PMA2020 Methodological Report No. 5:

Levels, Trends, and Patterns of Contraceptive Method Availability:

COMPARATIVE ANALYSES IN EIGHT SUB-SAHARAN AFRICAN COUNTRIES

Yoonjoung Choi, Sally Safi, Julien Nobili, PMA2020 Principal Investigators Group, and Scott Radloff

PMA2020
Performance Monitoring and Accountability 2020

Johns Hopkins Bloomberg School of Public Health

Bill & Melinda Gates Institute for Population and Reproductive Health

PMA2020 Methodological Report No. 5

Title: Levels, Trends, and Patterns of Contraceptive Method Availability: Comparative Analyses in Eight Sub-Saharan African Countries

Authors: Yoonjoung Choi, Sally Safi, Julien Nobili, PMA2020 Principal Investigators Group, and Scott Radloff

Suggested citation: Choi, Yoonjoung; Safi, Sally; Nobili, Julien; PMA2020 Principal Investigators Group; Radloff, Scott. 2019. Levels, trends, and patterns of contraceptive method availability: Comparative analyses in eight sub-Saharan African countries. Performance Monitoring and Accountability 2020 Methodological Reports No. 5. Baltimore, Maryland, USA: Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins University Bloomberg School of Public Health.

Table of Contents

List of Tables, Figures, and Appendices

Tables:

Figures:

Appendices:

Acronyms

CHPSs	Community-Based Health Planning and Services
DMPA-IM	Depot-medroxyprogesterone acetate (intramuscular injectable; Depo Provera®)
DMPA-SC	Depot-medroxyprogesterone acetate (subcutaneous injectable; Sayana Press®)
DRC	Democratic Republic of the Congo
EA	Enumeration area
FP2020	Family Planning 2020
HMIS	Health management information systems
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
NGO	Non-governmental organization
ODK	Open Data Kit
PMA2020	Performance Monitoring and Accountability 2020
SDP	Service delivery point

Preface

Performance Monitoring and Accountability 2020 (PMA2020) employs an innovative survey approach to gather population data on family planning; water, sanitation, and hygiene; maternal and neonatal health; menstrual hygiene management; nutrition; schistosomiasis; and other health issues. Data are collected at both the household and health facility levels via mobile phones through a network of local female interviewers, known as resident enumerators, stationed throughout the country. PMA2020 generates high quality, rapid-turnaround data. As such, PMA2020 continues to assess, revise, and publicize the methodology with which the data are gathered. The Methodological Report series aims to examine various issues relevant for survey data quality to enhance the understanding and analysis of PMA2020 survey data for researchers, policy makers, and survey specialists. This edition presents data from nine geographies based on the unique population-SDP linked design of PMA2020, which enables the monitoring of progress at both the population-level and the SDP-level. The PMA2020 project is funded by the Bill & Melinda Gates Foundation, whose support is gratefully acknowledged.

Scott Radloff, PhD

Director, PMA2020

Abstract

Background: Service delivery point (SDP) surveys are essential to monitor the extent to which contraceptives are accessible to populations. PMA2020, population-SDP linked monitoring surveys, provides a unique opportunity to understand levels and trends in method availability.

Methods: We used four rounds of PMA2020 SDP survey data from nine geographies in sub-Saharan Africa conducted from 2014 to 2017: Burkina Faso, Ethiopia, Ghana, Kenya, and Uganda as well as Kinshasa in DRC, Niamey in Niger, and Kaduna and Lagos states in Nigeria. The sample included SDPs that are accessible to the representative population in the geography. We first documented the SDP survey method and described the sample characteristics in each geography. We then examined individual method availability based on whether SDPs offer each method and the status of current and 3-month stock-outs. We also determined whether primary level SDPs had three or more methods available, whether secondary and tertiary level facilities had five or more methods, and whether available methods included long-acting reversible contraceptives (LARCs). Finally, to assess service readiness for LARC provision, we identified SDPs that have equipment, supplies, and trained personnel to provide IUDs and implants. For all of these measures, we assessed levels in the most recent survey and trends over the four survey rounds.

