USAID | DELIVER PROJECT

Measuring Contraceptive Security Indicators in 36 Countries

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Abstract
In 2009, the USAID | DELIVER PROJECT developed a set of standard contraceptive security indicators and surveyed 36 countries on these indicators. This paper presents summary findings and advocates for the continued use of contraceptive security indicators to help in-country stakeholders monitor and foster progress toward contraceptive security.

Cover photo: A woman in Bangladesh obtains counseling on family planning methods.

USAID | DELIVER PROJECT
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: askdeliver@jsi.com
Internet: deliver.jsi.com

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Acronyms

CAR	countries at risk
CPR	contraceptive prevalence rate
CPT	Contraceptive Procurement Table
CS	contraceptive security
IMF	International Monetary Fund
IUD	intrauterine device
LMIS	logistics management information system
MOH	Ministry of Health
NEML	National Essential Medicines List
NGO	nongovernmental organization
NHA	National Health Account
PPMR	Procurement Planning and Monitoring Report
PRSP	Poverty Reduction Strategy Paper
RHA	Reproductive Health Account
RHSC	Reproductive Health Supplies Coalition
SDP	service delivery point
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
UN	United Nations
USAID	U.S. Agency for International Development

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Executive Summary

Contraceptive security (CS) exists when every person is able to choose, obtain, and use quality contraceptives and condoms for family planning and for the prevention of HIV and AIDS and other sexually transmitted infections. After many years of working to improve CS, country stakeholders and other CS advocates have increasingly emphasized the importance of monitoring progress at the country level. In response and in recognition that "what gets measured gets done," this paper proposes a set of standard CS indicators; the paper also presents data on these indicators for 36 countries.

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

The data collected for this analysis indicate that countries have worked diligently to improve CS: 78 percent of the surveyed countries have coordination committees that work on contraceptive security, 63 percent contribute government funds for contraceptives, 72 percent have strategies for working on contraceptive security, and 79 percent include stock on hand (an essential logistics data item) in their logistics information system reports. On average, five of eight modern contraceptive methods are included in the National Essential Medicines Lists (NEML) for the surveyed countries; seven of the eight are offered in public sector, social marketing, or nongovernmental organization (NGO) facilities.

In many of the surveyed countries, however, there is still room for additional gains, including in the amount of government funds contributed for contraceptives, the range of contraceptives offered and included within essential medicine lists, the degree of implementation of CS strategies, and the availability of contraceptive supplies at warehouses and service delivery points (SDPs).

The survey responses also indicate that data to measure CS improvements are not always readily available to in-country respondents. Ideally, over the long term country CS committees and other stakeholders will become better versed in the utility of these types of data and will begin to institutionalize similar monitoring tools within their broader CS strategic planning and implementation processes.

1 This framework includes components considered vital to achieve reproductive health commodity security. Often referred to as the seven C's, the components include context, commitment, capital, coordination, capacity, client demand and utilization, and commodities.

Contraceptive Security Indicators

The CS indicators were developed to reflect key aspects of CS to help in-country stakeholders monitor and evaluate their country's CS status. (See annex 1 for a complete list of indicators assessed.) Indicators include the following topics:

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

- **Finance for Procurement (Capital)**
  - amount of funding for contraceptive procurement
  - funding sources
  - existence of a government budget line item for contraceptives
  - information about the procurement mechanism.
- **Commodities**
  - range of contraceptive methods offered in public facilities
  - range of contraceptive methods offered in social marketing or NGO facilities.
- **Policies (Commitment)**
  - existence of a national contraceptive security strategy
  - existence of policies affecting access to family planning
  - inclusion of contraceptives on the NEML
  - inclusion of contraceptive security concepts in the Poverty Reduction Strategy Paper (PRSP).
- **Coordination and Leadership**
  - existence of a national committee that works on contraceptive security and types of organizations represented
  - frequency of committee meetings
  - legal status of the committee
  - existence of a contraceptive security *champion*.
- **Supply Chain (Capacity)**
  - existence of essential logistics data items on information system reports

- whether forecasts are updated annually and incorporated into budget planning
- whether correct amounts are obtained at the appropriate time
- whether physical inventories are conducted annually at storage facilities
- existence of product quality complaint procedures
- occurrence of visual quality insurance inspections at storage facilities
- stockout data.

The indicators were designed to ensure that the data could be routinely updated with accessible and relatively objective information from either key informants or a document review. See annex 2 for an in-depth description of limitations and considerations related to the study and particular indicator topic areas. See annex 3 for the data collection methodology (including the basis for country selection).[2]

This CS indicators activity complements the *Contraceptive Security Index* (*CS Index*), which was published in 2003, 2006, and 2009. The *CS Index* is a composite index comprising a wide range of contraceptive security indicators; the data are obtained primarily through secondary data analysis. While the *CS Index* is a valuable resource for analyzing CS, it is published only every three years; its data draws from multiple sources—many are not updated annually. The CS indicators developed and analyzed in this report offer a more timely understanding of the CS situation in a country and can be updated more routinely by the countries themselves. In addition, the CS indicators tend to focus more on specific CS interventions and processes; it is important to track them more routinely (e.g., existence of government financing for contraceptives, presence of a coordinating mechanism, etc.).

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

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

3 UNFPA has recently developed an interactive monitoring tool for reproductive health commodity security (RHCS), which is populated by data from the UNFPA country offices.

Summary Findings

The following sections provide a summary analysis of the CS indicator data collected. Major observations are illustrated in aggregated form, by topic area (finance for procurement [capital], commodities, policies [commitment], coordination and leadership, and supply chain [capacity]). For the raw data collected by country, please refer to the complete dataset on the USAID | DELIVER PROJECT website.

How can I use the CS indicators data spreadsheet?

Because the results presented here are only a summary, you may want to use the data spreadsheet to—

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

To access each country's CS indicator answers visit
http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CS_Indicators_Data_2009.xls

for the *Contraceptive Security Indicators Data 2009* spreadsheet.

Finance for Procurement (Capital)

Finance-related indicators help stakeholders understand the amount spent by the government and other funding sources on contraceptive procurement for the public sector[4]. Government financing indicates a strong government commitment to contraceptive security; it also suggests sustainability.

Key Findings: Finance for Procurement

- The majority of surveyed countries (22 out of 35) used government funding* for contraceptive procurement.
  - In these countries, government funds constitute between 4 and 100 percent of all financing spent on public sector contraceptive procurement.
  - Internally generated funds were used by most (14 out of 18) of the countries that provided a breakdown of government funding sources.
- More than half of the countries (20 out of 35) had a government budget line for contraceptive procurement.
  - However, while a budget line item may help ensure that funding is allocated for contraceptives, findings indicate that a designated budget line does not guarantee funding. Some countries had a line item, yet did not fund contraceptive procurements, while others funded contraceptive procurement without having a line item.

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

4 In this paper public sector contraceptives, contraceptive financing, and contraceptive procurement refer to contraceptives for public sector facilities, regardless of whether government resources were used to finance these contraceptives. However, in some countries, funding amounts may also include procurement for NGOs or social marketing organizations that obtain their supplies from the public sector.

Financing Sources for Public Sector Contraceptives

For this analysis, government funds include a combination of internally generated funds, World Bank credits or loans, basket funds, and other funds that donors provide to the government. Although it can be argued that World Bank credits and loans, basket funds, and other funds provided to the government are not true national resources, governments consider these funds part of their national budgets, count them as part of government funding, and usually decide how and where to spend them. Therefore, in this analysis they are considered part of government funding. Other (nongovernment) financing of contraceptive procurement are in-kind donations provided by the donors.

Surveyed countries were asked whether government funds (including internally generated funds, World Bank credits or loans, basket funds, and other funds donated to the government) were spent on contraceptive procurement for the public sector in the most recent complete fiscal year. *Almost two-thirds of the responding countries (22 out of 35) indicated that government funds were spent on contraceptive procurement during the year.* (See figure 1.)

Financing Sources

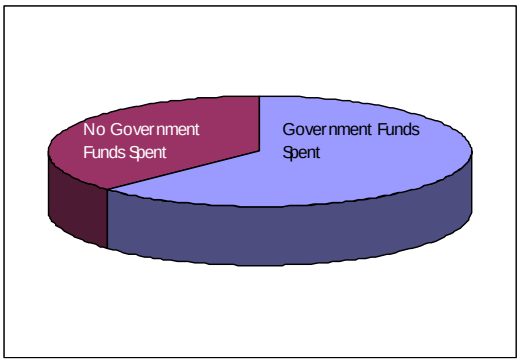
Government financing:

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

Other (nongovernment) financing:

- In-kind donations. When donors provide contraceptive supplies (instead of funds) to the government (as USAID does, for example), this is considered nongovernment financing of contraceptive procurement because the donor was likely the entity that decided to spend the money on contraceptive procurement.

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



Notes: (1) Government funds include internally generated funds, World Bank credits or loans, basket funds, and other funds given to the government. (2) Respondents were asked to provide information about the most recent complete year. See the notes for table 1 for the time periods used.

Respondents were also asked to disaggregate the government funding and distinguish whether these funds were sourced from internally generated funds, basket funds, World Bank funds, or other funding. Table 1 highlights the amount of government funds used to procure public sector contraceptives, by country, disaggregated by the specific type of funding. Of the 22 countries that used government funds, 18 identified the specific sources of government funding. *Of the countries that provided specific details about the source of government funds, 78 percent (14 out of 18) used internally generated funds;* this indicates the government's commitment to family planning in these countries.

