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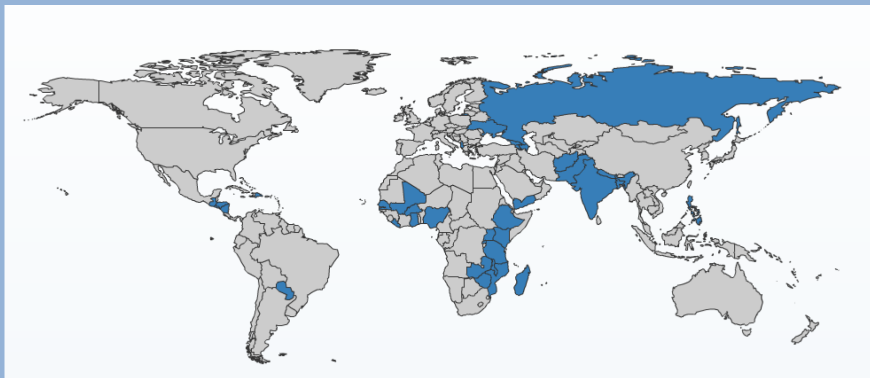
Measuring Contraceptive Security Indicators in 2010: Data Update



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Measuring Contraceptive Security Indicators in 2010: Data Update

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Abstract
In 2010, the USAID | DELIVER PROJECT conducted its second annual round of data collection on contraceptive security indicators, gathering data from 35 USAID first tier priority countries for family planning and from USAID | DELIVER PROJECT countries. This paper updates the data in *Measuring Contraceptive Security Indicators in 36 Countries*, which was based on similar data collection in 2009. It also continues to advocate for the increased use of contraceptive security indicators to help in-country stakeholders monitor and foster progress toward contraceptive security.

Cover photos: (1) Contraceptive products, including social marketing condoms, are displayed in a drugstore. (2) A young Afghani mother receives contraceptive pills and family planning education during a visit to her midwife. (3) A billboard advertises oral contraceptives. (4) The map displays the countries represented in this report. (5) A family planning agency employee reviews educational materials. (6) A new mother and father take a family photo with their newborn in a state health facility. (7) The coins represent the importance of finance for contraceptive procurement. Finance, along with commodities, policies, coordination/leadership, and supply chain factors, is discussed in this paper as a crucial contributor to contraceptive security.

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Acronyms

CARhs	Coordinated Assistance for Reproductive Health Supplies
CIDA	Canadian International Development Agency
CS	contraceptive security
DANIDA	Danish International Development Agency
DFID	Department for International Development (British)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IUD	intrauterine device
LMIS	logistics management information system
NEML	National Essential Medicines List
NGO	nongovernmental organization
PPMR	Procurement Planning and Monitoring Report
PRSP	Poverty Reduction Strategy Paper
RHCS	reproductive health commodity security
RHSC	Reproductive Health Supplies Coalition
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

Acknowledgments

The USAID | DELIVER PROJECT expresses its heartfelt thanks to the many people who contributed to this paper by responding to the contraceptive security indicators survey or otherwise provided country-specific information; including USAID Mission staff and USAID | DELIVER PROJECT staff. In some cases, survey respondents consulted with employees of other USAID cooperating agencies or Ministry of Health representatives; we greatly appreciate their input.

Executive Summary

Contraceptive security (CS) exists when every person is able to choose, obtain, and use quality contraceptives and condoms for family planning and the prevention of sexually transmitted infections. After many years of working to improve CS, country stakeholders and other CS advocates increasingly emphasize the importance of monitoring progress at the country level. In response to this need, and in recognition that *what gets measured gets done*, a previous paper, *Measuring Contraceptive Security in 36 Countries*, proposed a set of standard CS indicators. This paper presents updated data from 35 countries on these indicators, which we obtained during the second annual round of data collection.

The contraceptive security indicators included in this paper are examples of relevant information country governments, policymakers, CS committees, and advocates can use to monitor and foster progress toward CS. Building on the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework,[1] the indicators cover various aspects of CS, including finance for procurement (capital), commodities, policies (commitment), coordination and leadership, and the supply chain.

The data collected for this analysis indicate that in-country stakeholders have worked diligently to improve CS: 89 percent of surveyed countries have instituted coordination committees to improve contraceptive security, 86 percent have strategies regarding CS, and 65 percent contribute government funds for contraceptive procurement. On average, surveyed countries offer eight of the 11 assessed contraceptive methods in public-sector facilities.

Many of the surveyed countries, however, showed substantial room for progress on CS issues. Opportunities for improvement include the expansion of CS coordinating committees' membership, an increase in government funding for contraceptives, a broadening of contraceptive methods offered and those included in essential medicine lists, and an improvement in the availability of contraceptives at warehouses and service delivery points.

Survey responses indicate that relevant CS data are not always readily available to in-country stakeholders. This document intends to inform country CS committees and other stakeholders about the importance of using CS data and to encourage CS committees to incorporate similar monitoring tools within broader CS strategic planning and implementation processes. Institutionalizing mechanisms to assess country progress toward CS is essential to the monitoring and promoting of CS.

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1. *The Strategic Pathway to Reproductive Health Commodity Security: A Tool for Assessment, Planning, and Implementation* (SPARHCS Tool) has been used extensively to help improve reproductive health commodity security (RHCS). The *SPARHCS process* attempts to measurably strengthen RHCS by paying attention to each phase of the cycle of RHCS activities—from awareness raising to monitoring the effectiveness of a funded and implemented RHCS strategic plan. This framework includes components considered vital to achieve RHCS. Often referred to as the *seven C's*, the components include context, commitment, capital, coordination, capacity, client demand and utilization, and commodities.

Contraceptive Security Indicators

CS indicators, developed to reflect key aspects of contraceptive security, help in-country stakeholders monitor and evaluate their country's CS status. Most indicators in 2010 are the same as those presented in 2009; however, a few indicators have been revised and others added. (See appendix C for the data collection tool with the complete list of indicators assessed in 2010.)

What is an indicator?
An indicator, similar to a sign or symptom, is an easy way to measure performance, over time. The results indicate progress toward or away from a goal.

Indicators include the following topics:

Finance for Procurement (Capital)

- total expenditures for contraceptive procurement
- funding sources
- existence of a government budget line item for contraceptives
- procurement mechanism.

Commodities

- range of contraceptive methods offered in public facilities
- range of contraceptive methods offered in nongovernmental organization (NGO) facilities
- range of contraceptive methods offered in private facilities.

Policies (Commitment)

- existence of a national contraceptive security strategy
- existence of policies affecting access to family planning
- inclusion of contraceptives on the National Essential Medicines List (NEML)
- inclusion of contraceptive security concepts in the Poverty Reduction Strategy Paper (PRSP).

Coordination and Leadership

- existence of a national committee that works on contraceptive security and organizations represented
- frequency of committee meetings
- legal status of the committee
- existence of a contraceptive security *champion*.

Supply Chain

- central-level stockout data
- whether stockouts are a serious problem at the service delivery point (SDP) level and at the central level.

The indicators were designed to ensure that data could be routinely updated with accessible information from either key informants or document reviews. See appendix A for an in-depth description of limitations and considerations related to the study. See appendix B for the data collection methodology (including the basis for country selection).[2]

This *Contraceptive Security Indicators* (*CS Indicators*) activity complements the *Contraceptive Security Index* (*CS Index*) published in 2003, 2006, and 2009. The *CS Index,* a composite index, comprises a wide range of contraceptive security indicators based on data obtained primarily from secondary data analysis. While the *CS Index* is a valuable resource for analyzing CS, it is only published every three years. Data informing the *CS Index* draws from multiple sources—many sources are not updated annually. Most of the CS indicators examined in this report can be updated annually and, therefore, offer a current understanding of the CS situation in a country; also, the countries can update their data. In addition, the *CS Indicators* tend to focus more on specific CS interventions and processes than the *CS Index*.

This *CS Indicators* data also complement the UNFPA *Reproductive Health Monitoring Tool* (http://countryoffice.unfpa.org/rhmt/).[3]

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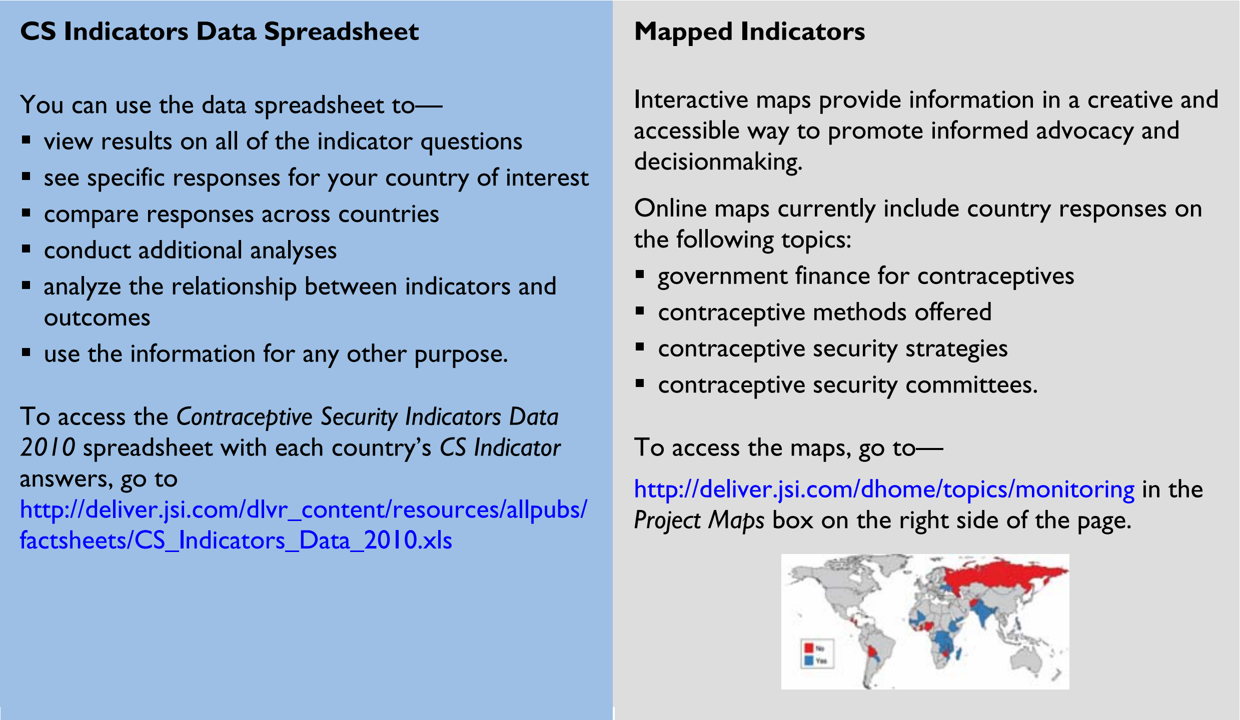
2. The surveyed countries were Afghanistan, Albania, Armenia, Azerbaijan, Bangladesh, Burkina Faso, Dominican Republic, El Salvador, Ethiopia, Georgia, Ghana, Guatemala, Honduras, India, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Pakistan, Paraguay, Philippines, Russia, Rwanda, Senegal, Tanzania, Uganda, Ukraine, Yemen, Zambia, and Zimbabwe.

3. UNFPA developed an interactive monitoring tool for reproductive health commodity security, which the UNFPA country offices populated with data.