Results: SDP sample size ranged from 27 facilities surveyed in Niamey, Niger Round 3 to 456 facilities surveyed in Ethiopia Round 4. On average, across the nine geographies, injectables, pills, and condoms were offered in 86%, 92%, and 92% of SDPs, respectively. Among the facilities offering each method, 16%, 20%, and 13%, respectively, had a stock out of the method at the time of or in the three months prior to the survey. Compared to short-acting methods, IUDs and implants were offered at lower levels, with greater variation across geographies: 58% for IUD (range: 35% in Kaduna, Nigeria to 85% in Burkina Faso) and 72% for implant (range: 44% in Kaduna, Nigeria to 95% in Burkina Faso). An average of 11% and 18% of SDPs providing the IUD and implant, respectively, were stocked out of the method at the time of the survey or in the three months prior to the survey. Implant availability increased universally in the geographies studied, on average nine percentage points from the first to last round studied. In the most recent survey in each geography, 81% of primary level SDPs had three or more methods available and 83% of secondary and tertiary level facilities had five or more. The availability of five or more methods at higher level facilities increased six percentage points, on average, over the four rounds studied. Among primary SDPs with three or more methods, 86% had at least one LARC method available; among higher level SDPs with five or more methods, 88% had two LARC methods. On average across the geographies, the percent of SDPs offering the IUD that were fully ready to provide the service was 23 percentage points below the percent that had the IUD commodity in stock; the percent of SDPs offering implants that were fully ready to provide the service was 18 percentage points below the percent that had the implant commodity in stock.

Conclusions: The percentage of facilities offering IUDs and implants ranged widely across geographies, while short-acting method availability was high overall. Within geographies, availability of individual methods remained fairly stable over time except for implants, which increased universally. Service readiness figures indicate that access to LARCs may be lower than what commodity availability statistics suggest. This research demonstrates that SDP survey data can and should be used to monitor levels and trends of method and service availability and to inform program management.

1. Introduction

Voluntary, informed choice for contraceptive methods is a cornerstone of family planning. Contraceptive security aims to ensure access to a wide range of high-quality, affordable contraceptive methods, responding to the family planning needs of a population. Commodity availability and choice of methods at the facility level are critical dimensions of the rights and empowerment principles for family planning (FP2020 2015). Thus, contraceptive supply and related logistics have been a key aspect of government and donor programs in low-resource settings. Ensuring method availability and accessibility is a function of complex supply chain systems, but its monitoring ultimately requires data from individual service delivery points (SDPs); this is beyond logistics management information systems data.

Method availability at SDPs can be monitored using various data, including routine health management information systems (HMIS) and health facility assessment surveys. Though efforts to improve and use routine HMIS data have been growing and should continue, poor data quality – especially suboptimal completeness and varying definitions on data elements even within a country – remains a challenge. Further, routine HMIS data cover only public sector SDPs, and limited coverage is an additional issue in countries where the private sector plays an important role in family planning service delivery (Campbell et al. 2015). SDP surveys are a critical data source to monitor method availability at health facilities. The surveys can measure and monitor method availability as well as service quality, which routine HMIS data are typically not designed to monitor. There has been a growing number of countries conducting national or subnational SDP surveys, but few have been designed and implemented for the purpose of monitoring over time.

Performance Monitoring and Accountability 2020 (PMA2020) is a rapid-turnaround survey project, launched in 2013 to monitor progress toward the Family Planning 2020 (FP2020) partnership goals. The surveys are conducted in select countries where the government made political and financial commitments to achieve FP2020 goals in their country. Since 2013, the surveys have been conducted semi-annually for the first two years and annually thereafter in 11 countries, including nine in sub-Saharan Africa. A unique feature of PMA2020 is the population-SDP linked design, enabling monitoring of progress at both the population-level and the SDP-level. As monitoring core FP2020 indicators is a key objective of the surveys, PMA2020 has used a common methodology to generate comparable data for the indicators within and across countries. The population-based survey methods have been documented (Zimmerman, Olson, Tsui, Radloff, et al. 2017) and data are being used increasingly for research and programmatic purposes (Babazadeh et al. 2018; Guiella et al. 2018; Shiferaw et al. 2017; Tsui, Brown, and Li 2017; Zimmerman et al. 2017). The unique design of the SDP surveys, however, has

not been documented comprehensively, which is critical for increased and correct use of the unique SDP survey data.

The purpose of this report is to assess trends and patterns of contraceptive method availability in eight sub-Saharan African countries. The report has four specific aims: to document the SDP survey methods and describe the sample characteristics; to assess individual method availability at SDPs; to examine availability of multiple methods at SDPs, including long-acting reversible contraceptive (LARC) methods; and to assess service readiness for provision of LARCs.