Table 1. Government Expenditures on Contraceptive Procurement during the Most Recent Complete Year

Region/Country	Internally Generated Funds Spent ($)	World Bank Assistance Spent ($)	Basket Funds Spent ($)	Other Government Funds Spent ($)	Total Government Funds Spent ($)
Ethiopia[i]	910,000	0	11,900,000	0	**12,810,000**
Ghana[ii]	0	1,000,000	300,000	0	**1,300,000**
Madagascar[iii]	127,788	0	0	0	**127,788**
Malawi[i]	0	0	1,620,000	0	**1,620,000**
Rwanda[iii]	500,000	0	1,278,600	0	**1,778,600**
Tanzania[i]	870,000	0	870,000	0	**1,740,000**
Uganda[i]	280,000	0	0	0	**280,000**
Zambia[iii]	275,000	0	0	275,000	**550,000**
Albania[iii]	63,900	0	0	0	**63,900**
Bangladesh[i]	0	34,540,000	0	0	**34,540,000**
India[i]	99,250,000	0	0	0	**99,250,000**
Nepal[iii]	1,688,000	422,000[iv]	0	94,806	**2,110,000**
Ukraine[iii]	225,000	200,000	0	0	**425,000**
Yemen[iii]	0	2,500,000	723,613	0	**3,223,613**
Dominican Republic[iii]	700,000	0	0	0	**700,000**
El Salvador[iii]	680,000	0	0	0	**680,000**
Nicaragua[iii]	150,000	0	441,665	0	**591,665**
Paraguay[iii]	539,537	0	0	0	**539,537**

i Fiscal year 2007–2008 (timing of fiscal year varies by country)
ii Calendar year 2007
iii Calendar year 2008
iv. World Bank/DFID through pooled funds

Notes:
1. The following countries reported that they did not use government funds for contraceptive procurement during the given time period: Afghanistan, Armenia, Azerbaijan, Georgia, Guatemala, Haiti, Liberia, Mali, Mozambique, Nigeria, Russia, Senegal, and Zimbabwe.
2. Although government funds were spent on contraceptive procurement, data on amounts was not available for Bolivia, DRC, Pakistan, or the Philippines. Financial data was not provided for Kenya.
3. The time period covered may differ slightly by funding source. Amounts are approximate.

Government Share of Public Sector Contraceptive Financing

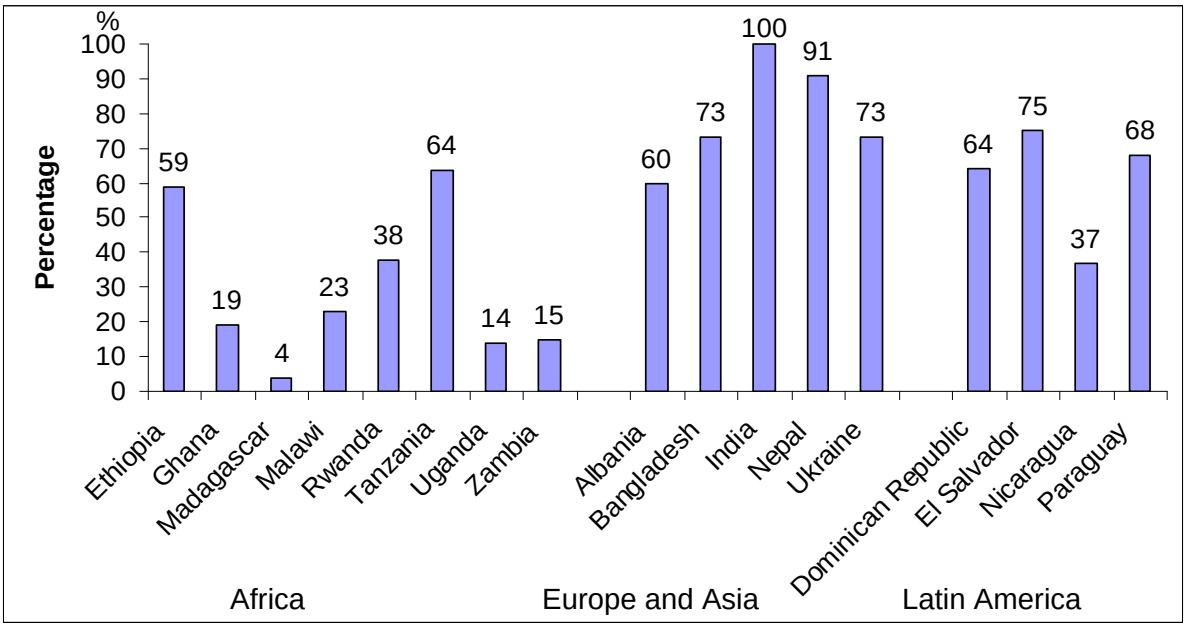
To understand the government's role in contraceptive financing, survey respondents were asked what percentage of the previous year's financing for public sector contraceptive procurement was covered by government resources (including internally generated funds, World Bank assistance, basket funds, and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

In the surveyed countries using government funds for contraceptive procurement, government funds constituted between 4 percent (Madagascar) and 100 percent (India) of all financing spent on public sector contraceptives. (See figure 2.) *In these countries, on average, government funds represented 52 percent of the financing spent on public sector contraceptives.* Of the countries using government funds, those in Europe/Asia and Latin America reported that government funds represented a higher percentage of the total funding for public sector contraceptives than did the surveyed African countries. An average of 79 percent of contraceptive financing was covered by the government in Asian countries, compared to an average of 61 percent in the Latin American countries and 30 percent in the responding African countries.[5] This finding is consistent with USAID's historical provision of in-kind donations of contraceptives; they have decreased contributions to Latin American countries and are working to graduate the countries from USAID assistance. Many governments in Latin America have increased their share of spending accordingly.

Even within regions, the government's share of spending for public sector contraceptive procurement varies significantly; in Latin America, for example, of the countries that reported using government funds, the government share of spending ranges from 37 percent in Nicaragua to 75 percent in El Salvador.

5 The sample size for this analysis was small—five countries in Europe/Asia, four in Latin America, and eight in Africa.

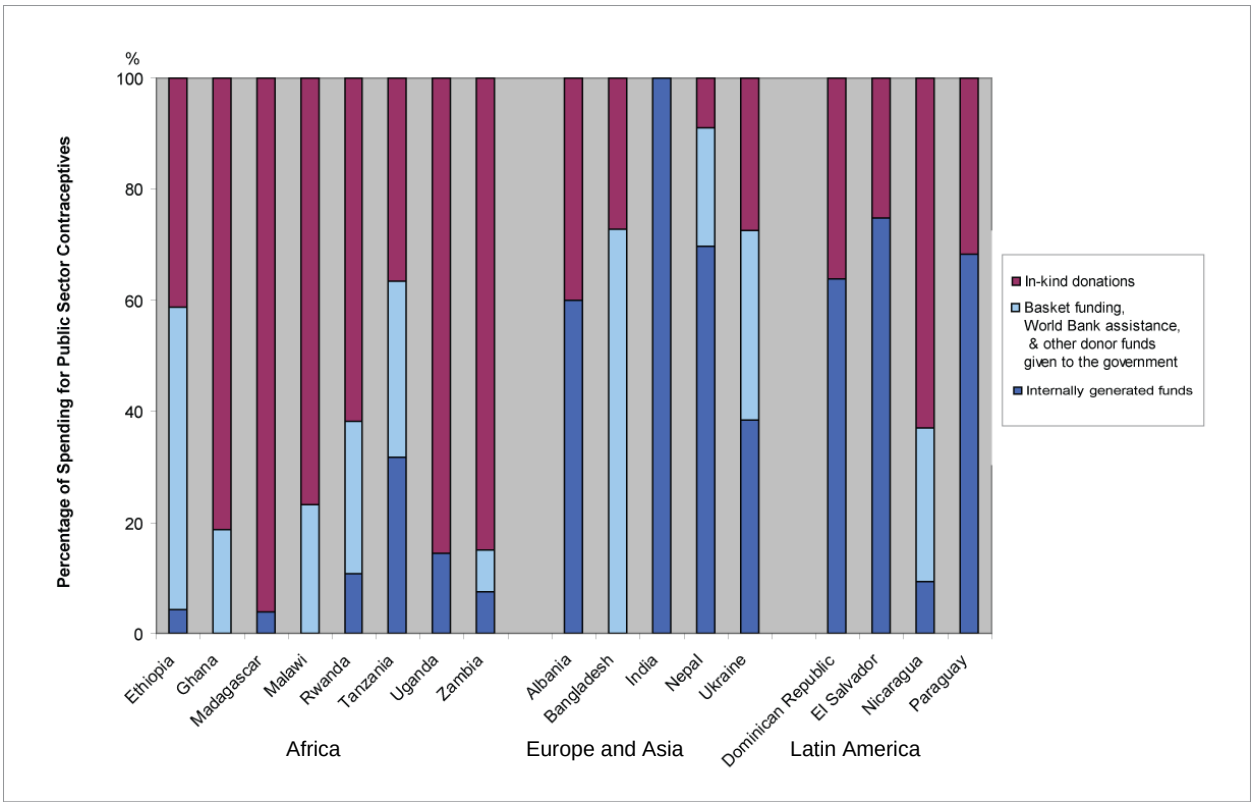
Figure 2. Government Share of Total Spending for Public Sector Contraceptives



Notes: (1.) Government funds include internally generated funds, World Bank credits or loans, basket funds, and other funds given to the government. (2.) Respondents were asked to provide information about the most recent complete year. The time periods used can be found in the notes for table 1. (3.) The following countries were reported to have no government expenditures for contraceptive procurement during the year: Afghanistan, Armenia, Azerbaijan, Georgia, Guatemala, Haiti, Liberia, Mali, Mozambique, Nigeria, Russia, Senegal, or Zimbabwe.
(4.) Although government funds were reportedly spent on contraceptive procurement, this data was not available for Bolivia, DRC, Pakistan, the Philippines, or Yemen. (5.) Financial data was not provided for Kenya.

