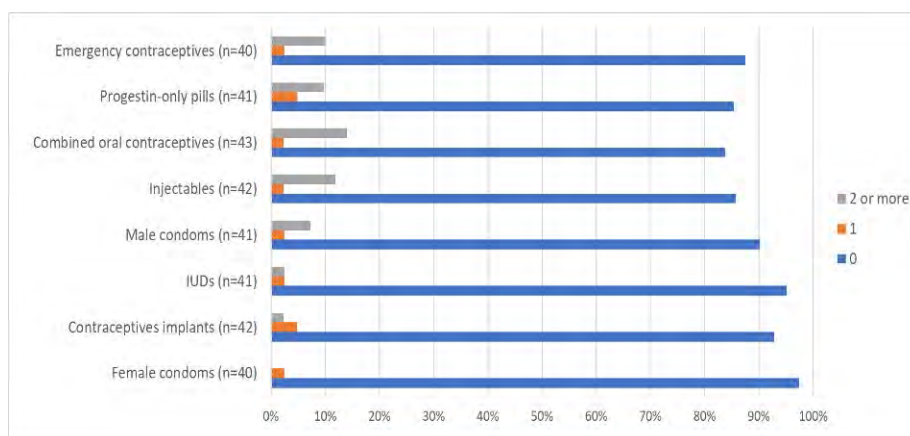
Any WHO-PQ and/or stringent regulatory authority (SRA)-approved products registered for distribution in the country



**EXHIBIT 53.**

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

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 2–14 percent of countries reported the existence of two or more manufacturers for any of the methods, and a range of 2–5 percent of countries reported the existence of one manufacturer. Meanwhile, 84 to 98 percent of countries reported for each method that there were no in-country local manufacturers (Exhibit 53).

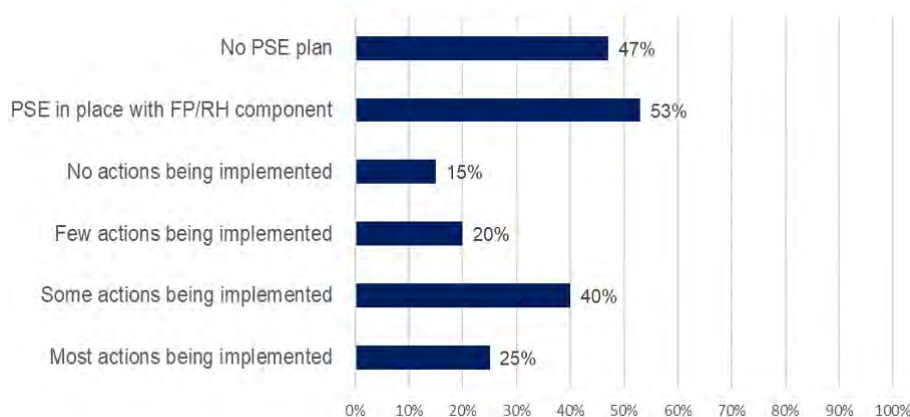
**EXHIBIT 54.**

FP/RH PSE plan developed by government and extent of implementation (n=38)

Only one country, Zambia, has joint ventures between multinational pharmaceutical companies and local manufacturers.

The percentage of countries in which public-private partnerships have been established within the last two years to expand private-sector FP products is 41 percent (15 of 37). In 2019, this was 53 percent (18 of 34).

Fifty-three percent of countries (20 of 38) reported having a government private-sector engagement (PSE) plan with an FP/RH component. For those countries with a PSE plan, 40 percent (eight countries) have implemented some actions, most actions are being implemented in 25 percent (five countries), few actions are being taken in 20 percent (four countries), no action is being taken in 15 percent (three countries), and 47 percent (18 of 38 countries that responded) do not have a PSE in place, or the PSE does not have an FP/RH component. (Exhibit 54).



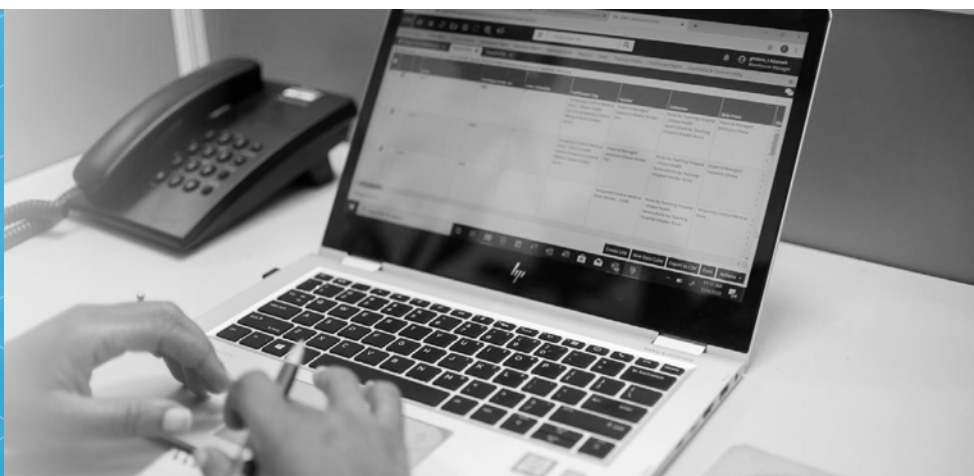
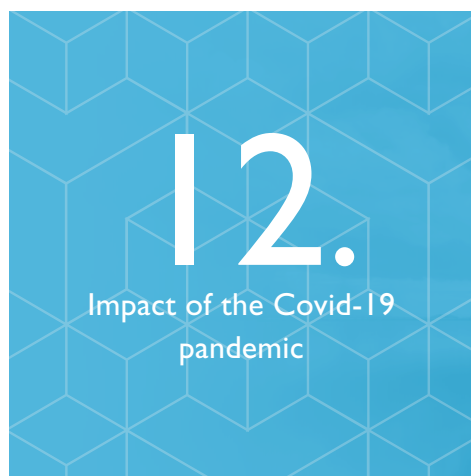


PHOTO CREDIT: USAID GHSC-PSM

## Impact of the Covid-19 pandemic

The COVID-19 pandemic caused disruptions in the global supply chain for FP/RH commodities that impacted many countries. Manufacturing and shipments of contraceptive commodities were delayed due to lockdowns, quarantines, and other global supply chain disruptions, while at the country-level, FP/RH services were impacted in some countries due to lockdowns, closures, quarantines, isolation, and fear of accessing health facilities.

However, while this survey did not attempt to directly quantify the impact of the pandemic and the related global supply chain disruptions on service delivery, qualitative responses provided anecdotal evidence of potential impacts to availability of FP/RH commodities in some countries, while many countries (18) did not note any evidence that commodity availability was affected. More than half of respondents (59 percent of countries, 24 out of 41) reported the pandemic had no impact on government spending on contraceptives. Most countries (81 percent) had emergency preparedness plans in place, and a wide variety of mitigating strategies were employed that may have blunted the worst effects of the pandemic on access to FP/RH services.

This section assesses the impact of the COVID-19 pandemic on some key elements of contraceptive security and

gauges the mechanisms in place to prepare for and alleviate the impacts of pandemics and other emergencies on access to family planning.

### Highlights

- Half of the countries surveyed (21 out of 42) reported no impact of the COVID-19 pandemic on frequency of CS committee meetings in 2020. Forty percent reported a reduced frequency of CS committee meetings that year.
- 63 percent of countries (26 out of 41) reported the COVID-19 pandemic had no impact on the approved budget line for contraceptives.
- 59 percent (24 out of 41) reported the COVID-19 pandemic had no impact on the amount of government spending for contraceptives.