Findings

This paper updates the data in *Measuring Contraceptive Security in 36 Countries* (based on 2009 data collection). As explained in appendix B, the countries included in this paper differ slightly from those included in the previous paper: Burkina Faso and Honduras are new additions; while Bolivia, Democratic Republic of Congo, and Haiti are not represented this year.

The sections that follow provide a summary analysis of the *CS Indicator* data collected in 2010. Findings are by topic area (finance for procurement [capital], commodities, policies [commitment], coordination and leadership, and supply chain). For the raw data collected by country, please refer to the complete dataset on the USAID | DELIVER PROJECT website (deliver.jsi.com). You can also find data-rich maps displaying country data on some of the indicators on the project website. These tools are described below.



CS Indicators Data Spreadsheet

You can use the data spreadsheet to—

- view results on all of the indicator questions
- see specific responses for your country of interest
- compare responses across countries
- conduct additional analyses
- analyze the relationship between indicators and outcomes
- use the information for any other purpose.

To access the *Contraceptive Security Indicators Data 2010* spreadsheet with each country's *CS Indicator* answers, go to http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CS_Indicators_Data_2010.xls

Mapped Indicators

Interactive maps provide information in a creative and accessible way to promote informed advocacy and decisionmaking.

Online maps currently include country responses on the following topics:

- government finance for contraceptives
- contraceptive methods offered
- contraceptive security strategies
- contraceptive security committees.

To access the maps, go to—

http://deliver.jsi.com/dhome/topics/monitoring in the *Project Maps* box on the right side of the page.

Finance for Procurement (Capital)

Finance-related indicators help stakeholders understand the amount the government spends on contraceptive procurement and the amount donors provide for the public sector[4] through in-kind donations. As explained later, government financing includes internally generated funds, as well as funds from other sources (i.e., donors) that are given to the government and that the government decides to spend on contraceptive procurement. Government financing indicates government commitment to contraceptive security and suggests sustainability.

Key Findings: Finance for Procurement

- In sixty-five percent of the surveyed countries (22 out of 34), government funds* were used for contraceptive procurement.
  - In these countries, government funds constituted between 4 and 100 percent of all financing spent on public sector contraceptive procurement.
  - Internally generated funds were used by most (17 out of 22) countries that used government funds.
- Sixty percent of countries surveyed (21 out of 35) had a government budget line for contraceptive procurement.
  - However, while a budget line item may help ensure that funding is allocated for contraceptives, findings indicate that a designated budget line item does not guarantee funding. Some countries had a budget line item, yet failed to fund contraceptive procurements, while others funded contraceptive procurements, but lacked a budget line item.

* Government funds include internally generated funds, World Bank credits or loans, basket funds, and other funds given to the government for their use.

Financing Sources for Public-sector Contraceptives

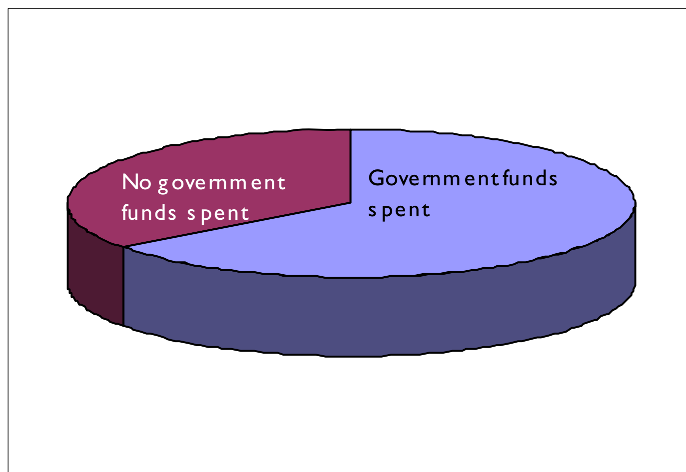
For this analysis, government funds include a combination of internally generated funds and other government funds (e.g., basket funds, World Bank credits or loans, and other funds that donors provide to the government). Although it can be argued that these sources are not true national resources, governments consider the funds part of their national budgets, count them as part of government funding, and can spend them how and where they choose. In-kind contraceptive donations are another source of public-sector contraceptives.

Surveyed countries were asked whether government funds, including those listed above, were used to procure public-sector contraceptives in the most-recent complete fiscal year. *Sixty-five percent of the countries (22 out of 34) indicated that their country spent government funds on contraceptive procurement during the most recent fiscal year.*[5] (See figure 1.)

4. In this paper, public sector contraceptives, contraceptive financing, and contraceptive procurement refer to contraceptives for public sector facilities, whether or not government resources were used to finance these contraceptives. However, in some countries, funding amounts may also include procurement for NGOs, or social marketing organizations, that obtain their supplies from the public sector.

5. While respondents were asked about the fiscal year, some reported on a different twelve-month time period.

Figure 1. Percentage of Surveyed Countries that Spent Government Funds on Contraceptive Procurement



Notes:

a) Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government.

b) Respondents were asked to provide information about the most recent complete year. See the notes for table 1 for the time periods used.

Respondents were asked to disaggregate government funding by source and to distinguish whether these funds were internally generated funds or other government funds (basket funds, World Bank credits or loans, or other donor funds given to the government). Table 1 highlights the amount of government funds used to procure public-sector contraceptives, by country, disaggregated by the specific type of funding. *Of the 22 countries that used government funds, 77 percent (17 out of 22) used internally generated funds, indicating government commitment to family planning in these countries.* Of all the respondent countries, 50 percent (17 out of 34) used internally generated funds for contraceptive procurement.

Financing Sources

Government Financing:

- Internally generated funds: Funds drawn from government revenue sources—usually various taxes, duties, and fees. They can be generated at the central or lower levels of government.
- Other government funds. For this paper, other government funds include—
  - Basket funds: The government manages these pooled funds, with input from financing partners. The funds originate from various sources, which may include donors and the government. These funds can be given as general support or specifically earmarked for particular programs and activities.
  - World Bank assistance: World Bank funding, either credits or loans, can be used for general budget support, sector budget support, or earmarked interventions. In each case, the government defines the priority area for which the funds will be used, so using World Bank assistance for contraceptive procurement shows the government's commitment to family planning.
  - Other funds: Additional funds provided to the government by donors and used to finance the procurement of contraceptives. This category can include situations when a donor provides funds earmarked for contraceptive procurement.

In-kind Donations:

Contraceptive supplies that donors (USAID, for example) provide to a government.

Table 1. Government Expenditures (U.S.$) Spent on Contraceptive Procurement during a Recent Year

Region/Country	Internally Generated Funds (U.S.$)	All Other Government Funds (U.S.$)	Total Government Funds Spent (U.S.$)
Africa			
Burkina Faso[3]	138,579	872,902	**1,011,481**
Ethiopia[2]	889,000	20,000,000	**20,889,000**
Ghana[3]	0	600,000	**600,000**
Kenya[2]	6,106,555	2,519,694	**8,626,249**
Madagascar[3]	125,127	0	**125,127**
Malawi[1]	0	900,000	**900,000**
Rwanda[3]	2,347,048		**2,347,048**
Tanzania[2]	2,850,531	3,912,593	**6,763,124**
Zambia[3]	0	1,629,104	**1,629,104**
Europe & Asia			
Albania[3]	21,931	0	**21,931**
Bangladesh[4]	700,000	20,342,200	**21,042,200**
Nepal[2]	1,691,440	422,860	**2,114,300**
Pakistan[2]	9,257,171	0	**9,257,171**
Ukraine[3]	235,000	No Data	**No Data**
Yemen[5]	0	2,488,515	**2,488,515**
Latin America			
Dominican Republic[3]	486,204	0	**486,204**
El Salvador[3]	784,000	0	**784,000**
Guatemala[3]	1,325,301	0	**1,325,301**
Nicaragua[3]	227,120	1,106,618	**1,333,738**
Paraguay[3]	566,000	0	**566,000**

Notes:

a) The amounts attributed to *all other government funds* include basket and donor funds given to the government.

b) Respondents were asked about the most recent complete year. The time periods reported on are indicated next to the country name: (1) October 2008–September 2009, (2) July 2008–June 2009, (3) January–December 2009, (4) 2008–2009 (months not specified), and (5) FY2008 (months not specified). The time period covered may differ slightly by funding source.

c) The following countries did not use government funds for contraceptive procurement during the given time period, so they are not included in the table: Mozambique and Zimbabwe (for October 2008–September 2009); Armenia, Azerbaijan, Georgia, Liberia Nigeria, Russia, Senegal, and Uganda (for January–December 2009); Mali (for July 2009–June 2010); and Honduras (for August 2009–July 2010).

d) Although government funds were spent on contraceptive procurement, because of decentralization, data on amounts was not available for the Philippines (for calendar year 2009). Financial details were not provided for India (for the April 2009–March 2010 time period). Respondents in Afghanistan did not have information on whether government funds were spent on contraceptive procurement.

e) The amount for Rwanda is a combination of internally generated and basket funds.

f) Amounts are approximate.

Respondents in Honduras noted that the political crisis disrupted the flow of funds for contraceptive procurement and that the Ministry of Health generally uses government funds to procure contraceptives.

Government Share of Public-sector Contraceptive Financing

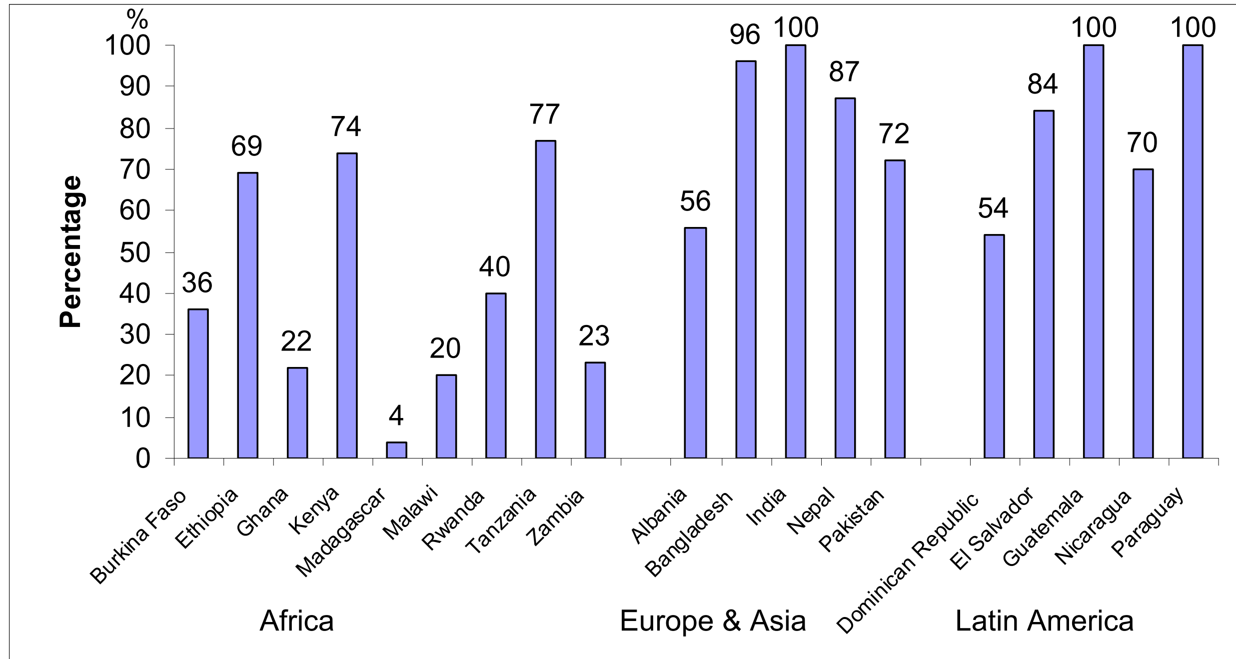
To better understand the government's role in contraceptive financing, the survey instrument calculated the percentage of the previous year's financing for public-sector contraceptive procurement covered by government resources (including internally generated funds, basket funds, World Bank assistance, and other funds given to the government).