Figure 3 presents the share of spending information in more detail by dividing government funding into internally generated funds and a combination of basket funds, World Bank assistance, and other funds that donors provided to the government. In addition, it also displays in-kind donations to complete the picture of expenditures on contraceptives for the public sector.

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



Notes: (1.) Only surveyed countries reporting amount of government expenditures on contraceptive procurement are included here. (Government funds include internally generated funds, World Bank credits or loans, basket funds, and other funds given to the government.) The list of countries not included in this graph are in the notes for figure 2, along with the explanation for exclusion. (2.) Respondents were asked to provide information about the most recent complete year. The time periods used can be found in the notes for table 1. The time period covered may differ slightly by funding source. (3.) Amounts are approximate.

In surveyed countries using government funds, an average of 33 percent of the financing for public sector contraceptives was sourced through internally generated funds; 19 percent through basket funds, World Bank assistance, or other funds that donors provide to the government; and 48 percent through in-kind donations. This differed considerably by region, with the responding countries in Europe/Asia and Latin America providing an average of 54 percent of funding through internally generated funds, compared to 9 percent in the responding African countries. The Latin American countries were less likely to use basket funds or other funds provided to the government by donors—only Nicaragua did. In-kind donations accounted for 71 percent of the contraceptive financing in the responding African countries, 39 percent in the Latin American countries, and 21 percent in the countries responding in Europe/Asia.

It is important to note that the government's share of total spending for public sector contraceptives only considers government and other funds *spent*; it does not consider need. Even if a government provides a large percentage, the actual monetary contribution could be small, depending on the country's needs. The following *Spotlight on Tanzania* illustrates this point.

Spotlight on Tanzania

Public sector contraceptive procurement: How high government share of spending can mask a problem

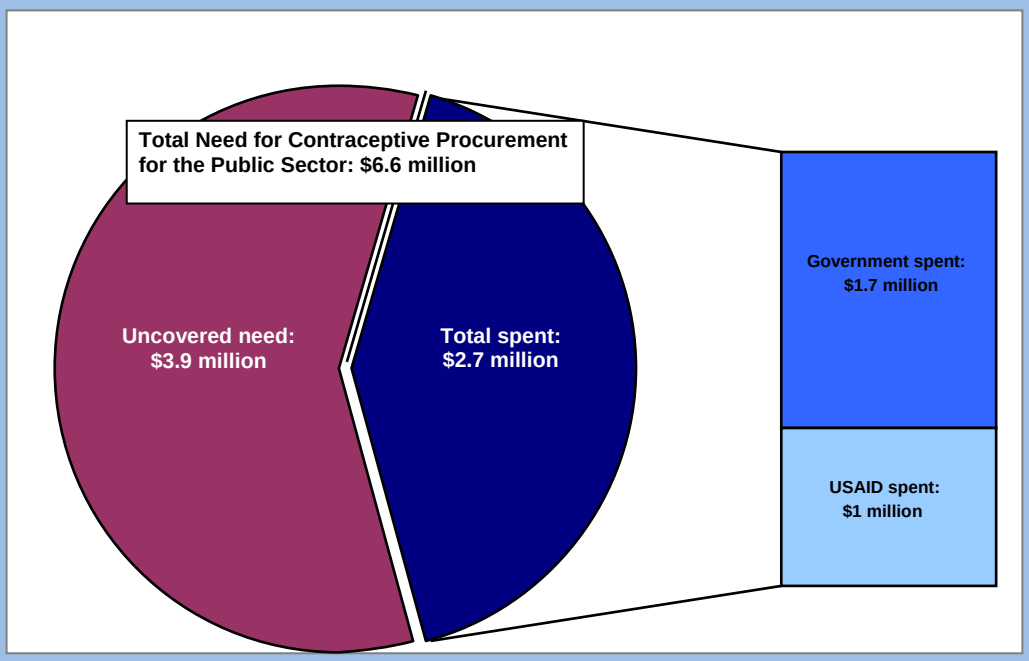
A recent experience in Tanzania highlights the need to consider not only the government's share of spending but also how overall spending compares with actual need.

The total need for public sector contraceptives in Tanzania was estimated to be $6.6 million for the 2007–2008 fiscal year. The government and partners developed a plan: USAID would provide $1 million in contraceptives; together, government internally generated funds and basket funds would provide the remaining $5.6 million.

USAID provided their $1 million contribution in combined oral contraceptives and IUDs. Of the government internally generated and basket funding commitment, however, only $1.7 million (rather than $5.6 million) was allocated and spent on contraceptives—leaving a funding gap of $3.9 million.

While government funds constituted 64 percent of funding *spent* on contraceptives for the public sector, these funds represented only 26 percent of the total *need*. See figure 4.

Figure 4. Tanzania Public Sector Contraceptive Procurement Need and Expenditures

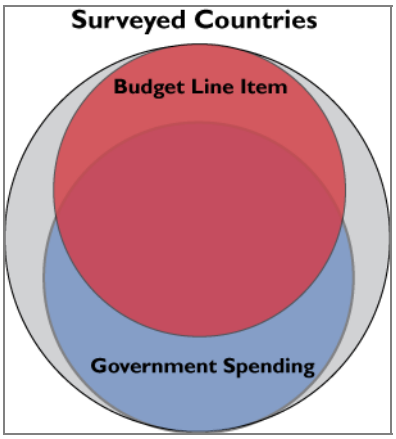


The Spotlight on Tanzania highlights the importance of comparing government and overall spending to need. To determine the cost of contraceptives required to cover the country's public sector need, country-level contraceptive procurement forecasts are a good source of information.

Budget Line Item

Twenty out of 35 responding countries (57 percent) reported having a government budget line for contraceptive procurement. The existence of a budget line item for contraceptives indicates the government's commitment to contraceptive procurement. However*, while a budget line item helps ensure that contraceptives are a priority in annual budgeting, it does not guarantee funding.* The Venn diagram (figure 5) illustrates the degree of overlap between surveyed countries securing a budget line item and mobilizing government funding for contraceptive procurement. As the figure shows, although there is a large degree of overlap, *some countries funded contraceptive procurement without having a line item, while others had a line item but did not follow through with funding.* Sixteen countries (46 percent) had a budget line item and funded contraceptive procurement. Six countries (17 percent) used government funds for contraceptives despite not having a line item for this purpose (Bolivia, Dominican Republic, El Salvador, Ghana, Malawi, and Nicaragua). By comparison, four countries (11 percent) had a budget line item but the funds were not released or spent on contraceptives (Haiti, Mali, Mozambique, and Senegal). This could be caused by various factors, including budget shortfalls or a delay in the release of funding from the Ministry of Finance. In Senegal, for example, it was reported that for the last three years funding was allocated to the Central Medical Store for contraceptive procurement, but it was returned to the treasury unspent. The remaining nine countries (26 percent) did not have a budget line item and did not use government funds on contraceptive procurement in the most recent complete year.

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



Commodities

Providing a mix of contraceptive methods is essential to ensure that clients have the choice to use the contraceptive that best fits their needs. Survey respondents were asked which contraceptive methods are offered in public sector and social marketing or NGO facilities. The survey included the following methods: combined oral pills, progestin-only pills, injectables, implants, intrauterine devices (IUDs), male condoms, female condoms, and emergency contraceptives. In addition, respondents were asked to indicate if any other methods are offered in public, social marketing, or NGO facilities.

On average, countries reported offering seven of the eight aforementioned contraceptives in public sector, social marketing, or NGO facilities. Azerbaijan reported offering the fewest contraceptives—three. Nine of the countries reported offering all eight. Other methods reported were the contraceptive patch, spermicides, surgical methods, and the standard days method (i.e., CycleBeads).

Key Findings: Commodities

- On average, countries reported offering seven of the eight contraceptives within the public, social marketing, or NGO sectors.
- Most countries (33 out of 36) offer male condoms, combined oral contraceptives, IUDs, and injectables.
- Public sector facilities are the least likely to offer emergency contraceptives and female condoms; less than half of surveyed countries

The methods more likely to be offered in public sector facilities are also those more likely to be offered in social marketing or NGO facilities (see figure 6). *Most countries offer male condoms, combined oral contraceptives, IUDs, and injectables;* these products are offered in 90 percent of the surveyed countries through public sector facilities and in at least 70 percent of the countries through social marketing or NGO facilities. Progestin-only pills and implants are offered in 60–75 percent of countries through the public sector, but in only 45–50 percent through social marketing or NGO facilities. *Female condoms and emergency contraceptives are offered less often*—in approximately 45 percent of surveyed countries through public sector facilities and a similar percentage through social marketing or NGO facilities.