- 81 percent (35 out of 43) of countries reported having an emergency preparedness plan in place for pandemics that includes impact on FP. 79 percent (30 out of 38) have an emergency preparedness plan in place for other types of emergencies that includes impact on FP.
- 18 countries did not report any evidence that COVID-19 disrupted the availability of FP/RH commodities.
- Nine countries established mobile clinics and/or community health worker home visitations for the provision of FP services, while seven countries initiated telehealth capacities.

The COVID-19 pandemic impacted the approved budget line for contraceptives in 36 percent of countries. All or most of

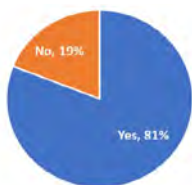
the contraceptive budget line was shifted to the COVID-19 response in 12 percent of countries (five of 41), and some of the CS budget was shifted in 24 percent (10 of 41).

Of 41 countries, 14 (34 percent) reported medium or high impact of the COVID-19 pandemic on the amount of government spending for contraceptives. Three countries (7 percent) reported low impact, while 59 percent reported no impact.

Emergency preparedness plans are essential to ensure continued contraceptive access during emergencies. More than 80 percent (35 out of 43 countries) reported having an emergency preparedness plan for pandemics in place (Exhibit 55). Nineteen percent did not have a pandemic emergency preparedness plan.

#### EXHIBIT 55.

Emergency preparedness plan in place for pandemics (that includes impact on FP) (n=43)



Out of 38 responding countries, 30 (79 percent) had an emergency preparedness plan in place that includes impact on FP for other types of emergencies (Exhibit 56).

#### EXHIBIT 56.

Emergency preparedness plan in place for other types of emergencies (that includes impact on FP) (n=38)



Despite the supply chain disruptions and potential for service delivery interruptions, the qualitative responses show that country governments and other entities stepped up in many instances to put in place innovative solutions to safeguard access to family planning and reproductive health (RH). Some of these innovations may outlast the pandemic and help to improve access going forward.

Respondents were asked about any operational practices put in place to facilitate access to FP services during the COVID-19 pandemic, and in response, reported the following:

- Nine countries reported that they established mobile clinics and/or community health worker home visitations for the provision of FP services.
- Seven countries initiated telehealth capacities.
- Six countries increased task-sharing and task-transfer for providers and CHWs to maximize efficiency.
- Four countries expanded distribution minimums for contraceptives and FP/RH pharmaceuticals.
- Four countries encouraged or advocated for additional self-care administration to minimize health care visits.
- Three countries implemented awareness campaigns to minimize fear of visiting health care establishments.
- Cameroon piloted a Baby Box Strategy, where kits of essential necessities for mothers and newborns were put together to give to women during prenatal consultation, childbirth, and postnatal consultations.

Nine countries did not indicate any specific operational practices to facilitate FP access during the pandemic.

When asked about any evidence that the COVID-19 pandemic disrupted the availability of FP/RH commodities, 18 countries did not note any disruptions to availability, while thirteen countries cited some impact or risk of impact to stock levels (though not necessarily at the facility level) due to lockdowns, quarantines, manufacturing delays, fewer coordination meetings and trainings, and other global supply chain disruptions. Some countries noted more severe disruptions, such as closure of health establishments (Honduras), reduced health facility visits due to fear of contracting COVID-19 (Botswana), and potential negative impacts to health indicators (Burundi).



# 13.

## Conclusions



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## 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 2021 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 (44 percent meet one to three times, and 46 percent meet the recommended four or more times annually).
- While 76 percent of CS committees have developed policies, procedures, or action plans, 100 percent of those countries noted these are taking place or are being implemented.
- The commercial/private sector is participating in one third of CS committees, unchanged from previous years, despite the popularity of the “Total Market Approach” in the donor community.

### Finance and Procurement

- Governments are chiefly responsible for conducting procurement (in 74 percent of countries).
- Donors typically finance procurement (53 percent), though less so than in 2019, when the survey reported that 62 percent of financing came from in-kind donations.

### Policies

- Of all countries surveyed, 91 percent offer all five of the most commonly offered methods in public-sector facilities (male condoms, COCs, injectables, IUDs, and implants). In 2019, this was 96 percent, and in 2017 it was 86 percent.
- The number of countries with policies that hinder the ability of the private sector to distribute contraceptives

stayed constant in 2021 at 18 percent. These had been steadily declining since 2010.

- Twenty percent of countries have policies that limit access to FP for unmarried youth between 15 and 19 years of age, a decrease from nearly 30 percent in 2019.
- More countries are enacting policies that establish family planning/reproductive health (FP/RH) as a human right for all.
- In most countries, public sector clients can access many contraceptive methods (seven of 14 surveyed methods) through community health workers. However, in the private sector, only 4 of 14 methods were most commonly available through community health workers; most



clients must see a nurse to access contraceptives in the private sector.

- In 65 percent of countries, more than half of FP providers had been trained in implant and IUD insertion and removal. In 2019, most countries reported fewer than half of FP providers had been trained in these procedures.
- Promotion of family planning is widespread: 91 percent of countries (41 of 45) use community mobilization/engagement to promote family planning; 40 percent (18) say they use this approach “extensively.” Eighty-six percent of countries (38) reported using social marketing, 96 percent use mass media, and 91 percent use mobile outreach/education either somewhat or extensively to promote family planning.
- Although 87 percent of surveyed countries made FP2020 commitments (39 of 45), 80 percent have made or plan to make an FP2030 commitment. Of those with current or anticipated FP2030 commitments, 80 percent have committed to increasing domestic financing for contraceptives.

## Supply Chain

- Most countries (93 percent) have an LMIS that includes contraceptives. The same percentage collects SDP-level commodity data, and 79 percent of these countries use electronic reporting in at least a few sites.
- Twenty percent of reporting countries had zero stockouts of any contraceptive commodity at the central level, while 34 percent reported zero central level stockouts of the five most common FP/RH products (combined oral contraceptives, injectable contraceptives, contraceptive implants, copper-bearing intrauterine devices, and male condoms).

## Quality

- Most countries (98 percent) require the registration of locally manufactured or imported contraceptives by the in-country national medicines regulatory authority (NMRA).
- However, in less than one-third of the countries (32 percent), the NMRA conducts field surveillance monitoring to identify substandard and falsified (SF) contraceptives. Of the 10 countries that conduct field surveillance and reported on the extent of enforcement actions taken, five (50 percent) reported that they take extensive actions, while three (30 percent) report that they take limited or no actions.
- More than half of the national quality control laboratories (NQCL) in the 34 countries that reported, 56 percent, (19 of 34), are neither ISO 17025-certified nor WHO-prequalified.

## Private Sector

- 41 percent (15 of 37) have established or brokered public-private partnerships in the past two years to expand private-sector FP products or services. This is a decrease from 53 percent in 2019.
- 53 percent of countries (20 of 38) have a private sector engagement (PSE) plan in place with an FP/RH component. Eighty-five percent of those countries with a PSE (17 countries) have taken some action to implement the plan. In 2019, 63 percent of countries reported having a PSE plan in place with an FP/RH component.

## Impact of COVID-19 Pandemic

- Half of the countries surveyed (21 out of 42) reported the COVID-19 pandemic had no impact on the

frequency of CS committee meetings in 2020.