In surveyed countries using government funds for contraceptive procurement, government funding constituted between 4 percent (Madagascar) and 100 percent of the total expenditures on public-sector contraceptives (Guatemala, India, and Paraguay) (see figure 2). In these countries, on average, government funds represented 62 percent of funding for public-sector contraceptives. (The remaining financing was through in-kind donations.) Of the countries using government funds, those in Europe & Asia and Latin America reported that government funds represented a higher percentage of the total funding for public-sector contraceptives than did the countries surveyed in Africa. Governments provided an average of 82 percent of contraceptive funding in the surveyed European & Asian countries, compared to an average of 81 percent provided by Latin American governments, and 41 percent provided by African governments.[6] This finding is consistent with USAID's provision of in-kind donations of contraceptives for the public sector. Overall, donated contraceptive commodities for many Latin American and European & Asian countries have decreased as these countries progress toward graduation from USAID assistance. Consequently, many governments have increased their share of funding.

Even within regions, the government's share of the spending on public-sector contraceptive procurement varies significantly. In Latin America, for example, of the countries that reported using government funds, the governments' share of spending ranged from 54 percent in the Dominican Republic to 100 percent in Guatemala and Paraguay. The range is similar in responding European & Asian countries. However, among African respondents, government spending varied widely—from 4 percent in Madagascar to 77 percent in Tanzania.

6. The sample size for this analysis was small—five countries in Europe & Asia, five in Latin America, and nine in Africa.

Figure 2. Government Share of Total Spending for Public-sector Contraceptives



Notes:

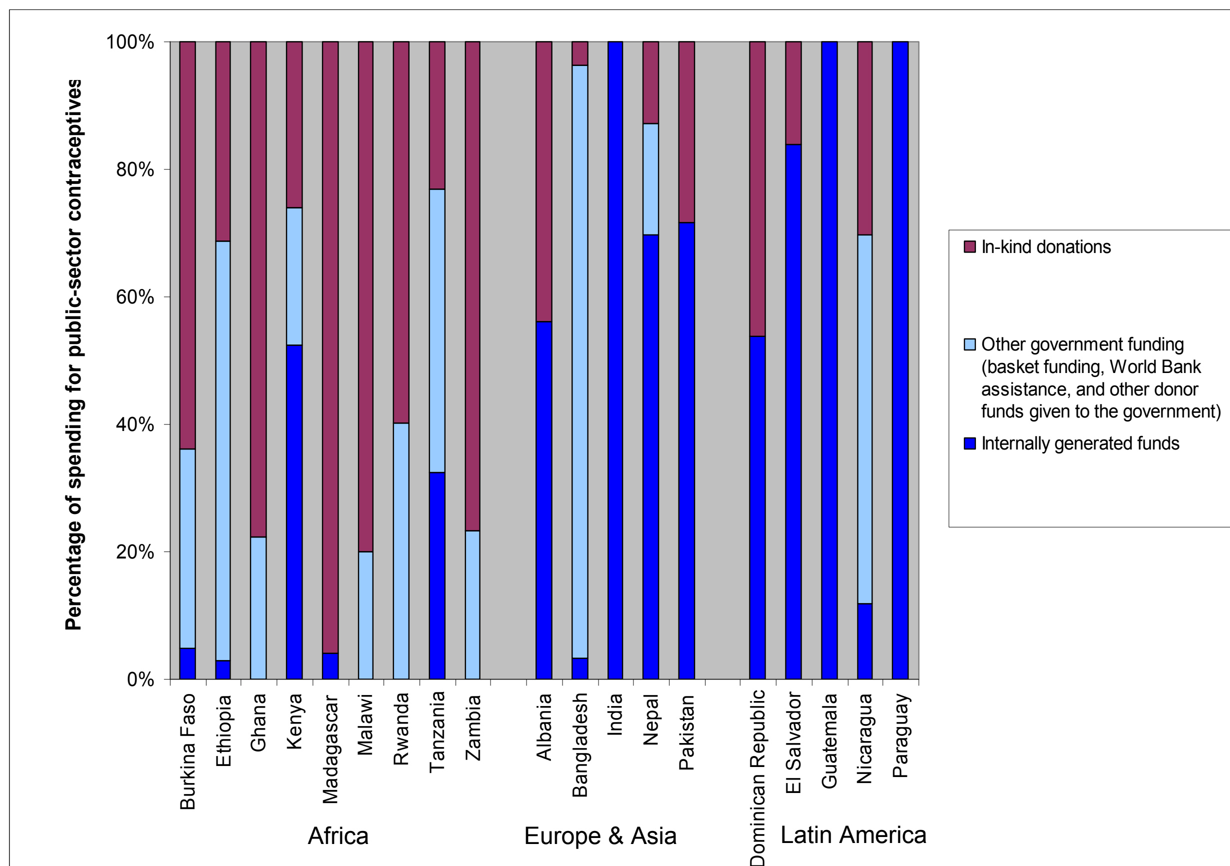
a) Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government.

b) Respondents were asked to provide information about the most recent complete year. The time periods used can be found in the notes for table 1.

c) The following countries were reported to have no government expenditures for contraceptive procurement during the year and so are not included in the figure: Armenia, Azerbaijan, Georgia, Honduras, Liberia, Mali, Mozambique, Nigeria, Russia, Senegal, Uganda, and Zimbabwe. Respondents in Afghanistan did not have information on whether such funds were spent. In the Philippines, Ukraine, and Yemen, although government funds were spent on contraceptive procurement, complete data was not available for this analysis.

Figure 3 presents this share of spending information in more detail—it divides government funding into internally generated funds and other government funds (i.e., basket funds, World Bank assistance, and/or other funds that donors provided to the government). In addition, it also displays in-kind donations to complete the picture of expenditures on contraceptives for the public sector.

Figure 3. Percentage of Total Spending for Public-sector Contraceptives, by Funding Source



Notes:

a) Only countries that spent government funds on contraceptive procurement and reported the amount spent are included in this figure. See figure 2 notes for a list of countries not included in figure 3, and an explanation for exclusion. In addition, in Russia and Azerbaijan, not only were no government funds spent, but there were also no reported in-kind donations in the time period.

b) In Rwanda, other government funding includes internally generated funds and basket funds. (Rwanda does not track these funds separately.)

c) Respondents were asked to provide information about the most recent complete year. See table 1 notes for the time periods used. The time period may differ slightly by funding source.

d) Amounts are approximate.

In surveyed countries using government funds, on average, 39 percent of each country's financing for public sector contraceptives was sourced through internally generated funds, 23 percent through other government funds,[7] and 38 percent through in-kind donations.[8] This differed considerably according to region, with the Latin American respondent countries providing an average of 70 percent of each country's funding through internally generated funds, compared to 60 percent in Europe & Asia and 11 percent in respondent African countries. Latin American countries were less likely to use other government funds; only Nicaragua did. In-kind donations accounted for an

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7. Other government funds were from basket funds, World Bank credits/loans, UNFPA, AusAID, DANIDA, DFID, KfW, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the Netherlands embassy.

8. In-kind donations were from USAID, UNFPA, CIDA, DFID, DKT, and KfW.

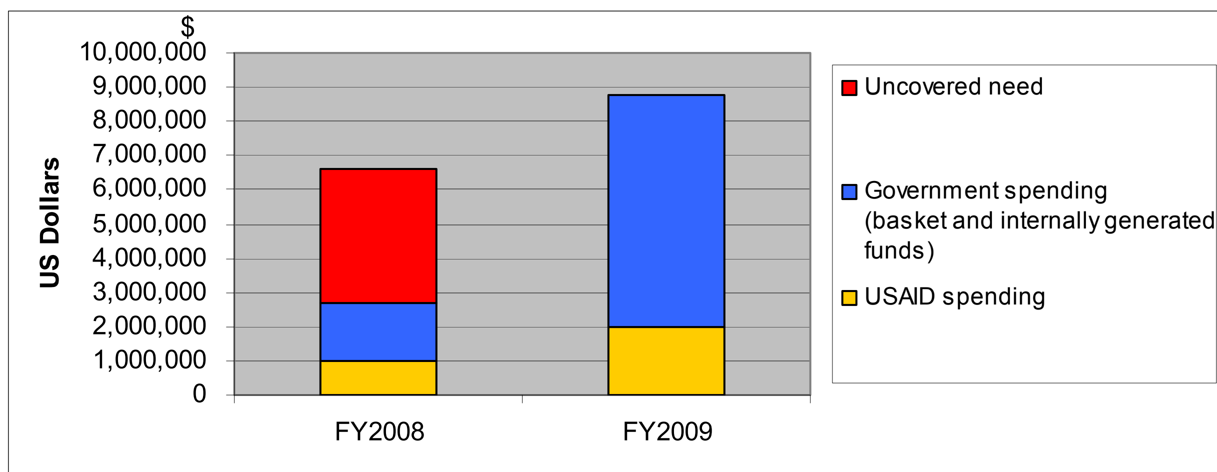
average of 59 percent of contraceptive financing in the respondent African countries, 19 percent in respondent Latin American countries, and 18 percent in respondent European & Asian countries.

In considering figures 2 and 3, it is important to note that the government's share of total spending for public-sector contraceptives only considers government and other funds *spent*; not the total need for public-sector contraceptives. Although government expenditures may constitute a large percentage of total spending on public-sector contraceptives, contributions may still represent a small percentage of actual need.[9]

As explored in depth in *Measuring Contraceptive Security in 36 Countries*, the situation in Tanzania in fiscal year (FY)2008 highlightshow important it is to analyze the need for family planning against total expenditures on contraceptives. In Tanzania, in recent years, the funding released for contraceptive procurement was, at times, less than the amounts originally allocated, and allocations were usually less than the amounts requested. In FY2009, however, after much advocacy, the situation in Tanzania vastly improved—the amounts released (i.e., spent) covered the forecasted need.[10] See figure 4 for a comparison of expenditures in FY2008 and FY2009 in Tanzania.

Many countries face similar disparities between funding needs, allocations, and actual spending; this highlights the need for tools to track needs, commitments, allocations, and expenditures (by source), as well as increased advocacy for and monitoring of contraceptive funding.

Figure 4. Tanzania Contraceptive Procurement Need and Expenditures for the Public Sector



Note: The increase in need between FY2008 and FY2009 is due, in large part, to the need to refill the pipeline. (Because much was unfunded in FY2008, the pipeline was low).

In some countries, the government does not regularly contribute any funds toward contraceptive procurement. While there are additional concerns around the sustainability of public-sector contraceptives in these countries, donors may currently be stepping in to provide sufficient quantities of contraceptives to meet the need for family planning in public-sector facilities. For example, while the governments in Mozambique or Zimbabwe have not spent any funds on contraceptive procurement recently, the countries had sufficient funding because of in-kind

9. A correctly conducted procurement quantification (i.e., forecast and supply plan) can provide information to determine the cost of contraceptives required to cover a country's public sector need, adjusted for quantities already in-country and those needed for buffer stock.

