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Measuring Contraceptive Security Indicators in 2011

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Measuring Contraceptive Security Indicators in 2011

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Abstract
In 2011, the USAID | DELIVER PROJECT conducted its third annual round of data collection on contraceptive security indicators. The project gathered data from 40 countries, primarily USAID first tier priority countries for family planning or USAID | DELIVER PROJECT countries. This paper updates the data from the previous years' data collection; 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) Trained volunteers in Kano, Nigeria, use a flipchart to educate women about the importance of family planning for healthy timing and spacing of pregnancies. (2) In Uttar Pradesh, India, women gather for a meeting to present the results of a community audit of local health expenditures to local government officials. The meeting was arranged by a group that works to improve women's right to health and safe motherhood. (3) A health care worker in a commune health station provides family planning counseling to a couple in southeast Asia. (4) A regional-hospital employee in El Salvador explains the different family planning methods to her clients. (5) Women discuss health monitoring in Kenya.

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Contents

Acronyms v

Acknowledgments vii

Overview 1

Contraceptive Security Indicators 3

Findings 5

- Finance for Procurement (Capital) 5
- Commodities 20
- Policies (Commitment) 25
- Coordination and Leadership 28
- Supply Chain 30

Conclusions 33

References 35

Appendices

A. Data Collection Methodology 37

B. Finance Considerations 39

C. Additional Analyses 41

D. Finance Data from 2009, 2010, and 2011 *CS Indicators* Surveys 47

E. Finance Data from 2011*CS Indicators* Survey 51

F. Methods Offered, By Country and Sector 55

G. Indicator Questions 63

Figures

1. Percentage Change in Government and Total Financing for Contraceptive Procurement 13
2. Government Share of Total Spending for Public-sector Contraceptives 15
3. Percentage of Total Spending for Public-sector Contraceptives, by Funding Source 17
4. Percent of Quantified Need Covered in the Year 19
5. Percentage of Respondent Countries that Offer Contraceptive Methods, by Method and by Sector 21
6. Percentage of Respondent Countries with Methods Offered by Any Sector 24
7. Comparison of Methods Offered in Public-sector Facilities and Included in NEMLs in Respondent Countries 26
8. Percentage of Respondent Countries' Contraceptive Security Committees that Include Specific Organizations 29
9. Number of Respondent Countries and Their Central-level Stockout Information, by Product 32
10. Total Financing for Public-sector Contraceptives per Woman of Reproductive Age 42

11. Government Expenditures as Percent of Government Allocations 44
12. Percentage of Respondent Countries with Family Planning or Contraceptive Security-Related Items Included in their Poverty Reduction Strategy Paper (PRSP) 46

Tables

1. Government Expenditures for Contraceptive Procurement during FY2010 (in U.S.$) 8
2. Respondent Countries That Did Not Spend Government Funds on Contraceptive Procurement during FY2010 9
3. Value of In-Kind Contraceptive Donations and Global Fund Grants Used for Contraceptives during FY2010 (in U.S.$) 10
4. Median of Expenditures in Select Countries 45
5. Government and Total Expenditures on Contraceptive Procurement during Three Recent Years (in U.S.$) 47
6. Percentage Contribution by Financing Source and Total Expenditures for Contraceptive Procurement during FY2010 51
7. Methods Offered in Public-Sector Facilities 55
8. Methods Offered in NGO Facilities 57
9. Methods Offered through Social Marketing 59
10. Methods Offered in Commercial-Sector Facilities 61

Acronyms

CARhs	Coordinated Assistance for Reproductive Health Supplies
CPR	contraceptive prevalence rate
CS	contraceptive security
CSL	commodity security and logistics
CY	calendar year
DANIDA	Danish International Development Agency
DFID	Department for International Development (British)
FY	fiscal year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IUD	intrauterine device
LAC	Latin America and the Caribbean
LMIS	logistics management information system
MOH	Ministry of Health
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
SDP	service delivery point
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SWAp	sector wide approach
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WRA	women of reproductive age

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Overview

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**, an earlier USAID | DELIVER PROJECT paper, *Measuring Contraceptive Security in 36 Countries*, proposed a set of standard CS indicators. Following that publication—*Measuring Contraceptive Security Indicators in 2010: Data Update*—refined some of the indicators and provided updated data. This paper presents several new indicators—primarily in the finance section— and it provides more updated data on all the indicators, now from 40 countries.

The contraceptive security indicators included in this paper are examples of relevant information that country governments, policymakers, CS committees, and advocates can use to monitor and encourage 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.

Key findings include—

Finance for procurement (capital)

- In 61 percent of the respondent countries (22 out of 36), government funds were used to procure contraceptives.
- Only one respondent country (out of 39) used grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to procure contraceptives other than condoms.
- Fifty-five percent of respondent country surveys indicated there was insufficient funding for contraceptive procurement (18 out of 33). On average, 85 percent of the quantified need was covered.
- Financing for many countries varied significantly over time, indicating that financing for contraceptives can be unpredictable and unreliable.
  - In a two-year period, government financing varied by 100 percent or more in 27 percent of respondent countries (6 out of 22).

1. The SPARHCS framework includes components considered vital to achieve reproductive health commodity security (RHCS)—the components include context, commitment, capital, coordination, capacity, client demand and utilization, and commodities—often referred to as the seven C's.

Commodities

- On average, surveyed countries offer at least eight of the 11 assessed contraceptive methods in public-sector facilities, seven in nongovernmental organizations (NGOs) facilities, eight in private facilities, and five through social marketing.
- Of the methods assessed, public-sector facilities are least likely to offer CycleBeads, female condoms, and emergency contraceptives. However, more countries are offering these methods than in 2010.

Policies (commitment)

- On average, countries include six of nine assessed contraceptive methods in their National Essential Medicine Lists (NEML) or equivalent.
- Eighty percent of surveyed countries (32 out of 40) have either a specific CS strategy or they include CS in a broader national strategy.

Coordination and Leadership

- Ninety percent of surveyed countries (36 of 40) have a committee that works on contraceptive security issues.
  - Most of the committees include the Ministry of Health (MOH), United Nations agencies, donors, NGOs, and social marketing groups. One-third of the committees (12 out of 36) include the commercial sector. Only 25 percent of the committees (nine out of 36) include a Ministry of Finance or Ministry of Planning counterpart.

Supply Chain

- Seventy-one percent of respondent countries (25 out of 35) had a central-level stockout at some point during the last year.
- On average, countries reported central-level stockouts of two products (of an average of six products stocked at the central warehouse).

Opportunities for improvement on CS issues include an increase in government and donor funding for contraceptives, an expansion of CS coordinating committees' membership, 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 (SDPs).

Survey responses indicated 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 when monitoring and promoting CS.

Contraceptive Security Indicators

Contraceptive security (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 2011 are the same as those presented in 2010; however, a few indicators have been revised and others have been added, primarily in the finance section. (See appendix G for the data collection tool, including the complete list of indicators assessed in 2011.)

Indicators include the following topics:

Finance for Procurement (Capital)

- dollar value of estimated need for contraceptives to be procured for the public sector (value of quantification)
- existence of a government budget line item for contraceptives
- amount government allocated for contraceptives
- government expenditures for contraceptive procurement for the public sector
- value of in-kind contraceptive donations and Global Fund grants used for contraceptives for the public sector
- information on whether there was a funding gap
- information about the government's 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 through social marketing
- range of contraceptive methods offered in commercial-sector facilities.

Policies (Commitment)

- existence of a national contraceptive security strategy
- policies limiting or promoting access to family planning
- inclusion of contraceptives on the NEML
- inclusion of CS concepts and family planning indicators 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 major problem at the central level
- whether stockouts are a major problem at the SDP 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 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 used in the *CS Index* are drawn 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 picture of the CS situation in a country; also, the countries can update their data. In addition, the *CS Index* indicators tend to be a mix of higher-level indicators for finance and policy, and outcome indicators related to family planning. *CS Indicators* tend to focus more on specific CS interventions, and they contain more process indicators than the *CS Index*.

This *CS Indicators* data also complements the data in UNFPA's *Reproductive Health Monitoring Tool*.

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

Findings

This paper updates the data in *Measuring Contraceptive Security in 36 Countries* (based on 2009 data collection) and *Measuring Contraceptive Security Indicators in 2010: Data Update*. It also provides findings on several new indicators. The countries included in this paper differ slightly from those included in the previous paper: Bolivia, Democratic Republic of Congo, and Haiti are represented again in 2011 (after an absence in 2010), and Gambia and South Sudan are new additions to the *CS Indicators*. Sampling was not random, and results for surveyed countries in a region may not represent the entire region. (See appendix A.)

Overall findings for the surveyed countries offer insight about the status of CS. It is important to consider a few additional limitations when reviewing the findings, however. 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, although most of the indicator questions were designed to be objective, the data are still contingent on the knowledge of the respondents and, therefore, are subject to some subjectivity, misinformation, and missing information. In some cases, it may be difficult for respondents to find precise data, especially related to finances and, especially, in decentralized countries. (See appendix B for additional finance-related considerations for this study.) In addition, some of the indicator questions refer to official policies, while actual practices may vary. These study limitations should be considered when interpreting individual countries' findings.

The sections that follow offer an analysis of the *CS Indicator* data collected in 2011. Findings are by topic area: finance for procurement (capital), commodities, policies (commitment), coordination and leadership, and supply chain. (For additional analyses, see appendix C.) For the raw data collected by country, please refer to the complete dataset on the USAID | DELIVER PROJECT website (deliver.jsi.com). On the project website, you can also find updated, data-rich maps displaying country data on some of the indicators. These tools and their website locations are described in the boxes below.

Contraceptive Security Indicators Data Spreadsheet

You can use the data spreadsheet to—

- view results on all 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.

(USAID | DELIVER PROJECT 2011a)

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—

- government and total financing for contraceptives
- contraceptive methods offered
- contraceptive security strategies
- contraceptive security committees.

(USAID | DELIVER PROJECT 2011d)

Finance for Procurement (Capital)

Finance-related indicators help stakeholders understand the amount the government spends on contraceptive procurement and the value of in-kind donations and Global Fund grants for the public sector.[3] Finance indicators also provide a snapshot of the financial planning process, as well as provide information about whether the anticipated need for contraceptive procurement was covered. Strong government financing indicates the government's commitment to contraceptive security and suggests sustainability.

Key Findings: Finance for Procurement

- In 61 percent of the respondent countries (22 out of 36), government funds* were used for contraceptive procurement.
  - In these countries, on average, government funds constituted 61 percent of all financing spent on public-sector contraceptive procurement.
  - Almost all countries that used government funds (at least 21 out of 22) used internally generated funds.
- Only one respondent country (out of 39) used Global Fund grants for contraceptives other than condoms.
- Fifty-five percent of respondent countries' surveys indicated insufficient funding for contraceptive procurement (18 out of 33). On average, 85 percent of the quantified need was covered.
- Fifty-nine percent of respondent countries (23 out of 39) had a government budget line for contraceptive procurement.
  - Countries with a designated budget line are more likely to use government funds for contraceptives,
- Financing for many countries varied significantly over time, indicating that financing for contraceptives can be unpredictable and unreliable.
  - In a two-year period, government financing varied by 100 percent or more in 27 percent of respondent countries (6 out of 22).

* Government funds include internally generated funds, basket funds, and other funds given to the government for their use.

Financing Sources and Expenditures 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 authentic national resources, governments consider the funds as part of their national budgets, count them as part of government funding, and can spend them how and where they choose. In the *CS Indicators*, government funds are tracked separately from in-kind contraceptive donations and Global Fund grants, which are other sources of public-sector contraceptives.

3. 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 receive their supplies from the public sector.

Financing Sources for Public-Sector Contraceptives

Government Financing:

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

In-Kind Donations:

Contraceptive supplies that donors provide to a government.

Global Fund Grants:

These grants can be used to procure condoms or other contraceptives.

Government Expenditures

Sixty-one percent of respondent[4] countries (22 out of 36) indicated that their country spent government funds on contraceptive procurement during FY2010.[5]

Table 1 highlights the amount of the government funds used to procure public-sector contraceptives, by country, disaggregated by the specific type of government funding. **Of the 22 countries that used government funds, at least[6] 95 percent (21 out of 22) used internally generated funds.** Fifty-two percent (11 out of 21) used other government funds. On average, in respondent countries, 70 percent of government funds were from internally generated funds.[7] This varied from 2 percent in Bangladesh and 5 percent in Ethiopia to 100 percent in Albania, the Dominican Republic, El Salvador, Guatemala, Honduras, Madagascar, Paraguay, and the Ukraine. In the eight countries listed, all the government funds used to procure public-sector contraceptives were sourced from internally generated funds.

4. The term respondent (instead of surveyed) countries indicates that only countries responding to the question are included in the analysis.

5. Some countries reported on a slightly different 12-month period, as shown in the notes for table 1.

6. With Malawi's sector wide approach (SWAp), it is impossible to determine whether internally generated funds were used for contraceptive procurement or whether only other basket funds were used.

7. This average does not include Ghana, Malawi, or Rwanda because, in these countries, the amount of basket versus internally generated funds could not be disaggregated.

Table 1. Government Expenditures for Contraceptive Procurement during FY2010 (in U.S.$)

Region/Country	Internally Generated Funds Spent (U.S.$)	All Other Government Funds Spent (U.S.$)	Total Government Funds Spent (U.S.$)	Internally Generated Funds Spent, as Percentage of Total Government Funds Spent
Africa				
Burkina Faso[a]	365,205	404,000	**769,205**	**47%**
Ethiopia[b]	481,849	9,000,000	**9,481,849**	**5%**
Ghana[a]	1,237,550		**1,237,550**	**Unknown**
Kenya[b]	4,478,168	629,918	**5,108,086**	**88%**
Madagascar[a]	58,625	0	**58,625**	**100%**
Malawi[b]	1,223,717		**1,223,717**	**Unknown**
Rwanda[a]	1,454,420		**1,454,420**	**Unknown**
Tanzania[b]	1,800,000	5,000,000	**6,800,000**	**26%**
Europe & Asia				
Albania[a]	67,000	0	**67,000**	**100%**
Bangladesh[b]	714,285	35,714,285	**36,428,570**	**2%**
Nepal[b]	2,242,941	347,701	**2,590,642**	**87%**
Pakistan[c]	1,600,000	3,150,000	**4,750,000**	**34%**
Ukraine[a]	275,000	0	**275,000**	**100%**
Latin America & the Caribbean				
Dominican Republic[a]	652,174	0	**652,174**	**100%**
El Salvador[a]	675,674	0	**675,674**	**100%**
Guatemala[a]	1,500,000	0	**1,500,000**	**100%**
Honduras[a]	2,699,112	0	**2,699,112**	**100%**
Nicaragua[a]	321,935	721,759	**1,043,694**	**31%**
Paraguay[a]	566,000	0	**566,000**	**100%**

Notes:

1. The amount attributed to all other government funds includes basket funds and funds that donors gave the government for their use.
2. Respondents were asked about the most recent complete fiscal year (typically FY2010). The time period covered may differ slightly by funding source. The time periods reported on are indicated next to the country name: (a) January–December 2010, (b) July 2009–June 2010, and (c) July 2009–June 2010 for internally generated funds and January–December 2010 for other government funds.
3. The following countries did not use government funds for contraceptive procurement during the specified time period, so they are not included: Armenia, Azerbaijan, Democratic Republic of Congo, Georgia, Haiti, Mali, Mozambique, Nigeria, South Sudan, Yemen, and Zambia (for January–December 2010), Liberia and Uganda (for July 2009–June 2010), and Senegal (for October 2009–September 2010).
4. Although government funds were spent on contraceptive procurement, because of decentralization, data on amounts was not available for the Philippines or Russia (for January–December 2010). Financial details were not provided for India (for April 2010–March 2011). Respondents in Afghanistan, Bolivia, and Zimbabwe did not have information on whether government funds were spent on contraceptive procurement in calendar year 2010. Gambia did not have information on whether government funds were spent on contraceptive procurement in calendar year 2009.
5. The government expenditures for Ghana, Rwanda, and possibly Malawi, are a combination of internally generated and basket funds. (Malawi was not able to determine whether any of the funds were internally generated.)
6. Amounts are approximate.

Of the respondent countries providing government funds for contraceptive procurement, the Bangladeshi government spent the most ($36.4 million), mainly from basket funds. Kenya spent the most from internally generated funds ($4.5 million). Madagascar spent the least in total ($58,625). The median amount of government funds spent was $663,924 from internally generated funds and $404,000 from other government funds.[8] The range for other government funds was much larger than the range for internally generated funds; almost half of the countries using government funds only used internally generated funds and did not use other government funds, while Bangladesh used $35.7million of other government funds.

See table 2 for the respondent countries where no government funds were spent on contraceptive procurement.