- 63 percent of countries (26 out of 41) reported that the COVID-19 pandemic had no impact on the approved budget line for contraceptives. 59 percent (24 out of 41) reported no impact of the COVID-19 pandemic on the amount of government spending for contraceptives.
- 81 percent (35 out of 43) of countries reported having an emergency preparedness plan in place for pandemics that includes impact on FP.
- 18 countries did not report any evidence that COVID-19 disrupted the availability of FP/RH commodities.
- Many countries implemented new or innovative approaches to increase access to FP/RH services in the wake of the pandemic. These included: mobile clinics, additional community health worker visits, telehealth services, task-sharing for health providers, expanding minimum distribution quantities for FP/RH commodities, advocating for additional self-care administration, and awareness campaigns to minimize fear of visiting health facilities, among other approaches.

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## Annexes

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## ANNEX A | Contraceptive Security Indicators Survey Questionnaire

USAID GLOBAL HEALTH SUPPLY CHAIN PROGRAM PROCUREMENT AND SUPPLY MANAGEMENT				Respondent's name (survey point person): Job title: Organization: E-mail: Telephone: Date (dd/mm/yy):	
<b>Contraceptive Security (CS) Indicators Survey, 2021</b> Country: <input type="text"/> (Select from drop-down menu)					
The CS Indicators are presented in the following sections: A. Leadership & Coordination    B. Finance & Procurement    C. Commodities    D. Policies    E. Supply chain    F. Quality    G. Private Sector    H. Impact of COVID-19 Pandemic					
<b>Instructions:</b> - Please indicate your answers in the yellow and white spaces. Most questions contain dropdown lists for your selection. Yellow calls denote required responses. - Please select from the dropdown lists in columns O and P to indicate the main and, if applicable, additional data sources used. - To help keep track of survey completion, response calls 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 autofill the row height in order to see the whole response. (To autofill the row height, select the answer(s) and go to Home tab - Cells group - Format - Autofill Row Height in newer versions of Excel or Format - Row - Autofill 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. <b>Interviewer:</b> Read the following statement to the Ministry of Health representative with authority to provide agreement. This full survey will be published on the GHSC-PSM website ( <a href="https://www.ghsupplychain.org/">https://www.ghsupplychain.org/</a> ), and will be aggregated and summarized along with the surveys of other countries and published as an Excel database, narrative report, and interactive dashboard. In accordance with USAID policies, these data may be used in other research venues for the purpose of building the global evidence base for family planning programming. This survey has been conducted since 2010 with more than 50 countries participating. The information collected is used to share and assess family planning policies and best practices.					
				<b>Before proceeding with data collection:</b> Select an option from the drop-down menu to the left to confirm if a representative of the Ministry of Health has agreed to this statement. Ministry of Health official's name: <input type="text"/> Job title: <input type="text"/>	
<b>A. Leadership and Coordination</b>					
A1. Is there a national committee that works on contraceptive security? Committees can range from advisory committees to those responsible for decision-making on supply management or other policies, and they do not need to have formal legal or administrative status to be considered a committee for this survey. Also, a committee should have some aspect of contraceptive security as part of its Terms of Reference, even if it is known by a different name, for example: Family Planning, Reproductive Health, Maternal Mortality, Essential Medicine Committee, etc.				Comments: <input type="text"/>	
<b>IF NO, SKIP TO SECTION B.</b>					
A2. Are the following organizations represented on the committee? a. Social marketing (for example: PSI, DKT, SFH, etc.) b. NGOs (for example: service delivery, advocacy, Planned Parenthood affiliates, Muna Shoppes affiliates, faith-based organizations, etc.) c. Commercial sector (for example: wholesalers, distributors, pharmacy associations, manufacturers, etc.) d. Donors e. UN agencies f. Ministry of Health (for example: policies, reproductive health, family planning, maternal and child health, HIV/AIDS, pharmacy units, MOH department of finance, etc.) g. Central Medical Store or Central Warehouse h. Ministry of Finance or Ministry of Planning i. Other (for example: professional associations, educational institutions, civil society)				(Y/N dropdown) If yes, specify name(s) of organizations: If yes, specify name(s) of organizations: If yes, specify name(s) of organizations: If yes, specify name(s) of donors: If yes, specify name(s) of agencies: If yes, specify name(s) of units: If yes, specify: If yes, specify: 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, recommendations, and/or action plans in the last year? If yes, is there evidence that the committee has adhered to its policies and procedures, implemented its action plans, and/or followed up on and addressed issues raised at previous meetings?				Please describe the key functions and role of the committee.	
<b>B. Finance and Procurement</b>					
B1. What is the most recent completed 12-month period for which both contraceptive commodity forecast data and expenditure data are available for the public sector (ideally the country government's previous fiscal year)? This must be the same 12-month period used for questions B2-B17, hereinafter referred to as "complete year." Please explain any exceptions in the comments section.				Beginning month: <input type="text"/> Ending month: <input type="text"/> Beginning year: <input type="text"/> Ending year: <input type="text"/>	
B2. What was the forecasted (estimated) dollar value of contraceptives needed to be procured for the public sector* for the most recent complete year (as indicated above in B1)? (in USD) *In addition to public sector needs, include any family planning commodities which the government provides to NGOs and/or social marketing organizations. The information will be used to compare with actual expenditures later in this section. a. Quantity of contraceptive forecast (in B2), in Couple Years of Protection (CYP) (See CYP Calculation tab for assistance)				Comments: <input type="text"/>	
B3. Who conducted the forecast/quantification? (Specify organizations.) a. What is the frequency of forecast updates? (Please select from drop-down menu)				<input type="text"/>	
B4. Is there a government budget line item specifically for the procurement of contraceptives? Please select from the drop-down menu.				Comments: <input type="text"/>	
Please complete the questions below regarding <b>government allocations</b> for contraceptive procurement. Allocated funds are those originally designated for contraceptives, whether or not they ended up being spent on contraceptives.					
B5. Were government funds allocated (i.e., committed) for contraceptive procurement in the most recent complete year? This question refers to funds planned to be spent on contraceptives, whether or not they ended up being spent. (Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.) <b>IF NO, SKIP TO QUESTION B7.</b>				Comments: <input type="text"/>	
In the table below, the time period should reflect when the allocations were supposed to be spent, and will ideally be the most recent complete fiscal year.					
B6. Source of government funds allocated for contraceptive procurement				Amount allocated (in USD) Time period (mm/yy-mm/yy) (should be the same as indicated in B1) Data source (for example: Ministry records) Comments	
a. Internally generated funds allocated for contraceptive procurement				<input type="text"/>	
Total of all other government funds allocated for contraceptive procurement.				<input type="text"/>	
b. (For example, these other government funds could include basket funds, World Bank credits or loans, and other funds provided to the government for their use.)				<input type="text"/>	

## ANNEX A | Contraceptive Security Indicators Survey Questionnaire

Total of all other government funds allocated for contraceptive procurement. b. (For example, these other government funds could include basket funds, World Bank credits or loans, and other funds donors give to the government [e.g., direct budget support])						
c. TOTAL government funds allocated for contraceptive procurement This will auto-calculate. (It will sum a & b above.)		\$	-			

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

B7.	Were government funds spent on procuring contraceptive commodities in the most recent complete year? (Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.) *Include cases where the government funded contraceptive supply for NGOs or social marketing.		Comments:
IF NO, SKIP TO QUESTION B9.			

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

B6.	Source of government funds spent on contraceptive procurement	Was this a source? (Y/N)	Amount spent (in USD)	Time period: (mm/yy-mm/yy) (should be the same as indicated in B1)	Quantity (in Couple Years of Protection) (See CYP Calculator tab for assistance)	Spending type	Details of government procurement (List of contraceptive methods and/or products procured, if available)
a.	Internally generated funds spent on contraceptive procurement						
	i. Specify source(s) of internally generated funds spent (for example, from taxes)						
	Total of all other government funds spent on contraceptive procurement. (For example, these other government funds could include basket funds, World Bank credits or loans, and other funds donors gave to the government [e.g., direct budget support])						
	i. Specify source(s) of other government funds spent (for example: basket funding or specific donor)						
	c. TOTAL government funds spent on contraceptive procurement This will auto-calculate. (It will sum a-b above.)	\$	-				

Please complete the table below to indicate **in-kind donations and grants** for contraceptives in the most recent complete year (per question B1).  
The time period should be the same for all sources of funding.  
\*This can include cases where donors provided products to the Ministry for NGOs or social marketing.