10. Products had not arrived in 2009 but were expected to arrive in 2010.

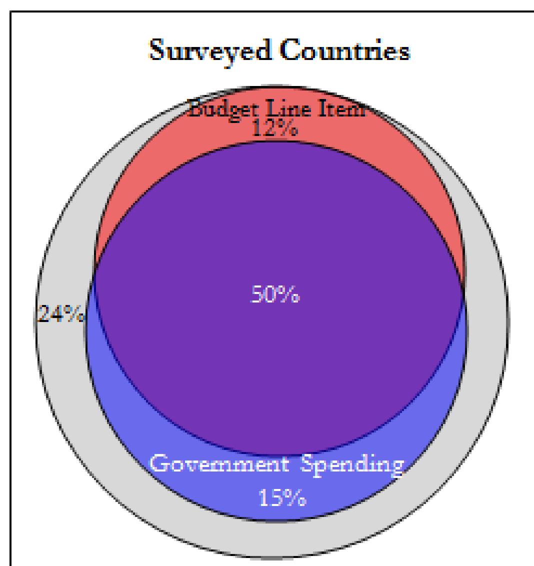
donations from USAID, UNFPA, and Department for International Development (British) (DFID). However, countries without regular government contributions are at a greater risk of supply problems as donors reduce their provision of in-kind contraceptive donations.

Budget Line Item

Twenty-one out of 35 respondent countries (60 percent) reported having a government budget line item for contraceptive procurement. Having a budget line item for contraceptives is an important indicator of a government's commitment to contraceptive procurement. However, *while a budget line item helps ensure contraceptives are a priority in annual budgets, it does not guarantee funding.*

Figure 5 illustrates the degree of overlap between budget line items in surveyed countries and the mobilization of government funding used for contraceptive procurement.[11] Although there is a large degree of overlap, several countries funded contraceptives for the public sector, but lacked a budget line item; while others had a line item, but ultimately failed to release funding. Of the countries surveyed, 17 countries (50 percent) had a budget line item and funded contraceptive procurement. Five countries (15 percent) used government funds for contraceptives but lacked a budget line item (the Dominican Republic, Guatemala, Malawi, the Philippines, and Yemen). Conversely, four countries (12 percent) had a budget line item, but they ultimately failed to release funds for contraceptives (Mali, Nigeria, Senegal, and Uganda). Eight countries (24 percent) both lacked a budget line item and did not use government funds on contraceptive procurement in the reported year.[12,13]

Figure 5. Degree of Overlap between Surveyed Countries with a Budget Line Item and Government Spending on Contraceptive Procurement



Senegal provides a good example for further examination. For the last few years, the Central Medical Store was allocated funding for contraceptive procurement but the money was returned to the treasury unspent. Several factors may contribute to such a situation, including budget shortfalls, delays in the release of funding from the Ministry of Finance, or an inability to conduct procurement (e.g., because of no response to procurement solicitations or a slow procurement process). In this case, having a budget line was not enough to ensure that funds were actually spent on contraceptive procurement.

11. Go to deliver.jsi.com to see the country-level responses on this indicator displayed in map form.
12. Because respondents in Afghanistan did not know if government funds were spent, we did not include it in this analysis.
13. Because of rounding, the percentages appear to total 101% instead of 100%.

Commodities

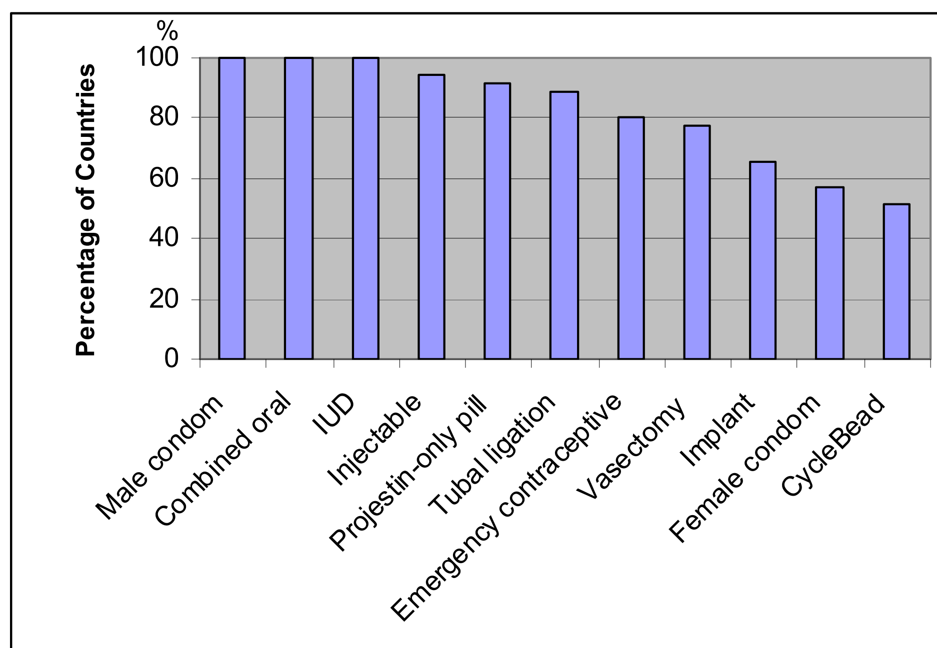
Providing a broad range of contraceptive methods is essential if a country is to ensure that clients are able to choose a contraceptive method that best fits their needs. Consequently, survey respondents were asked which contraceptive methods are offered in public sector, NGO, and private-sector facilities. (Respondents were asked to consider a method as *offered* if it is intended to be stocked, regardless of current availability.) The survey included the following methods: combined oral contraceptives, progestin-only pills, injectables, implants, intrauterine devices (IUDs), male condoms, female condoms, emergency contraceptives, vasectomies, tubal ligations, and the standard days method (i.e., CycleBeads). In addition, respondents were asked to indicate if any other methods are offered; additional methods offered in some countries were the contraceptive patch, ring, and various spermicides.

Key Findings: Commodities

- On average, surveyed countries, offer eight of the 11 assessed contraceptive methods in public sector facilities, seven in nongovernmental organizations facilities, and eight in private facilities.
- Most countries (31 out of 35) offer male condoms, combined oral contraceptives, intrauterine devices, and injectables in public sector facilities.
- Of the methods examined, public-sector facilities are least likely to offer emergency contraceptives, CycleBeads, and female condoms.

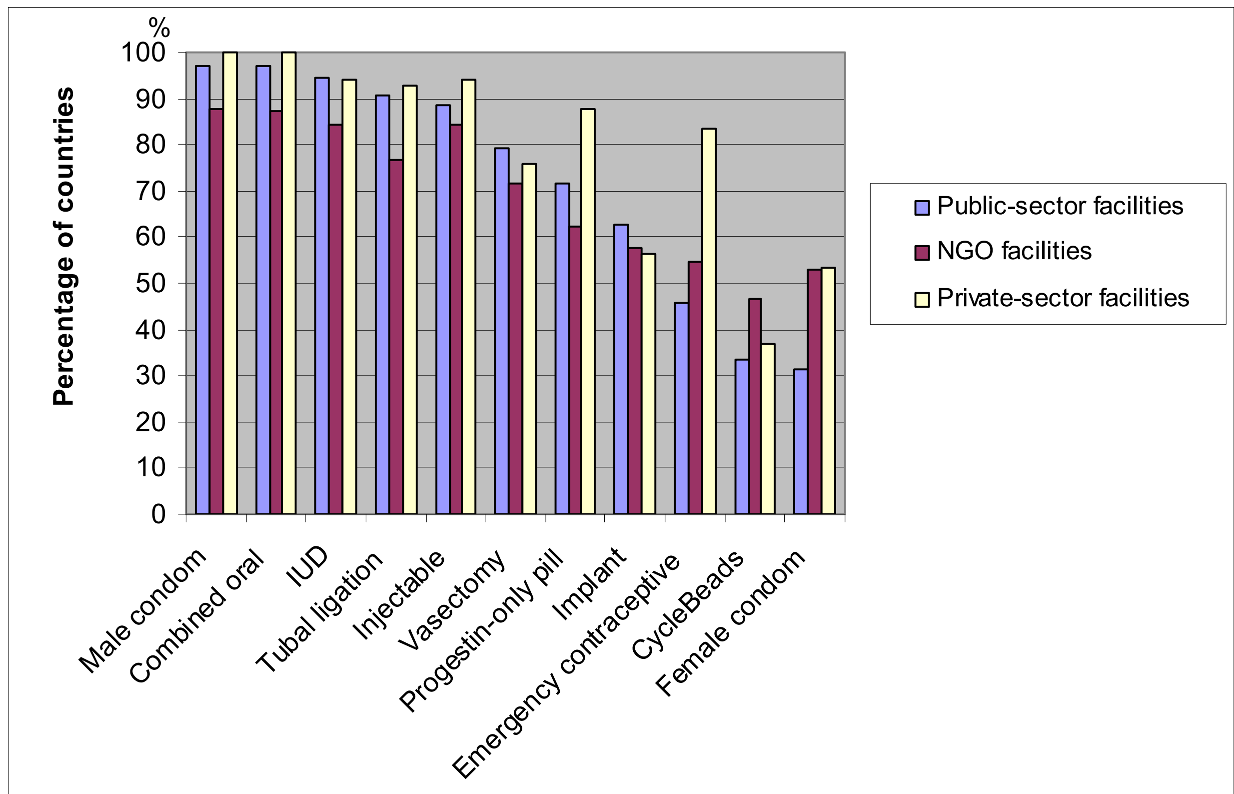
Figure 6 shows the percentage of respondent countries that offer a contraceptive method, regardless of which sector(s) provides the method. As shown, male condoms, combined oral contraceptives, and IUDs are offered in all the surveyed countries; injectables, progestin-only pills, and tubal ligations are offered in approximately 90–95 percent of surveyed countries; implants are offered in approximately 65 percent; and female condoms and the standard days method (i.e., CycleBeads) in approximately 50–60 percent of the surveyed countries.

Figure 6. Percentage of Surveyed Countries with Methods Offered by Any Sector



In addition to ensuring that a broad range of contraceptive methods are offered to clients, it is important to examine the methods offered by sector. For example, while emergency contaceptives are offered in 80 percent of the countries, they are typically only offered through private-sector facilities.[14] Other examples abound: progestin-only pills are most often offered in private-sector facilities, but not public or NGO facilities; female condoms are often offered in private or NGO facilities, but not public; and the standard days method (i.e., CycleBeads) is most likely to be offered in NGO facilities. For most methods, the percentage of countries offering the method through the public sector is similar to the percentage offering it through private and NGO facilities. (See figure 7.)

Figure 7. Percentage of Surveyed Countries that Offer Contraceptive Methods, by Method and by Sector



Most surveyed countries offer male condoms and combined oral contraceptives (97 percent), IUDs (94 percent), tubal ligations (91 percent), and injectables (89 percent) through public-sector facilities. The public sector offers vasectomies in 79 percent, progestin-only pills in 71 percent, and implants in 63 percent of the responding countries. The public sector is less likely to offer emergency contraceptives, CycleBeads, and female condoms. In 46 percent of surveyed countries, public-sector facilities offer emergency contraceptives, while the public sector offers CycleBeads in only 33 percent, and female condoms in just 31 percent, of the surveyed countries.

14. In some cases, providers may prescribe a high dose of other oral contraceptives for emergency contraception purposes, however. In Honduras, the Parliament approved a bill prohibiting the promotion, commercialization, free distribution, and use of emergency contraceptive pills.