Table 2. Respondent Countries That Did Not Spend Government Funds on Contraceptive Procurement during FY2010

Region/Country
Africa
Democratic Republic of Congo[a]
Liberia[b]
Mali[a]
Mozambique[a]
Nigeria[a]
Senegal[c]
South Sudan[a]
Uganda[b]
Zambia[a]
Europe & Asia
Armenia[a]
Azerbaijan[a]
Georgia[a]
Yemen[a]
Latin America & the Caribbean
Haiti[a]

Notes:
1. Government funds include internally generated funds, basket funds, and funds donors gave to the government for their use.
2. Respondents were asked about the most recent complete fiscal year (typically FY2010). The time periods reported on are indicated next to the country name: (a) January–December 2010, (b) July 2009–June 2010, and (c) October 2009–September 2010.

In-Kind Donations and Global Fund Grants

Table 3 shows the value of in-kind donations of contraceptives and Global Fund grants used for contraceptives, by country, as reported in the 2011 survey.

8. Because some countries spent much more than others, the averages (means) were higher: $1,156,123 for internally generated funds and $3,099,124 for other government funds.

Table 3. Value of In-Kind Contraceptive Donations and Global Fund Grants Used for Contraceptives during FY2010 (in U.S.$)

Region/Country	In-Kind Donations (U.S.$)	Global Fund Grants (U.S.$)	Total of In-kind and Global Fund Grants (U.S.$)
Africa			
Burkina Faso[a]	1,066,253	0	**1,066,253**
Democratic Republic of Congo[a]	5,859,613	0	**5,859,613**
Ethiopia[b]	6,421,656	0	**6,421,656**
Gambia[6]	60,222	0	**60,222**
Ghana[a]	2,327,890	1,450,000	**3,777,890**
Kenya[b]	7,213,274	606,300	**7,819,574**
Liberia[b]	798,187	0	**798,187**
Madagascar[a]	5,639,717	0	**5,639,717**
Malawi[b]	6,693,039	186,698	**6,879,737**
Mali[a]	2,733,719	0	**2,733,719**
Mozambique[a]	6,209,890	0	**6,209,890**
Nigeria[a]	5,000,000	0	**5,000,000**
Rwanda[a]	4,575,402	772,108	**5,347,510**
Senegal[d]	1,982,561	0	**1,982,561**
Tanzania[b]	4,355,176	1,211,960	**5,567,136**
Uganda[a&b]	6,588,411	0	**6,588,411**
Zambia[a]	4,500,501	0	**4,500,501**
Zimbabwe[a]	7,282,420	0	**7,282,420**
Europe & Asia			
Albania[a]	0	0	**0**
Armenia[a]	13,105	39,688	**52,793**
Azerbaijan[a]	0	31,356	**31,356**
Bangladesh[b]	7,142,857	0	**7,142,857**
Georgia[a&c]	18,361	23,529	**41,890**
India[e]	0	0	**0**

Region/Country	In-Kind Donations (U.S.$)	Global Fund Grants (U.S.$)	Total of In-kind and Global Fund Grants (U.S.$)
Nepal[b]	1,085,706	insignificant quantity	**1,085,706**
Pakistan[a]	12,000,000	0	**12,000,000**
Philippines[a]	728,769	0	**728,769**
Russia[a]	0	0	**0**
Ukraine[a]	382,500	764,000	**1,146,500**
Yemen[a]	0	0	**0**
Latin America & the Caribbean			
Bolivia[a]	540,000	0	**540,000**
Dominican Republic[a]	157,500	0	**157,500**
El Salvador[a]	0	24,300	**24,300**
Guatemala[a]	0	0	**0**
Haiti[a]	2,198,963	0	**2,198,963**
Honduras[a]	890,003	0	**890,003**
Nicaragua[a]	0	0	**0**
Paraguay[a]	0	0	**0**

Notes:

1. Respondents were asked about the most recent complete fiscal year (typically FY2010). The time periods reported on are indicated next to the country name: (a) January–December 2010, (b) July 2009–June 2010, (c) 2010–2011, (d) October 2009–September 2010, (e) April 2010–March 2011, and (f) January–December 2009. The time period covered may differ slightly by funding source.
2. Respondents in South Sudan did not have information on whether in-kind donations were provided or Global Fund grants used in the January–December 2010 time period. Respondents in Afghanistan indicated that in-kind donations were provided, but they did not know the value of the donations.
3. The in-kind donation information for Zimbabwe includes only products distributed through the delivery team topping up (DTTU) system only (male and female condoms; the injectable, Petogen; the combined oral contraceptive, Control; and the progestin-only pill, Secure. In addition, this information includes only products distributed to clients, not products in storage facilities.
4. The in-kind donation information for Senegal includes contraceptives for the MOH divisions for social marketing and AIDS.

Seventy-seven percent (30 out of 39 respondent countries) had in-kind contraceptive donations provided during the year, including all the respondent African countries. On average, the values of the donations were also the highest in the African countries (at an average of $4.4 million). The value of in-kind donations was highest for Pakistan, with USAID contributing $12 million worth of contraceptives in 2010. Several countries reported no in-kind donations for the public sector: Albania, Azerbaijan, El Salvador, Guatemala, India, Nicaragua, Paraguay, Russia, and Yemen. In countries with in-kind donations, the average value of the in-kind donations was $3.6 million.

Only 28 percent (11 out of 39 respondent countries) used Global Fund during the year for condoms or other contraceptives.[9] The following countries specified that the donations were only used to prevent HIV and other sexually transmitted infections: Armenia, Kenya, and Ukraine. However, the amounts are included here. El Salvador was the only surveyed Latin America and the Caribbean (LAC) country to use Global Fund grants for condoms. **Rwanda was the only respondent country that used Global Fund grants for contraceptives other than condoms.** This is in spite of a significant effort by advocates to encourage countries to use the Global Fund grants to procure contraceptives, based on strong arguments for family planning as an HIV prevention strategy, and an expressed willingness on the part of the Global Fund to allow this funding to be used to procure contraceptives, thus promoting linkages between HIV and family planning programs.

Advocates report that some countries have included non-condom contraceptives in their Global Fund proposals. However, except for Rwanda, this has not resulted in the actual procurement of contraceptives in the surveyed countries.[10] Advocates need to increase their efforts to encourage countries to use Global Fund grants to procure contraceptives—this will help decrease the unmet need for family planning and decrease the prevalence of HIV transmitted through unintended pregnancies.

Comparison of Finances over Time

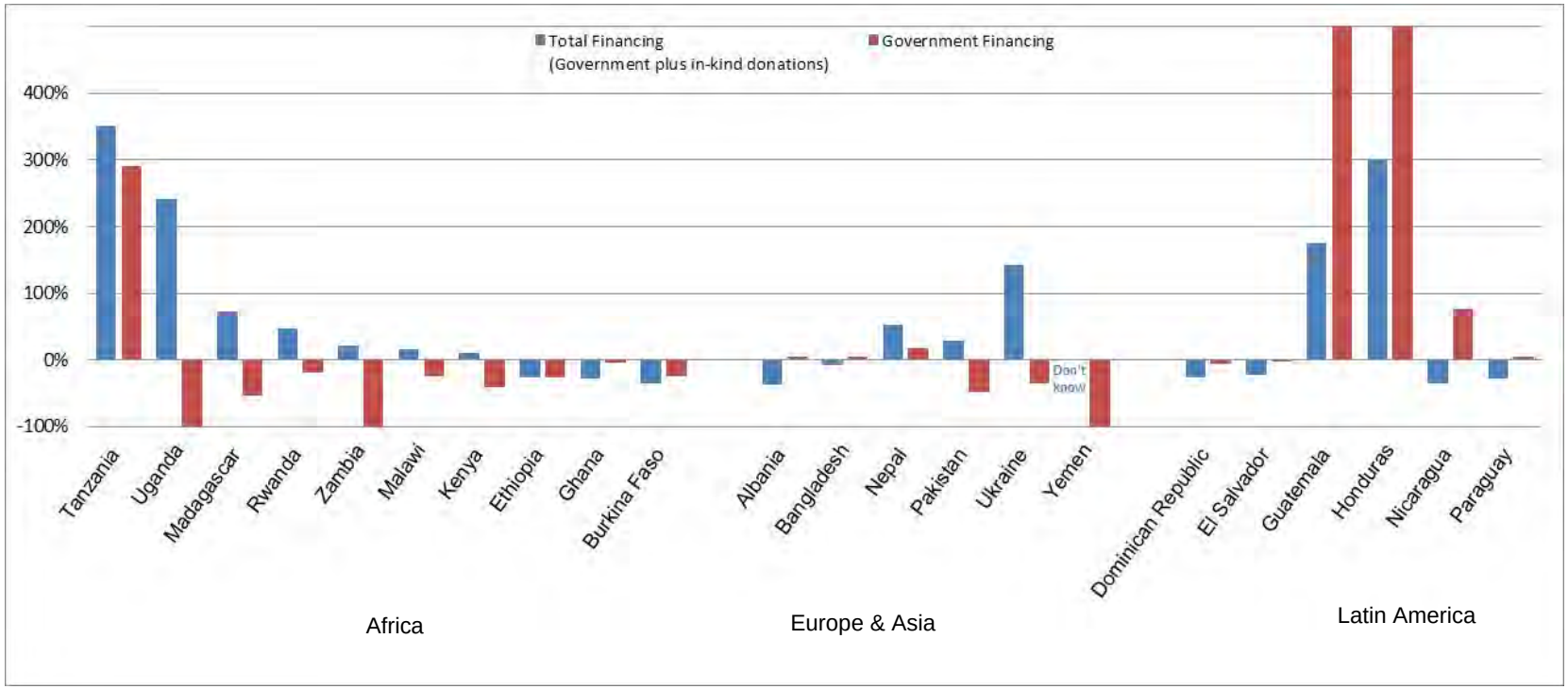
Responses to the three annual *CS Indicators* surveys indicate that **financing for many countries varied significantly over time, indicating that financing for contraceptives can be unpredictable and unreliable.** Financing amounts may change for good reasons; for example, in one year, programs may decide to procure additional supplies to fill the supply chain pipeline. In addition, a change in desired method mix could cause a program to buy greater quantities of a more expensive method and less of an inexpensive method (or vice versa). Nevertheless, major swings in financing are a concern because client demand for family planning is usually predictable and rarely shows dramatic changes. Large changes in financing are likely to impact the stability of programs and affect their ability to consistently respond to client demand (see appendix D).

Countries' percentage change in financing over time can be seen in figure 1, both for government and total financing. The figure includes respondent countries that had government expenditures for contraceptive procurement reported in at least one of the surveys. For most countries, the figure represents the percentage change between the 2009 and 2011 surveys. In countries without the necessary data in the 2009 survey, the figure represents the percentage change in financing between the 2010 and 2011 surveys.

9. Nepal is included as using Global Fund grants here, although the value of condoms was reportedly insignificant.

10. Further research revealed that a few non-surveyed countries—Cambodia and Lesotho—have also used Global Fund grant funding to procure non-condom contraceptives.

Figure 1. Percentage Change in Government and Total Financing for Contraceptive Procurement



Notes:

a. Only countries that reported spending government funds on contraceptive procurement in at least one of the surveys are included in the figure. See appendix D and its notes for more information on which countries were not included in this figure and why.

b. The percentage change in government funding in Guatemala and Honduras extends beyond the graph because funding increased from zero.[11]

   a. In each survey, respondents were asked to provide information about the most recent complete fiscal year. For the time periods reported on, see the notes for appendix D. For most countries, the figure represents the percentage change between the 2009 and 2011 surveys. However, for Burkina Faso, Honduras, Kenya, and Pakistan, the figure represents the percentage change between the 2010 and 2011 surveys because the necessary finance information was not available from the 2009 survey.

   b. Government funds include internally generated funds, basket funds, and other funds given to the government for their use.

11. To display the percentage change in government financing for Guatemala and Honduras, the calculation was done by indicating that initially these countries made a very small government contribution (because indicating a zero contribution would lead to an inability to perform the calculation due to division by zero.)

For most countries, figure 1 represents the percentage change between the 2009 and 2011 surveys. In these countries, changes in the 2010 survey are not shown in the figure, but they are listed in appendix D. For example, Ethiopia government funds increased by 63 percent between the 2009 and 2010 surveys; but, by the 2011 survey had decreased to a level 26 percent below that of the 2009 survey. Similarly, Ghana government funds decreased by 54 percent between the 2009 and 2010 surveys, but then increased again by the 2011 survey. Therefore, the change in government financing shown in figure 1 (between the 2009 and 2011 surveys) is quite small—just five percent.

Of the countries listed in figure 1, total financing for 12 countries increased (57 percent) and nine decreased (43 percent). Eight out of the 22 countries' government funds increased (36 percent), and 14 countries' government funds decreased (64 percent). The median country experienced a 13 percent decrease in government funding for contraceptive procurement, but a 15 percent increase in total financing.

Over time, the countries' finances varied considerably**. Government financing varied by 100 percent or more in 27 percent of the countries in figure 1 (6 out of 22).** In 23 percent of the countries (5 out of 22), total financing changed by 100 percent or more.

Examples of variability in expenditures for contraceptives follow. In Uganda and Zambia, by the 2011 survey, government contributions had decreased to zero, but overall financing had increased from the amount reported in the 2009 survey. In Yemen, government contributions also decreased to zero. Explanations for some of the notable increases in government funding follow:

- In 2010, respondents in Honduras noted that, although the MOH generally uses government funds to procure contraceptives, the political crisis had disrupted the flow of funds; therefore, these funds were not used from August 2009 to July 2010. Soon after, the government resumed funding contraceptive procurement, increasing the total financing, as well.
- Although the government in Guatemala did not technically spend money in 2008, UNFPA procured contraceptives on their behalf through the co-financing agreement, which was set up at the time, and that usually includes a blend of funds from donors and the Guatemalan government. At the time of the 2009 *CS Indicators* survey, the ministry had not transferred funds to the co-financing account because provisions in the regulatory framework disrupted financial transfers to international organizations. This regulatory barrier was eventually removed, but data are not available for the amounts and timing of the government transfer of funds to UNFPA and to which year these funds were applied. In subsequent years, government contributions for contraceptives were used (Olson et al. 2010).

Table 5 in appendix D compares the amount of government funds spent in respondent countries on contraceptive procurement, as well as the final total of financing for contraceptive procurement reported in the 2009, 2010, and 2011 *CS Indicator* surveys. As shown in appendix D, total financing for contraceptive procurement in respondent countries ranged from $0 in Azerbaijan in 2009 and Yemen in 2010 to more than $47 million in Bangladesh in FY2007/FY2008.[12] In Tanzania, both government contributions and in-kind donations increased each year; while, in Burkina Faso, they both decreased. In other countries with government contributions, either one increased and the other decreased, or the situation varied by year.

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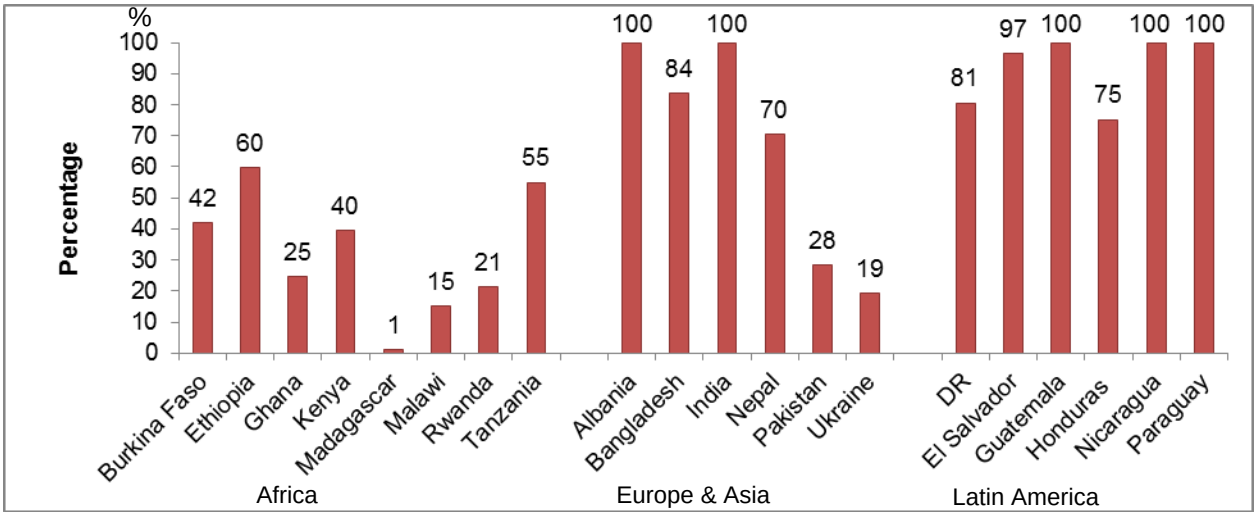
12. The dollar value of contraceptives needed for the public sector will vary by country, based on factors including population size, contraceptive prevalence rate and unmet need for family planning, method mix, and source of supply for contraceptives. The information used for figures 4 and 10 considers some of these factors.