B9.	Source of donated funds for contraceptives for the public sector	In-kind or cash?	Value of donation	Time period: (mm/yy-mm/yy) (should be the same as indicated in B1)	Quantity (in Couple Years of Protection) (See CYP Calculator tab for assistance)	Spending type	Details of donations (List of contraceptive methods and/or products procured, if available)
a.	USAID						
b.	UN agencies						
c.	Global Fund						
d.	Other bilateral (specify)						
e.	Other						
f.	Other						
	i. TOTAL value of in-kind donations and grants spent on contraceptive procurement This will auto-calculate. (It will sum a-f above.)	\$	-				

The answers to B10 - B16 should calculate automatically based on the information you provided. Please review the answers to ensure they make sense to you, and if you have explanations or additional information to add, please note it in the comment boxes provided. If the answers do not calculate automatically, please provide relevant information in the comments boxes.

B10.	Government share of funds spent on contraceptive procurement for the public sector - Of the total amount spent on contraceptives for the public sector in the most recent complete year (including government and donor funds), what percent was covered by government funds (including internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government)?	#DIV/0!	Comments:
B11.	Internally generated share of the total government funds spent on contraceptive procurement for the public sector - Of the total amount of government funds spent on contraceptives for the public sector in the most recent complete year, what percent was covered by internally generated government funds?	#DIV/0!	Comments:
B12.	Total expenditures on public sector contraceptives This will automatically calculate the total amount from government expenditures (G40) and donations (G57).	\$	Comments:
B13.	Total expenditures on public sector contraceptives as percent of amount that needed to be procured (forecast) - Of the estimated value of the contraceptives needed to be procured for the public sector for the most recent complete year, what percent was provided by any source (whether government or donor)?	#DIV/0!	Comments:
B14.	Total quantity of contraceptives procured in Couple Years of Protection as a percent of the quantity that needed to be procured (forecast) - Of the estimated quantity of contraceptives needed to be procured for the public sector for the most recent complete year, what percent was provided by any source (whether government or donor)? This will automatically calculate the quantity of contraceptives procured (K49+K57) divided by the quantity forecasted (J30).	#DIV/0!	Comments:
B15.	Was there a funding gap for public sector contraceptives in the last complete year? (This will automatically calculate based on whether the result in B13 was at least 99 percent of the forecasted need.)	#DIV/0!	Comments:
B16.	Internally generated government funds as a percentage of the total value of contraceptives that needed to be procured (forecast)	#DIV/0!	Comments:
B17.	If the government financed any contraceptive procurement in the most recent complete year, which entity(ies) conducted the procurement(s)? (Please select from the drop-down menus to indicate all that apply)		Comments:
	a. Government (e.g. Central Medical Stores/MOH logistics unit/MOH procurement unit)		
	b. Third-party agent (e.g. UNFPA or private sector)		
	c. Parastatal (including if the government central medical store is a parastatal)		
	d. Other		
	e. Specify entity(ies):		
B18. a.	At what level(s) does government-financed procurement of public sector contraceptives occur? (Please use the drop-down menus to indicate all levels that apply)		
	i. Central		
	ii. Intermediate (e.g. regional, district)		
	iii. Service delivery point level		
	For government-financed procurement, regardless of centralized or decentralized procurement, what is the delivery point (i.e. to what level does the supplier deliver the commodities)?		



## ANNEX A | Contraceptive Security Indicators Survey Questionnaire

<p>For government-financed procurement, regardless of centralized or decentralized procurement, what is the delivery point (i.e., to what level does the supplier deliver the commodities)? (Please use the drop-down menus to indicate all that apply).</p>		Comments:	
I.	Central		
II.	Intermediate (e.g., regional, district)		
III.	Direct to service delivery points		
IV.	Other		
V.	If other, specify:		
B19. Please note any additional comments about finance and procurement:			
The previous questions were about the most recently completed fiscal year. This question refers to the current fiscal year.			
B20. Have funds been allocated by the government for the procurement of contraceptives for the current fiscal year?		Comments:	
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
Combined Oral Contraceptive Pills (for example, levonorgestrel/ethinyl estradiol 150/30 mcg + e 75mcg, levonorgestrel/ethinyl estradiol 150/30 mcg [Microgynon], Seroquel, Livial, Jellestad, Depo-Provera 0.15mg + ethinyl estradiol 0.03mg [Beyonce, Maryon, Estelle], drospirenone/ethinyl estradiol 3mg/20mcg [Yaz, norgestrel/ethinyl estradiol 0.3mg/20mcg [Cryselle, Ovral, Low-Dose, Lo/Ovral], norgestrel/ethinyl estradiol 0.5mg/20mcg [Opastral, norethindrone acetate/ethinyl estradiol (Loastrin, Junel)])			
Progestin-only Oral Contraceptive Pills (for example, levonorgestrel 30 mcg [Norgeston, Mirogyn], norethindrone 35mcg [Microgyn, Camila, Enni], desogestrel 75mcg [Cerazette, Alina, ethinyl estradiol 0.02mg (Femderin)])			
Injectables (for example, depot medroxyprogesterone acetate 104mg/0.8mL auto-injector [Depo Sub-Q Provera, Sayana Press], depot-medroxyprogesterone acetate 150 mg intramuscular [Depo-Provera], norethisterone enanthate [Noristerat])			
Contraceptive Implants (for example, levonorgestrel 75mcg [Jadelle, Sino-Implant (D/Lavipant), etonogestrel 68mcg [Replaxon, Nexplanon])			
Intrauterine devices (IUDs) (for example, copper-bearing [Optima Copper T], levonorgestrel-releasing [Mirena])			
Male condoms			
Female condoms			
Emergency contraceptive pills (for example, levonorgestrel 0.75mg, levonorgestrel 1.5mg) (Planonor)			
Long-acting permanent method for males (vasectomy)			
Long-acting permanent method for females (tubal ligation)			
Contraceptive patches (for example, norgestrel/ethinyl estradiol 150/30mcg [Xiana, Evra])			
Vaginal contraceptive rings (for example, etonogestrel/ethinyl estradiol 120/15mcg [NuvaRing], progestrone-releasing [Phexenon])			
Calendar-based awareness methods (for example, CycleBeads)			
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.)			
1. Other method:			
2. Other method:			
3. 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			
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			Comments:
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 traineeships, accreditation, training and continuing education for private sector providers, and financing mechanisms, such as social marketing, vouchers, incentives, and the government contracting out delivery of services to the private sector.)			
a. If yes, describe the policies			