On average, countries reported offering eight of the 11 aforementioned contraceptive methods in public-sector facilities.[15] Six countries reported offering at least 10 of these contraceptive methods through the public sector. The public sector in Azerbaijan was identified as offerring the most limited range of contraceptives. Apart from the few clinics that offer a limited amount of combined oral contraceptives and IUDs donated by UNFPA, Azerbaijan does not offer any contraceptives in public-sector health facilities, nor do the NGOs. Four methods[16] (male condoms, combined oral contraceptives, IUDs, and emergency contraceptives) are offered in private pharmacies, but are reportedly quite expensive.

On average, countries offered seven of the 11 methods in NGO facilities and eight in private facilities.

As shown in figure 8, the percentage of surveyed countries offering each method varied according to region. Most notably—

- Female condoms are offered in public-sector facilities in many of the surveyed African countries, but were not offered in any of the surveyed Latin American or European & Asian countries.[17]
- Progestin-only pills are offered in public-sector facilities in all the surveyed African countries, but only in one Latin American country.
- Injectables are offered in public-sector facilities in all of the surveyed African and Latin American countries and in 70 percent of the respondent European & Asian countries.
- Implants are offered in public-sector facilities in 88 percent of respondent African countries, 50 percent of Latin American, and 38 percent of respondent European & Asian countries.
- Tubal ligations and vasectomies are offered in public-sector facilities in all the surveyed Latin American countries, but are offered in a smaller percentage of surveyed countries from other regions.
- Compared to the other regions, vasectomies were the least likely to be offered in surveyed European & Asian countries.

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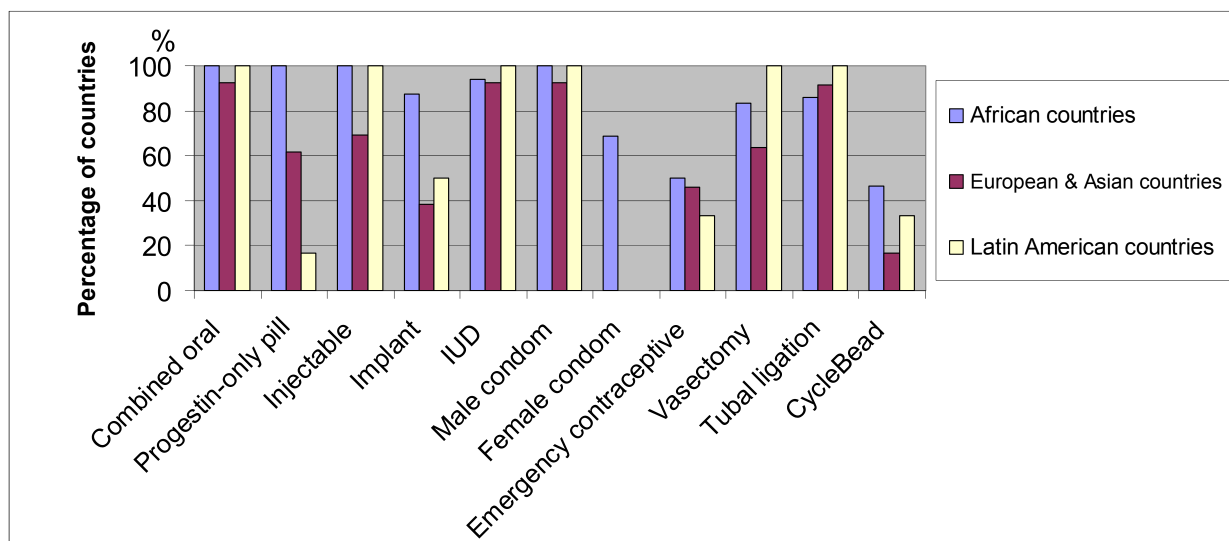
15. Go to deliver.jsi.com to see country-level information, in map form, about the methods offered in public sector facilities.

16. In Azerbaijan, progestin-only pills are rarely available in private pharmacies. There was no data on whether tubal ligations or vasectomies are offered in private facilities.

17. Female condoms are offered in private or NGO facilities in 2/13 (15 percent) of the surveyed European & Asian countries and in 3/6 (50 percent) of the surveyed Latin American countries.

Figure 8. Percentage of Surveyed Countries with Methods Offered through the Public Sector, by Method and by Region



Even when a broad range of contraceptive methods are offered, clients often face barriers to obtaining them. Barriers can involve the percentage of facilities that stock the methods, facility locations, level of stock in facilities, provider training, and cost to clients, among others. Supportive government policies are essential to ensuring that potential barriers are reduced and clients are able to choose, obtain, and use quality family planning products. The next section addresses policies that can affect contraceptive security.

Policies (Commitment)

Policies can reflect the level of government commitment to contraceptive security, as well as significantly impact client access to family planning. The survey included several key policy indicators to determine whether countries fostered supportive political environments for CS.

Key Findings: Policies

- On average, countries include five of eight examined contraceptive methods in their National Essential Medicine Lists (NEML) or equivalent.
- Most countries (30 out of 35) have either a specific contraceptive security (CS) strategy or include CS in a broader national strategy.
- More than half of the surveyed countries (19 out of 27) explicitly indicated family planning or reproductive health as a priority in their Poverty Reduction Strategy Papers (PRSP). However, less than half of countries (10 of 27) included the contraceptive prevalence rate as an indicator within the PRSP. No country included a contraceptive supply indicator in the PRSP.
- Nineteen of 35 countries reported taxes, import duties, or fees on contraceptives.
- Twenty-four percent of countries (8 out of 33) reported charges to clients for family planning services or commodities in the public sector. Three-fourths of these countries have exemptions for those who cannot afford to pay.

Contraceptives on National Essential Medicine Lists (NEMLs)

Essential medicines address priority health care requirements for a given population and are expected to be available. Including contraceptives in NEMLs highlights their significance and can help ensure their availability by influencing decisions on resource allocation, procurement, prescriber protocols, and provider training.

On average, surveyed countries included five of the eight assessed contraceptive methods[18] in their NEML or NEML equivalent. Burkina Faso, Ghana, Rwanda, Senegal, Zambia, and Zimbabwe included all eight of these contraceptive methods in their NEML or NEML equivalent. Ninety-seven percent of responding countries (33 out of 34) incorporated at least one contraceptive method on the list. Russia included only the progestin-only pill in their NEML; Georgia was the only country surveyed that did not include any contraceptive methods.[19] While last year Azerbaijan's NEML did not include any contraceptive, it was updated in 2010 and it now includes combined oral contraceptives, male condoms, and IUDs. Rwanda and Senegal are also among the countries that recently updated their NEMLs; emergency contraceptives were newly included in the NEML lists in both countries. In addition, Senegal included female condoms in their NEML. Kenya is expected to incorporate implants, IUDs, and barrier methods in their NEML in the near future. Other contraceptive methods found in countries' NEMLs included diaphragms, spermicides, vaginal foaming tablets, and CycleBeads.

Figure 9 shows the correlation between the methods offered in public-sector facilities and those included in NEMLs. As shown, non-inclusion in an NEML does not necessarily mean that the method is not available in public-sector facilities. For instance, despite being offered in public-sector facilities in 97 percent of surveyed countries, only 77 percent of countries surveyed include male condoms in their NEMLs. (However, partly because condoms [and sometimes implants and IUDs] are often considered medical devices, they may be included instead in a separate medical device or equipment list; these were not evaluated in all cases.) In Albania, Bangladesh, Russia, and Yemen, injectables are offered in public-sector facilities but are not included in the NEMLs.

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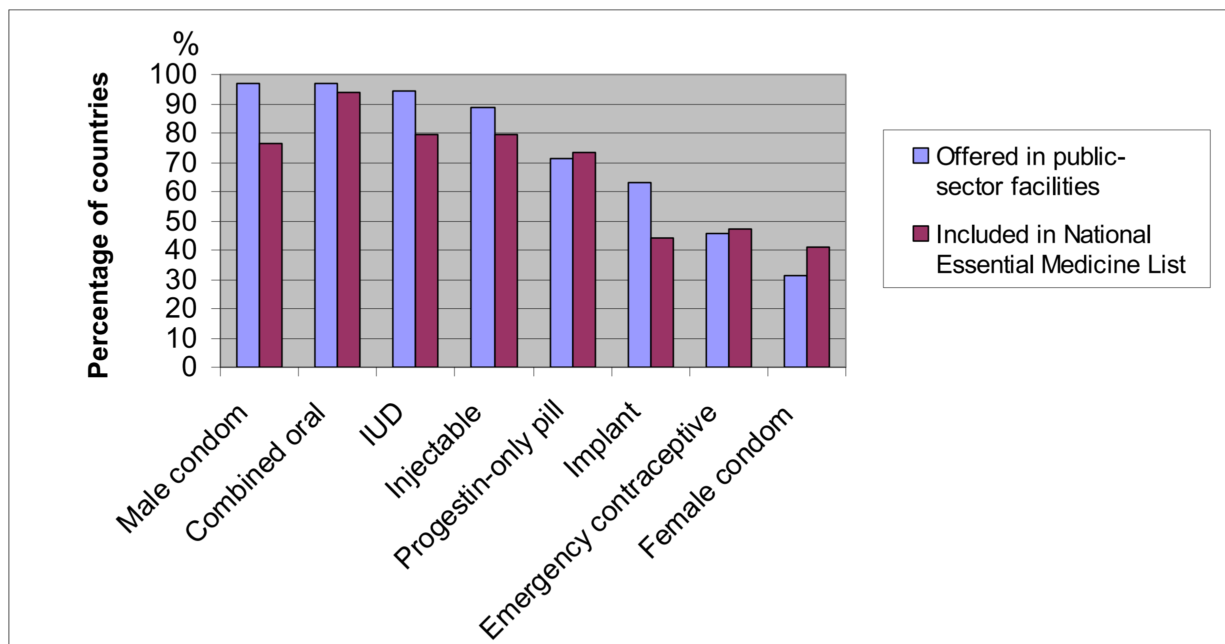
18. The methods included in this analysis were combined oral pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, and emergency contraceptives. Because Guatemala does not have a national list, it was not included in this analysis.

19. While Georgia does not have a national, legally approved essential drug list, most insurance companies in Georgia maintain their own lists. A few years ago, an essential drug list was drafted under a World Bank–funded program, but the Ministry of Health and Parliament never approved it. Contraceptives are not on the list of generics prepared as the national essential drug list draft (which includes just 200 drugs), or on any essential drug lists developed by the insurance companies.

Figure 9. Comparison of Methods Offered in Public-sector Facilities and Included in NEMLs in Surveyed Countries



Note: Some data for contraceptive methods may be less reliable than others. For example, if condoms were included in NEMLs examined by the review team—without specifically stating whether condoms referred to male, female, or both types of condoms—it was assumed that only male condoms were included in the list. It is unknown whether in-country respondents made the same assumption though.

Contraceptive Security in Government Strategies

A country strategy that explicitly includes contraceptive security shows the government's commitment to CS and can help ensure that CS remains a priority on political agendas. *Of the 35 surveyed countries, 30 (86 percent) reported having a contraceptive security strategy or another strategy (for example, a family planning or reproductive health strategy) that included a CS component—an increase from last year.*[20] Mozambique and Pakistan, for example, developed strategies during the last year. The ministries of health in surveyed countries formally approved 90 percent (27 out of 30) of these strategies. The degree of implementation varies by country; 79 percent (23/29) of the strategies are reportedly being implemented.