Share of Public-Sector Contraceptive Financing

To better understand the government's role in contraceptive financing, the survey instrument calculated the percentage of the recent year's financing for public-sector contraceptive procurement that the government resources covered (including internally generated funds, basket funds, and other funds given to the government for their use).[13]

In respondent countries using government funds for contraceptive procurement, on average, government funds represented 61 percent of financing for public-sector contraceptives. The remaining financing was through in-kind donations or Global Fund grants. In these countries, government funding ranged from a low of 1 percent of the total expenditures on public-sector contraceptives (in Madagascar) to 100 percent. In the 2011 survey, in Albania and Nicaragua, the government share of total spending for public-sector contraceptives increased to 100 percent for the first time. However, as shown in figure 1, the total amount of financing in both countries was less than it was in 2009.[14] The other countries where the government covered all the spending were India, Guatemala, and Paraguay (see figure 2).

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



Notes:

a. Government funds include internally generated funds, basket funds, and other funds given to the government for their use.

b. Respondents were asked to provide information about the most recent complete fiscal year (typically FY2010). See table 1 for notes on the time periods used.

c. Information about the surveyed countries not included in this figure (because either there were no government expenditures for contraceptive procurement during the year or there was not enough information available to conduct this analysis), can be found in the notes for table 1.

Of the countries using government funds, those in Latin America reported that government funds represented a higher percentage of the total spending for public-sector contraceptives than the countries surveyed in Europe and Asia, followed by those in Africa. Of the surveyed countries using government funds for contraceptive procurement, governments provided an average of 92 percent of contraceptive financing in the Latin American countries, compared to an average of 67 percent in European and Asian countries, and 32 percent provided by African countries.[15] This finding is

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

14. This does not appear to be a problem; according to the 2011 survey, these countries did not have a funding gap (see figure 4).

15. The sample size for this analysis was small—eight countries in Europe & Asia, six in Latin America, and eight in Africa.

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 and Asian countries have decreased as these countries move toward graduation from USAID assistance. Consequently, government shares of total financing for contraceptives have increased in many of these countries, whether because in-kind donations have decreased or because actual government contributions have also increased.

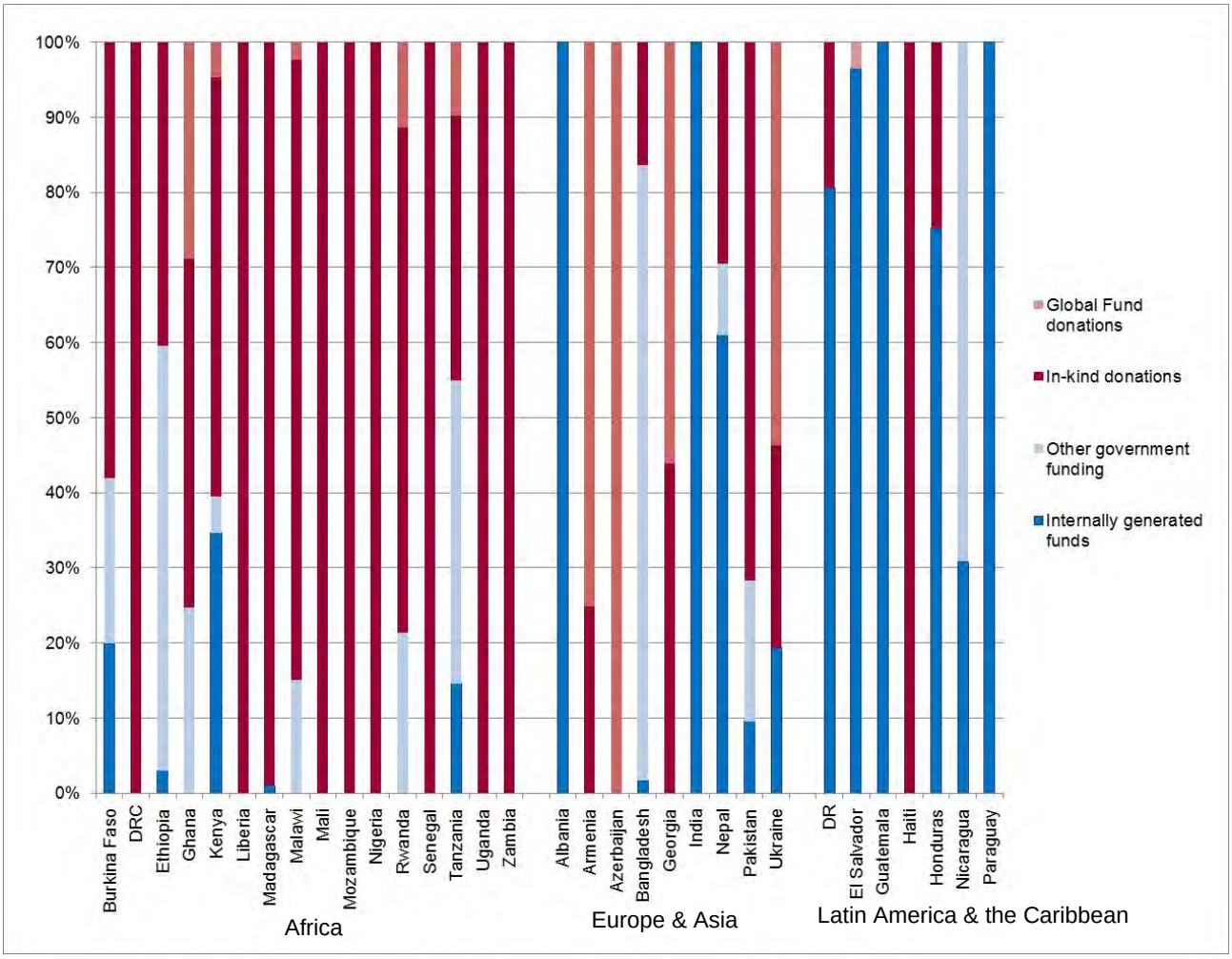
Even within regions, the government's share of the spending on public-sector contraceptive procurement varies significantly. In responding European and Asian countries that provide government funds for contraceptive procurement, government spending varied from 19 percent in Ukraine[16] to 100 percent in Albania and India. Among surveyed African countries that reported using government funds, government spending varied from 1 percent in Madagascar to 60 percent in Ethiopia. In Latin America, of the countries that reported using government funds, the governments' share of spending ranged from 75 percent in Honduras to 100 percent in Guatemala, Nicaragua, and Paraguay.

Figure 3 shows the share of spending information in more detail—it divides government funding into internally generated funds and other government funds. In addition, it also shows in-kind and Global Fund grants to present a complete picture of expenditures on contraceptives for the public sector. It shows all respondent countries, regardless of whether they used government funds for contraceptive procurement.

For more detailed country data on the share of spending, see table 6 in Appendix E.

16. If Global Fund grants were not included in the calculation, the government's share of public-sector contraceptive financing would be 42 percent.

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



Notes:

a. Complete financing data was not available for the following countries—they are not included in the figure: Afghanistan, Bolivia, Gambia, the Philippines, Russia, South Sudan, and Zimbabwe. In Yemen, contraceptives for the public sector were not purchased from January–December 2010.

b. In Ghana, Malawi, Rwanda, other government funding includes internally generated funds and basket funds. (These funds are not tracked separately.)

c. Respondents were asked to provide information about the most recent complete year (typically FY2010). See notes in appendix E for the time periods used. The time period may differ slightly by funding source.

d. See notes in appendix E for more information.

Of note, in Yemen, contraceptives were not purchased for the public sector during the year. In other words, not only were government funds not spent, but there were also no new in-kind donations during the time period, nor were Global Fund grants used. In Azerbaijan, there was no government funding and the only commodities came from a Global Fund grant.

In surveyed countries using government funds, on average, 42 percent of each country's financing for public sector contraceptives was sourced through internally generated funds, 18 percent through

other government funds,[17] 34 percent through in-kind donations, and 6 percent through Global Fund grants.[18] This differed considerably according to region, with the respondent Latin American countries providing an average of 81 percent of each country's funding through internally generated funds, compared to 49 percent in Europe and Asia, and 9 percent in African countries.[19] Latin American countries were less likely to use other government funds; Nicaragua was the exception. In-kind donations accounted for an average of 61 percent of contraceptive financing in the respondent African countries, 34 percent in respondent Latin American countries, and 24 percent in respondent European and Asian countries. Global Fund grants accounted for an average of 9 percent of the contraceptive financing in the respondent European and Asian countries, 7 percent in the respondent African countries, and 1 percent in the respondent Latin American countries.

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 providing sufficient quantities of contraceptives to meet the need for family planning in public-sector facilities. For example, while the government of Mozambique has not spent any funds on contraceptive procurement recently, it had sufficient in-kind donations from USAID, UNFPA, and the World Bank to meet its needs. However, countries without regular government contributions are at a greater risk of supply problems as donors reduce their in-kind contraceptive donations.

Need for Public-Sector Contraceptive Financing

In figures 3 and 4, it is important to note that the government's share of total spending for public-sector contraceptives only looks at 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.[20]

The survey tool compared the year's financing for contraceptives with the value of the amount quantified as needing to be procured. In cases when information was not available to make this calculation, respondents were asked whether there was a funding gap.[21] **Fifty-five percent of respondent countries' surveys (18 out of 33) indicated that there was insufficient funding for contraceptive procurement, while 45 percent (15 out of 33) noted that there was sufficient funding.**

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17. Other government funds were from UNFPA, Danish International Development Agency (DANIDA), and basket funds. Contributors to these basket funds included World Bank, Department for International Development (DFID), and AusAID; and contributions from Finland, Holland, and Spain.

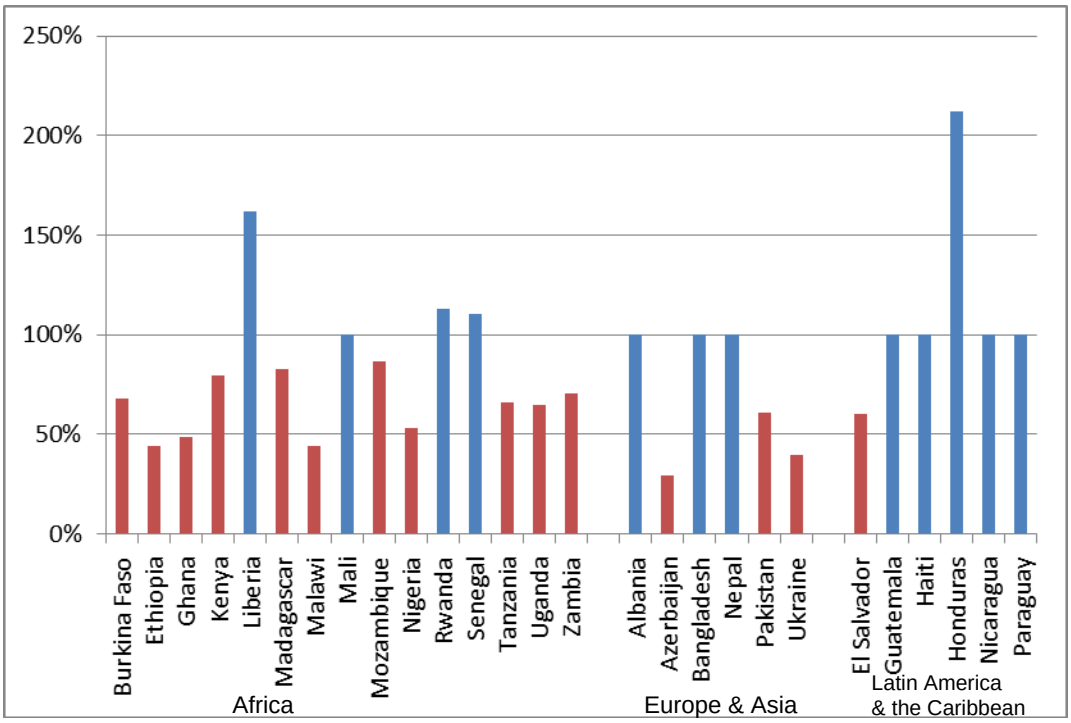
18. In-kind donations were from USAID, UNFPA, DFID, and KfW, and the World Bank.

19. This analysis includes only countries that used government funds.

20. 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.

21. This question may be considered especially subjective, as there was no data to support respondents' answers.

Figure 4. Percentage of Quantified Need Covered during the Year



Notes:

a. The following countries also noted a funding gap but did not have the information to calculate how much: Bolivia, Democratic Republic of Congo, and Dominican Republic. Gambia, India, and Zimbabwe noted there was not a funding gap.

b. Respondents for the following countries did not know if there was a funding gap: Afghanistan, Armenia, Georgia, Philippines, Russia, South Sudan, and Yemen.

c. Respondents were asked to provide information about the most recent complete year (typically FY2010). See table 1 and 5 notes for the time periods used. The time period may differ slightly by funding source.

On average, in respondent countries, 85 percent of the quantified need was covered. This ranged from 29 percent in Azerbaijan to 212 percent in Honduras. (In figure 4, the countries where the amount expended was less than the amount quantified are indicated in red.) Respondents in El Salvador noted that the amount expended was sufficient to cover historical consumption, but not enough to cover the cost of adding new products (e.g., monthly injectables). In Ethiopia, funding was insufficient to provide enough contraceptives to meet the Federal Ministry of Health's ambitious national targets for scale-up of implants and intrauterine devices (IUDs).

In Honduras, the amount expended for contraceptives was more than the amount that had been quantified as necessary. Respondents noted that expenditures included the last donation that UNFPA will provide to the Honduras government. In addition, less than 50 percent of the amount expended in 2010 arrived in 2010; but it arrived in 2011. So, although more was expended than quantified, this was not a problem. Respondents in Liberia noted that consumption of implants and injectables increased after the quantification, leading to expenditures greater than what had originally been quantified.

In some countries, the variance found between the amount quantified and the amount of financing mobilized could be due to the uncertainty when a quantification is conducted. If a quantification did not accurately reflect the demand for contraceptive procurement (inclusive of client and supply chain needs), then figure 4 does not reflect the true funding gap. When doing their quantifications,

countries and programs make different assumptions about the future demand; also, the quality of a quantification may be compromised by poor quality data on current demand. In addition, other factors can impact the discrepancy between a quantification and expenditures, including different time frames, exchange rates, and changing costs of contraceptives.

Budget Line Item

Respondents were asked whether their country had a budget line item for contraceptive procurement. Having a budget line item can be an important indicator of a government's commitment to contraceptive financing. **Twenty-three out of 39 respondent countries (59 percent) reported that they have a government budget line item for contraceptive procurement.**[22]

Seventy-seven percent of respondent countries with a budget line for contraceptive procurement followed up with funding for contraceptive procurement (17 out of 22).[23] Of the respondent countries without a budget line, only 31 percent (four out of 13)[24] funded contraceptive procurement. [25] Therefore, **while a budget line alone is not enough to ensure that contraceptives will be funded, it is usually a good predictor**, because it helps ensure that contraceptives are a priority in annual budgets.[26]

Commodities

Providing a broad range of contraceptive methods is essential for a country 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 facilities, NGO facilities, private-sector facilities, and through social marketing.[27] (Respondents were asked to consider a method as *offered* if it is intended to be stocked, regardless of the current availability.) The survey included combined oral contraceptive pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, emergency contraceptive pills, vasectomies, tubal ligations, and the standard days method (i.e., CycleBeads).[28] In addition, respondents were asked to indicate if any other methods are offered; additional methods offered in some countries were the contraceptive patch, vaginal ring, foaming vaginal tablets, and spermicides.

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22. This budget line refers to an item in the budget template specified for contraceptive procurement. In some cases though, respondents may have answered that the government has a budget line for contraceptive procurement even if the budget line is actually more broad—for example, for family planning or reproductive health, in general; as opposed to specifically for contraceptive commodity procurement. Funds do not have to be allocated to the budget line for it to count for this indicator.

23. The countries that had a budget line item but ultimately failed to release funds for contraceptives were Mali, Mozambique, Senegal, Uganda, and Zambia.

24. The Dominican Republic, Malawi, the Philippines, and Russia spent government funds on contraceptives despite lacking a budget line item.

25. Because respondents in Afghanistan, Bolivia, Gambia, and Zimbabwe did not know if government funds were spent, and respondents in Albania did not indicate if there was a budget line item, these countries are not included in this analysis.