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Please complete the following table to indicate the country's policies regarding the <b>lowest provider cadre</b> that is allowed to sell or dispense particular contraceptive methods. Please select from the dropdown list if possible. If you cannot find a provider cadre that fits, please select the closest appropriate cadre title. (If you indicated in C1 that a method is not offered in a particular sector (public or private), select "not applicable" for that method and sector.)				
D4.	Contraceptive Method(s)	Note the lowest level provider that is allowed to sell or dispense the method in the <b>public sector</b>	Note the lowest level provider that is allowed to sell or dispense the method in the <b>private sector</b>	Comments
a.	Combined Oral Contraceptive Pills (for example, levonorgestrel/ethinyl estradiol 150/30 mcg + Fe 75 mcg, levonorgestrel/ethinyl estradiol 150/30 mcg [Microgynon, Seasonique, Lincara, Jolissa], desogestrel 0.15 mg + ethinyl estradiol 0.03 mg [Ervaya, Mervion, Evella], drospirenone/ethinyl estradiol 3mg/20 mcg [Yas], norgestrel/ethinyl estradiol 0.3 mg/30 mcg [Cryselle, Ovral, Low-Dosgestral, LoOvral], norgestrel/ethinyl estradiol 0.5 mg/50 mcg [Ogestrel], norethindrone acetate/ethinyl estradiol [Looslin, Junell])			
b.	Progestin-only Oral Contraceptive Pills (for example, levonorgestrel 30 mcg [Norplanon, Microgynon], norethindrone 35 mcg [Micronor, Camila, Enril], desogestrel 75 mcg [Contracept, Azela], ulipristal acetate [EllaOne])			
c. i.	Injectables (depo medroxyprogesterone acetate 104 mg/0.85 mL subcutaneous [Depo Sub-Q Provera, Sayena Press])			
c. ii.	Injectables (depo medroxyprogesterone acetate 150 mg intramuscular [Depo-Provera], acetonide norgestrel [Progestal])			
d.	Contraceptive Implants (for example, levonorgestrel /5 mg [Jadelle, Sino-Implant], etonogestrel 68 mg [Implanon, Nexplanon])			
e.	Intrauterine devices (IUDs) (for example, copper-bearing [Optima Copper-T], levonorgestrel-releasing [Mirena])			
f.	Male condoms			
g.	Female condoms			
h.	Emergency contraceptive pills (for example, levonorgestrel 1.5 mg, ulipristal 3 mg) [EllaOne]			
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 150/30 mcg [Xulane, Evra])			
l.	Vaginal contraceptive rings (for example, etonogestrel/ethinyl estradiol 120/15 mcg [NuvaRing], progestin-releasing [Pessary])			
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 (vaginal))	Type of contraceptive		
The following questions (D5 and D6) will ask about laws and practices that may <b>increase access</b> by specific subpopulations to effective family planning services/commodities, while questions D7 and D8 will ask about any laws or practices that may <b>prevent or reduce access</b> by those subpopulations.				
D5.	Does the country have laws, regulations, or policies that <b>increase access</b> 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 <b>increase access</b> 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 <b>make it difficult</b> for the following sub-populations to access effective family planning services/commodities? (e.g. spouse approval required to access contraceptive)	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 <b>make it difficult</b> for the following sub-populations to access effective family planning services/commodities? (for example, providers not willing to offer services to young people)	Y/N (dropdown)	If yes, describe the operational, cultural, or other barriers and practices affecting access	
a.	Unmarried youth (ages 15-19)			
b.	Married youth (ages 15-19)			
c.	Unmarried youth (ages 20-24)			
d.	Married youth (ages 20-24)			
e.	Rural population			
f.	Populations in disadvantaged sub-regions (i.e. certain geographic areas)			

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f. Populations in disadvantaged sub-regions (i.e. certain geographic areas)				
g. Populations with lower educational attainment				
h. Lower income populations				
i. Disabled				
j. Minority populations (e.g. ethnic or religious groups)				
k. Other (e.g. migrants, internally displaced populations)				
D9. Are any family planning commodities subject to duties?				
a. If yes, for which sectors? (Please use the dropdown menus to indicate all that apply)				Comments:
i. Public sector health facilities				
ii. NGO Sector				
iii. Social Marketing 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?				
e. If yes, describe the charges.				
D11. If a fee is charged for family planning services or commodities in the public sector, does public/government/national health insurance cover family planning?				
a. If yes, what proportion of the population does this health insurance cover?				
D12. Are the following contraceptives included in the country's National Essential Medicines List (NEML) or other equivalent priority list? (for example, the National Medical Device List)				
a. Combined Oral Contraceptive Pills (for example, levonorgestrel/ethinyl estradiol 150/30 mcg + Fe 75 mg; levonorgestrel/ethinyl estradiol 150/30 mcg [Microgynon, Seasonale, Levora, Jellella]; desogestrel 0.15 mg + etonogestrel 0.03 mg [Enkvyok, Minivon, Exalt]; drospirenone/ethinyl estradiol 3 mg/20 mcg [Yale]; norgestimate/ethinyl estradiol 0.3 mg/30 mcg [Dyella, Ovral, Low-Ogestrel, LoOvral]; norgestimate/ethinyl estradiol 0.5 mg/50 mcg [Ogestrel]; norethindrone/ethinyl estradiol [Loestrin, Junel])				Comments:
b. Progestin-only Oral Contraceptive Pills (for example, levonorgestrel 30 mcg [Borgeston, Microlet], norethindrone 35 mcg [Minipor, Camila, Enril], desogestrel 75 mcg [Cerasette, Azina], ethinodiol diacetate [Femulen])				
c. Injectables (for example, depot medroxyprogesterone acetate 104 mg/0.85 mL, subcutaneous [Dect Sub-Q Provera, Sayana Press], depot medroxyprogesterone acetate 150 mg intramuscular [Depo-Provera], norethisterone enanthate [Noristerat])				
d. Contraceptive Implants (for example, levonorgestrel 75 mcg [Jadelle, Sino-implant (MLevoimplant), etonogestrel 68 mcg (implanon, Neoplanon))				
e. Copper-bearing intrauterine devices (IUDs) (for example, Optima Cooper T)				
f. Hormone-releasing intrauterine devices (IUDs) (for example, levonorgestrel-releasing [Mirena])				
g. Male condoms				
h. Female condoms				
i. Emergency contraceptive pills (for example, levonorgestrel 0.75 mg, levonorgestrel 1.5 mg)				
j. Contraceptive Patches (for example, norgestimate/ethinyl estradiol 150/20 mcg [Xlaxo, Evra])				
k. Vaginal Contraceptive Rings (for example, etonogestrel/ethinyl estradiol 120/15 mcg [NuvaRing], progesterone-releasing [Progestic])				
l. Calendar-based Awareness Methods (for example, CycleBeads)				
m. Any other contraceptive(s)? (e.g. SILCS diaphragm)				
n. If yes, name(s) of other contraceptive(s) on the list(s)				
D13. What year(s) was the NEML/list(s) issued?				
D14. Name of the list(s)				
D15. Is family planning actively promoted through any of the following channels? (use the drop-down menus to select all that apply)				
a. Social marketing				Comments:
b. Mass media				
c. Mobile outreach/education				
d. Community mobilization/engagement				
e. Other				
f. If other, please specify:				
D16. Approximately what percentage of public sector family planning providers have been trained in implant and IUD insertion and removal? (Select the percentage range that is the closest approximation.)				Comments:
Question D17 concerns the FP2020 partnership in its previous iteration through the year 2020. Questions D17a through D17c concern the new FP2030 partnership, "A Collective Vision for Family Planning Post-2020".				
D17. Looking back to the period of FamilyPlanning2020, did the country make an FP2020 commitment?				Comments:
a. Has the country made an FP2030 commitment?				Comments:
b. If not, does the country anticipate making an FP2030 commitment?				Comments:
D18. If the country has or plans to make an FP2030 commitment, which of the following components will be included? (Indicate yes, no, don't know, or not applicable for each component)				Comments:
a. Improving domestic financing for contraceptives				Comments:
b. Increasing affordability of contraceptives for clients				Comments:
c. Improving access to or availability of contraceptives (beyond any commitments for domestic financing or affordability)				Comments:
D19. Is the country a Global Financing Facility (GFF) partner?				
a. If yes, does the financing include provisions for family planning?				Comments:
b. Does it include provisions for procurement of contraceptive commodities?				