Figure 6. Percentage of Surveyed Countries that Offer Contraceptive Methods, by Method and Sector

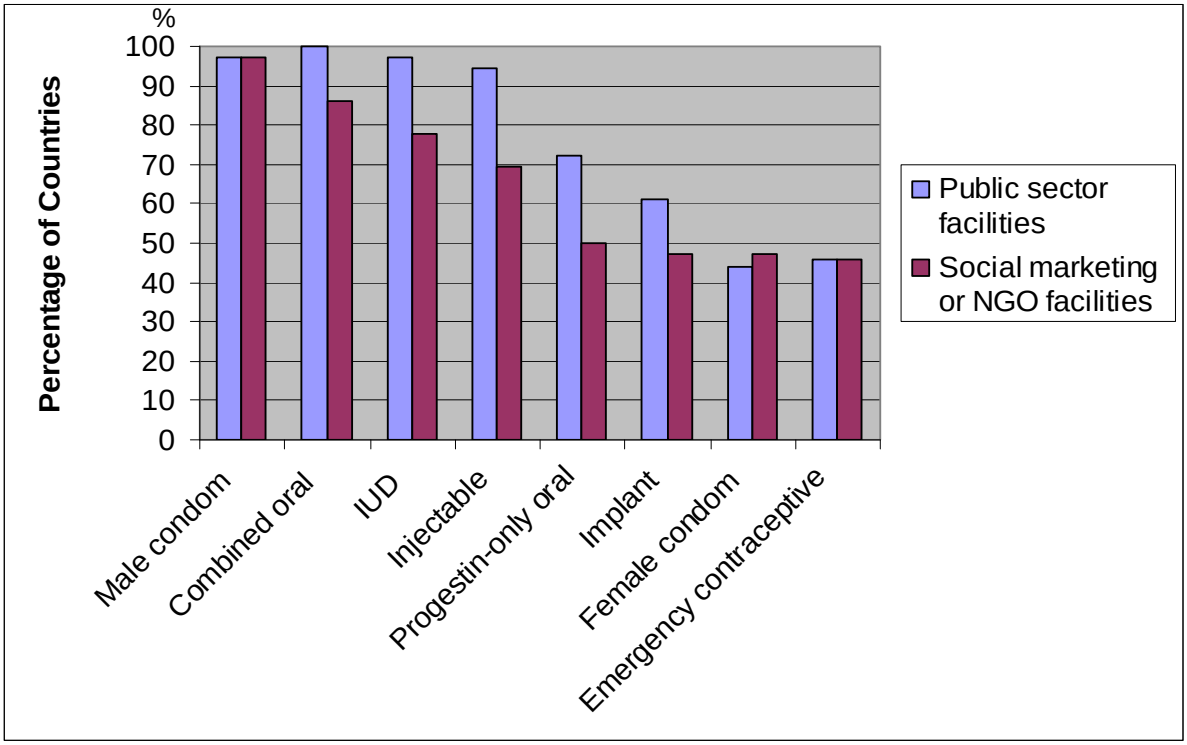
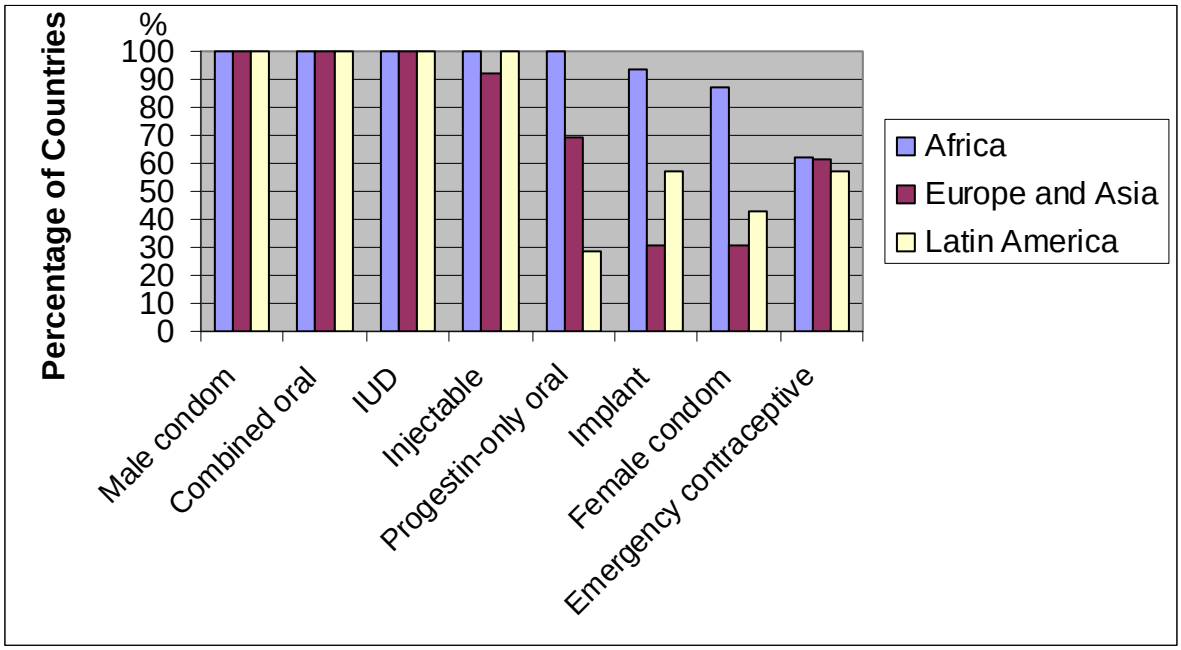


Figure 7 shows which contraceptive methods are offered in public, social marketing, or NGO facilities. Male condoms, combined oral contraceptives, and IUDs were reported to be offered in all

the surveyed countries. As shown in figure 7—with the exception of injectables, which are offered in most of the surveyed countries in all regions—other methods varied by region. All methods were offered in a larger percentage of the African countries surveyed. Progestin-only orals are not offered in public, social marketing, or NGO facilities in most of the Latin American countries surveyed. Implants are not offered in these facilities in most of the Asian countries surveyed, which limits women's choices for long-acting methods. Female condoms are not offered in these facilities in most of the Latin American or Asian countries surveyed. Emergency contraceptives were offered in approximately 60 percent of the countries surveyed; this did not vary by region.

This question did not ask whether contraceptives that are reportedly offered are actually available.[6] Clients may also face other barriers to accessing contraceptives, such as access to facilities, cost, etc., some of which are addressed in the *Policies (Commitment)* section.

Figure 7. Percentage of Surveyed Countries with Methods Offered through the Public Sector, Social Marketing, or NGOs, by Method and Region



Policies (Commitment)

Policies indicate the level of government commitment to contraceptive security, as well as influence practices that can promote or hinder CS. The survey, therefore, included indicators to help understand key policies affecting contraceptive security to help determine whether a country has an enabling environment for and is committed to CS.

6 However, some respondents may have provided information on actual availability instead of planned management of the contraceptives.

Key Findings: Policies

- On average, countries include five of eight methods on their NEML or equivalent.
- Most countries (26 out of 36) either have a specific CS strategy or include CS in a broader strategy.
- More than half of countries (17 out of 27) explicitly indicate family planning or reproductive health as part of their Poverty Reduction Strategy Papers (PRSP). However, less than half of the countries (11 of 27) included contraceptive prevalence rate as an indicator within the PRSP and only one country (Pakistan) included a contraceptive supply indicator in its PRSP.
- Twenty-four of 35 countries reported taxes, import duties, or fees on contraceptives.
- Thirty-six percent of countries (13 out of 36) reported charges to clients for family planning services or commodities in the public sector. Half of these countries have exemptions for those who cannot afford to pay.

Contraceptives on National Essential Medicine Lists

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

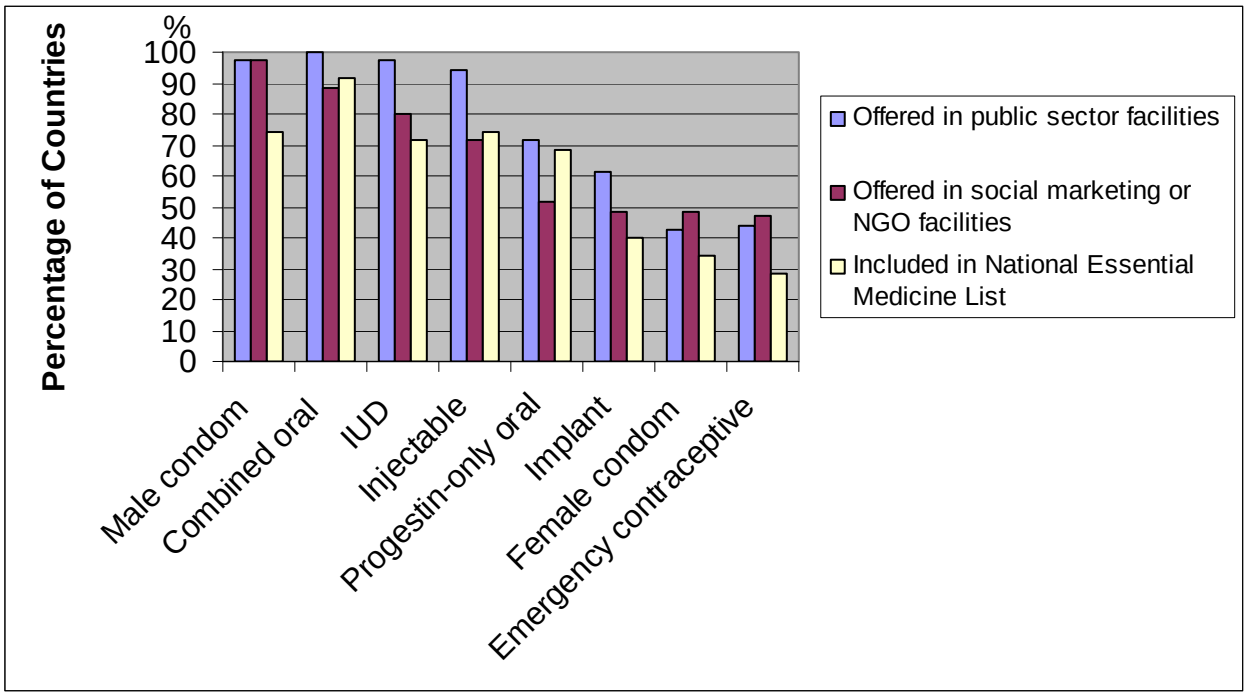
On average, countries had five (of the eight) contraceptive methods included in this analysis[7] *listed on their NEML (or NEML equivalent).* Ninety-four percent (33 out of 35) had at least one method on the list. Azerbaijan[8] and Georgia did not have any contraceptive methods included; Haiti only had implants on their NEML. Ghana and Zambia had all eight of the studied methods. Other contraceptives found on countries' NEMLs included diaphragms, spermicide, vaginal foaming tablets, and the standard days method (i.e., CycleBeads).