2. PMA2020 SDP survey

2.1 SAMPLE DESIGN

PMA2020 SDP surveys are designed to gather information on access to services and the service environment at facilities that serve a representative population in a country (or selected subnational administrative units in a few countries).[1] First, PMA2020 household surveys are designed to employ two-stage, stratified cluster sampling. Enumeration areas (EAs) are selected using probability proportional to size, and a defined number of households are randomly selected in each EA. All women between 15 and 49 years of age in sampled households are eligible and invited to participate in the female survey. Detailed sampling methods and field implementation results are available elsewhere (Zimmerman, Olson, Tsui, and Radloff 2017).

For each sampled EA, up to six SDPs are selected for SDP surveys – described in detail briefly. The sample is representative of the SDPs, including both public and non-public SDPs, serving the population sampled for the household and female PMA2020 surveys. Non-public SDPs are those run by non-government organizations (NGOs), faith-based organizations, and private businesses and include both formal health facilities, such as hospitals and clinics, and non-formal health facilities, such as pharmacies and drug shops. PMA2020 selects up to three non-public SDPs that are located within each EA. If an EA has more than three non-public SDPs (which is relatively rare in resource-poor settings), three are selected randomly by survey supervisors.[2] Figure 1 shows an example from Kenya: a map with a subset of unidentified EAs included in the PMA2020 sample along with the

1. National surveys have not been conducted in the Democratic Republic of Congo (DRC) or in Nigeria because of large land areas and population, making it challenging to implement the survey methodology at scale and requiring high associated costs. Thus, in DRC, the PMA2020 survey launched in one province (Kinshasa) first and expanded to include Kongo Central. In Nigeria, the survey started in two select states first (Kaduna and Lagos) and subsequently added six additional states. In Niger, PMA2020 is conducted in Niamey, the capital, with expansion to the national-level only in even rounds (e.g. round two, round four, etc.).
2. In Kinshasa, DRC, the same sampling approach was used. However, due to the country's health system and ambiguity in classifying facilities as public or private, more than three private SDPs per EA are found in the data.

location of non-public SDPs. Although many non-public facilities exist outside the selected EAs, only non-public SDPs located within the EAs are included in the PMA2020 SDP sample.

In addition to non-public SDPs, PMA2020 selects public facilities at three levels that are designated to serve each sampled EA. The set of three public facilities typically consists of a primary level, a secondary level, and a tertiary level facility (e.g., health post, health center, and district hospital, respectively) and they may or may not be located within the EA. It is possible and likely that higher level facilities (especially district hospitals) serve multiple EAs that are selected for the PMA2020 household survey. Figure 2 shows the same map as in Figure 1 with public facilities included in the PMA2020 SDP sample. It illustrates the location of public SDPs that serve each EA by facility level. Also, depending on the country's health systems, some EAs may have fewer than three public facilities that serve the EA, as shown in Ethiopia (description to follow shortly). Figure 3 depicts the complete SDP sample of both public and non-public facilities (combining Figure 1 and Figure 2) for a subset of EAs in Kenya.

As explained above, the PMA2020 facility sample is representative of SDPs serving the population sampled for the PMA2020 household survey. When SDPs are sampled in relation to a population-based survey sample, the SDP sample reflects the service environment that is accessible to the population. This population-linked SDP survey design is unique compared to the sample of most facility surveys, which are representative of facilities in the country – regardless of accessibility among the population. Especially when the geographic distribution of facilities does not align with the geographic distribution of the population, PMA2020's SDP sample differs from a sample representative of facilities in the country.

Since the SDP sample design is linked to the household survey design, the SDP sample size is determined by two factors: the number of EAs selected for the population-based survey, and the country's health system. Even with the same number of EAs selected for the population-based survey, the SDP sample size can vary depending on public health care system (i.e. how many public health facilities are assigned to serve a defined population) and the number of non-public sector SDPs in the country. For example, in Ethiopia, the urban population is served by only two types of public health facilities: a health center and a district hospital. In Niger, a majority of EAs have no non-public SDP within their boundaries and thus, the number of private facilities is substantially smaller than the number of EAs.