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

27. Socially marketed products can be distributed through various channels, but they are predominantly distributed through commercial channels. Respondents may have reported that a product is offered in the private sector when it is really offered through social marketing, but distributed in a commercial outlet.

28. Most of these methods overlap with those on the WHO Model List of Essential Medicines, 17th list (March 2011). This WHO list also includes diaphragms but does not specify whether condoms include female condoms. (However, the Interagency List of Essential Medical Devices for Reproductive Health (WHO et al, 2008) includes female condoms in a reproductive health kit for crisis situations.) The WHO Model List of Essential Medicines specifies the types of many of the methods on the list though, while the CS Indicators survey typically includes broader categories (e.g., the WHO list specifies copper-containing IUDs, while the CS Indicators survey does not differentiate between types of IUDs).The *CS Indicators* survey does not include diaphragms since they are not typically offered in the surveyed countries. Neither WHO list includes CycleBeads.

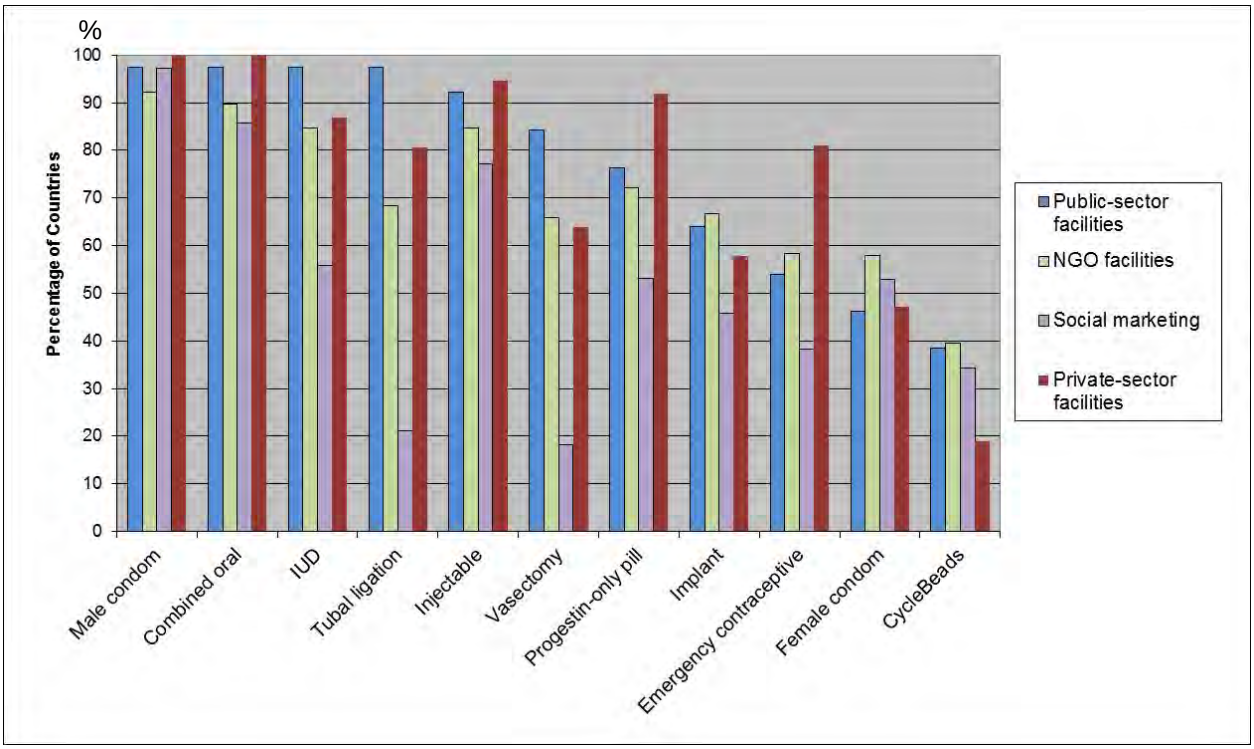
Key Findings: Commodities

- On average, surveyed countries offer at least eight of the 11 assessed contraceptive methods in public-sector facilities, seven in nongovernmental organizations facilities, eight in private facilities, and five through social marketing.
- Ninety-two percent of respondent countries (34 out of 37) offer all five of the following, most commonly offered methods in public-sector facilities: male condoms, combined oral contraceptives, IUDs, tubal ligations, and injectables.
- Of the methods assessed, public-sector facilities are least likely to offer CycleBeads, female condoms, and emergency contraceptives. However, more countries are offering these methods than in 2010.

Methods Offered by Sector

Figure 5 shows the methods offered by sector.

Figure 5. Percentage of Respondent Countries that Offer Contraceptive Methods, by Method and by Sector



Some contraceptive methods are more likely to be found in certain sectors. For example, emergency contraceptives are more likely to be offered through private-sector facilities than through any other sector.[29] They may, therefore, be accessible to fewer people than if they were also widely offered through the public sector or other sectors. Other examples abound: progestin-only pills are offered most often in private-sector facilities; female condoms are offered most often in NGO facilities or through social marketing; and IUDs, tubal ligations, and vasectomies are most likely to be offered in

29. In some cases, if an emergency contraceptive pill is not offered or available, providers may prescribe a high dose of other oral contraceptives for emergency contraception purposes.

public-sector facilities. CycleBeads is least likely to be offered in private facilities; it is more commonly found through other sectors.

As shown in figure 5, most of the respondent countries offer the following methods through public-sector facilities: male condoms (98 percent of respondent countries); combined oral contraceptives, IUDs, and tubal ligations (97 percent); and injectables (92 percent). Vasectomies are offered in public-sector facilities in 84 percent of respondent countries, and progestin-only pills in 76 percent. **Public-sector facilities are less likely to offer implants, emergency contraceptives, female condoms, and CycleBeads;** this sector offers implants in 64 percent of respondent countries, emergency contraceptives in 54 percent, female condoms in 46 percent, and CycleBeads in 38 percent of the respondent countries.

On average, countries offer at least eight of the 11 assessed contraceptive methods in public-sector facilities.[30] Fifteen percent of the surveyed countries (six out of 40) reported offering all 11 of these contraceptive methods in public-sector facilities. Azerbaijan reported offering only one—tubal ligations.[31] Respondents in South Sudan did not have information about whether most of the methods are offered. All other countries have at least six methods offered through public-sector facilities. **Ninety-two percent of respondent countries (34 out of 37) offer all five of the most commonly offered methods in public-sector facilities: male condoms, combined oral contraceptives, IUDs, tubal ligations, and injectables.**

Some differences were found between the findings from the 2010 and the 2011 *CS Indicators* surveys in terms of methods offered in public-sector facilities. For example, in 2011—

- Several more countries began offering female condoms in public-sector facilities—Bolivia,[32] El Salvador, Mali, and Mozambique.
- The number of countries offering emergency contraceptive pills in public-sector facilities increased—the Democratic Republic of Congo,[33] El Salvador, Liberia, Malawi, Rwanda, Ukraine,[34] and Zimbabwe[35] now offer them.[36]
- El Salvador and Zimbabwe respondents reported that public-sector facilities now offer CycleBeads.
- Respondents in Liberia reported that public-sector facilities now offer implants.
- Armenia respondents reported that injectables are now offered in public-sector facilities.

On average, at least seven of the 11 methods are offered in NGO facilities, eight in private facilities, and five through social marketing.[37]

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

31. In Azerbaijan, private-sector facilities now offer the following methods: combined oral contraceptives, IUDs, male condoms, emergency contraceptives, tubal ligations, and spermicides. Social marketing offers male condoms. NGOs do not offer any methods.

32. Because the CS Indicators survey was not completed for Bolivia in 2010 but was completed in 2009, it is unclear whether this change in methods offered in public-sector facilities occurred between 2009 and 2010, or between 2010 and 2011.

33. Because the CS Indicators survey was not completed for the Democratic Republic of Congo in 2010, but was in 2009; it is unclear whether this change in methods offered in public-sector facilities occurred between 2009 and 2010, or between 2010 and 2011.

34. Ukraine respondents reported that public-sector facilities can offer emergency contraceptives, although they are currently unavailable.

35. Although in Zimbabwe, the public sector is, in theory, supposed to manage IUDs, emergency contraceptives, and CycleBeads, their supply is erratic. They are not routinely distributed to all SDPs; instead they are distributed on a target basis—sold from the Zimbabwe National Family Planning Council warehouse to institutions and doctors, upon request.

36. In Nicaragua, the MOH prescribes emergency contraception but does not provide the actual packaged product.

See tables 7-10 in appendix F for each surveyed country's information about which methods are offered in which sector.

Methods Offered by Region

For some methods, there are notable differences between the regions.

For example—

- Female condoms are offered in public-sector facilities in more than 80 percent of the respondent African countries; but in less than 40 percent of the surveyed LAC countries, and in none of the surveyed European and Asian countries.[38]
- Progestin-only pills are offered in public-sector facilities in all the respondent African countries, but in less than 30 percent of the respondent LAC countries.
- Implants are offered in public-sector facilities in 89 percent of respondent African countries, 50 percent of surveyed LAC countries, and 38 percent of surveyed European and Asian countries.
- CycleBeads are offered in just 8 percent of the surveyed European and Asian countries. The Philippines is the only country that offers this method in public-sector facilities. In contrast, it is offered by 50 percent of respondent African and 63 percent of LAC countries.
- Emergency contraceptive pills are offered in 61 percent of respondent African, 55 percent of European and Asian, and 38 percent of LAC countries.

Methods Offered by Country Overall (in at least one sector)

Figure 5 shows how often the contraceptive methods are offered in particular sectors. Figure 6 shows the percentage of respondent countries that offer a contraceptive method at all, regardless of which sector provides the method. As shown in figure 6, male condoms, combined oral contraceptives, and IUDs are offered in all the respondent countries. Tubal ligations, injectables, progestin-only pills, and emergency contraceptives are offered in 93–97 percent of respondent countries; vasectomies are offered in 87 percent; implants and female condoms are offered in 76 percent; and CycleBeads are offered in 62 percent.[39]

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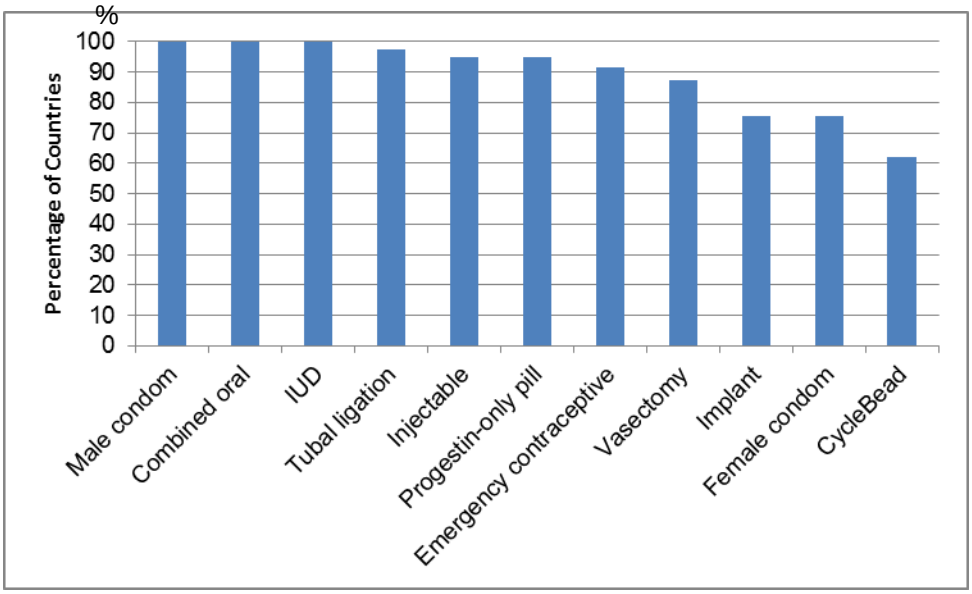
37. Go to deliver.jsi.com to see the country-level responses on these indicators displayed in map form.

38. Female condoms are offered in private facilities, NGO facilities, or through social marketing in at least four out of 13 (31 percent) of the surveyed European and Asian countries.

39. If respondents in a country did not know whether a particular method was offered through any sector, the country was exculded from the analysis for that method. One surveyed country was excluded from the analysis for combined orals, IUDs, vasectomies, and tubal ligations, respectively. Three were excluded from the analysis for implants, female condoms, and CycleBeads. Four countries were excluded from the analysis for emergency contraceptives.

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



Some changes were found between the the 2010 and the 2011 *CS Indicators* surveys.

For example, in 2011—

- El Salvador, Georgia, and Pakistan respondents reported that female condoms are now offered through at least one sector.
- El Salvador and Madagascar respondents reported that they now offer emergency contraceptives.[40]
- El Salvador and Georgia respondents reported that they now offer CycleBeads.
- Nepal respondents reported that they now offer progestin-only pills.

These changes should help more clients access their methods of choice.

Even when a broad range of contraceptive methods are offered, clients often face barriers to obtaining them—the percentage of facilities that stock the methods, facility locations, level of stock in facilities, provider training, cost to clients, and others. In addition, in some cases, only a small amount of product may be available for a pilot, or the method may only be available in a particular sector or for a specific sub-population. For example, in India, female condoms have been supplied through the government's social marketing program exclusively for female sex workers. In the Ukraine, NGOs are prohibited by law from providing family planning services and commodities.

40. In 2010, the El Salvador respondents indicated that they did not know whether emergency contraceptives were offered in private sector facilities but that emergency contraceptives were not offered through any other sector. In 2011, respondents noted that emergency contraceptives are now offered in public, NGO, and private facilities.

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 six of nine assessed contraceptive methods in their National Essential Medicine Lists (NEML) or equivalent.
- Eighty percent of surveyed countries (32 out of 40) have either a specific contraceptive security (CS) strategy or include CS in a broader national strategy.
- Seventy percent of surveyed countries (28 out of 40) reported taxes, import duties, or fees on contraceptives.
- Fifteen percent of surveyed countries (6 out of 40) charge clients for family planning services and 20 percent (8 out of 40) for commodities in the public sector. This means that a total of 23 percent of surveyed countries have one or both of these charges. Eighty-nine percent of these countries (8 out of 9) have exemptions for those who cannot afford to pay.

Contraceptives on National Essential Medicine Lists

Essential medicines address priority health care requirements for a population and are expected to be available and accessible at all times. 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 six of the nine assessed contraceptive methods[41] in their NEML or NEML equivalent. The Democratic Republic of the Congo, Liberia, Madagascar, Mali, Rwanda, Senegal, and Zimbabwe included all nine of these contraceptive methods. Other contraceptive methods found in some countries' NEMLs included diaphragms, spermicides, and vaginal foaming tablets. Russia included only the progestin-only pill in their NEML; Georgia was the only country surveyed that did not include any contraceptive method.[42] Kenya updated their list in 2010 and, for the first time, incorporated implants, IUDs, and barrier methods.

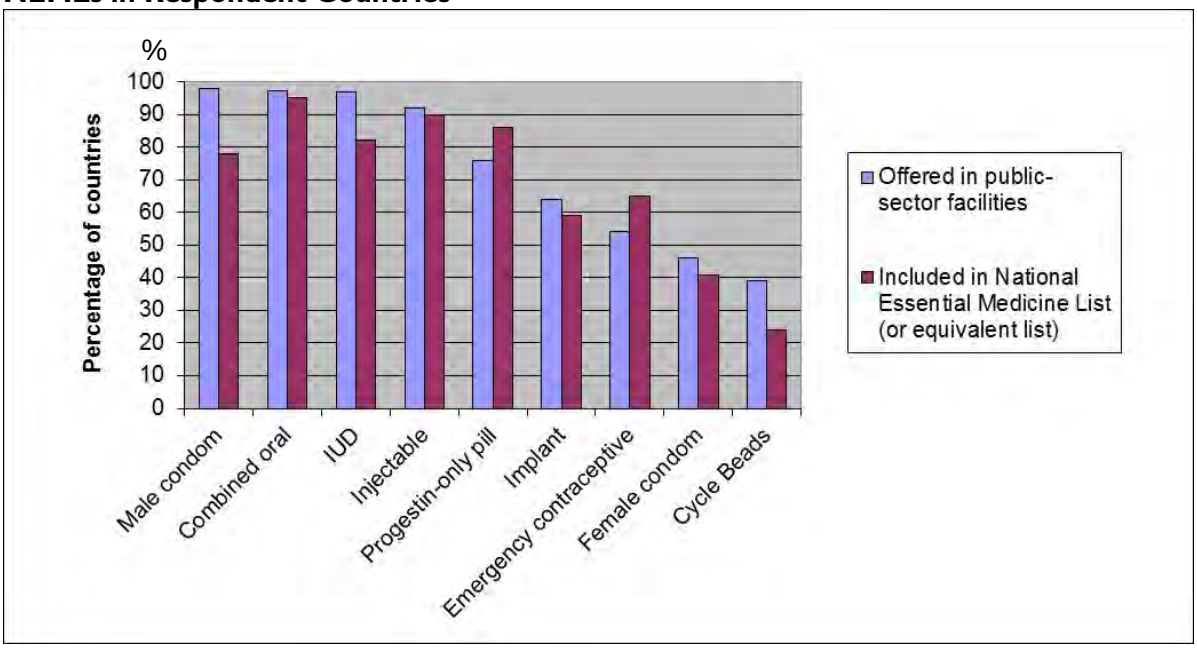
Figure 7 compares the methods offered in public-sector facilities and those included in NEMLs. As shown, non-inclusion in an NEML does not necessarily mean that the method is not offered in public-sector facilities, and vice versa. For instance, despite being offered in public-sector facilities in 98 percent of surveyed countries, only 78 percent of countries surveyed include male condoms in their NEMLs. (However, partly because condoms—and sometimes implants, IUDs, and potentially CycleBeads—are often considered medical devices, they may be included instead in a separate

41. The methods included in this analysis were combined oral pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, emergency contraceptives, and CycleBeads. (In 2011, CycleBeads were added to the list of methods included in the NEML analysis, so the number of assessed methods increased from eight to nine.)