Figure 8 shows the correlation between the methods offered in countries and those included in NEMLs. As shown in the graph, non-inclusion on a NEML does not necessarily mean a method is not offered in a country. For instance, despite their availability in most countries, only 71 percent of country NEMLs include male condoms. (This may be the case, however, because, in many countries, condoms (and sometimes implants and IUDs) are considered medical devices and are included on a separate equipment list; these were not evaluated in all cases.) While almost half of the surveyed countries offer emergency contraceptives in public sector facilities, only 29 percent included them explicitly in their NEML.

7 The following methods were included in this analysis: combined oral pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, and emergency contraceptives.

8 While Azerbaijan's NEML does not currently include any contraceptive, it is expected that the list will be updated in 2010 to include combined oral contraceptives and IUDs; following subsequent revisions, it is expected to include injectables, as well.

Figure 8. Comparison of Methods Offered and Included on National Essential Medicine Lists, by Method and Sector in Surveyed Countries



Note: Russia was excluded from this analysis because the country's NEML was not available.

Data on some of the methods may be less reliable than others. For the NEMLs evaluated by the review team, if condoms were mentioned without specifically stating whether the term was meant to include male, female, or both types of condoms, it was assumed that only male condoms were included on the list. It is unknown whether in-country respondents made the same assumption.

Contraceptive Security in Government Strategies

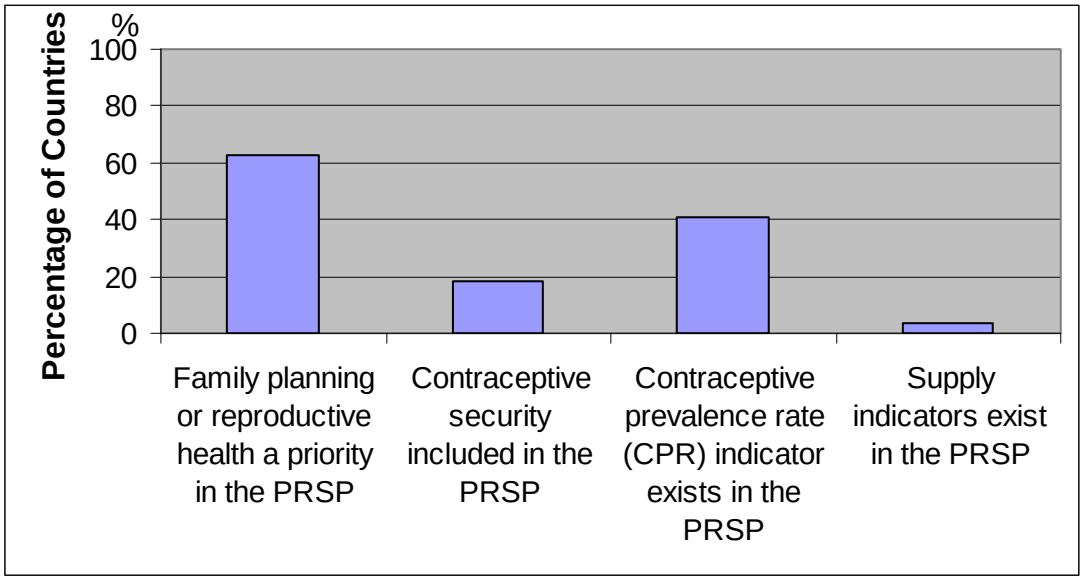
A country strategy that explicitly includes contraceptive security can be indicative of an in-country commitment to CS and can help ensure that CS remains a priority for the political agenda. *Of the 36 surveyed countries, 26 (72 percent) reported having a contraceptive security strategy or another strategy (for example, a family planning or reproductive health strategy) that includes a CS component.* The Ministry of Health has formally approved 88 percent of these strategies (23/26). The degree of implementation varies by country; 73 percent (19/26) of the strategies are reportedly being implemented.

Family Planning and Contraceptive Security in Poverty Reduction Strategy Papers

A country's Poverty Reduction Strategy Paper (PRSP) describes its macroeconomic, structural, and social policies and programs to promote growth and reduce poverty. The strategy is determined through a collaborative process involving domestic as well as external stakeholders and development partners, including the International Monetary Fund and World Bank. Because PRSPs are key policy documents used by many countries, if family planning and contraceptive security are to be given proper attention, they should be included in the countries' PRSPs.

Of the 36 countries surveyed, the research team was able to identify PRSPs for 27 of them.[9] *Out of these 27 countries, 17 (63 percent) explicitly indicated family planning or reproductive health as a priority.* Fewer included contraceptive prevalence rate as an indicator within the PRSP (11/27), and only Pakistan included a contraceptive supply indicator (such as contraceptive stockout rates) among the country's PRSP indicators. (See figure 9.)

Figure 9. Percentage of Surveyed Countries with Particular Family Planning– or Contraceptive Security-Related Items Included in their PRSP



The indicator about whether contraceptive security is included in the PRSP was found to be more subjective than the other indicators. The reviewers were not looking for the term but were looking for the concept of contraceptive security, including items such as the availability and funding of contraceptives. This indicator, therefore, depended more on the judgment of the individual reviewer. Only 5/27 (19 percent) of the PRSPs included the concept of contraceptive security.

Policies Impacting Provision of or Access to Contraceptives

To help determine whether there is generally an enabling policy environment for CS, the survey includes indicators related to operational policies. The CS indicators used for this analysis include questions about policies that may impact the public sector and the private sector, recognizing that the private (i.e., non-public) sector can play an important role in contraceptive security.

Twenty-four out of 35 of the respondents (69 percent) mentioned taxes, import duties, or fees on contraceptives. In general, these affected imported and commercial sector goods. Depending on the country, such taxes, duties, or fees were reported to be between 1 and 20 percent of the price of the product.

Fifty-eight percent (21/36) of the surveyed countries reported policies or regulations that restrict who can dispense or sell particular contraceptive methods. Regulations like these can affect the public or the private sector and may relate to facility type or service provider cadre. In Senegal, a law prohibits a single private sector

9 The PRSPs reviewed ranged in publication year from 2001–2008. Interim reports were not reviewed.

facility from counseling for, prescribing, and dispensing contraceptives to the same individual. If a private sector provider counsels and writes a prescription, he is restricted from providing the contraceptive, which may cause an additional burden for the family planning client. For example, to obtain an injectable contraceptive, the client must first go to a doctor for counseling and a prescription, then to a pharmacy to buy the contraceptive, and then to a doctor, for a second visit, to administer the injection.

Respondents were also asked whether policies, laws, or regulations restrict access to family planning services for particular segments of the population. Bangladesh and Pakistan mentioned limited access for unmarried women; Bangladesh, Ghana, and Pakistan noted limited access for young people. Respondents did not specify whether these restrictions were due to official policies or community practices.

Thirty-six percent of respondents reported charges to clients for family planning services or commodities in the public sector. Fifty-four percent (7/13) of these respondents, however, indicated that there are some exemptions for people who cannot afford to pay. Based on this information alone, the impact of these policies, or to what extent they are enforced, cannot be determined.

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. Therefore, the survey included indicators related to coordination.

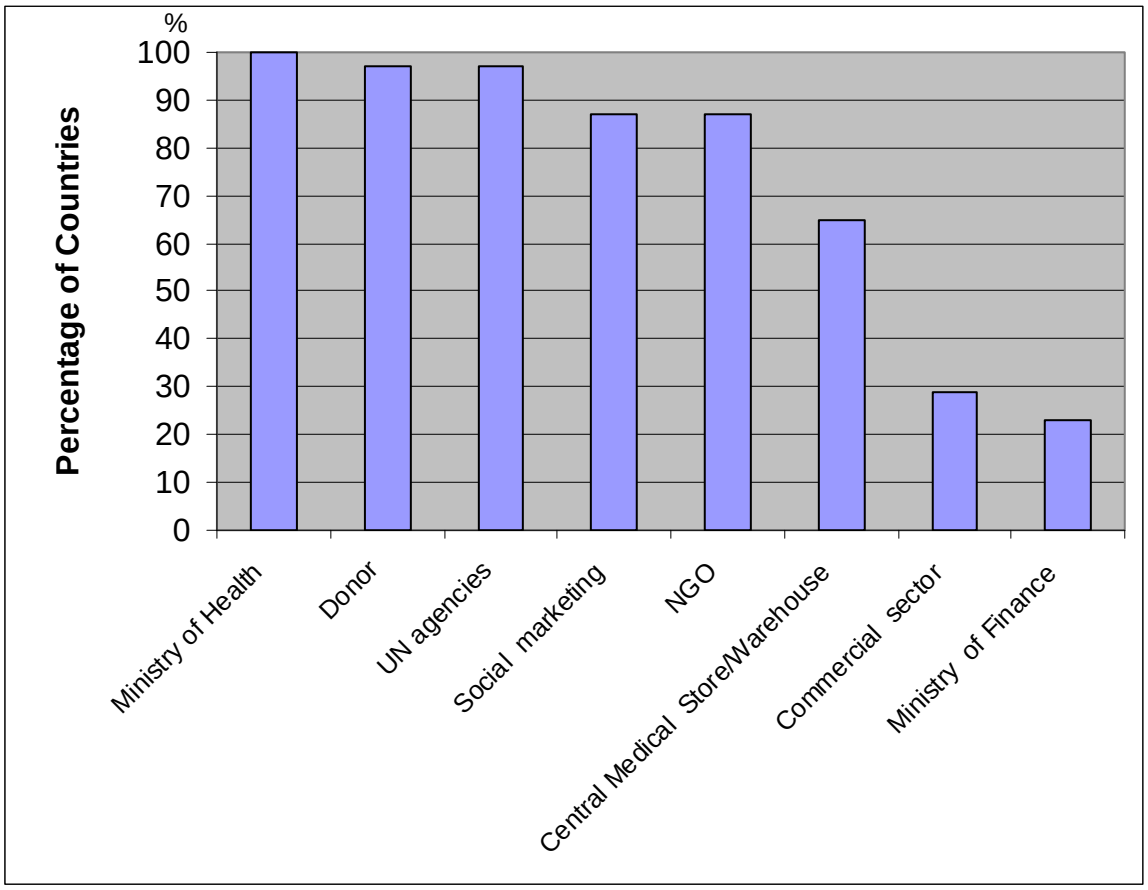
Key Findings: Coordination and Leadership

- The majority of surveyed countries (31 of 36) reported having a CS committee (or a group that works on CS issues).
- Most of the committees include NGO and social marketing groups.
- Only 9 out of 31 committees include the commercial sector.
- Only 7 out of 31 committees include a Ministry of Finance counterpart.