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b. Does it include provisions for procurement of contraceptive commodities?			Comments:	
c. Does the financing include provisions for supply chain management?				
d. Does technical assistance support a transition to domestic financing of contraceptives?				
<b>E. Supply Chain</b>				
E1	Is there a national logistics management information system (LMS) that collects data on contraceptive commodities?	Yes	Comments:	
IF NO, SKIP TO QUESTION E2.				
If there is a national LMS, does it capture stock data down to the individual service delivery point (SDP) level? <small>(At a minimum, data elements reported for health facilities must include: stock on hand/ending balance, rate of consumption, losses and adjustments)</small>			Comments:	
b. If yes, what types of health facilities report into the system? (Use the dropdown menus to select all that apply)				
i. Public sector health facilities:				
ii. Private sector health facilities:				
iii. NGO health facilities:				
iv. Social marketing sites:				
If there is a national LMS that captures stock data at the service delivery point (SDP) level, please select the option that best describes how data is reported at the SDP level. <small>(At a minimum, data elements reported for health facilities must include: stock on hand/ending balance, rate of consumption, losses and adjustments. Otherwise, please select "N/A" for this question.)</small>			Comments:	
Please provide the public sector <b>stockout rates</b> for contraceptive commodities for the most recent available 12-month period for the central and service delivery point levels for the following product categories.				
E2	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.		<p><b>a. Central level</b> (i.e., central level warehouse for the public sector)</p> <p>Number of stock status observations where the commodity was stocked out during the fiscal year (numerator)</p> <p>Total stock status observations during the year (denominator)</p> <p>Annual stockout rate at the central level</p> <p>Automatically calculated by dividing column H by column I</p>	<p><b>b. Service delivery point (SDP) level</b> (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)</p> <p>Sum of the number of SDPs stocked out of the commodity as of the ending balance of all monitoring quarterly logistics reports for the fiscal year (numerator)</p> <p>Sum of the total numbers of SDPs reporting across all monitoring quarterly logistics reports for the fiscal year (denominator)</p> <p>Annual stockout rate at SDPs</p> <p>Automatically calculated by dividing column K by column L</p>
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, Jovelle)			#DIV/0!	#DIV/0!
iii. Other combined oral contraceptive pills (not included for aggregate calculation) Specify:			#DIV/0!	#DIV/0!
b. Progestin-only oral contraceptive pills (Levonorgestrel 30 mcg (Norgestrel, Mirena))			#DIV/0!	#DIV/0!
c. Injectable contraceptives				
i. Depot medroxyprogesterone acetate 104mg/0.65mL subcutaneous (Depo Sub-Q Provera, Sayana Press)			#DIV/0!	#DIV/0!
ii. Depot medroxyprogesterone acetate 150 mg intramuscular (Depo-Provera)			#DIV/0!	#DIV/0!
iii. Norethisterone enanthate (Noristerat)			#DIV/0!	#DIV/0!
iv. Norethisterone enanthate (Noristerat)			#DIV/0!	#DIV/0!
d. Contraceptive implants				
i. Levonorgestrel 75mg/rod, 2 rod implant (Janelle, Janelle-Implant, Janelle)			#DIV/0!	#DIV/0!
ii. Etonogestrel 68mg/rod, 1 rod implant (Implanon, Neoplanon)			#DIV/0!	#DIV/0!
e. Copperbearing intrauterine devices (IUDs) (for example, Olympe Cooper-T)			#DIV/0!	#DIV/0!
f. Hormone-releasing intrauterine devices (IUDs) (for example, levonorgestrel-releasing (Mirena))			#DIV/0!	#DIV/0!
g. Male condoms			#DIV/0!	#DIV/0!
h. Female condoms			#DIV/0!	#DIV/0!
i. Emergency oral contraceptive pills				
i. Levonorgestrel 0.75 mg, 2 tablets			#DIV/0!	#DIV/0!
ii. Levonorgestrel 1.5 mg, 1 tablet			#DIV/0!	#DIV/0!
j. Calendar-based awareness methods (for example, Cyclesett)			#DIV/0!	#DIV/0!
k. Total stockout rate for all commodities <b>This will auto-calculate.</b> (It will sum H and I and divide H by I, and will sum K and L and divide by L)		0	#DIV/0!	0
E3	(Optional) What have been the main drivers of stockouts of contraceptives in the country during the previous year?			
<b>F. Quality</b>				
F1	Is there a requirement that all contraceptives that are locally manufactured or imported be registered by the in-country national medicines regulatory authority (NMRA)?		Comments:	
F2	Are drug (including contraceptives) registration requirements strictly adhered to?		Comments:	
a. If yes, are there exceptions?				
b. Please explain any exceptions				
F3	What is the average lead time for the registration of contraceptive products?		Comments:	
F4	Does the NMRA participate in WHO-prequalified (WHO-PQ) Collaborative Procedures?		Comments:	
F5	Is there a requirement that contraceptives, imported or locally manufactured, be tested by the in-country national quality control laboratory (NQCL)?		Comments:	
F6	Is the NQCL currently ISO 17025 (International Organization of Standards) certified/accredited and/or currently WHO-prequalified?			
F7	In the past year, to what extent were contraceptives, excluding condoms, tested by the NQCL post-shipment?			
a. In the past year, to what extent were condoms tested by the NQCL post-shipment?				
F8	In the past year, did the NMRA conduct field surveillance monitoring to identify SF (substandard and falsified) contraceptives, to protect the public from ineffective and/or harmful products?			
a. If yes, to what extent were regulatory enforcement actions taken following field surveillance of contraceptives?				