42. 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 MOH and Parliament never approved it. Contraceptives are not on the list of generics prepared as the national essential drug list draft (which includes only 200 drugs), nor on any essential drug lists developed by the insurance companies. Azerbaijan's essential drug list was never approved by the Ministry of Health, but there is hope that it will be published this year.

medical device or equipment list. Although countries were expected to include information from these lists as well, not all did.) In, Russia and Yemen, injectables are offered in public-sector facilities but are not included in the NEMLs. However, progestin-only pills and emergency contraceptives are more likely to be included in a country's NEML than they are to be offered in public-sector facilities.

Figure 7. Comparison of Methods Offered in Public-Sector Facilities and Included in NEMLs in Respondent Countries



Note: For each method, only countries with information about whether the method is offered and whether it is on the NEML (or equivalent list) are included in this analysis.

Contraceptive Security in Government Strategies

A country strategy that explicitly includes contraceptive security can show the government's commitment to CS, help ensure that CS remains a priority on political agendas, identify priorities, and provide guidance for CS strengthening activities. **Of the 40 surveyed countries, 32 (80 percent) reported having a contraceptive security strategy or another strategy (for example, a family planning or reproductive health strategy) that included a CS component.**[43] The ministries of health in surveyed countries formally approved 84 percent of these strategies (27 out of 32). The degree of implementation varies by country; 87 percent of the strategies (27/31) are reportedly being implemented.[44]

Policies That Impact 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

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

44. Strategy implementation is a particularly subjective indicator.

public sector and/or the private sector are included because the private (i.e., non-public) sector often plays an important role in CS.

Taxes, Duties, and Fees

Of the countries surveyed, 28 out of 40 (or 70 percent) mentioned taxes, import duties, or fees on contraceptives. These charges primarily affected commercial-sector goods. Bolivia noted the highest import tax, at 40 percent, and also noted that there is an exemption for products donated to the ministry of health.

Advertising Bans

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; permission from the ministry of health is required to advertise other methods. In the Philippines, hormonal contraceptives are classified as ethical/regulated drugs, and the Pharmacy Law bans brand advertising of such drugs and prohibits their distribution without a prescription. Russia, Senegal, Tanzania, Ukraine, and Zambia have similar laws. In Honduras, a bill prohibits the dissemination of information, promotion, free distribution, commercialization, and use of emergency contraceptives. It also prohibits the dissemination of information about the use of contraceptive pills for emergency contraception. In Azerbaijan, condoms can only be advertised after midnight.

Policies That Enable the Private Sector

Fifty-six percent of respondent countries (18 out of 32) reported policies that enable the private sector to provide contraceptive methods. These policies could apply to the commercial sector, NGOs, or social marketing. In India, the government provides a product subsidy to select social marketing agencies. In Kenya, there are provisions for the private sector and NGOs to access and dispense public-sector contraceptives. In Mozambique, a law allows the private sector to import and prescribe all contraceptive methods. In Pakistan, there is an exemption on duties for certain providers, as well as over-the-counter availability.

Dispensing Restrictions

Sixty-two percent of the respondent countries (24 out of 39) 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. Private doctors are restricted from dispensing contraceptives; they cannot keep stock in their offices. Such regulations create unnecessary obstacles to clients seeking access to family planning. For example, to obtain an injectable contraceptive, IUD, or implant, the client must (1) first see a doctor for counseling and to obtain a prescription, (2) go to a pharmacy to buy the contraceptive, and (3) return to a doctor for administration or insertion of the contraceptive.

On the other hand, some countries recognize that certain policies regarding who can administer particular methods are unnecessarily restrictive. Various countries have, therefore, increased the role of community health workers; for example, in Senegal, public-sector community health workers can now provide oral contraceptives and injectables.

Policies Restricting Access to Sub-Populations

Respondents were also asked whether policies, laws, or regulations restrict access to family planning services for certain segments of the population. Most countries answered that they did not.[45] However, in Bangladesh, restrictions apply for unmarried and low-parity individuals. Unmarried women and women without children cannot obtain injectables, implants, IUDs, or tubal ligations. In addition, low-parity clients cannot obtain IUDs, tubal ligations, or vasectomies. A law in Pakistan states that contraceptives can only be distributed to married women of reproductive age. In the Gambia, parental consent is required for an unmarried minor to obtain contraceptives.

Charges

Fifteen percent of surveyed countries (six out of 40) reported charges to clients for family planning services in the public sector and 20 percent (eight out of 40) reported charges for contraceptive commodities—for a total of 23 percent of surveyed countries (nine out of 40) that have one or both charges. Eighty-nine percent of these respondents (eight out of nine), however, indicated that there are some exemptions for people who cannot afford to pay. Nigeria was the one country without exemptions. However, a few months after the *CS Indicators* survey was completed, their user fee policy changed; they no longer charge clients in the public sector for contraceptives. Further research is needed to determine exactly how different user fee policies affect clients' 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

- Ninety percent of surveyed countries (36 of 40) have a committee that works on contraceptive security issues.
  - Most of the committees include the Ministry of Health, United Nations agencies, donors, nongovernmental organizations, and social marketing groups.
  - Over two-thirds of committees (24 out of 35) include the Central Medical Stores or warehouses.
  - One-third of committees (12 out of 36) include the commercial sector.
  - Only one-quarter of committees (nine out of 36) include a Ministry of Finance or Ministry of Planning counterpart.

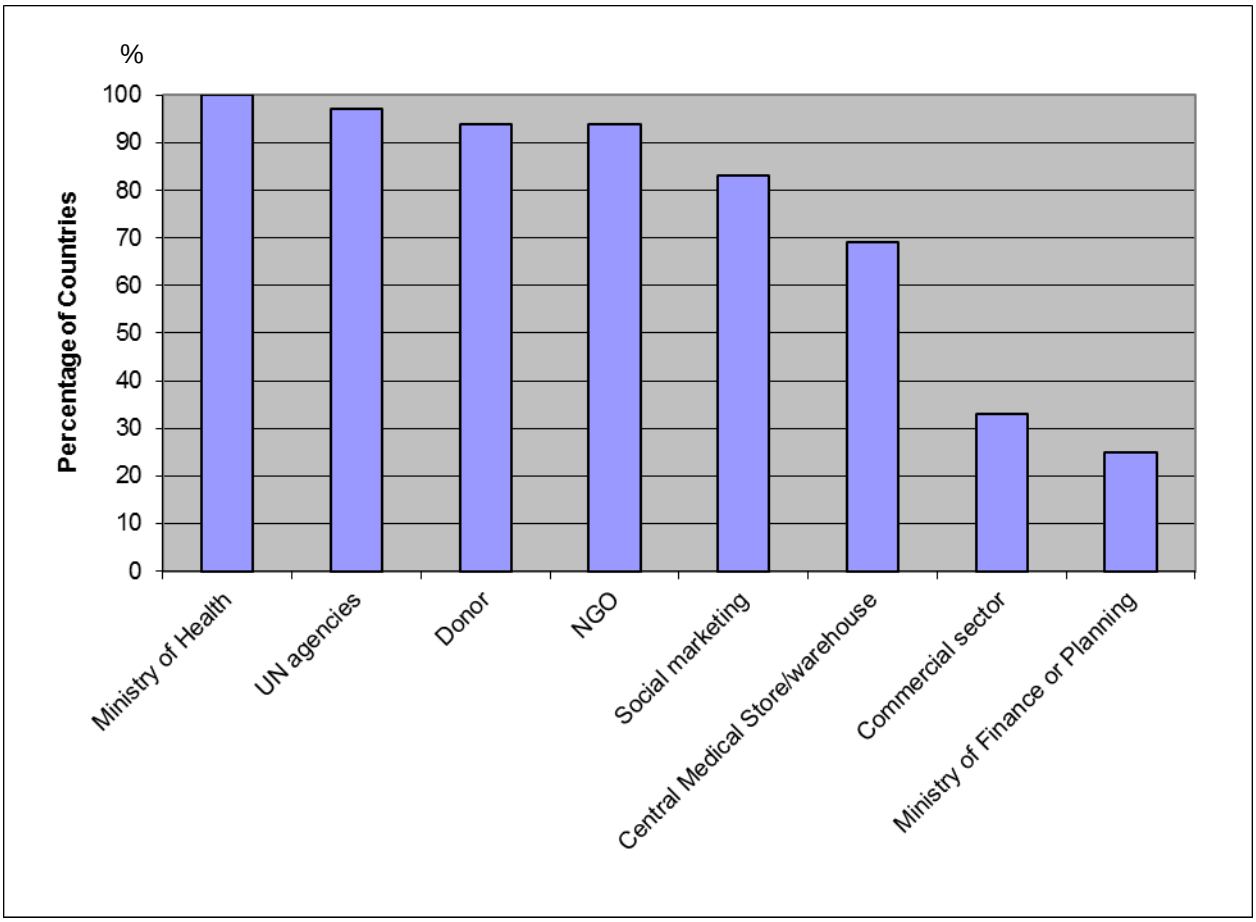
Coordinating Committee for Contraceptive Security

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

45. The survey asked about official policies; it did not investigate unofficial practices.

reduce duplication and inefficiencies. **Ninety percent of countries surveyed (36 out of 40) reported having a committee that works on contraceptive security.**[46] With the exception of South Sudan, all the reporting African and Latin American countries have a committee.[47] Fifty-five percent of the committees have legal status. Figure 8 shows the types of entities represented on surveyed countries' CS committees.

Figure 8. Percentage of Respondent Countries' Contraceptive Security Committees that Include Specific Organizations



Ministries of health are represented on all the CS committees, and various units are often represented. Except in Afghanistan and India, **donors and United Nations (UN) agencies also participate in the CS committees**. (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 69 percent of committees, the commercial sector**[48] **in 33**

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

47. The committees met with varying frequency. Three of the committees did not meet at all in the last year, but in two of these countries similar groups met.Of the remaining committees, nine met once or twice during the year, 11 met three to five times, and nine met at least six times. There was no information about how often the remaining four met.

48. Commercial sector organizations represented included drug companies, manufacturers, marketing companies, distributors, professional associations, and health insurance companies.

percent of surveyed country committees, and the ministry of finance or planning participates in just 25 percent of CS committees in respondent countries. Other organizations on some countries' committees included the ministry of labor, ministry of population, implementing partners, and civil society organizations. As country government financing becomes an increasingly important source of funding for contraceptives, it is important to engage ministries of finance and to consider including them in these committees to help ensure adequate and timely funding for contraceptives.

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

- Seventy-one percent of respondent countries (25 out of 35) 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).

When asked to comment on their country's challenges regarding contraceptive security, many key informants described supply chain issues. These included challenges related to ensuring the availability of data, forecasting and quantification capacity, procurement lead times, storage, and distribution, which can all impact product availability.

Product Availability

Product availability is an important indicator of a country's contraceptive security status. 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). Specifically, they were asked to report whether there had been a central-level stockout of any contraceptive in the last 12 months.[49] Additionally, respondents were asked to indicate which contraceptive method(s) stocked out.[50] **Seventy-one percent of responding countries (25 out of 35) reported a central-level stockout of at least one contraceptive method during the last year.**[51]

Survey respondents reported that their data sources for information on central-level stockouts of contraceptives included logistics management information systems (LMISs); periodic physical inventories; warehouse records or reports; the Procurement Planning and Monitoring Report

49. While respondents were asked about the most recent 12 months, some reported on other time periods. Five countries reported on periods of less than a year.

50. The methods asked about were combined oral pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, emergency contraceptives, and CycleBeads.

51. Azerbaijan, the Philippines, Russia, and South Sudan 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. The Ukraine was excluded from the analysis because data was not available.

(PPMR);[52] and other reports from or interviews with the ministry of health, donors, and 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.

This central-level data must be interpreted with caution because central-level stockouts are not the same as stockouts at SDPs (such as clinics or hospitals). Although central-level stockouts, if not resolved, will inevitably lead to stockouts at lower levels, current stockouts at the central level do not necessarily mean current stockouts at facilities. Also, central-level warehouses may have stock, but SDPs may be experiencing stockouts. For example, Senegal respondents noted that while there were no stockouts at the central level, smaller health posts and health centers frequently had stockouts. 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, approximately two-thirds of a country's contraceptives were stocked at the central level at all reporting times, while one-third were stocked out at some reporting point during the year. However, product stockouts were not necessarily concurrent; information relating to the timing and duration of stockouts was not collected.

Figure 9 shows the number of respondent countries with central-level stockouts of a particular contraceptive method, as well as those without stockouts of the method.[53] As shown in figure 9, of the 34 countries reporting about central-level availability of male condoms, 8 (24 percent) had a central-level stockout in the last year—the remaining 26 did not. By comparison, nine out of the 34 countries reporting on IUDs (26 percent) had a stockout. Out of 21 respondent countries reporting stocking implants in their central-level warehouse, one-third (seven) had a stockout in the last year. This was a notable decrease from the results in the 2010 *CS Indicators* survey, when 55 percent of respondent countries (11 out of 20) stocked out of implants during the year.

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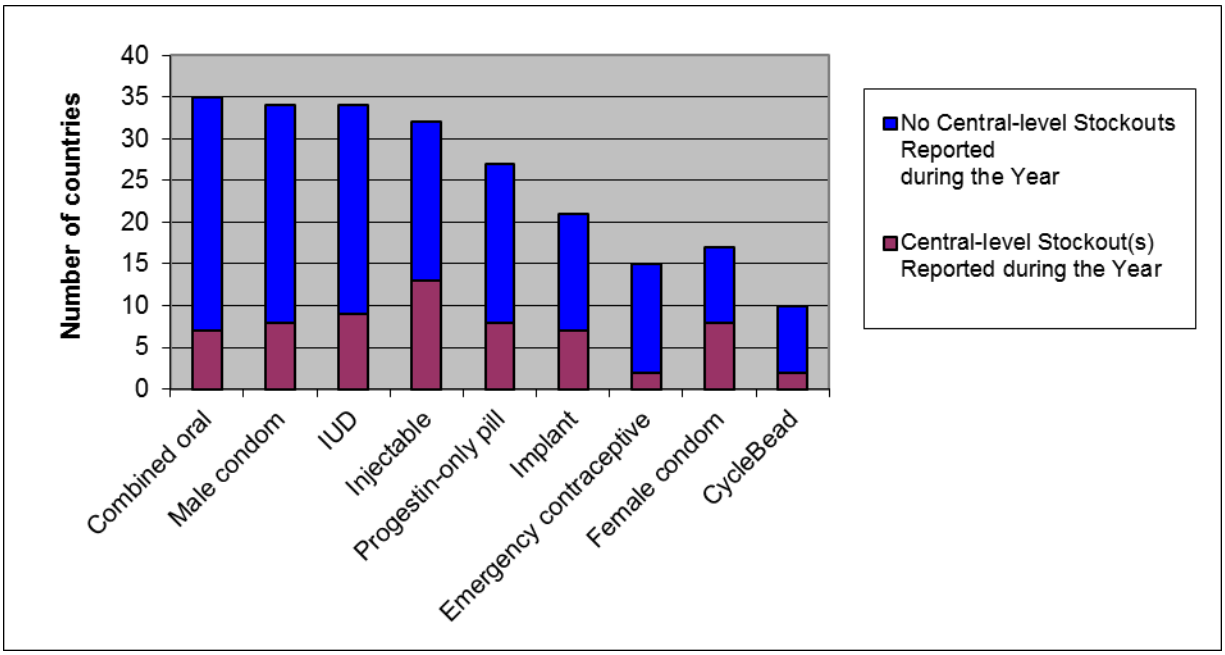
52. Through the PPMR, participating countries report on their current stock status, along with qualitative information on contraceptive security. High-level decisionmakers at USAID, UNFPA, and other donors who participate in the Coordinated Assistance for Reproductive Health Supplies (CARhs) Group of 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.