Coordinating Committee for Contraceptive Security

The presence of an active, multi-sectoral CS coordination committee can help maintain a focus on CS and long-term product availability issues, strengthen coordination between a broad range of stakeholders, and reduce duplication and inefficiencies. *Seventy-eight percent of countries surveyed (31/36) reported having a committee that works on contraceptive security.* All seven of the reporting Latin American countries have such a committee. Figure 10 shows the types of organizations and entities that are represented on surveyed countries' committees.

Figure 10. Percentage of Surveyed Countries' CS Committees That Include Specific Organizations



Ministries of Health are part of the committee in all of the countries that have a CS committee. Donors and United Nations (UN) agencies also participate in all the committees, except in India, where there is no donor support for contraceptive procurement. (India is also the only country where the committee consists solely of the Ministry of Health.) *Social marketing and NGOs play a role in most of the committees.* Central Medical Stores or warehouses are included in 65 percent of the committees, while *the commercial sector is present in just 29 percent and the Ministry of Finance in only 23 percent.* As government financing becomes an increasingly important source of funding for contraceptives, it is important to engage the Ministry of Finance and include them in these committees.

Supply Chain (Capacity)

An effective supply chain enables the continuous availability of high-quality contraceptives, which is key to ensuring contraceptive security. Information about supply chain management practices and outcomes were included as CS indicators.[10]

10 Supply chain indicators are from the CS Index and the Procurement Planning and Monitoring Report (PPMR) (see annex 2 for more information).

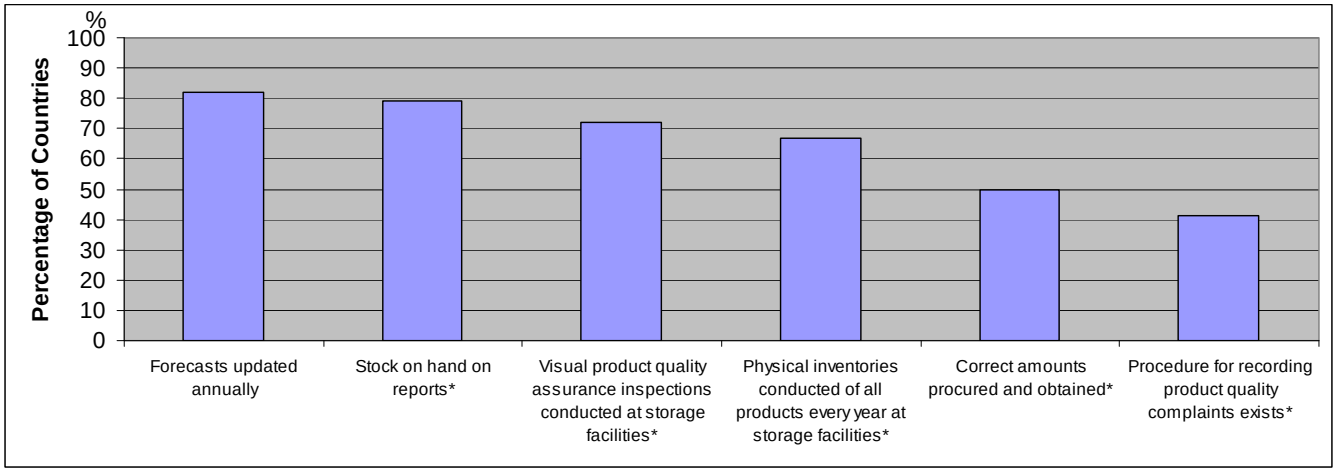
Key Findings: Supply Chain

- The majority of countries (26 out of 33) include *stock on hand* data in their LMIS reports.
- Twenty-two out of 33 countries conduct a yearly physical inventory of contraceptives at all levels of the supply chain.
- Although most countries (82 percent) update their forecasts annually, the correct amounts of contraceptives are reportedly being procured and obtained much less often (in just 50 percent of countries).

Stock on hand is one of the three essential logistics data items—quantity dispensed and losses and adjustments are the other two. These three items are the foundation of an effective logistics information system; they enable logistics managers to ensure that facilities are well stocked within adequate minimum and maximum levels. For this reason, information was collected about whether these three essential data items are included in the logistics management information system (LMIS) reports at each level of the system**.** *Seventy-nine percent of countries surveyed reported that stock–on-hand data is included in the LMIS reports at each level. Most surveyed countries (67 percent) also reported that physical inventories are conducted every year at storage facilities at all levels.* (See figure 11.)

Information was also collected on forecasting and procurement. *Despite the fact that the majority of responding countries (82 percent) update their forecasts annually, the correct amounts of contraceptives are reportedly being procured and obtained in just 50 percent of the countries.*

Figure 11. Percentage of Surveyed Countries Reporting Supply Chain Practices[11]



*at all levels of the system

Product Availability

For stockout data, the survey team reviewed the Procurement Planning and Monitoring Report (PPMR)—a tool used by donors and in-country counterparts to avert impending shortages and stockouts of contraceptives. Participating countries report every month or every quarter on their current stock status, as well as qualitative information on contraceptive security.[12] The information is reviewed by high-level decisionmakers at USAID, UNFPA, and other donors who participate in

11 The sample size for most of these supply chain questions is 33 countries.

12 The information displayed in the report usually reflects the country's situation one to two months prior to the publication of the report.

the Countries at Risk (CAR) Group of the Reproductive Health Supplies Coalition (RHSC). The report promotes international donor collaboration and coordination and affords in-country project and ministry staff a way to communicate important contraceptive security issues to decisionmakers.[13]

Table 2 indicates stockouts reported on the PPMR during one year. The stockouts indicate a lack of stock on the day of the data collection. Most countries report monthly, while a few report quarterly. As shown in the table, the majority of countries report on the central level only (i.e., the Central Medical Store). A few countries report data based on the district or zonal level stores, as well. Bangladesh reports on the entire system, including health care facilities (i.e., service delivery points).

For countries not reporting stockout data for the entire system, the data must be interpreted with caution because it does not indicate product availability at health care facilities or lower-level warehouses. Strong LMISs are crucial to ensure timely product availability information from all levels of the system; such information on the entire system is key to elucidating stock status and needs.

13 Currently, fifteen countries report regularly for the PPMR. In most of these countries, the USAID | DELIVER PROJECT or the Strengthening Pharmaceutical Systems (SPS) program works with in-country partners to obtain the information. For more information on the PPMR and how your country can become involved, please contact the USAID | DELIVER PROJECT.

Table 2. Stockouts Reported in the Procurement Planning and Monitoring Report, by Method

	Male Condom	Combined Oral Contraceptive	IUD	Injectable	Progestin-only Pill	Implant	Emergency Contraceptive	Female Condom	Levels Included in PPMR
Bangladesh					N/A		N/A	N/A	Entire system (warehouses & service delivery points)
Dominican Republic**	X	X		X		N/A	N/A	N/A	Central
El Salvador			X	X	N/A	N/A	N/A	N/A	Central
Ethiopia*							N/A	N/A	Central
Ghana	X	X		X	X				Central
Kenya**		X	X	X	X	X	X	X	Central
Malawi**						X	N/A	N/A	Regional
Mozambique		X				N/A	N/A	N/A	Central
Nicaragua	X			X	N/A	N/A	N/A	N/A	Central
Paraguay	X	X			N/A	N/A	N/A	N/A	Central
Rwanda		X					X	X	Central and district
Tanzania*								X	Central and zonal
Uganda							X		Central
Zambia* **		X					X		Central

Notes: N/A = not applicable; this indicates that the country does not report on this method in the PPMR.

*These countries report quarterly (all others report monthly).

**Data cover a twelve-month period from 2008–2009 (all other countries' data cover the 2008 calendar year).

The surveyed countries not included here do not regularly report to the PPMR.

Conclusions

The systematic tracking of contraceptive security indicators aims to inform stakeholders of country progress toward improving contraceptive availability, highlight focal areas for interventions, enable cross-country and longitudinal analyses, and provide more visibility for CS in the future.

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

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 specific types of accurate data to effectively monitor progress toward achieving CS. Survey responses indicate that data to measure CS improvements are not always readily available. Ideally, over the long-term, CS committees and other in-country stakeholders will become better versed in collecting and monitoring these types of data and will begin to institutionalize similar monitoring tools within their broader CS strategic planning and implementation processes, lessening the need for global data collection processes (such as this activity) over time.

The data collected for this analysis indicate that countries have made efforts to improve CS:

- 78 percent of the surveyed countries have coordination committees that work on contraceptive security
- 63 percent contribute government funds for contraceptives
- 72 percent possess strategies for working on contraceptive security
- 79 percent include stock on hand (an essential logistics data item) in their information system reports.