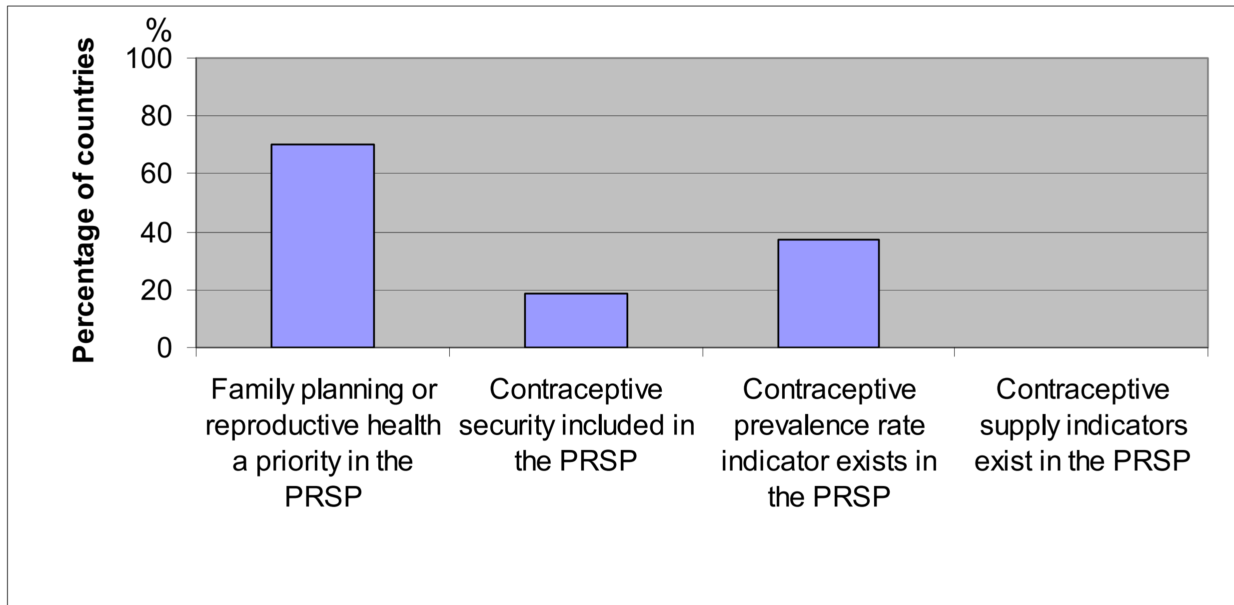
Family Planning and Contraceptive Security in Poverty Reduction Strategy Papers

A country's Poverty Reduction Strategy Paper (PRSP) outlines its macroeconomic, structural, and social policies and programs aimed at promoting growth and reducing poverty. The strategy is developed through a collaborative process that involves domestic and external stakeholders and development partners, including the International Monetary Fund and World Bank. Because PRSPs are key policy documents that many countries use, it is essential that family planning and, more specifically, contraceptive security, is included in these documents.

20. Go to deliver.jsi.com to see the country-level responses on this indicator displayed in map form.

Of the 35 countries surveyed, the research team located PRSPs for 27 of them.[21] *Out of these 27 countries, 19 (or 70 percent) explicitly indicated family planning or reproductive health as a priority.* Fewer countries (10 of 27) included contraceptive prevalence rate as an indicator within the PRSP; none included a contraceptive supply indicator (such as contraceptive stockout rates) among the country's PRSP indicators. Only 5/27 (19 percent) of the PRSPs included the concept of contraceptive security.[22] (See figure 10.)

Figure 10. Percentage of Surveyed Countries with Family Planning or Contraceptive Security-Related Items Included in their Poverty Reduction Strategy Paper (PRSP)



Policies Impacting the Provision of or Access to Contraceptives

To determine whether a country had a supportive policy environment for CS, the survey included indicators related to government operational policies. Questions about policies that impact both the public sector and/or the private sector are included since the private (i.e., non-public) sector often plays an important role in contraceptive security.

Of the countries surveyed, 19 out of 35 (or 54 percent) mentioned taxes, import duties, or fees on contraceptives. These charges primarily affected imported and commercial sector goods. Depending on the country, such taxes, duties, or fees were between 1 and 20 percent of the product price.

Several countries also reported advertising bans that affect the provision of private-sector contraceptives. For example, in Armenia, prescription products, including contraceptive pills and spermicides, cannot be advertised, and permission from the Ministry of Health is required to advertise other methods. In the Philippines, hormonal contraceptives are classified as

21. The PRSPs reviewed were published from 2001–2008. We did not review interim reports.

22. This indicator was somewhat subjective because the reviewers were not looking for the specific term, but were, instead, looking for the concept of contraceptive security, including the availability and funding of contraceptives.

ethical/regulated drugs, and the Pharmacy Law bans the advertising of such drugs and prohibits their distribution without a prescription. In Honduras, a bill prohibits the dissemination of information, promotion, free distribution, commercialization, and use of emergency contraceptives.

Seventy-one percent of the surveyed countries (25 of 35) reported policies or regulations that restrict who can dispense or sell specific contraceptive methods. Such regulations may affect the public or the private sector and may relate to facility type or service provider cadre. For example, Senegal prohibits a single private-sector facility from both prescribing *and* dispensing contraceptives to an individual. If a private-sector provider counsels and provides a prescription, they are restricted from dispensing the contraceptive. Such regulations create unnecessary obstacles to clients seeking access to family planning. For example, to obtain an injectable contraceptive, the client must (1) first see a doctor for counseling and to obtain a prescription, (2) then go to a pharmacy to buy the contraceptive, and (3) return to a doctor for the injection. Also, in Senegal, although currently only doctors, midwives, and nurses dispense oral contraceptives in the public sector, they are piloting the community-based distribution of pills via community health workers.

Respondents were also asked whether policies, laws, or regulations restrict access to family planning services for certain segments of the population. In Bangladesh, restrictions exist for unmarried and *low parity* individuals. Unmarried women and women without children cannot receive injectables, implants, IUDs, or tubal ligations. In addition, low-parity clients cannot receive IUDs, tubal ligations, or vasectomies.

Twenty-four percent of respondents reported charges to clients for family planning services or contraceptive commodities in the public sector. Seventy-five percent (6 out of 8) of these respondents, however, indicated that there are some exemptions for people who cannot afford to pay. However, further research is needed to determine to what extent such policies are enforced and what the full impact of these policies is on clients seeking access to contraceptives.

Coordination and Leadership

For contraceptive security to become a reality, stakeholders from various sectors—public, NGO, social marketing, and private—must work together to promote effective and efficient service delivery and supply chain systems. To measure country coordination and leadership for CS, the survey included indicators related to the participation of government and other stakeholders on CS coordinating committees.

Key Findings: Coordination and Leadership

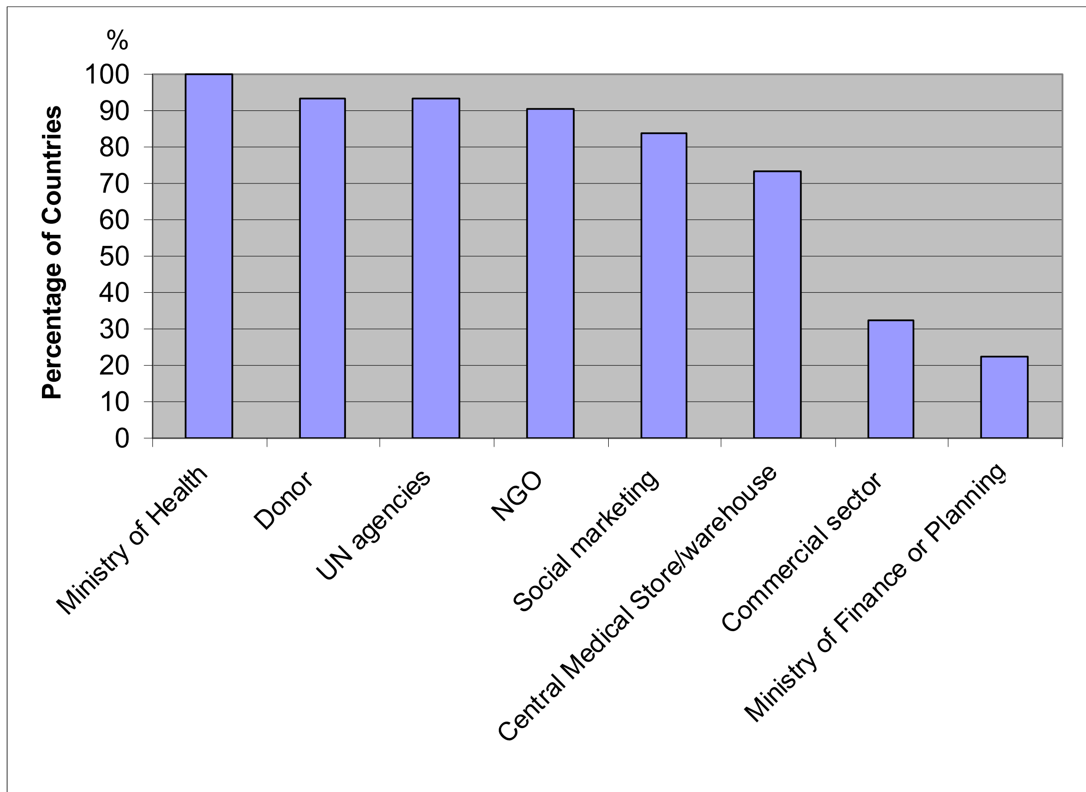
- Most of the surveyed countries (31 of 35) have a committee that works on contraceptive security issues.
- Most of the committees include nongovernmental organizations and social marketing groups.
- Only 10 out of 31 committees include the commercial sector.
- Only 7 out of 31 committees include a Ministry of Finance or Ministry of Planning counterpart.
- Two-thirds of the surveyed countries (23 of 35) reported having a contraceptive security *champion*.

Coordinating Committee for Contraceptive Security

An active, multi-sectoral CS coordinating committee can help maintain a focus on CS and long-term product availability issues, strengthen coordination between a broad range of stakeholders, and reduce duplication and inefficiencies. *Eighty-nine percent of countries surveyed (31 out of 35) reported having a*

committee that works on contraceptive security.[23] All the reporting Latin American and African countries have such a committee. Figure 11 shows the types of organizations and entities represented on surveyed countries' CS committees.

Figure 11. Percentage of Surveyed Countries' Contraceptive Security Committees that Include Specific Organizations



Ministries of health were represented on all CS committees in surveyed countries that have a committee. Except in Guatemala and India, donors and United Nations (UN) agencies also participate in the CS committees. (In both countries, there was no donor support for contraceptive procurement during the last year.[24] India is the only country where the committee includes only the Ministry of Health.) Regarding participation by other stakeholders, *NGOs and social marketing organizations are represented in most of the committees, Central Medical Stores or warehouses are included in 73 percent of committees, the commercial sector in 32 percent of surveyed country committees, and the Ministry of Finance or Planning participates in just 23 percent* of CS committees in countries surveyed. As country government financing becomes an increasingly important source of funding for contraceptives, it is important to engage ministries of finance and consider including them in these committees to help ensure adequate and timely funding for contraceptives.

23. Go to deliver.jsi.com to see the country-level responses on this indicator displayed in map form.
24. Guatemala reported on calendar year 2009. India reported on April 2009–March 2010.

Contraceptive Security Champions

Two-thirds of surveyed countries (23 of 35) reported having a contraceptive security champion—someone who consistently brings up CS issues and advocates for contraceptive supplies. CS champions help ensure that CS remains a priority on the political agenda and that important CS issues are addressed.