53. A country was not included in the analysis for a particular method if the central warehouse never stocks the method (or if there were no data). For example, several Latin American and other countries were excluded from the analysis for progestin-only pills because their central warehouses do not stock this method. Therefore, the total number of countries included in the analysis varies by method, as shown in the figure.

Figure 9. Number of Respondent Countries and Their Central-level Stockout Information, by Product



Note: While most countries reported on a 12-month period, a few reported on shorter periods of time.

Respondents were also asked if stockouts were a large problem at the SDP and central levels—for example, if stockouts are common or if they tend to last a long time. Fifty-three percent of respondents (18 out of 34) reported that SDP stockouts represented a serious problem and 30 percent (10 of 33) reported that central-level stockouts were a serious problem. Of countries reporting a central-level stockout during the last year, 43 percent (10 of 23) said they were a large problem.

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 Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework, the indicators cover various aspects of CS, including finance for procurement (capital), commodities, policies (commitment), coordination and leadership, and the supply chain.

Some of the data collected for this analysis are encouraging.

Of the surveyed countries—

- 90 percent have coordination committees that address contraceptive security
- 80 percent have strategies for working on contraceptive security
- 61 percent contribute government funds for contraceptives.

On average, they offer at least eight 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 collected should encourage tailored, in-depth analyses; the availability of maps displaying responses on some of the indicators can add to advocacy efforts.

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 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

Data Collection Methodology

The research team collected data from 40 countries—mainly USAID's first tier priority countries for family planning or countries with USAID | DELIVER PROJECT field offices.[54] The 40 countries were: Afghanistan, Albania, Armenia, Azerbaijan, Bangladesh, Bolivia, Burkina Faso, Democratic Republic of the Congo, Dominican Republic, El Salvador, Ethiopia, Gambia, Georgia, Ghana, Guatemala, Haiti, Honduras, India, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Pakistan, Paraguay, Philippines, Russia, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Ukraine, Yemen, Zambia, and Zimbabwe. This was an increase from the 36 countries responding to the 2009 survey and the 35 responding to the 2010 survey.[55]

Data collection and review occurred from late February through June 2011 and included the following elements:

Survey: Survey responses from key informants at USAID missions or USAID | DELIVER PROJECT field offices provided data for most of the indicators. Some key informants asked for assistance from ministries of health or cooperating agencies to complete the survey.

Review of responses: The research team reviewed the responses and contacted respondents for clarifications.

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 or 2010; therefore, in most cases the team used the information from a previous literature review.)

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54. The Gambia was also included because a USAID | DELIVER PROJECT employee conducted a TA trip there and worked with others to complete it during his visit. This country's survey was completed in September 2010. The others were completed in 2011.

55 Key informants for Bolivia, the Democratic Republic of the Congo, and Haiti responded to the survey in 2009 and 2011, but they did not submit their responses in 2010. Burkina Faso and Honduras were surveyed for the first time in 2010, as the project had recently opened field offices there. The Gambia and South Sudan were surveyed for the first time during the most recent round of data collection. Sudan had recently become a USAID first tier priority country for family planning.

Appendix B

Finance Considerations

Because the *Finance for Procurement* indicators were the most challenging to collect and interpret, more in-depth explanations of the limitations are explained below.

When the survey asked for 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, respondents obtained funding information from various sources and, therefore, this information may reflect slightly different time periods (e.g., if they obtained governmental information from the MOH and information on in-kind donations from the Reproductive Health Interchange [RHInterchange website]).

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.

Readers are encouraged to contact the USAID | DELIVER PROJECT with corrections, additional information for the countries surveyed, or information for countries not included in the survey.

Appendix C

Additional Analyses

Contraceptive Financing per Woman of Reproductive Age

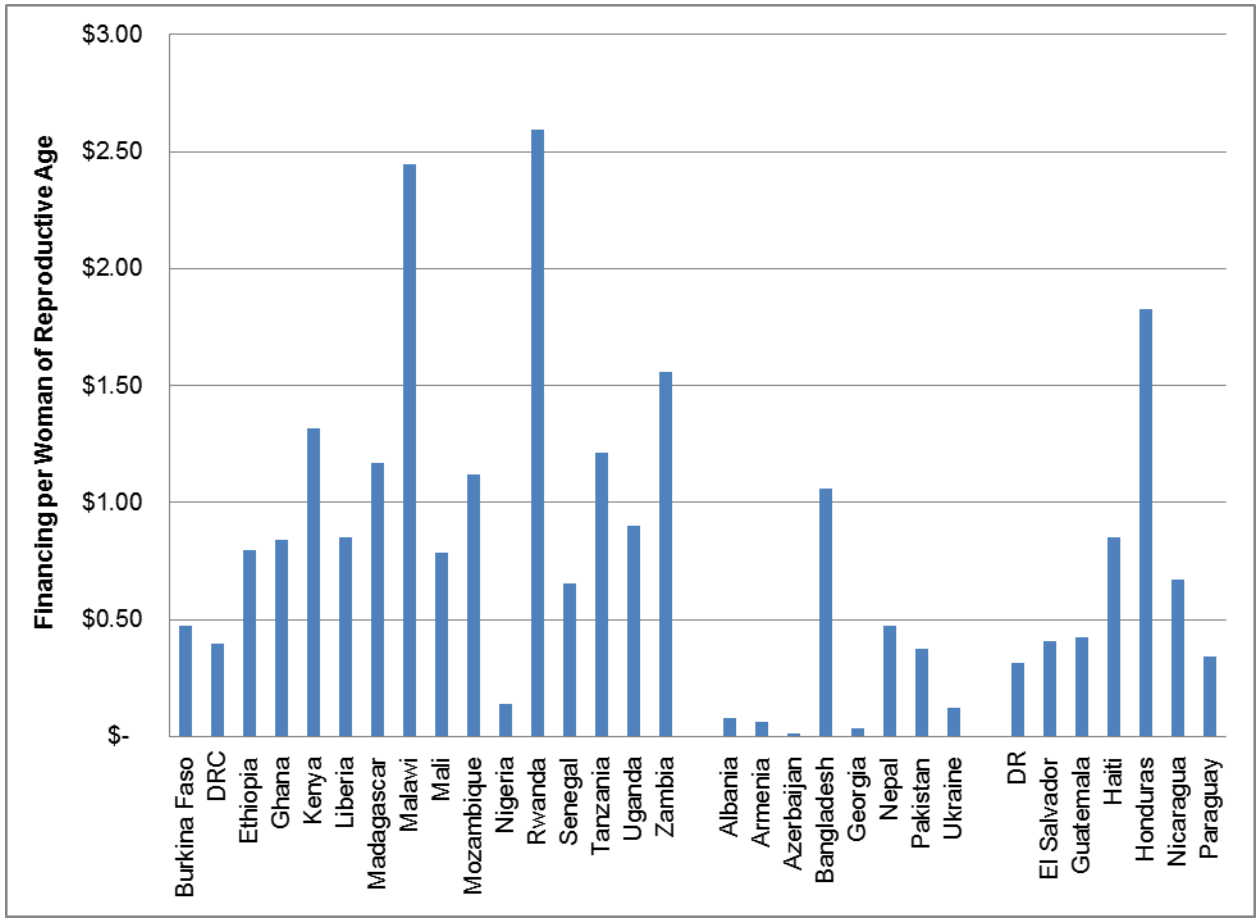
Tables 1 and 3 in the main body of the paper together show the amount of total financing for contraceptive procurement for the public sector—considering government funds, in-kind donations, and Global Fund grants. To compare the situation in various countries in a more meaningful way, it is helpful to consider the amount of financing in the country per woman of reproductive age (WRA).[56]

The total expenditures on contraceptive procurement for the public sector were calculated per woman of reproductive age for each country; this information is displayed in Figure 10.[57]

56. WRA are defined here as women ages 15-49. The number of women of reproductive age per country were obtained from the estimates for 2010 values from the United Nations' World Population Prospects: The 2010 Revision.

57. The figure shows the results of a calculation only—it does not indicate that the amount shown was actually spent on each woman. Some of the financing will be used to fill the supply chain and will not currently be provided to clients. Some of the financing will be used for condoms used only by men or for women ouside the reproductive age range.

Figure 10. Total Financing for Public-Sector Contraceptives per Woman of Reproductive Age



Notes:

a. Respondents were asked about finance information for the most recent complete fiscal year (typically, FY2010). See tables 1–5 for the time periods .

b. Population figures used for this calculation are the 2010 values from the United Nations' *World Population Prospects: The 2010 Revision*.

c. There was no financing spent on contraceptive procurement for the public sector in Yemen. Respondents in Afghanistan, Bolivia, Gambia, Philippines, Russia, South Sudan, and Zimbabwe did not have information on the total amount spent on contraceptive procurement for the public sector. However, based on the information some countries provided about in-kind donations and Global Fund grants, the amount of financing per woman of reproductive age would be at least $0.14 for Gambia, at least $2.31 for Zimbabwe, at least $0.22 for Bolivia, and more than $0.03 for the Philippines. India did not provide financial details.

d. Amounts are approximate and include government and donor financing.

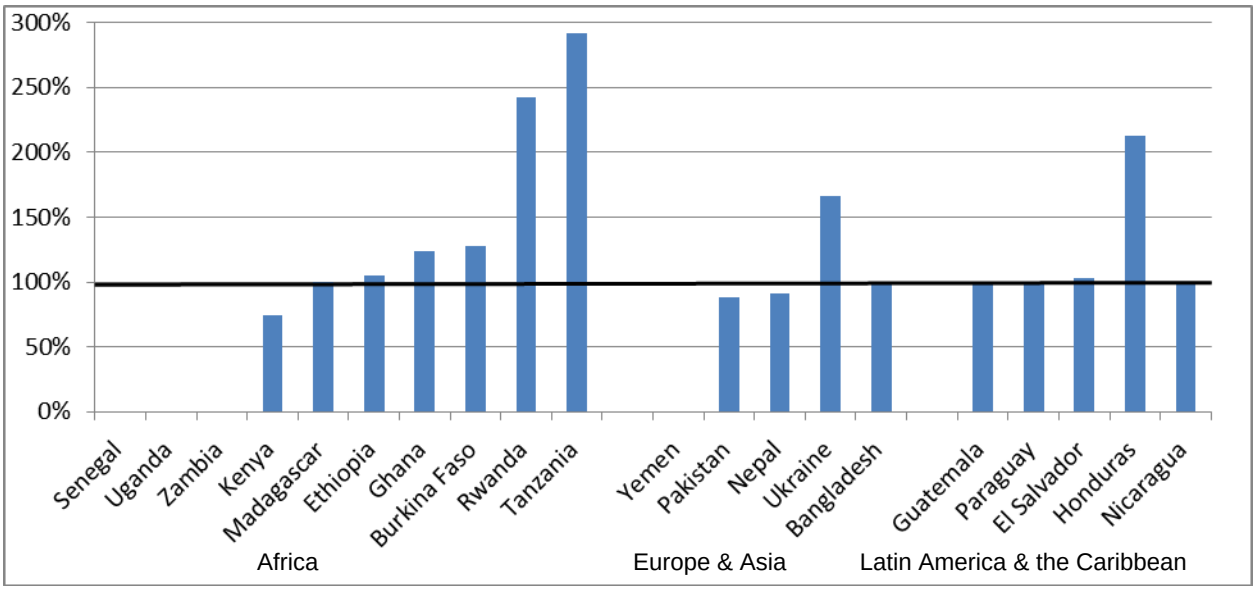
Financing for public-sector contraceptives averaged $0.76 per woman of reproductive age for the year. Financing ranged from $0 for the year, per woman of reproductive age, in Yemen; $0.01 in Azerbaijan; and $0.04 in Georgia; to $2.45 in Malawi; and $2.59 in Rwanda. Forty-seven percent of the respondent countries (15 out of 32) had financing amounts less than $0.50 per woman of reproductive age, 25 percent had financing amounts between $0.50 and $1, and 28 percent had financing amounts above $1. Average financing per woman of reproductive age was $1.08 in the respondent African countries, $0.25 in the respondent European and Asian countries, and $0.69 in the responding LAC countries. When considering this financing, it is helpful to keep in mind the cost to procure a year's supply of contraceptives, which varies by method—for example, it costs approximately $0.60 for a new IUD, $3.60 for male condoms, and $22 for a new implant. (These costs do not include the costs to fill the supply chain though.)

Depending on the method mix in the country, the funding needed per woman of reproductive age will vary. In addition, countries with high contraceptive prevalence rates and high public sector market shares would be expected to have more financing for public-sector contraceptives per woman of reproductive age than would other countries.

Government Allocations

Government allocations of money for contraceptive procurement refer to commitments—funds that were designated or planned to be spent on contraceptives, regardless of how they ended up being spent. A question about allocations was asked to help identify where funding bottlenecks exist in particular countries—whether in the lack of a budget line, the lack of allocations, the lack of expenditures, or a combination of these factors. In 70 percent of respondent countries (23 out of 33), there were allocations for contraceptive procurement. Paraguay even has a law that ensures the allocation of funds for contraceptive procurement. The following graph compares government spending to allocations.

Figure 11. Government Expenditures as a Percentage of Government Allocations



Notes:

a. The Dominican Republic had government spending despite no allocations. The other surveyed countries not included in this figure either had no government allocations and no government spending or did not know the information on allocations and/or spending.

b. In most countries, the figure compares allocations to all government funds spent. However, for Bangladesh and Nicaragua, it was clear that government allocations were only meant for internally generated funds, so the figure compares allocations to internally generated funds only in these two countries.[58]

c. Respondents were asked to provide information about the most recent complete year (typically FY2010). See table 1 notes for the time periods used. The time period may differ slightly by funding source.

For most countries, government expenditures were comparable to the allocations. Of concern however, is that in Senegal, Uganda, Yemen, and Zambia, there were government allocations but no government spending for contraceptives. (Yemen did not have a budget line for this, but the other countries did.) Senegal is a good example for further examination. For the last four 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, an inability to conduct procurement (e.g., because of no response to procurement solicitations or a slow procurement process), and the recent financial crisis. In Senegal's case, having a budget line and allocations have not been sufficient to ensure that government funds are actually spent on contraceptives. In Zambia, the ministry of health committed funds for procuring reproductive health commodities, but it was not specified whether any of the funds were meant for contraceptives.

In Tanzania and Rwanda, expenditures for contraceptives vastly exceeded allocations. Tanzania respondents noted though that none of the products bought from the allocation arrived during the fiscal year. In Rwanda, less than half of the government expenditures were received in the country during the fiscal year; the rest were expected in the following year.

58. If government allocations only included internally generated funds in some of the other countries, then the percentages should be lower than they are in figure 11.

The Dominican Republic had government spending despite a lack of allocations.

Median Expenditures

Looking exclusively at the 15 countries with full data for all three years and with government funds reported spent in at least one of the surveys, the median government expenditure for contraceptives was highest in the 2010 survey, which typically represented FY2008/2009 or calendar year 2009.[59] The median of total financing in these countries increased over time, as shown in table 4.

Table 4. Median of Expenditures in Select Countries

	2009 Survey	2010 Survey	2011 Survey
Median of government expenditures	$680,000	$784,000	$675,674
Median of total financing	$2,419,106	$2,686,343	$4,500,501

Note: The countries included in this analysis were those with data from all three surveys and with government expenditures reported in at least one of the surveys: Albania, Dominican Republic, El Salvador, Ethiopia, Ghana, Guatemala, Madagascar, Malawi, Nepal, Nicaragua, Paraguay, Rwanda, Tanzania, Uganda, and Zambia.

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, are included in these documents.