On average, five of the eight aforementioned modern contraceptive methods are included in surveyed countries' NEML; seven of the eight are offered in the public sector, social marketing, or NGO facilities.

In many of the surveyed countries, however, there is room for additional gains, including in the amount of government funds contributed for contraceptives, the range of contraceptives offered and included within essential medicine lists, the degree of implementation of CS strategies, and the availability of contraceptive supplies at warehouses and service delivery points.

The data collected for this analysis can improve advocacy and decisionmaking, and the availability of the raw country-level data (see the USAID | DELIVER PROJECT website[14]) should encourage more tailored and in-depth analyses. It is anticipated that CS indicator data will be collected

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14 The *Contraceptive Security Indicators Data 2009 spreadsheet is available at* http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CS_Indicators_Data_2009.xls.

regularly, with the data presented here serving as a baseline from which to monitor progress. Such data can be used to uncover correlations between various indicators and outcomes such as stockouts, contraceptive prevalence rates, or measures of CS (such as *CS Index* scores).

As health systems continue to evolve, with greater government involvement; new financing mechanisms, such as sector wide approaches and basket funding; and expanding decentralization and integration processes, it may be more challenging to track and attribute funding levels and other CS indicators. However, it may be equally, if not more important, to do so. The CS indicators presented here highlight topics that are worth tracking through the institutionalization of monitoring tools.

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Annex 1

List of Indicators

Leadership and Coordination
L1. Is there a national committee that works on contraceptive security? (Note: Committee should include some aspect of contraceptive security as part of its Terms of Reference, even if it has a different name; e.g., Family Planning/Reproductive Health/Maternal Mortality/Essential Medicine Committee, etc.).
L1a. If yes, what is the name of the committee?
L2. Are the following organizations represented on the committee?
L2a. Are social marketing organizations on the committee?
L2ai. List the names of the social marketing organizations on the committee.
L2b. Are NGOs on the committee (e.g., service delivery, advocacy, Planned Parenthood affiliate, Marie Stopes affiliate)?
L2bi. List the names of the NGOs on the committee.
L2c. Are commercial sector organizations on the committee (e.g., pharmacy associations, manufacturers)?
L2ci. List the names of the commercial sector organizations on the committee.
L2d. Are donors on the committee?
L2di. List the names of the donors on the committee.
L2e. Are UN agencies on the committee?
L2ei. List the names of the UN agencies on the committee.
L2f. Are Ministry of Health units on the committee (e.g., Logistics, Family Planning, Reproductive Health, Maternal and Child Health units, etc.)?
L2fi. List the names of the of Ministry of Health units on the committee.
L2g. Is the Central Medical Store or Central Warehouse on the committee?
L2gi. List the names of Central Medical Store or Central Warehouse on the committee.
L2h. Is the Ministry of Finance on the committee?
L3. How many times did the committee meet during the last year? (0, 1–3, 3–5, or 6+)
L4. Does the committee have legal status?
L5. Is there a contraceptive security "champion"?
Finance and Procurement (Capital)
F1. Is there a government budget line item for the procurement of contraceptives?
F2. Were government funds ***spent*** on contraceptives in the most recent complete fiscal year (including internally generated funds, World Bank credits or loans, basket funds, or other government funds)?
F2a. What was the time period of funding?
F2b. Did the government spend internally generated funds (for example, from public sector sources or taxes) for contraceptive procurement?
F2bi. What was the amount of internally generated funds spent on contraceptive procurement (in U.S.$)?

F2c. Did the government spend World Bank credits or loans for contraceptive procurement?
F2ci. What was the amount of World Bank credits or loans spent on contraceptive procurement (in U.S.$)?
F2d. Did the government spend basket funds for contraceptive procurement?
F2di. What was the amount of basket funds spent on contraceptive procurement (in U.S.$)?
F2e. Did the government spend other funding sources for contraceptive procurement (including only funds given to the government used for contraceptive procurement)? This does NOT include contraceptive supplies donated to the government (for example, NOT from USAID).
F2ei. Specify the source of other government funding.
F2eii. What was the amount of other government funds spent on contraceptive procurement (in U.S.$)?
F2f. In total, how much funding did the government spend on contraceptive procurement (including internally generated funds, World Bank credits or loans, basket funds, and other government funds) (in U.S.$)?
F3. What was the total amount of non-government funds spent on contraceptive procurement (in U.S.$)? (This includes contraceptive supplies donated directly to the government, procured by donors [e.g., USAID]. *This is actual supplies donated, not funds.* How much were these supplies worth?)
F4. Of the total amount of financing spent on public sector contraceptives for the most recent complete fiscal year, what percentage was covered by government funding (including internally generated funds, World Bank credits or loans, basket funds, and other government funds)? (F2f./(F2f.+F3.)
F4a. Specify data source, e.g., Contraceptive Procurement Table (CPT), National Health Account (NHA), Reproductive Health Account (RHA), etc.
F5. If the government is financing contraceptive procurement, which entity does the procurement: the government or another entity?
F5a. Specify the government entity that does the procurement; e.g., Central Medical Store, Ministry of Health (MOH) logistics unit, MOH procurement unit, etc.
F5ai. Is this procurement entity a parastatal?
F5b. Specify the nongovernment entity that does procurement; e.g., third-party agent such as UNFPA or Crown Agents, or private entity.
F6. Comments about government procurement and financing.
Commodities
C1. Are the following contraceptive methods offered in public sector facilities?
C1a. Combined oral hormonal pills offered in public sector facilities (estrogen + progestin—e.g., Lo-Femenol, Microgynon)?
C1b. Progestin-only oral hormonal pills offered in public sector facilities (e.g., Ovrette, Microlut)?
C1c. Hormonal injections offered in public sector facilities (e.g., Depo-Provera, Noristerat)?
C1d. Hormonal implants offered in public sector facilities (e.g., Jadelle, Implanon)?
C1e. Intrauterine devices (IUDs) offered in public sector facilities (e.g., Optima Copper T)?
C1f. Male condoms offered in public sector facilities?
C1g. Female condoms offered in public sector facilities?
C1h. Emergency contraceptive oral hormonal pills offered in public sector facilities (e.g., Postinor)?
C1i. Other contraceptive offered in public sector facilities? (Please specify.)
C2. Are the following contraceptive methods offered in social marketing or NGO facilities?

C2a. Combined oral hormonal pills offered in social marketing or NGO facilities (estrogen + progestin—e.g., Lo-Femenol, Microgynon)?
C2b. Progestin-only oral hormonal pills offered in social marketing or NGO facilities (e.g., Ovrette, Microlut)?
C2c. Hormonal injections offered in social marketing or NGO facilities (e.g., Depo-Provera, Noristerat)?
C2d. Hormonal implants offered in social marketing or NGO facilities (e.g., Jadelle, Implanon)?
C2e. Intrauterine devices (IUDs) offered in social marketing or NGO facilities (e.g., Optima Copper T)?
C2f. Male condoms offered in social marketing or NGO facilities?
C2g. Female condoms offered in social marketing or NGO facilities?
C2h. Emergency contraceptive oral hormonal pills offered in social marketing or NGO facilities (e.g., Postinor)?
C2i. Other contraceptive offered in social marketing or NGO facilities? (Please specify.)
Policies (Commitment)
P1. Is there a contraceptive security or reproductive health commodity security strategy or is contraceptive security explicitly included in a country strategy?
P1a. What is the name of the strategy?
P1b. What years does the strategy cover?
P1c. Is the strategy formally approved by the Ministry?
P1d. Is the contraceptive security strategy being implemented?
P2. Are there policies that affect the ability of the private sector (commercial sector or NGOs) to provide contraceptives (e.g., price controls, distribution limitations, taxes/duties, or advertising bans)?
P2a. If yes, describe the policies.
P3. Do policies or regulations exist that restrict who can dispense or sell particular contraceptive methods? Please note any restrictions below.
P3a. Name of contraceptive method 1
P3ai. Describe the public sector restriction regarding who is allowed to dispense or sell method 1.
P3aii. Describe the private sector restriction regarding who is allowed to dispense or sell method 1.
P3b. Name of contraceptive method 2
P3bi. Describe the public sector restriction regarding who is allowed to dispense or sell method 2.
P3bii. Describe the private sector restriction regarding who is allowed to dispense or sell method 2.
P3c. Name of contraceptive method 3
P3ci. Describe the public sector restriction regarding who is allowed to dispense or sell method 3.
P3cii. Describe the private sector restriction regarding who is allowed to dispense or sell method 3.
P4. Does the country have laws, regulations, or policies that make it difficult for the following sub-populations to access effective family planning services?
P4a. Laws/regulations/policies limiting access to family planning services for women?
P4b. Laws/regulations/policies limiting access to family planning services for unmarried women?
P4c. Laws/regulations/policies limiting access to family planning for young people?
P4d. Other laws/regulations/policies limiting access to family planning services?
P4di. Specification of other policies limiting access