Most of these countries—approximately 70 percent (or 16 of 23)—reported that they have champions from the government (usually the Ministry of Health). Nine percent of surveyed countries with CS champions (or two respondent countries) indicated that they have champions both from the government and from donor or partner organizations. Another 9 percent have champions from donor organizations, and 13 percent (three respondents) indicated that their champions work for NGOs.

Supply Chain

An effective supply chain enables the continuous availability of high-quality contraceptives, which is essential to ensuring contraceptive security.

Key Findings: Supply Chain

- Sixty-one percent of countries (19 of 31) had a central-level stockout at some point during the last year.
- On average, countries reported central-level stockouts of two products (out of an average of six products stocked at the central warehouse).

Product Availability

Information about product availability is an important indicator of the status of contraceptive security in a given country.

Because respondents do not always receive information on SDP stockout rates, surveyed countries were instead asked to report about stockouts at the central level (i.e., the public-sector central warehouse).[25] Specifically, they were asked to report whether there had been a central-level stockout of any contraceptive in the last 12 months.[26] Additionally, respondents were asked to indicate which contraceptive method(s) stocked out.[27] *Sixty-one percent of responding countries (19 out of 31) reported a central-level stockout of at least one contraceptive method during the last year.*[28] The stockouts indicate a lack of stock on the days of data collection.

Data sources for central-level stockouts of contraceptives included logistics management information systems (LMISs), periodic physical inventories, warehouse reports, the Procurement

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25. Some countries may have reported data based on a combination of levels—for example, the central-level as well as the district-level warehouses, or the whole system (i.e., warehouses and health care facilities). If their data source grouped information from these levels, a product would not be considered stocked out unless it was stocked out at all the reporting levels.

26. While respondents were asked about the most recent 12 months, some reported on other time periods.

27. The methods asked about were combined oral pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, emergency contraceptives, and the standard days method (i.e., CycleBeads).

28. Azerbaijan, the Philippines, and Russia were not included in this analysis because contraceptives were not stocked in the central-level public sector warehouse. In the Philippines, this relates to decentralization. Data from the Ukraine was not available.

Planning and Monitoring Report (PPMR),[29] and other reports from donors or partners. The data reflect snapshots of available stock at several points during the year. For example, stockout data for the PPMR is collected monthly or quarterly, depending on the country.

The data must be interpreted with caution because it does not represent stockouts at SDPs (such as clinics or hospitals). Although it may be likely that a country experiencing central-level stockouts will also experience stockouts at SDPs, this is not always the case. Similarly, the reverse may be true. Central-level warehouses may have stock, but SDPs may be experiencing stockouts. Consequently, strong LMISs are essential for relaying timely information on product availability and stock levels from each level of the supply chain system.

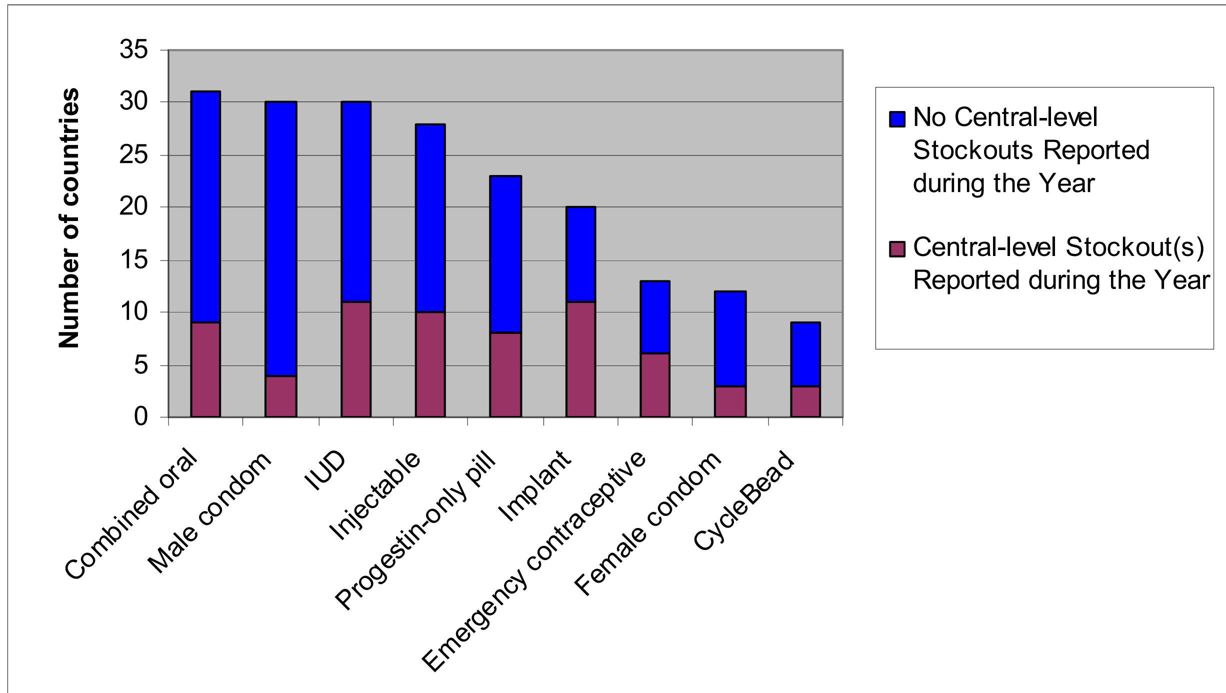
On average, countries reported central-level stockouts of approximately two out of an average of six products. In other words, two-thirds of a country's contraceptives were continuously stocked at the central level. One country reported experiencing a stockout of all of its contraceptive methods. However, the stockouts were not necessarily concurrent; information relating to the timing and duration of stockouts was not collected.

Figure 12 shows surveyed countries that reported central-level stockouts of various contraceptive methods.[30] As shown in the figure, of the 30 countries reporting on male condoms, 4 (13 percent) experienced a central-level stockout in the last year. (The remaining 26 did not.) By comparison, 11 out of the 30 countries reporting on IUDs (37 percent) experienced a stockout. Only 20 surveyed countries reported stocking implants in their central-level warehouse, but 11 of them (55 percent) had a stockout during the year.

29. Through the Procurement Planning and Monitoring Report (PPMR) participating countries report on their current stock status, along with qualitative information on contraceptive security. High-level decisionmakers at USAID, UNFPA, and other donors who participate in the Coordinated Assistance for Reproductive Health Supplies (CARhs) Group of the Reproductive Health Supplies Coalition (RHSC) review this informatioin. The PPMR aims to avert impending shortages and stockouts of contraceptives; the report promotes international donor collaboration and coordination and affords in-country project and ministry staff a way to communicate important CS issues to decisionmakers.

30. The method was not included in this analysis if the central warehouse never stocks the method (or if there was no data). For example, information about progestin-only pills in most Latin American countries was excluded from the analysis because their central warehouses do not stock this method.

Figure 12. Number of Surveyed Countries and Their Central-level Stockout Information, by Product



Respondents were also asked if stockouts were a serious problem at the SDP and central levels. These questions were included to gauge whether stockouts are a significant issue in the country.[31] Fifty-six percent of respondents (18 of 32) reported that SDP stockouts represented a serious problem and 44 percent (14 of 32) reported that central-level stockouts were a serious problem. Of countries reporting a central-level stockout during the last year, 63 percent (12 of 19) considered them to be a serious problem.

31. However, in some cases, respondents may have misinterpreted the question as more theoretical (i.e., the respondent's opinion about whether stockouts, in general, are problematic) instead of related to the specific country and whether stockouts pose a significant threat to contraceptive security.

Conclusions

The systematic tracking of contraceptive security indicators informs stakeholders of country progress toward contraceptive security, highlights key areas for intervention, allows for comparisons between countries, and increases awareness about the need for improved CS.

The contraceptive security indicators presented in this paper are examples of the significant information country governments, policymakers, and advocates can and do use to monitor progress toward CS. Building on the SPARHCS framework, the indicators cover various aspects of CS, including finance for procurement (capital), commodities, policies (commitment), coordination and leadership, and the supply chain.

The data collected for this analysis indicate that countries have worked to improve CS. Of the surveyed countries—

- 89 percent have coordination committees that address contraceptive security
- 86 percent have strategies for working on contraceptive security
- 65 percent contribute government funds for contraceptives.

On average, they offer 8 of the 11 assessed contraceptive methods in public-sector facilities.

In many of the surveyed countries, however, substantial improvements in CS can still be made, including—

- diversifying the membership in CS coordinating committees
- increasing the amount of government contributions for contraceptives
- expanding the range of contraceptive methods offered in health centers and included in essential medicine lists
- enhancing the reliable availability of contraceptives at warehouses and SDPs.

The accessibility of the raw country-level data[32] collected should encourage tailored, in-depth analyses; the availability of maps displaying responses on some of the indicators can add to advocacy efforts.[33]

Involving local counterparts in data collection helps raise awareness about the essential components of CS that can be strengthened in-country, as well as the need for data to effectively monitor progress toward achieving CS. Survey responses indicate that data related to key CS indicators are not always readily available or accessible. Ideally, in the future, CS committees and other in-country stakeholders will implement similar monitoring tools within their broader CS strategic planning and

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32. To access the *Contraceptive Security Indicators Data 2010 spreadsheet,* go to the USAID | DELIVER PROJECT website at http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CS_Indicators_Data_2010.xls.

33. To access select maps, go to the *Project Maps* box at http://deliver.jsi.com/dhome/topics/monitoring.

implementation processes. The CS indicators used in this analysis highlight topics that are worth continuing to track by institutionalizing tools to monitor progress. Such monitoring should improve informed advocacy and decisionmaking and promote contraceptive security.

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Appendix A

Study Limitations and Considerations

When interpreting the findings, you should consider a few limitations. For example, indicator questions were written to enable various respondents to answer them without doing extensive background research. This limited the indicator questions that could be included. In addition, the data are contingent on the knowledge of the respondents and, therefore, are subject to subjectivity, misinformation, and missing information.

Certain contextual factors may have affected a respondent's ability to provide data. For example, with decentralization, various responsibilities have shifted from the central government to lower levels of the government (such as regions or districts); survey respondents in decentralized countries were, in some cases, unable to complete some of the questions, particularly the funding levels for contraceptives.

Considering these study limitations, you should cautiously consider the data for any individual country. However, you should be able to identify overall trends for surveyed countries in years to come. (Sampling is explained in appendix B and was not random; therefore, results for surveyed countries in a region may not represent the entire region.)

Because the *Finance for Procurement* indicators were the most challenging to collect and interpret, we included more in-depth explanations of the limitations for these indicators (below).

You are encouraged to contact the USAID | DELIVER PROJECT with corrections, additional information for the countries surveyed, or information on countries not included in the survey. We may update the data spreadsheet on the project website with such information.

Finance for Procurement (Capital)

While we tried to find information about funds *spent* on contraceptives for the public sector in the most recent complete fiscal year, depending on the data sources used, some answers may instead reflect *allocations* or, by contrast, products *received* during that year. Also, even within a given country, in some cases, we obtained funding information from various sources and, therefore, it may reflect slightly different time periods (e.g., if we obtained governmental information from the Ministry of Health and information on in-kind donations from the Reproductive Health Interchange [RHInterchange website]). Additionally, some countries reported based on their fiscal year, while others used the calendar year, or a different period of time. In some cases, we estimated or approximated the amount, sometimes because of varying exchange rates. Also, while we made every effort to clarify terminology to ensure accurate and precise reporting of information, some countries do not have the financial tracking mechanisms to capture the information requested.