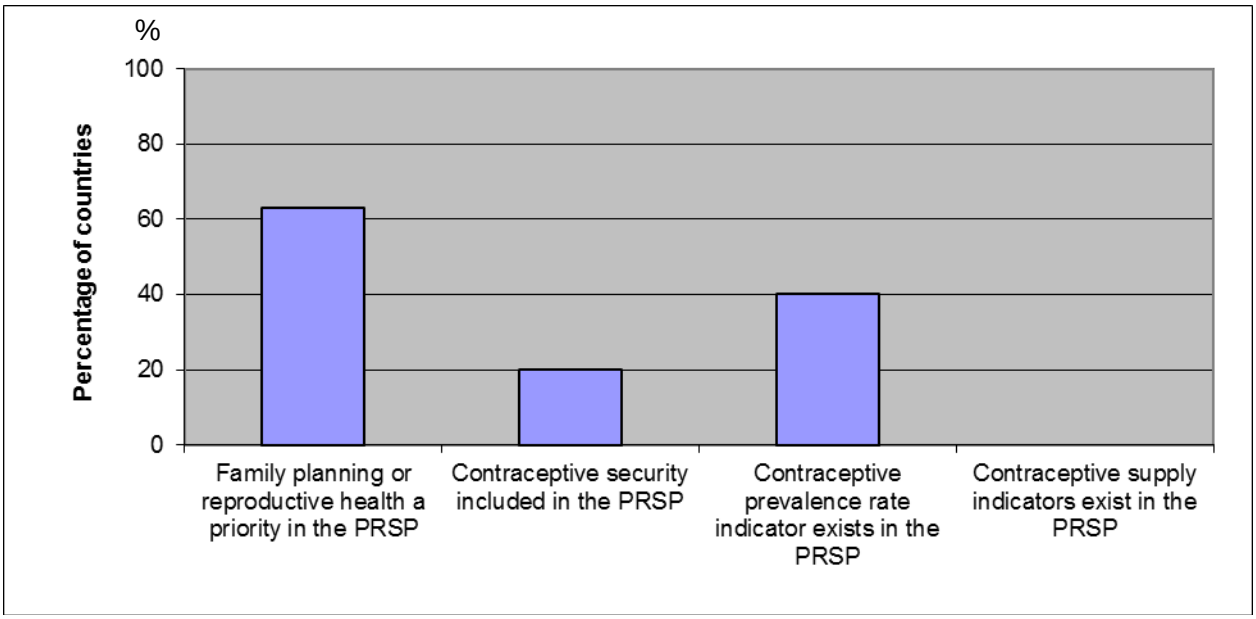
Of the 40 countries surveyed, the research team located PRSPs for 30.[60] Out of these 30 countries, 19 (or 63 percent) explicitly indicated family planning or reproductive health as a priority. Fewer countries (12 of 30, or 40 percent) included contraceptive prevalence rate as an indicator within the PRSP; none included a contraceptive supply indicator (such as contraceptive stockout rates) among the country's PRSP indicators. Only six out of 30 (20 percent) of the PRSPs included the concept of contraceptive security.[61] (See figure 12.)

59. El Salvador represented the median for all three years.

60. The PRSPs reviewed were published from 2001–2010. The research team reviewed the actual PRSPs, not the interim reports.

61. 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, such as the availability and funding of contraceptives.

Figure 12. Percentage of Respondent Countries with Family Planning or Contraceptive Security-Related Items Included in their Poverty Reduction Strategy Paper



Contraceptive Security Champions

Over 75 percent of surveyed countries (31 out of 40) reported having a contraceptive security champion—someone who consistently brings up CS issues and advocates for contraceptive supplies. Almost 75 percent of respondent countries with champions (or 22 out of 30)—reported that they have champions from the government (usually the ministry of health). (In Mozambique the First Lady was indicated as a CS champion.) The remaining countries noted champions from donor organizations and/or NGOs. CS champions help ensure that CS remains a priority on the political agenda and that important CS issues are addressed. CS champions in the government indicate government commitment and sustainability.

Appendix D

Finance Data from 2009, 2010, and 2011 *CS Indicators* Surveys

Table 5. Government and Total Expenditures on Contraceptive Procurement during Three Recent Years (in U.S.$)

Region/Country	2009 Survey Total Government Funds Spent in Recent Year	2010 Survey Total Government Funds Spent in Recent Year	2011 Survey Total Government Funds Spent in Recent Year	2009 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2010 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2011 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations & Global Fund Grants) in Recent Year
Africa						
Burkina Faso[a]	Unknown (country was not surveyed in 2009)	1,011,481	769,205	**Unknown (country was not surveyed in 2009)**	**2,804,527**	**1,835,458**
Ethiopia[b]	12,810,000	20,889,000	9,481,849	**21,810,000**	**30,389,000**	**15,903,505**
Ghana[c]	1,300,000	600,000	1,237,550	**6,940,000**	**2,686,343**	**5,015,440**
Kenya[b]	Unknown	8,626,249	5,108,086	**Unknown**	**11,654,612**	**12,927,660**
Liberia[d]	0	0	0	**1,427,844**	**930,434**	**798,187**

Region/Country	2009 Survey Total Government Funds Spent in Recent Year	2010 Survey Total Government Funds Spent in Recent Year	2011 Survey Total Government Funds Spent in Recent Year	2009 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2010 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2011 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations & Global Fund Grants) in Recent Year
Madagascar[a]	127,788	125,127	58,625	**3,292,250**	**3,052,539**	**5,698,342**
Malawi[e]	1,620,000	900,000	1,223,717	**7,017,180**	**4,506,025**	**8,103,454**
Mali[f]	0	0	0	**1,000,000**	**2,348,095**	**2,733,719**
Mozambique[g]	0	0	0	**3,410,437**	**2,604,765**	**6,209,890**
Nigeria[a]	0	0	0	**1,250,629**	**1,775,578**	**5,000,000**
Rwanda[a]	1,778,600	2,347,048	1,454,420	**4,656,791**	**5,826,426**	**6,801,930**
Senegal[h]	0	0	0	**Unknown**	**1,600,000**	**1,982,561**
Tanzania[b]	1,740,000	6,763,124	6,800,000	**2,740,000**	**8,797,214**	**12,367,136**
Uganda[i]	280,000	0	0	**1,937,172**	**4,700,000**	**6,588,411**
Zambia[a]	550,000	1,629,104	0	**3,681,530**	**6,997,208**	**4,500,501**
Zimbabwe[j]	0	0	Don't know	**8,808,638**	**5,623,632**	**Unknown**
Europe & Asia						
Albania[a]	63,900	21,931	67,000	**106,500**	**39,137**	**67,000**
Armenia[a]	0	0	0	**Unknown**	**12,628**	**52,793**

Region/Country	2009 Survey Total Government Funds Spent in Recent Year	2010 Survey Total Government Funds Spent in Recent Year	2011 Survey Total Government Funds Spent in Recent Year	2009 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2010 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2011 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations & Global Fund Grants) in Recent Year
Azerbaijan[a]	0	0	0	**Unknown**	**0**	**31,356**
Bangladesh[b]	34,540,000	Unknown[62]	36,428,570	**47,470,000**	**Unknown**	**43,571,427**
Georgia[k]	0	0	0	**Unknown**	**86,555**	**41,890**
Nepal[l]	2,204,806	2,114,300	2,590,642	**2,419,106**	**2,423,400**	**3,676,348**
Pakistan[m]	Don't know	9,257,171	4,750,000	**Unknown**	**12,931,974**	**16,750,000**
Ukraine[a]	425,000	Don't know (235,000 from internally generated funds but no data available on other government funds)	275,000	**585,000**	**Don't know**	**1,421,500**
Yemen[a]	3,223,613	Unknown[63]	0	**Unknown**	**Unknown**	**0**
Latin America & the Caribbean						
Dominican Republic[a]	700,000	486,204	652,174	**1,096,884**	**904,714**	**809,674**
El Salvador[a]	680,000	784,000	675,674	**909,866**	**934,000**	**699,974**

62. In Bangladesh's 2010 and 2011 surveys, the time period reported on was the same: July 2009–June 2010. There was no information about July 2008–June 2009 provided.

63. In Yemen's 2009 and 2010 surveys, the time period reported on was the same: January–December 2008. There was no information about 2009 provided.

Region/Country	2009 Survey Total Government Funds Spent in Recent Year	2010 Survey Total Government Funds Spent in Recent Year	2011 Survey Total Government Funds Spent in Recent Year	2009 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2010 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations) in Recent Year	2011 Survey GRAND TOTAL Financing (Government Funds and In-Kind Donations & Global Fund Grants) in Recent Year
Guatemala[a]	0	1,325,301	1,500,000	**545,473**	**1,325,301**	**1,500,000**
Haiti[n]	0	Unknown (survey not completed)	0	**3,100,000**	**Unknown (survey not completed)**	**2,198,963**
Honduras[o]	Unknown (country was not surveyed in 2009)	0	2,699,112	**Unknown (country was not surveyed in 2009)**	**900,000**	**3,589,115**
Nicaragua[a]	591,665	1,333,738	1,043,694	**1,601,986**	**1,911,571**	**1,043,694**
Paraguay[a]	539,537	566,000	566,000	**790,794**	**566,000**	**566,000**

Notes:

1. Government funds include internally generated funds, basket funds, and other funds given to the government for their use.
2. In the 2011 survey, a question about Global Fund grants was included for the first time in the *CS Indicators* survey. In countries using Global Fund grants, the grants were used for condoms, except in Rwanda, where they were for other contraceptives. The Global Fund condoms were, in many cases, procured for HIV prevention (instead of family planning).
3. In each survey, respondents were asked about the most recent complete fiscal year (FY2008, 2009, and 2010). The time periods reported on are indicated next to the country name: (a) January–December 2008, 2009, and 2010; (b) July–June 2007/2008, 2008/2009, and 2009/2010; (c) January–December 2007, 2009, and 2010; (d) January–December 2008, 2009, and July–June 2009/2010; (e) October–September 2007/2008 and 2008/2009; and July–June 2009/2010; (f) not specified, July–June 2009/2010 and January–December 2010; (g) January–December 2008, October–September 2008/2009, and January–December 2010; (h) not specified, January–December 2009, and October–September 2009/2010; (i) July–June 2007/2008, January–December 2009, and July–June 2009/2010; (j) January–December 2008, October–September 2008/2009, and January–December 2010; (k) January–December 2008, 2009, and 2010 for most sources but 2010/2011 for Global Fund; (l) January–December 2008, July–June 2008/2009 and 2009/2010; (m) July–June 2007/2008, 2008/2009, and 2009/2010 for most sources, but January–December 2010 for other government funds in the 2011 survey; (n) October–September 2007/2008, January–December 2009 and 2010; and (o) August–July 2008/2009 and 2009/2010, and January–December 2010. Since some time periods reported on overlap slightly in different surveys for Honduras, Liberia, Malawi, Mali, Mozambique, Nepal, Senegal, and Zimbabwe, respectively, select financing information may have been double-counted (if it was included in more than one survey).
4. Although government funds were spent in India, respondents did not provide the amounts in the 2010 and 2011 surveys. There were no in-kind donations from April 2008 to March 2011 in India.
5. There was no finance information provided for Afghanistan in any of the surveys. In Russia, there were no government funds spent in 2008, and information regarding in-kind donations was not known. In 2009 and 2010, the amount of government funds was not known, and there were no in-kind donations. There was no finance information provided for Bolivia, the Philippines, or the Democratic Republic of Congo until the 2011 survey. Gambia and South Sudan became part of the survey for the first time in 2011. Finance information from the 2011 survey can be found in tables 1–5.
6. Amounts are approximate.

Appendix E

Finance Data from 2011*CS Indicators* Survey

Table 6. Percentage Contribution by Financing Source and Total Expenditures[64] for Contraceptive Procurement during FY2010

Region/Country	Internally Generated Funds Spent, as Percentage of Total Financing	All Other Government Funds Spent, as Percentage of Total Financing	In-Kind Donations, as Percentage of Total Financing	Global Fund Grants, as Percentage of Total Financing	TOTAL Financing (Government Funds + In-Kind Donations + Global Fund Grants) (in U.S.$)
Africa					
Burkina Faso[a]	20%	22%	58%	0%	**1,835,458**
Democratic Republic of Congo[a]	0%	0%	100%	0%	**5,859,613**
Ethiopia[b]	3%	57%	40%	0%	**15,903,505**
Ghana[a]	25%		46%	29%	**5,015,440**
Kenya[b]	35%	5%	56%	5%	**12,927,660**
Liberia[b]	0%	0%	100%	0%	**798,187**
Madagascar[a]	1%	0%	99%	0%	**5,698,342**
Malawi[b]	15%		83%	2%	**8,103,454**

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

Region/Country	Internally Generated Funds Spent, as Percentage of Total Financing	All Other Government Funds Spent, as Percentage of Total Financing	In-Kind Donations, as Percentage of Total Financing	Global Fund Grants, as Percentage of Total Financing	TOTAL Financing (Government Funds + In-Kind Donations + Global Fund Grants) (in U.S.$)
Mali[a]	0%	0%	100%	0%	**2,733,719**
Mozambique[a]	0%	0%	100%	0%	**6,209,890**
Nigeria[a]	0%	0%	100%	0%	**5,000,000**
Rwanda[a]	21%		67%	11%	**6,801,930**
Senegal[c]	0%	0%	100%	0%	**1,982,561**
Tanzania[b]	15%	40%	35%	10%	**12,367,136**
Uganda[b]	0%	0%	100%	0%	**6,588,411**
Zambia[a]	0%	0%	100%	0%	**4,500,501**
Europe & Asia					
Albania[a]	100%	0%	0%	0%	**67,000**
Armenia[a]	0%	0%	25%	75%	**52,793**
Azerbaijan[a]	0%	0%	0%	100%	**31,356**
Bangladesh[b]	2%	82%	16%	0%	**43,571,427**
Georgia[d]	0%	0%	44%	56%	**41,890**
India[e]	100%	0%	0%	0%	**Don't know**
Nepal[b]	61%	9%	30%	Unknown but very small percentage	**3,676,348**
Pakistan[f]	10%	19%	72%	0%	**16,750,000**
Ukraine[a]	19%	0%	27%	54%	**1,421,500**
Latin America & the Caribbean					
Dominican Republic[a]	81%	0%	19%	0%	**809,674**
El Salvador[a]	97%	0%	0%	3%	**699,974**

Region/Country	Internally Generated Funds Spent, as Percentage of Total Financing	All Other Government Funds Spent, as Percentage of Total Financing	In-Kind Donations, as Percentage of Total Financing	Global Fund Grants, as Percentage of Total Financing	TOTAL Financing (Government Funds + In-Kind Donations + Global Fund Grants) (in U.S.$)
Guatemala[a]	100%	0%	0%	0%	**1,500,000**
Haiti[a]	0%	0%	100%	0%	**2,198,963**
Honduras[a]	75%	0%	25%	0%	**3,589,115**
Nicaragua[a]	31%	69%	0%	0%	**1,043,694**
Paraguay[a]	100%	0%	0%	0%	**566,000**

Notes:

1. Respondents were asked about the most recent complete fiscal year (FY2010). The time periods reported on are indicated next to the country name: (a) January–December 2010; (b) July–June 2009/2010; (c) October–September 2009/2010; (d) January–December 2010 for most sources, but 2010/2011 for Global Fund grants; (e) April–March 2010/2011; and (f) July–June 2009/2010 for most sources, but January–December 2010 for "other government funds."
2. The amounts attributed to *all other government funds* include basket funds and funds donors gave to the government for their use.
3. The government expenditures for Ghana, Rwanda, and possibly Malawi could not be disaggregated and are a combination of internally generated and basket funds. (Malawi was not able to determine whether any of the funds were internally generated.)
4. In countries using Global Fund grants, the grants were used for condoms except for in Rwanda, where they were for other contraceptives. The Global Fund condoms were in many cases procured for HIV prevention (as opposed to FP) purposes.
5. The in-kind donation information for Senegal includes contraceptives for the ministry of health divisions for social marketing and AIDS.
6. In some surveyed countries, not enough information was available to include the country in this table: Respondents in *Afghanistan* indicated that in-kind donations were provided in calendar year (CY) 2010, but they did not know the value of the donations. They did not have information on whether government funds were spent. Respondents in *Bolivia* did not have information on whether government funds were spent in CY2010. Respondents in the *Gambia* did not have information on whether government funds were spent on contraceptive procurement in CY2009. Although government funds were spent on contraceptive procurement, data on amounts was not available for the *Philippines* for January–December 2010. In *Russia*, the amount of government funds was not known, and there were no in-kind donations from January–December 2010. Respondents in *South Sudan* did not have information on whether in-kind donations were provided or Global Fund grants used in CY2010. No government funds were used. In *Yemen*, no contraceptives were bought for the public sector in CY2010. (No government funds were spent, and there were no new in-kind donations or Global Fund grants used.) Respondents in *Zimbabwe* did not have information on whether government funds were spent in CY2010. In addition, the in-kind donation information provided for Zimbabwe included only products distributed through the delivery team topping up (DTTU) system (male and female condoms; the injectable, Petogen; the combined oral contraceptive, Control; and the progestin-only pill, Secure). It only included products distributed to clients, not products in storage facilities.
7. Amounts are approximate.