P4e. Describe any laws, regulations, or policies that limit access to family planning services.
P5. Are any family planning commodities subject to duties, import taxes, or other fees?
P5a. If yes, for which methods and for which sector (public, NGO, commercial sector)?
P5b. How much are the duties, taxes, or fees?
P6. Are there charges to the client in the public sector for family planning services or commodities?
P6a. Are clients in the public sector charged for family planning services?
P6b. Are clients in the public sector charged for family planning commodities?
P6c. If clients are charged, are there exemptions for those who cannot afford to pay?
P6ci. If yes, describe the exemptions.
P7. Information in country's Poverty Reduction Strategy Paper (PRSP)
P7a. Year of PRSP (most recent actual PRSP on International Monetary Fund's (IMF) site—not progress or summary report)
P7b. Is family planning or reproductive health a priority in the PRSP?
P7c. Is the concept of contraceptive security included in the PRSP?
P7d. Is contraceptive prevalence rate (CPR) included as an indicator in the PRSP?
P7e. Is there a contraceptive supply indicator included in the PRSP?
P7f. Comments about the PRSP
P8. Inclusion of contraceptives in country's National Essential Medicine List (NEML)
P8a. Year of NEML
P8b. Is a combined oral hormonal pill included on the NEML?
P8c. Is a progestin-only oral hormonal pill included on the NEML?
P8d. Is a hormonal injection included on the NEML?
P8e. Is a hormonal implant included on the NEML?
P8f. Is an IUD included on the NEML?
P8g. Is a male condom included on the NEML?
P8h. Is a female condom included on the NEML?
P8i. Is an emergency contraceptive oral hormonal pill included on the NEML?
P8j. Are any other contraceptives included on the NEML?
P8ji. Name(s) of other contraceptive on NEML
P8k. Comments about the NEML
Supply Chain (Capacity)
S1. Do information system reports *at all levels* of the system show inventory balance (stock on hand)?
S2. Do information system reports *at all levels* of the system show quantity dispensed or issued during a specified reporting period?
S3. Do information system reports *at all levels* of the system show losses and adjustments?
S4. Do information system reports *at all levels* of the system show quantities received?
S5. Are forecasts updated at least annually?
S6. Are forecasts costed out and incorporated into budget planning by the MOH and/or donors?
S7. Does the program actively monitor/manage the coordination of procurement plans among suppliers/donors?
S8. Are the correct amounts of all products generally procured and obtained at the appropriate time *at all levels*?

S9. Does the program conduct at least one physical inventory of all products every year at storage facilities *at all levels*?
S10. Is there a procedure for recording complaints about product quality *at all levels*?
S11. Are visual quality assurance inspections of products conducted at the storage facility *at all levels*?
S12. Was a stockout reported in the Procurement Planning and Monitoring Report (PPMR) in the last year for the following products?
S12a. Combined oral hormonal pills reported stocked out in the PPMR?
S12b. Progestin-only oral hormonal pills reported stocked out in the PPMR?
S12c. Hormonal injections reported stocked out in the PPMR?
S12d. Hormonal implants reported stocked out in the PPMR?
S12e. Intrauterine devices (IUDs) reported stocked out in the PPMR?
S12f. Male condoms reported stocked out in the PPMR?
S12g. Female condoms reported stocked out in the PPMR?
S12h. Emergency contraceptive oral hormonal pills reported stocked out in the PPMR?
S12i. Levels of the system covered in the PPMR
S12j. Time period of PPMRs reviewed
Overall comments about issues with contraceptive security

Annex 2

Study Limitations and Considerations

Indicator questions were written so that a range of respondents could answer them easily with little background research necessary. For this reason, many questions do not explore in-depth issues or the causes for successes in or limitations to contraceptive security in a country. In addition, while efforts were made to verify the data provided, mainly through crosschecking with country informants, the data are contingent upon the knowledge of the respondents and, therefore, are subject to subjectivity, misinformation, and missing information.

Certain contextual factors affect a respondent's ability to provide data. For example, in the case of decentralization, whereby various responsibilities have shifted from the purview of the central government to that of lower levels of government (such as regions or districts), some survey respondents were unable to complete some of the information in the survey, most notably regarding funding levels.

Given these study limitations, the data for any individual country should be treated with caution. Notwithstanding, overall or regional trends should be able to be identified for the surveyed countries in the years to come. (Sampling is explained in annex 3 and was not random, so results for surveyed countries in a region may not be representative of the region as a whole.)

Because the Finance for Procurement and Supply Chain indicators proved the most challenging to collect and interpret, more in-depth explanations of the limitations and caveats are included below.

Readers are encouraged to contact the USAID | DELIVER PROJECT with corrections or more information on the countries concerned, or to provide information on additional countries.

Finance for Procurement (Capital)

The information for the finance indicators was the most challenging to collect; it is important to note a few caveats and considerations when interpreting this information.

While information regarding funds *spent* on contraceptives for the public sector in the most recent complete fiscal year was sought, depending on the data sources used, some answers may actually reflect *allocations* or, by contrast, products *received* during the year. Even within a given country, in some cases, the funding information was obtained from different sources and, therefore, may reflect slightly different time periods (e.g., if governmental information was obtained from the MOH while non-governmental figures—i.e., for in-kind donations—were obtained from the Reproductive Health Interchange [RHInterchange]). Additionally, some countries reported based on their fiscal year while others used the calendar year. In some cases, estimates or approximations were used, including because of varying exchange rates. Also, while every effort was made to clarify terminology

to ensure accurate and precise reporting of information, some countries do not have the financial tracking mechanisms to capture the information requested. For example, in reporting funding amounts and sources for contraceptives, some survey respondents may have double-counted some of their funding, reporting it both as part of World Bank assistance and basket funds; or alternatively, both internally generated funds and basket funds. (For this survey, attempts were made to list the amounts separately, notwithstanding the possibility that World Bank assistance and internally generated funds can also be part of basket funding.)

In addition, the distinction between government and nongovernment financing is not always clear. In this paper, all funds given to the government were considered government funds because the government would usually have decision-making authority for the use of the funds, even though a donor may have earmarked funds to be used for contraceptives.

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 obtain their supplies from the public sector.

Finally, as previously mentioned, the figures on the government's share of contraceptive financing refer only to actual spending and do not reflect overall need; even if the government share is high compared to total spending, it might be low compared to overall need. In addition, when reviewing the amounts spent on contraceptives, it is important to note that the data does not indicate quantities of supplies already in the country. (If the country already had a significant amount of stock in the system left over from the previous year, less stock would need to be procured in the current year.)

Supply Chain (Capacity)

The supply chain indicators incorporated in this analysis contain a subset of those included in the supply chain section of the *CS Index 2009*; therefore, the indicator questions were not revised for this analysis. Because *CS Index* responses had a separate verification process, this review team did not validate or verify the *CS Index* data again. In addition, stockout data from the Procurement Planning and Monitoring Report (PPMR) served as additional supply chain data for the countries that complete the report.[15]

Many of the supply chain questions do not leave room for nuance or explanation (for example, regarding variations by level of the system); they require respondents to classify situations by answering *yes* or *no*, even if the actual situation is not so clear. In Haiti, for example, the correct amounts are reportedly obtained and procured at the central level, but not at the service delivery points. Respondents may have interpreted the questions differently, with some respondents answering the questions exactly as written and others employing generalities. For example, when asked if information system reports at all levels of the system show stock on hand, some respondents seem to have answered *yes* only if every level of the system does, while others may have answered *yes* if most of the levels (or most of the facilities in each level) do.

15 More information about the CS Index can be found in the CS indicators section of this paper. Information about the PPMR is available in the Supply Chain section of the Summary Findings.

A similar issue exists regarding the content of the questions. Mozambique mentioned, for example, that although the quantity of products dispensed is included on information system reports, this information is not accurate at the service delivery point level. However, the indicator question does not ask about accuracy, so Mozambique looks good on this indicator, perhaps unfairly so. Such considerations should be taken into account when reviewing the supply chain results.

Annex 3

Data Collection Methodology

Data was collected for 36 countries, which were selected for the survey because they are USAID First Tier Priority Countries for family planning and/or countries with USAID | DELIVER PROJECT field offices. While the initial focus was on these 36 countries, it is hoped that more countries will contribute data to this activity and begin tracking this information themselves to inform their respective country's CS status and progress.

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

The data collection phase took place from January to August 2009 and included the following elements:

Survey of Key Informants. Data for most of the indicators were based on responses to a survey sent to key informants at USAID missions or USAID | DELIVER PROJECT field offices. Survey respondents often enlisted the assistance of in-country cooperating agencies or ministries of health to fill out the survey. In the few cases when targeted survey respondents did not respond to the survey request, every attempt was made to obtain the information from another source (for example, from someone knowledgeable about the country from USAID/Washington, the USAID | DELIVER PROJECT in Arlington, or another cooperating agency's project office, such as from EngenderHealth's ACQUIRE Project).

Literature Review. In addition to the extensive survey, a review of existing policies and documents was conducted to collect complementary data. Specifically, the research team reviewed each country's—

- National Essential Medicines List (NEML) to determine which contraceptives are included in the list; for the USAID | DELIVER PROJECT countries, the research team relied on the data previously reported by project field offices for internal monitoring purposes
- Poverty Reduction Strategy Paper (PRSP) to answer relevant contraceptive security indicator questions related to policies and commitment (International Monetary Fund. Poverty Reduction Strategy Papers 2009)
- *CS Index 2009* country data to assess the supply chain
- Procurement Planning and Monitoring Report (PPMR) to further assess the supply chain.

If NEML or *CS Index* documents were not available, key informants were asked to collect these complementary data.

Validation. After data collection was complete, various efforts were made to validate the information:

- Whenever possible, a USAID/Washington or USAID | DELIVER PROJECT staff member knowledgeable about the particular country reviewed the responses for accuracy.
- In addition, for the finance indicators, the review team compared the survey responses with data presented in the paper entitled, *Using National Resources to Finance Contraceptive Procurement* (USAID | DELIVER PROJECT. 2008).
- In the case of discrepancies, the review team contacted respondents to obtain clarifications and missing information.
- In the process of validating data, respondents were contacted for permission to publish these data publicly.

Data Management and Analysis—The data were entered in an Excel spreadsheet for data management and analysis. (The *Contraceptive Security Indicators Data 2009* spreadsheet can be found on the USAID | DELIVER PROJECT website.)

For more information, please visit deliver.jsi.com.

USAID | DELIVER PROJECT
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: askdeliver@jsi.com
Internet: deliver.jsi.com