In addition, the distinction between government and nongovernment financing is not always clear. In this paper, all funds given to governments were considered government funds because governments typically exercise discretionary spending of these funds.

It is also important to remember that, in some countries, the public sector is a source of commodities for NGOs, social marketing, and other programs. Therefore, while this paper focuses primarily on contraceptive financing for the public sector, in some cases, funding amounts may also include procurement for NGOs or social marketing organizations that receive their supplies from the public sector.

Last, when reviewing the amount spent on contraceptives, note that the data does not indicate quantities of supplies already in the country. If the country had a significant amount of stock in the system remaining from the previous year, they would need to procure less stock in the current year. Conversely, if the quantities of contraceptives already in the country were inadequate, they would need to procure more stock.

Appendix B

Data Collection Methodology

We collected data from 35 countries, both USAID's first tier priority countries for family planning and/or countries with USAID | DELIVER PROJECT field offices. We look forward to more countries tracking this information in the future in order to measure and inform their respective countries' progress toward contraceptive security.

The 35 responding countries were Afghanistan, Albania, Armenia, Azerbaijan, Bangladesh, Burkina Faso, Dominican Republic, El Salvador, Ethiopia, Georgia, Ghana, Guatemala, Honduras, India, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Pakistan, Paraguay, Philippines, Russia, Rwanda, Senegal, Tanzania, Uganda, Ukraine, Yemen, Zambia, and Zimbabwe. (The USAID | DELIVER PROJECT has recently opened field offices in Burkina Faso and Honduras. We surveyed these countries for the first time this year; they were not included in the 2009 data collection.) We solicited but did not receive responses from Bolivia, Democratic Republic of Congo, and Haiti. We did, however, obtain data from those countries in 2009.

Data collection and review was from late February through July 2010, including the following elements:

Survey and additional information from key informants: Survey responses from key informants at USAID missions or USAID | DELIVER PROJECT field offices provided data for most of the indicators. Survey respondents were also asked for information about which contraceptives (if any) were included in their country's NEML. Some respondents asked for assistance from in-country cooperating agencies or ministries of health to complete the survey.

Literature review: The research team reviewed each country's Poverty Reduction Strategy Paper (PRSP) to answer relevant *CS Indicator* questions. (In most cases, the countries did not have a new PRSP since 2009; therefore, we used the information from the last literature review.)

Review of responses: After we completed the data collection, we reviewed the responses and contacted respondents for clarifications and missing information.

Appendix C

Indicator Questions

A. Leadership and Coordination					
A1. Is there a national committee that works on contraceptive security? *(Committee should have some aspect of contraceptive security as part of its Terms of Reference, even if it is known by a different name, for example: Family Planning/Reproductive Health/Maternal Mortality/Essential Medicine Committee, etc.)*					
a. What is the name of the committee?					
A2. Are the following organizations represented on the committee?	(Y/N dropdown)				
a. Social marketing		If yes, specify name(s) of organizations			
b. NGO *(for example: service delivery, advocacy, Planned Parenthood affiliate, Marie Stopes affiliate, faith-based organizations, etc.)*		If yes, specify name(s) of organizations			
c. Commercial sector *(for example: pharmacy associations, manufacturers, etc.)*		If yes, specify name(s) of organizations			
d. Donors		If yes, specify name(s) of donors			
e. UN agencies		If yes, specify name(s) of agencies			
f. Ministry of Health *(for example: logistics, reproductive health, family planning, maternal and child health, HIV/AIDS, pharmacy units, etc.)*		If yes, specify name(s) of units			
g. Central Medical Store or Central Warehouse		If yes, specify			
h. Ministry of Finance or Ministry of Planning		If yes, specify			
A3. How many times did the committee meet during the last year? (0, 1-2, 3-5, or 6+) *(Please select from the dropdown list.)*					
A4. Does the committee have legal status?					
A5. Is there a Contraceptive Security "champion"? *(someone who consistently brings up and advocates for contraceptive supplies)*		If yes, specify person's organization		Specify person's job title	
B. Finance and Procurement (Capital)					
B2. Is there a health basket funding mechanism?					
B3. Is there a government budget line item for the procurement of contraceptives?					
B4. Were government funds ***spent*** on contraceptive procurement for the public sector in the most recent complete fiscal year? (Government funds include internally generated funds, basket funds, World Bank credits or loans, and other donor funds given to the government.)					

B4 & 5. Please complete the tables below to indicate expenditures on contraceptive procurement for the public sector, by source, in the most recent complete fiscal year. (This is how much was ***spent*** on contraceptive procurement (not what was committed or allocated). How much of this funding was provided from each source?)					
IF NO GOVERNMENT FUNDS WERE SPENT, SKIP TO QUESTION B5.					
B4. Source of ***government*** funds ***spent*** on contraceptive procurement for the public sector	Y/N	Amount spent *(in USD)*	Time period (mm/yy-mm/yy) *(should be the same for all sources of funds & ideally be the most recent complete fiscal year)*	Data source *(for example: Contraceptive Procurement Table, Reproductive Health Account, etc.)*	Comments
a. Internally generated funds *(for example, from public sector sources, taxes, or user fees used for procurement)*					
b. Total of all other government funds (basket funds, World Bank credits or loans, and other donor funds given to the government, such as from UNFPA, CIDA, DANIDA, etc.) *(This does NOT include contraceptive supplies donated to the government (so for example, NOT in-kind donations from USAID).)*					
i. Specify source(s) of funding from donors					
c. TOTAL government funding **This will auto-calculate.** *(It will sum a & b above.)*					
B5. In-kind donations of contraceptives provided for public sector	Y/N	Value of donated contraceptives *(in USD)*	Time period (mm/yy-mm/yy) *(should be the same for all sources of funds & ideally be the most recent complete fiscal year)*	Data source *(for example: Contraceptive Procurement Table, Reproductive Health Account, Donor Records, etc.)*	Comments
a. In-kind (non-monetary) donations provided (including emergency supplies) *(This includes contraceptive supplies donated to the government and procured by donors (for example, by USAID).*					
i. Specify source(s) of in-kind donations					
B6. Government Share of Spending on Contraceptive Procurement for the Public Sector - Of the total amount of financing spent on contraceptives for the public sector in the most recent complete fiscal year, what percent was covered by government funding *(including internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government)*? **This will auto-calculate.** *(It contains the following formula: Total government funding (Question B4c / Grand total of all funding for public sector contraceptives (Questions B4c+B5))*					

B7. If the government is financing contraceptive procurement, which type of entity does the procurement? *(Please select from the dropdown.)*	
a. Specify entity	
i. Is this a parastatal?	
B9. Comments about finance and procurement	

C. Commodities

C1. Are the following contraceptive methods offered in private sector, public sector, and/or NGO facilities? *(Please indicate which methods are intended to be offered. This question is not asking whether the method is in stock.)*

Contraceptive Method	Private Sector Facilities	Public Sector Facilities	NGO Facilities	Comments
a. Combined oral hormonal pills *(estrogen + progestin - for example, LoFemenol, Microgynon)*				
b. Progestin-only oral hormonal pills *(for example, Ovrette, Microlut)*				
c. Hormonal injections *(for example, DepoProvera, Noristerat)*				
d. Hormonal implants *(for example, Jadelle, Implanon)*				
e. Intrauterine devices (IUDs) *(for example, Optima Copper T)*				
f. Male condoms				
g. Female condoms				
h. Emergency contraceptive oral hormonal pills *(for example, Postinor)*				
i. Long-acting permanent method for males *(for example, vasectomy)*				
j. Long-acting permanent method for females *(for example, tubal ligation)*				
k. CycleBeads				
l. Other contraceptives - specify *(Please provide the name of the other contraceptive(s) offered, by sector.)*				

D. Policy (Commitment)

D1. Is there a contraceptive security or reproductive health commodity security strategy or is contraceptive security explicitly included in a country strategy?	

IF NO, SKIP TO QUESTION D2.

	Strategy name	Years Covered	Is the strategy formally approved by the Ministry?	Is the contraceptive security strategy being implemented?
a				

D2. Are any family planning commodities subject to duties, import taxes, or other fees?		
a. If yes, for which methods and for which sectors (public, NGO, commercial sector)?	Method(s)	
	Sector(s)	
b. If yes, how much are the duties, taxes, or fees?		
D3. Are there policies that affect the ability of the private sector (commercial sector or NGOs) to provide contraceptives (for example: price controls, distribution limitations, taxes/duties, advertising bans, etc.)?		
a. If yes, describe the policies.		

D4. Do policies or regulations exist that restrict who can sell or dispense particular contraceptive methods?		
Please note any restrictions in the following table.		
Contraceptive Method(s)	Describe **public sector** restriction on who is allowed to sell or dispense the method	Describe **private sector** restriction on who is allowed to sell or dispense the method
a		
b		
c		

D5. Does the country have laws, regulations, or policies that make it difficult for the following sub-populations to access effective family planning services?	Y/N	If yes, describe laws/regulations/policies affecting access	Are the rules/policies implemented?
a. Unmarried women			
b. Young people			
c. Other			

D6. Are there charges* to the client in the public sector for family planning:**(This question refers to charges by policy, not under-the-table charges.)*	
a. Services?	
b. Commodities?	
c. If yes, are there exemptions for people who cannot afford to pay?	
i. If yes, describe the exemptions.	

D7. Information on country's Poverty Reduction Strategy Paper (PRSP)	
a. What year is the Poverty Reduction Strategy Paper from? *(most recent actual PRSP on IMF's site [not progress or summary report])*	
b. Is family planning or reproductive health a priority in the PRSP?	
c. Is contraceptive security included in the PRSP?	
d. Is contraceptive prevalence rate (CPR) included as an indicator in the PRSP?	
e. Are contraceptive supply indicators included in the PRSP?	
f. Notes about the Poverty Reduction Strategy Paper	

D8. Are the following contraceptives included in the country's National Essential Medicine List (NEML)?	
a. Combined oral hormonal pills	
b. Progestin-only oral hormonal pills	
c. Hormonal injections	
d. Hormonal implants	
e. Intrauterine devices (IUDs)	
f. Male condoms	
g. Female condoms	
h. Emergency contraceptive oral hormonal pills	
i. Any other contraceptive(s)?	
i. Name of other contraceptive(s) on National Essential Medicine List	
D9. What year is the National Essential Medicine List from?	
D10. Notes about the National Essential Medicine List	

E. Supply Chain (Capacity)	
E1. Have stockouts occurred for any contraceptive at the ***central**** level in the last 12 months? **(The central level refers to the central level warehouse for the public sector.)*	
E2. In the last 12 months, has there ever been a stockout at the ***central*** level of any of the following contraceptives?	
a. Combined oral hormonal pills	
b. Progestin-only oral hormonal pills	
c. Hormonal injections	
d. Hormonal implants	
e. Intrauterine devices (IUDs)	
f. Male condoms	
g. Female condoms	
h. Emergency contraceptive oral hormonal pills	
i. CycleBeads	
j. Time period *(mm/yy - mm/yy) (for example, 1/09-12/09)*	
k. Data source *(for example: Procurement Planning and Monitoring Report, Logistics Management Information System, periodic physical inventory, warehouse reports)*	
E3. Do you think stockouts are a serious problem at the:	
a. service delivery point level	
b. central level	

F. Overall comments about issues with contraceptive security	

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