Appendix F

Methods Offered, By Country and Sector

Table 7. Methods Offered in Public-Sector Facilities

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Africa												
Burkina Faso	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Democratic Republic of Congo	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Ethiopia	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Gambia	✓	✓	✓		✓	✓	✓		✓	✓		
Ghana	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Kenya	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Liberia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Madagascar	✓	✓	✓	✓	✓	✓			*DK*	*DK*	✓	
Malawi	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Mali	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Mozambique	✓	✓	✓		✓	✓	✓		✓	✓		
Nigeria	✓	✓	✓	✓	✓	✓	✓		✓	✓		
Rwanda	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Senegal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
South Sudan	*DK*	*DK*	*DK*	*DK*	*DK*	✓	*DK*	*DK*			*DK*	
Tanzania	✓	✓	✓	✓	✓	✓	✓		✓	✓		
Uganda	✓	✓	✓	✓	✓	✓		✓	✓	✓		

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Zambia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Zimbabwe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Europe & Asia												
Afghanistan	✓	✓	✓		✓	✓		*DK*		✓		
Albania	✓	✓	✓		✓	✓		*DK*	✓	✓		
Armenia	✓	✓	✓		✓	✓		✓	*DK*	*DK*		
Azerbaijan										✓		
Bangladesh	✓		✓	✓	✓	✓			✓	✓		
Georgia	✓	✓			✓	✓		✓		✓		
India	✓				✓	✓		✓	✓	✓		
Nepal	✓		✓	✓	✓	✓			✓	✓		
Pakistan	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Philippines	✓	✓	✓		✓	✓			✓	✓	✓	
Russia	✓	✓	✓	✓	✓	✓		✓		✓		Patch Evra, and vaginal ring Novaring
Ukraine	✓	✓	✓		✓	✓		✓	✓	✓		Vaginal ring, spermi-cides, patch
Yemen	✓	✓	✓	✓	✓	✓			✓	✓		
Latin America & the Caribbean												
Bolivia	✓	*DK*	✓		✓	✓	✓		✓	✓	✓	
Dominican Republic	✓	✓	✓	✓	✓	✓		✓	✓	✓		
El Salvador	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	
Guatemala	✓		✓	✓	✓	✓			✓	✓	✓	

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Haiti	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Honduras	✓		✓		✓	✓			✓	✓		
Nicaragua	✓		✓		✓	✓			✓	✓	✓	
Paraguay	✓		✓		✓	✓		✓		✓		

Notes: ✓ = yes, blank = no, DK = don't know

Table 8. Methods Offered in NGO Facilities

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Africa												
Burkina Faso	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Democratic Republic of Congo	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Ethiopia	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Gambia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Ghana	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Kenya	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		Foaming tablets
Liberia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Madagascar	✓		✓	✓	✓	✓	✓	*DK*	✓	✓	*DK*	
Malawi	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Mali	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Mozambique	✓	✓				✓	✓					
Nigeria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Rwanda	✓	✓	✓		✓	✓		✓				
Senegal	✓	✓	✓	✓	✓	✓	✓	✓			✓	
South Sudan	✓	✓	✓			✓	✓				✓	
Tanzania	✓	✓	✓	✓	✓	✓	✓		✓	✓		

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Uganda	✓	*DK*	✓	✓	✓	✓	✓		✓	✓		
Zambia	✓	✓	✓	✓	✓	✓	✓	*DK*	*DK*	*DK*		
Zimbabwe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Europe & Asia												
Afghanistan	✓	✓	✓		✓	✓				✓		
Albania						✓		*DK*				
Armenia												
Azerbaijan												
Bangladesh	✓	✓	✓	✓	✓	✓			✓	✓		
Georgia	✓	✓			✓	✓						
India	✓		✓		✓	✓		✓	✓	✓	✓	
Nepal	✓		✓	✓	✓	✓		✓	✓	✓		
Pakistan	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	
Philippines	✓	✓	✓		✓	✓			✓	✓	✓	
Russia	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Ukraine												
Yemen	✓	✓	✓	✓	✓	✓						
Latin America & the Caribbean												
Bolivia	✓	*DK*	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Dominican Republic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Vaginal spermi-cides
El Salvador	✓	*DK*	✓	✓	✓	✓	*DK*	✓	✓	✓	✓	
Guatemala	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Haiti	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Honduras	✓		✓		✓	✓			✓	✓		
Nicaragua	✓		✓	✓	✓	✓		✓	✓	✓		
Paraguay	✓	✓	✓		✓	✓			✓	✓		

Notes: ✓ = yes, blank = no, DK = don't know, N/A = not applicable

Table 9. Methods Offered through Social Marketing

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Africa												
Burkina Faso	✓					✓	✓					
Democratic Republic of Congo	✓	✓	✓	✓	✓	✓	✓				✓	
Ethiopia	✓	✓	✓	✓	✓	✓	✓	✓				
Gambia	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	
Ghana	✓	✓	✓			✓	✓	✓				
Kenya	✓		✓	✓	✓	✓	✓	✓	✓	✓		
Liberia	*DK*	*DK*	*DK*	*DK*	*DK*	✓	*DK*	*DK*	*DK*	*DK*	*DK*	
Madagascar	✓	✓	✓	✓	✓	✓	✓		*DK*	*DK*	✓	
Malawi	✓	✓	✓	✓	*DK*	✓	✓	✓	✓	✓	✓	
Mali	✓	*DK*	✓	✓	✓	✓	✓				✓	
Mozambique	✓	✓				✓	✓					
Nigeria	✓	✓	✓	✓	✓	✓	✓	✓			✓	Neo Sampoon vaginal contra-ceptive tablets
Rwanda	✓		✓			✓					✓	
Senegal	✓	✓	✓	✓	✓	✓	✓	✓				
South Sudan						✓						
Tanzania	✓	*DK*	✓	✓		✓	✓					
Uganda	✓	✓	✓			✓					✓	
Zambia	✓	✓	✓	✓	✓	✓	✓					
Zimbabwe			✓			✓	✓	✓	*DK*	*DK*		
Europe & Asia												
Afghanistan	✓		✓			✓						
Albania		✓				✓		*DK*				

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Armenia	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	
Azerbaijan						✓						
Bangladesh	✓	✓	✓		✓	✓						
Georgia	✓	✓			✓	✓						
India	✓	✓	✓		✓	✓	✓	✓			✓	
Nepal	✓		✓	✓	✓	✓		✓	✓	✓		
Pakistan	✓		✓		✓	✓		✓		✓	✓	
Philippines	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	
Russia	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Ukraine												
Yemen	✓	✓	✓	✓	✓	✓						
Latin America & the Caribbean												
Bolivia	✓		✓		✓	✓	✓				✓	
Dominican Republic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Vaginal spermi-cides
El Salvador	✓	*DK*	✓	✓	✓	✓	*DK*					
Guatemala	✓		✓	✓	✓	✓			✓	✓	✓	
Haiti	✓		✓			✓	✓					
Honduras	✓		✓			✓						
Nicaragua	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Paraguay	✓					✓		✓				

Notes: ✓ = yes, blank = no, DK = don't know, N/A = not applicable

Table 10. Methods Offered in Commercial-Sector Facilities

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Africa												
Burkina Faso	✓	✓	✓			✓	✓	✓				
Democratic Republic of Congo	✓	✓	✓			✓		✓				
Ethiopia	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Gambia	✓	✓	✓		✓	✓						
Ghana	✓	✓	✓	✓	✓	✓	✓	✓		✓		
Kenya	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		Foaming tablets
Liberia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Madagascar	✓		✓	✓	✓	✓	✓	✓	*DK*	*DK*		
Malawi	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Mali	✓	✓	✓	✓		✓		✓				
Mozambique	✓	✓	✓			✓	✓					
Nigeria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Neo Sampoon vaginal contra-ceptive tablets
Rwanda	✓	✓	✓	✓	✓	✓		✓		✓		
Senegal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
South Sudan	*DK*	*DK*	*DK*	*DK*	*DK*	✓	*DK*	*DK*			*DK*	
Tanzania	✓	✓	✓	✓	✓	✓	*DK*	✓	✓	✓		
Uganda	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	*DK*	
Zambia	✓	✓	✓	✓	✓	✓	✓	✓	*DK*	*DK*	*DK*	
Zimbabwe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Europe & Asia												
Afghanistan	✓	✓	✓		✓	✓				✓		
Albania	✓	✓	✓		✓	✓		*DK*				

Region/ Country	Combined Orals	Progestin-only Pills	Injections	Implants	IUDs	Male Condoms	Female Condoms	Emergency Contraceptive Pills	Vasectomies	Tubal Ligations	Cycle-Beads	Other
Armenia	✓	✓	✓		✓	✓		✓	*DK*	*DK*		Spermi-cides
Azerbaijan	✓				✓	✓		✓		✓		Spermi-cides
Bangladesh	✓	✓	✓			✓		✓	✓	✓		
Georgia	✓	✓			✓	✓	✓	✓		✓	✓	
India	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Nepal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Pakistan	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Philippines	✓	✓	✓		✓	✓			✓	✓	✓	Patch, spermi-cide
Russia	✓	✓	✓	✓	✓	✓		✓		✓		Patch Evra and vaginal ring Novaring
Ukraine	✓	✓	✓		✓	✓		✓	✓	✓		Vaginal ring, spermi-cides, patch
Yemen	✓	✓	✓	✓	✓	✓			✓	✓		
Latin America & the Caribbean												
Bolivia	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Dominican Republic	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	Spermi-cides
El Salvador	✓	*DK*	✓	✓	✓	✓	✓	✓	✓	✓		
Guatemala	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Haiti	✓	✓	✓	✓	✓	✓	✓		✓	✓		
Honduras	✓		✓		✓	✓			✓	✓		
Nicaragua	✓	✓	✓	✓	✓	✓	*DK*	✓	✓	✓		
Paraguay	✓	✓	✓		✓	✓		✓	✓	✓		Patch

Notes: ✓ = yes, blank = no, DK = don't know

Appendix G

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			
i. Other *(for example: partners)*		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)				
B1. What is the timeline of the country's fiscal year?	Beginning month		Ending month	
B2. What was the estimated dollar value of contraceptives needed to be procured for the public sector for the most recent complete fiscal year? (*in USD currency*) (*for example, to cover the needs for the '09-'10 fiscal year*)				
B3. When was the last forecast/quantification conducted? (*mm/yy*)		Who conducted it? (*Specify organization.)*		
B4. Is there a government budget line item for the procurement of contraceptives?				
B5. Were government funds ***allocated*** for contraceptive procurement for the public sector in the most recent complete fiscal year? (This question refers to funds planned to be spent on contraceptives, whether or not they ended up being spent.) (Government funds include internally generated funds, basket funds, World Bank credits or loans, and other funds donors gave to the government for their use.)				
B6. Please complete the table below regarding **government allocations** for contraceptive procurement.				
	Amount allocated *(in USD)*	Time period during which allocations were supposed to be spent (mm/yy-mm/yy) *(should ideally be the most recent complete fiscal year ['09-'10])*	Data source *(for example: Ministry records)*	Comments
Government funds **allocated** for contraceptive procurement (*funds originally designated for contraceptives, whether or not they ended up being spent on them*)				
B7. 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 funds donors gave to the government for their use.)				
B8. Please complete the following table 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?)				

Source of ***government*** funds ***spent*** on contraceptive procurement for the public sector	Was this source used? (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 ['09-'10])*	Data source *(for example: Contraceptive Procurement Table, PipeLine, etc.)*	Comments
a. Internally generated funds **spent** on contraceptive procurement					
i. Specify source(s) of internally generated funds spent (*for example, from taxes or user fees*)					
b. Total of all other government funds **spent** on contraceptive procurement (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.*)					

B9. Please complete the table below to indicate **donor** expenditures on contraceptive procurement in the most recent complete fiscal year.

Source of ***donations and donor funds*** spent on contraceptive procurement for the public sector	Was this a source? (Y/N)	Amount of money spent on these procurements *(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 ['09-'10])*	Data source *(for example: Contraceptive Procurement Table, PipeLine, RHInterchange, etc.)*	Comments
a. In-kind donations of contraceptives					
i. Specify source(s) of in-kind donations					
b. Global Fund donations used to procure condoms					
c. Global Fund donations used to procure contraceptives besides condoms					
d. TOTAL value of in-kind donations and Global Fund donations spent on contraceptive procurement **This will auto-calculate**. (*It will sum a-c above.*)					

The answers to B10 and B11 should calculate automatically based on the information you provided. Please review the answers to ensure they make sense to you, and if you have additional information to add, please note it in the comments boxes. If the answers do not calculate automatically, please provide any relevant information you may have in the comments boxes.		
B10. **Government share of funds spent on contraceptive procurement for the public sector -** Of the total amount spent on contraceptives for the public sector in the most recent complete fiscal year (*including government and donor funds), what percent was covered by government funds (including internally generated funds, basket funds, World Bank credits or loans, and other funds given to the government*)? **This will auto-calculate.** (*It contains the following formula: Total government spending (Question B8c) / Grand total of all spending for public sector contraceptives from the government and donors (Questions B8c+B9d)*)		Comments:
B11. **Total expenditures on public sector contraceptives as percent of amount that needed to be procured -** Of the estimated value of the contraceptives needed to be procured for the public sector for the most recent complete fiscal year, what percent was provided by any source (whether government or donor)? **This will auto-calculate**. (*It contains the following formula: Grand total of all spending for public sector contraceptives from the government and donors (Questions B8c+B9d) / Value of estimated need for procurement (Question B2)*)		Comments:
B12. *If B11 did not calculate automatically, please answer the following question:* Was there a funding gap for the public sector in the last complete fiscal year (e.g., '09-'10 fiscal year)?		Comments:
B13. If the government financed any contraceptive procurement in the most recent complete fiscal year, which entity conducted the procurement(s)? *(Please select from the dropdown.)*		
a. Specify entity		
i. Is this a parastatal?		
B14. Please note any additional comments about finance and procurement.		

C. Commodities				
C1. Are the following contraceptive methods through the commercial sector, public sector, NGOs, or social marketing? *(Please indicate which methods are intended to be offered. This question is not asking whether the method is in stock.)*				
Contraceptive Method	Commercial Sector	Public Sector	NGO	Social Marketing
a. combined oral contraceptives *(estrogen + progestin - for example, Lo-Femenol, Microgynon)*				
b. progestin-only oral pills *(for example, Ovrette, Microlut)*				
c. hormonal injections *(for example, Depo-Provera, 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 pills *(for example, Postinor)*				
i. long-acting permanent method for males *(vasectomy)*				
j. long-acting permanent method for females *(tubal ligation)*				
k. CycleBeads				
l. other contraceptive methods - specify *(Please provide the name of the other contraceptive(s) offered, by sector.)*				
C2. Please note any comments about the commodities offered.				

D. Policy (Commitment)			
D1. Is there a contraceptive security or reproductive health commodity security strategy or is contraceptive security explicitly included in a country strategy?			
IF NO, SKIP TO QUESTION D2.			
Strategy name	Years Covered (*including strategy updates*)	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 sectors (public, NGO, social marketing, commercial)?			
b. If yes, how much are the duties, taxes, or fees?			
D3. Are there policies that hinder the ability of the private sector (commercial sector, NGOs, or social marketing) to provide contraceptive methods (for example: price controls, distribution limitations, taxes/duties, advertising bans, etc.)?			

a. If yes, describe the policies.	
D4. Are there policies that enable the private sector (commercial sector, NGOs, or social marketing) to provide contraceptive methods?	
a. If yes, describe the policies.	

D5. 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		

D6. 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			

D7. 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.	
D8. Are the following contraceptives included in the country's National Essential Medicine List (NEML) or other equivalent priority list?	
a. combined oral contraceptives	
b. progestin-only pills	
c. hormonal injections	
d. hormonal implants	
e. intrauterine devices (IUDs)	
f. male condoms	
g. female condoms	
h. emergency contraceptive pills	
i. CycleBeads	
j. any other contraceptive(s)?	
i. Name of other contraceptive(s) on the list(s)	
D9. What year(s) is the list(s) from?	
D10. Name of the list(s)	
D11. Notes about the list(s)	

D12. 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	

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 offered in public sector facilities? (*If a method is not intended to be offered in public sector facilities, please indicate that stockouts are not applicable (choose "N/A" from the dropdown list).)*	
a. combined oral contraceptives	
b. progestin-only pills	
c. hormonal injections	
d. hormonal implants	
e. intrauterine devices (IUDs)	
f. male condoms	
g. female condoms	
h. emergency contraceptive pills	
i. CycleBeads	
j. Time period of review *(mm/yy - mm/yy) (for example, 1/10-12/10)*	
k. Data source *(for example: Procurement Planning and Monitoring Report, logistics management information system, periodic physical inventory, warehouse reports)*	
E3. Are stockouts a large problem in your country at the following levels? (i.e., Are they common or do they tend to last for a long time?)	
a. service delivery point level (*i.e., public sector health facilities*)	
b. central level (*i.e., central level warehouse for the public sector*)	
F. Please note any overall comments about challenges and/or successes with contraceptive security in your country.	

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