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a. If yes, to what extent were regulatory enforcement actions taken following field surveillance of contraceptives?					
<b>G. Private Sector</b>					
G1.	According to the MoH, how many wholesalers are registered in the country (for distributing FP products)?				Comments:
	a. Are wholesalers required to report to the government their sales and services?				
	b. If yes, in the past year, approximately what proportion of wholesalers reported to the government on their sales and services?				
G2.	Does the MoH use market data from third party sources (i.e., IQVIA, Nelson, Kantar, or local market research companies) to guide programming?				Comments:
	a. If yes, how is the data used? (e.g. understanding commodity pricing, strategic planning, resource allocation, distribution, etc.)				
	b. If no, would they like to build this capacity?				
<p>The International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) aims to ensure that safe, effective and high quality medicines are developed, registered, and maintained in the most resource efficient manner whilst meeting high standards. The national drug regulatory authorities which are members, observers, or associates of the ICH are considered as <b>Stringent Regulatory Authorities (SRA)</b>, including: European Union member states, the United Kingdom, the United States, Canada, and Japan.</p>					
<p>For each of the following contraceptive methods, please provide the following information:</p>					
G3.	<p>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)</p> <p>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)</p> <p>iii. If there are any WHO-prequalified and/or SRA-approved contraceptive products, list one or more examples of the brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any products within the contraceptive method.</p>				
	<p><b>Combined Oral Contraceptive Pills</b> (for example, levonorgestrel/ethinyl estradiol 150/30 mcg + Fe 75 mcg, desogestrel/ethinyl estradiol 150/30 mcg [Microgynon], Seasonale, Lo/Ovral, Jukovet, drospirenone/ethinyl estradiol 3mg/20mcg [Yas], norethindrone acetate/ethinyl estradiol 0.02mg/0.01mg [Lo/Ovral])</p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-prequalified and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any combined oral contraceptives?</p>				
	<p><b>Progestin-only Oral Contraceptive Pills</b> (for example, levonorgestrel 30 mcg [Norgeston, Microdot], norethindrone 35 mcg [Microdot, Camila, Envy], desogestrel 75 mcg [Cerazette, Azela], etruodiol diacetate [Formilon])</p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any progestin-only contraceptives pills?</p>				
	<p><b>Injectables</b> (for example, depot medroxyprogesterone acetate 104mg/0.65mL subcutaneous [Depo-Jaso-Q Provera, Sayena Phari], depot medroxyprogesterone acetate 150 mg intramuscular [Depo-Provera], norethisterone enanthate [Noristerat])</p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any injectable contraceptives?</p>				
	<p><b>Contraceptive Implants</b> (for example, levonorgestrel 75 mcg Jilvade, Siro-implant [Mikoyplast], etonogestrel 68 mcg Implanon, Nexplanon)</p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any contraceptive implants?</p>				
	<p><b>Intrauterine devices (IUDs)</b> (for example, copper-bearing [Colima Copper T], levonorgestrel-releasing [Mirena])</p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any contraceptive implants?</p>				
	<p><b>Male condoms</b></p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any male condoms?</p>				
	<p><b>Female condoms</b></p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any female condoms?</p>				
	<p><b>Emergency contraceptive pills</b> (for example, levonorgestrel 0.75 mg, levonorgestrel 1.5 mg [Postinor])</p> <p>i. Are there any WHO-PQ or SRA-approved products registered for distribution in the country?</p> <p>ii. How many manufacturers are registered in the country for distribution of WHO-PQ and/or SRA-approved contraceptive products?</p> <p>iii. Example(s) of WHO-prequalified and/or SRA-approved brand and formulation</p> <p>iv. How many in-country local manufacturers exist who produce any emergency contraceptive pills?</p>				
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 broken in the last two years with the purpose of expanding private sector provision of health services including family planning products and services?		Comments:		
	(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)				
	a. If yes, please list/describe them:				
G6.	Has the government developed or started developing a private sector engagement (PSE) plan for family planning/reproductive health, or with an FP/RH component?				Comments:

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



## ANNEX B | Annex B. Contextual Reference Measures

(Formerly from the Contraceptive Security Index)

Indicator	Description	Nigeria	Benin	Burkina Faso	Burundi	Cameroon	Cote d'Ivoire	DRC	ES/Sudan	Ethiopia	Ghana	Guatemala	Guinea	Haiti	Indonesia	India	Kenya	Kenya Republic	Madagascar	Malawi	Uganda	Zambia
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 expenditure, this indicator is a measure of a government's political commitment to funding its public health system compared to other priorities. The greater the overall funding envelope for public health, the more that can be devoted to family planning and reproductive health, and the better the likelihood that those most in need will be covered by health services, including FP/RH. *Source: World Bank World Development Indicators, 2018. ( <a href="https://data.worldbank.org/indicators.aspx?source=28&amp;series=SH.UKSD.GHSD.CS.ZS">https://data.worldbank.org/indicators.aspx?source=28&amp;series=SH.UKSD.GHSD.CS.ZS</a> )	5.4%	3.0%	3.0%	14.3%	8.8%	8.5%	1.1%	10.4%	4.5%	18.6%	4.8%	6.4%	16.7%	4.1%	4.8%	10.7%	3.4%	8.6%	6.4%	4.4%	5.2%
2 Per Capita Gross National Income (GNI), purchasing power parity (PPP) (constant 2017 US\$ million)	Per capita gross national income refers to represent the ability of households to pay for goods and services, including contraceptives and family planning/reproductive health services. A higher GNI is generally associated with a higher level of contraceptive security. This indicator is measured in constant 2011 international dollars and purchasing power parity, which adjusts for the different market prices for goods in each country. *Source: World Bank World Development Indicators. Data was available for the years 2017 to 2020. ( <a href="https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD?locations=SD">https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD?locations=SD</a> )	\$ 5 093	\$ 5 108	\$ 3 288	\$ 14 650	\$ 2 055	\$ 736	\$ 2 586	\$ 5 898	\$ 1 051	\$ 7 559	\$ 2 280	\$ 5 601	\$ 8 241	\$ 2 577	\$ 2 940	\$ 4 792	\$ 6 107	\$ 4 267	\$ 4 495	\$ 6 875	\$ 1 424
Source year of periodicity: GNI data		2020	2020	2020	2020	2018	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2017	2017	
3 Poverty level: (Percentage of the national population living below the nationally defined poverty line)	While per capita gross national income measures the average person's ability to pay for goods and services, a higher poverty level, defined as the percentage of the national population living below the nationally defined poverty line, can indicate increased income inequality and an increased proportion of the population reliant on the public health system. This measure may indicate a need to target public health goods and services toward the poorest segments of the population. Higher poverty levels are generally associated with lower levels of contraceptive security. *Source: World Bank World Development Indicators. Data was available for years ranging from 2009 to 2020. ( <a href="https://data.worldbank.org/indicator/SL.POV.NAH?locations=SD">https://data.worldbank.org/indicator/SL.POV.NAH?locations=SD</a> )	32.3%	24.3%	38.5%	19.3%	41.4%	64.5%	37.5%	35.0%	83.9%	26.2%	23.5%	23.4%	59.3%	43.7%	58.5%	48.0%	21.9%	36.1%	25.3%	18.3%	50.9%
Source year of poverty level data		2018	2016	2019	2009	2018	2019	2014	2019	2012	2020	2019	2016	2014	2018	2012	2019	2011	2015	2020	2018	2016
Health & Social Environment																						
4 Governance																						
Regulatory Quality (Percentile rank: 0 to 100)	Regulatory quality, an element of good governance, is a composite measure that captures "perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development" (World Bank's Worldwide Governance Indicators, 1996-2020). Countries with a strong regulatory environment are more likely to attract international financing, and the private sector is more likely to invest in creating or expanding the market for contraceptives. This indicator assigns countries a percentile rank from 0 to 100, where 100 is the strongest regulatory quality. *Source: World Bank Worldwide Governance Indicators, 2020. ( <a href="http://info.worldbank.org/governance/wgi/reports">http://info.worldbank.org/governance/wgi/reports</a> )	15.87	16.35	38.94	65.38	37.50	12.50	16.71	50.48	5.29	50.96	14.42	52.40	44.71	19.23	10.10	34.13	47.60	35.58	37.08	21.15	13.46
5 Women's education (% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio)	Women's education is measured by the percent of females enrolled in secondary school out of the applicable age group, also known as the gross enrollment ratio. Women who are educated beyond the primary level are more likely to use contraceptives, and more likely to advocate for the protection of family planning/reproductive health programs. *Source: UNESCO's Institute for Statistics (UIS) STAT Database. Data was available for years ranging from 2013 to 2018. ( <a href="http://data.uis.unesco.org/">http://data.uis.unesco.org/</a> )	59.74%	81.49%	42.44%	83.52%	41.78%	52.25%	55.44%	92.69%	35.98%	68.97%	34.25%	77.84%	49.91%	31.64%	62.93%	75.28%	53.66%	58.08%	69.96%	32.91%	
Source year of gross enrollment ratio data		2016	2020	2020	2008	2020	2021	2016	2019	2015	2019	2015	2020	2020	2014	---	2020	2020	2009	2020	2020	2015
6 Adult HIV Prevalence	This measure has a complex relationship with contraceptive security. Higher burdens of HIV can put greater strains on the health system, leaving fewer health resources available for FP/RH programs. However, countries are increasingly linking HIV/AIDS and FP/RH programs, which boosts awareness of both. Furthermore, women who are HIV-positive and know their status are more likely to use family planning methods. This indicator is defined as the percentage of adults aged 15-49 who were infected with the HIV virus as of mid-2019. *Source: UNAIDS, 2020. ( <a href="http://aidsinfo.unaids.org/">http://aidsinfo.unaids.org/</a> )	1.8%	---	0.9%	19.9%	0.7%	1.0%	3.0%	0.5%	0.7%	0.5%	0.9%	1.7%	0.2%	1.4%	1.9%	0.2%	4.2%	0.2%	0.3%	1.1%	
Access																						
7 Access to FP Methods																						
Access to long-acting and permanent methods (LARPs)	Defined as the extent to which the entire population has ready access to LARPs (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 NCIPF ( <a href="http://www.track20.org/pages/data_analysis/policy/NCIPF.php">http://www.track20.org/pages/data_analysis/policy/NCIPF.php</a> )	N/A	47.1%	N/A	N/A	47.2%	57.3%	40.5%	N/A	41.4%	59.2%	35.7%	54.4%	39.4%	45.0%	23.8%	59.0%	60.5%	56.0%	41.8%	48.7%	30.4%
7a																						
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 NCIPF ( <a href="http://www.track20.org/pages/data_analysis/policy/NCIPF.php">http://www.track20.org/pages/data_analysis/policy/NCIPF.php</a> )	N/A	76.8%	N/A	N/A	83.8%	80.7%	73.2%	N/A	75.9%	82.6%	78.0%	86.2%	70.4%	75.1%	71.6%	86.4%	71.4%	85.5%	60.8%	77.4%	64.6%
7b																						
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 ( <a href="https://dhsprogram.com/Where-We-Work/Country-List.cfm">https://dhsprogram.com/Where-We-Work/Country-List.cfm</a> )	37.1%	19.9%	34.6%	10.8%	25.0%	31.9%	26.9%	17.4%	39.2%	14.6%	21.8%	31.4%	22.9%	23.4%	37.7%	17.4%	18.5%	17.9%	20.0%	21.0%	32.9%
9 Modern Contraceptive Prevalence Rate (mCPR)	Contraceptive prevalence rate, the percentage of married women of reproductive age currently using a modern method of family planning, is the most common measure of contraceptive security. Higher contraceptive use indicates better access and availability of contraceptives to the beneficiary population. *Source: Track20's Family Planning Estimation Tool (FPET), DHS Final Reports ( <a href="https://dhsprogram.com/Where-We-Work/Country-List.cfm">https://dhsprogram.com/Where-We-Work/Country-List.cfm</a> ), and the 2017 United Nations report on World Family Planning ( <a href="https://www.un.org/en/development/desa/population/publications/pdf/family/FP2017_Highlights.pdf">https://www.un.org/en/development/desa/population/publications/pdf/family/FP2017_Highlights.pdf</a> )	15.2%	54.5%	14.4%	68.8%	30.6%	27.4%	16.6%	56.2%	15.2%	68.6%	40.5%	30.8%	53.2%	12.1%	24.7%	67.3%	60.3%	58.2%	38.9%	53.0%	25.0%