Figure 1. Illustrative example of total non-public SDPs in a geography, sampled SDPs, and their location with respect to linked enumeration areas selected for PMA2020 household surveys

Figure 2. Illustrative example of sampled public SDPs and their location with respect to linked enumeration areas selected for PMA2020 household surveys

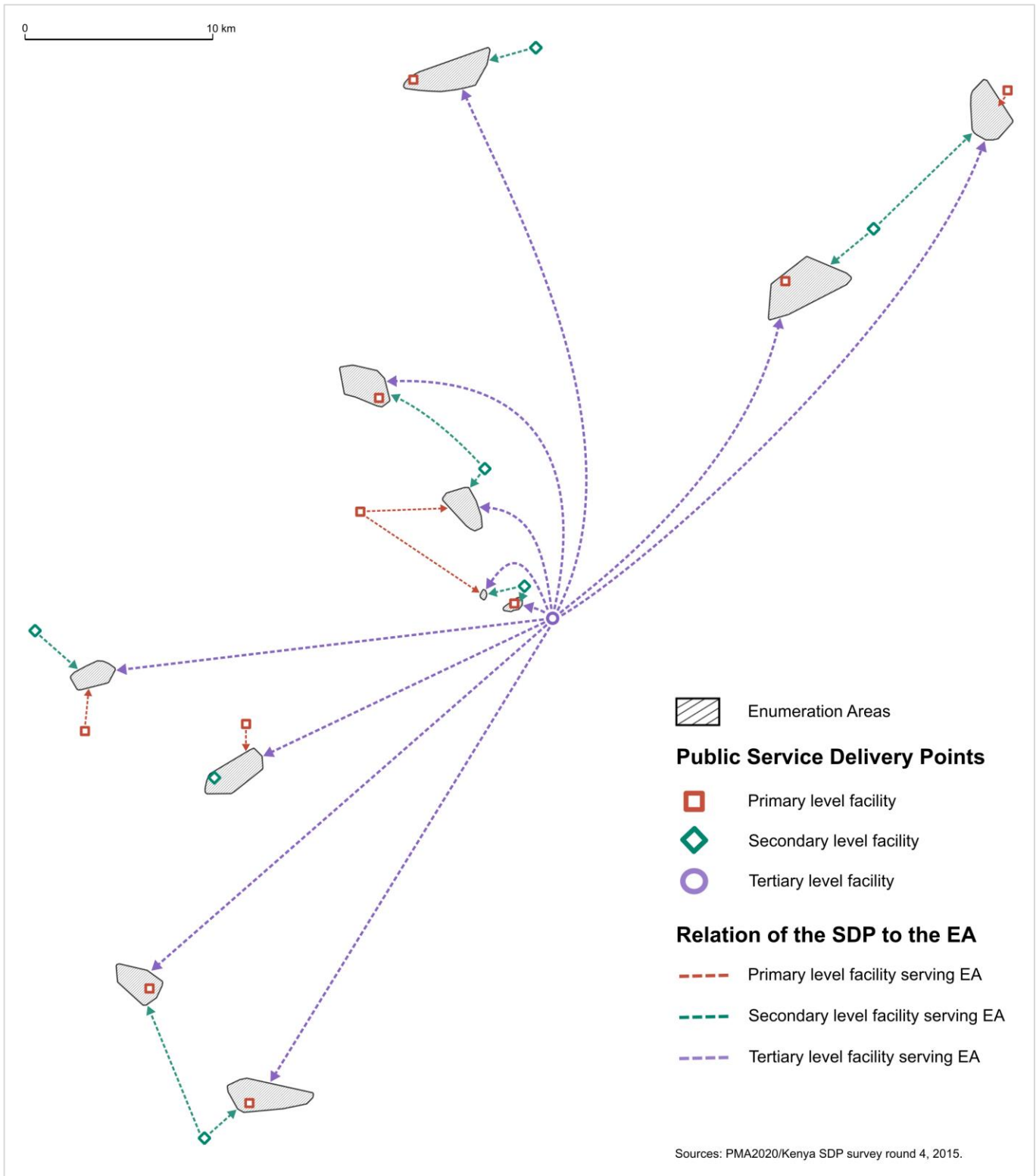
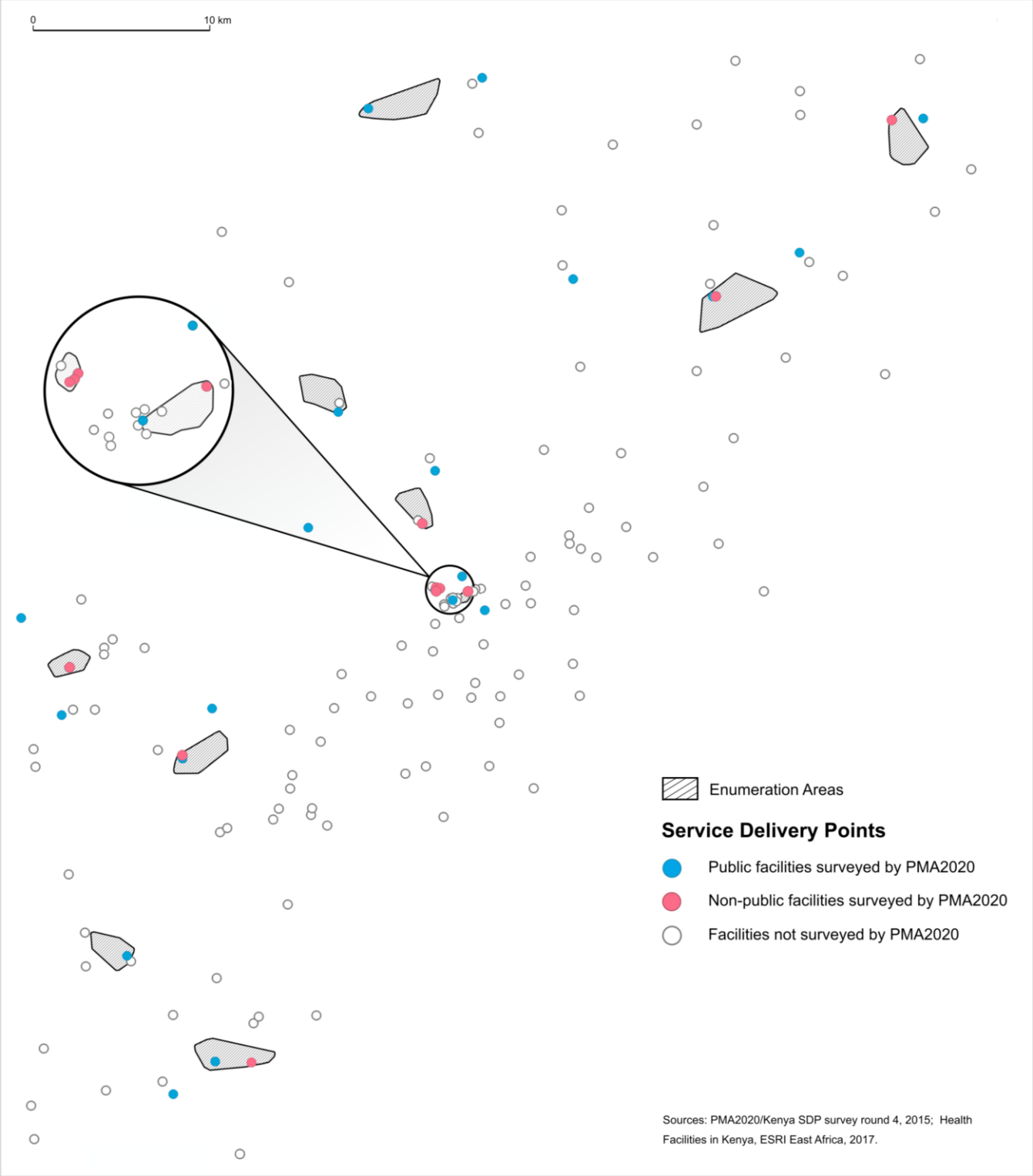