(Formerly from the Contraceptive Security Index)

Indicator	Madagascar	Malawi	Mali	Mauritania	Mozambique	Nepal	Niger	Nigeria	Pakistan	Peru	Philippines	Rwanda	Senegal	Sierra Leone	South Sudan	Sri Lanka	Tanzania	Togo	Uganda	Yemen	Zambia	Zimbabwe
Finance																						
1 Domestic general government health expenditure (% of general government expenditure)	10.5%	9.8%	5.4%	6.1%	5.6%	4.6%	8.4%	4.4%	5.3%	15.3%	6.6%	8.9%	4.3%	7.3%	2.1%	8.3%	9.4%	4.3%	5.1%	N/A	7.0%	7.6%
2 Per Capita Gross National Income (GNI), purchasing power parity (PPP) (constant 2017 international \$)	\$1 420	\$1 440	\$2 132	\$5 039	\$1 258	\$3 844	\$1 279	\$4 740	\$4 467	\$10 917	\$8 559	\$2 052	\$3 240	\$1 604	N/A	\$12 208	\$2 616	\$2 113	\$2 138	N/A	\$3 331	\$3 864
Source/year of per-capita GNI data	2020	2017	2020	2020	2019	2020	2019	2020	2020	2020	2020	2020	2020	2020	N/A	2020	2020	2020	2020	N/A	2017	2018
3 Poverty level (Percentage of the national population living below the nationally defined poverty line)	70.7%	51.5%	41.9%	51.0%	46.1%	25.2%	40.8%	40.1%	21.0%	20.2%	16.7%	38.2%	46.7%	56.8%	78.4%	4.1%	29.4%	55.1%	20.3%	48.6%	54.4%	38.3%
Source/year of poverty level data	2012	2016	2020	2014	2014	2010	2016	2018	2016	2019	2016	2016	2011	2018	2016	2016	2017	2015	2018	2014	2010	2018
Health & Social Environment																						
4 Governance																						
Regulatory Quality (Percentile rank: 0 to 100)	22.60	23.56	30.29	20.67	25.00	24.52	23.08	13.94	24.04	70.19	53.37	58.17	42.79	18.27	1.92	44.23	27.40	30.77	36.54	3.65	29.33	7.69
5 Women's education (% of females enrolled in secondary school, out of the applicable age group – gross enrollment ratio) <a href="http://data.uis.unesco.org/#">http://data.uis.unesco.org/#</a>	35.24%	33.65%	37.00%	40.45%	31.95%	86.90%	20.70%	42.41%	41.59%	106.91%	93.91%	47.05%	50.09%	41.06%	7.67%	102.63%	32.69%	52.06%	21.84%	43.26%	...	51.35%
Source/year of (gross enrollment) ratio data	2016	2016	2018	2016	2016	2020	2017	2018	2018	2020	2019	2019	2020	2017	2016	2018	2020	2017	2007	2018	...	2013
6 Adult HIV Prevalence	0.3%	8.1%	0.9%	0.3%	11.5%	0.1%	0.2%	1.3%	0.2%	0.3%	0.2%	2.5%	0.3%	1.5%	2.3%	<0.1	4.7%	2.0%	5.4%	<0.1	11.1%	11.9%
Access																						
7 Access to FP Methods																						
Access to long-acting and permanent methods (LAPMs)	39.9%	50.4%	46.1%	24.2%	35.0%	58.2%	42.5%	45.1%	36.1%	41.9%	43.1%	79.4%	40.3%	48.1%	23.4%	57.4%	44.4%	53.2%	40.0%	N/A	38.0%	36.8%
Access to short-term methods (STMs)	71.9%	81.2%	84.3%	88.5%	82.2%	88.4%	84.4%	86.5%	88.6%	81.5%	87.0%	86.7%	84.4%	92.5%	55.2%	87.4%	74.1%	86.4%	89.0%	N/A	78.8%	85.9%
Utilization																						
8 Percent unmet need for family planning	21.5%	16.3%	24.3%	30.2%	23.2%	26.3%	16.9%	24.2%	26.6%	26.0%	30.1%	21.1%	22.9%	24.6%	29.7%	19.6%	25.3%	32.7%	28.9%	35.0%	21.1%	10.2%
9a Modern Contraceptive Prevalence Rate (mCPR)	44.2%	63.1%	18.8%	19.1%	27.8%	46.7%	17.7%	14.6%	28.0%	57.0%	42.3%	53.1%	27.3%	23.6%	6.9%	54.9%	38.7%	23.9%	40.5%	31.7%	49.5%	68.3%