Figure 3. Illustrative example of sampled public and non-public SDPs and their location with respect to enumeration areas selected for PMA2020 household surveys



2.2 SURVEY QUESTIONNAIRE

A facility audit questionnaire is used to collect data on family planning service availability (e.g. if and when/how often family planning services are offered); general service readiness (e.g. infrastructure); service volume (e.g. number of visits and commodities dispensed during the month before the survey, by method); and method-specific service readiness (i.e. availability of contraceptive commodities, equipment, supplies, and trained health providers to provide services for specific contraceptive methods).

Each survey assessed a detailed – and in some cases slightly different – list of contraceptive methods that are approved and used in the country.[3] The number of methods assessed in a survey ranged from eight to 11. See Appendix 1 for the list of methods assessed in each country. Regarding contraceptive commodity availability, both current availability and history of stock-out are ascertained. By each method, surveyors are instructed to observe at least one unexpired unit to determine availability on the day of assessment – hereinafter referred to as current availability. Once availability is verified, surveyors further ask if the facility had a stock-out of the method in the past three months before the survey. History of stock-out is based on respondents' report without verifying any record.

In addition, information on basic characteristics of SDPs is collected such as managing authority (e.g. public, private, or non-governmental organization, etc.) and facility type (e.g. hospital, health center, health clinic, pharmacy, etc.). The latest PMA2020 core questionnaire is available online (PMA2020 2017).

2.3 SURVEY FIELDWORK IMPLEMENTATION

For the population-based PMA2020 surveys PMA2020, interviews are conducted by locally recruited and trained female resident enumerators (Hawes et al. 2017). For the SDP surveys, however, both field supervisors and resident enumerators conduct interviews, since surveyors' knowledge on health care can facilitate interviews with facility managers and staff, especially at higher level SDPs. Training for SDP survey data collection is part of the training of trainers and training of resident enumerators, which are conducted prior to the start of the first round of data collection. Refresher trainings are conducted before each subsequent survey round. Further information on training and survey field team structure is available elsewhere (Hawes et al. 2017).

3. For example, some countries measure availability and provision of contraceptive foam or jelly, diaphragm, and "other modern" methods.

2.4 DATA ENTRY AND TRANSFER USING MOBILE TECHNOLOGIES

PMA2020 uses innovative approaches to collect and disseminate data rapidly, relying on mobile phone technologies and an open source software to capture and manage data. A customized version of Open Data Kit (ODK) is programmed with the questionnaire, which includes automatic skip patterns and validation checks. The questionnaire is loaded onto a resident enumerators' Android smartphone, and the resident enumerator enters responses directly into the phone. Upon completion, the interview data are transferred to a server via a mobile network for further data quality checks and management.

3. Methods

3.1 DATA

This report uses data from eight sub-Saharan African countries where four or more rounds of PMA2020 SDP survey results are available as of February 2018. The geographies that meet these criteria are: Burkina Faso, the Kinshasa province in the Democratic Republic of the Congo (DRC), Ethiopia, Ghana, Kenya, the Niamey region in Niger, Kaduna State in Nigeria, Lagos State in Nigeria, and Uganda. Table 1 presents the SDP sample size and response rate by survey. The table also presents the survey round number, dates of data collection, and number of EAs included in the sample. The number of EAs included in a sample ranges from 33 EAs in Niamey, Niger to 221 EAs in Ethiopia. As previously mentioned, the number of SDPs in a sample varies based on the number of EAs sampled. The smallest sample of SDPs is 31 in Niamey, Niger and the largest is 461 in Ethiopia. The average response rate for a survey round is 95.8%.

In some geographies, Round 1 and/or Round 2 data are not included in this report. In these cases, the survey round included questions about availability of contraceptive commodities that are not comparable to questions asked in later rounds. In order to calculate indicators of interest for this report, those survey rounds are excluded and later survey rounds are used. For each geography, we present data from four survey rounds. All data were collected between September 2014 and November 2017.

Table 1. PMA2020 SDP sample characteristics, by country and round

Country	Round	Year	Dates of data collection: Start	End	Number of EAs*	Number of SDPs	Number of complete	Response rate
Burkina Faso	1	2014	Nov-14	Jan-15	53	107	106	99.1%
	2	2015	Apr-15	Jun-15		107	100	93.5%
	3	2016	Mar-16	May-16	83	134	132	98.5%
	4	2016	Dec-16	Jan-17		133	129	97.0%
DRC: Kinshasa	3	2015	May-15	Jun-15	58	254	247	97.2%
	4	2015	Nov-15	Jan-16		239	228	95.4%
	5	2016	Aug-16	Sep-16		183	171	93.4%
	6	2017	Sep-17	Nov-17		185	177	95.7%
Ethiopia	2	2014	Oct-14	Dec-14	200	407	398	97.8%
	3	2015	Apr-15	May-15	221	451	444	98.4%
	4	2016	Mar-16	May-16		461	456	98.9%
	5	2017	Apr-17	May-17		452	442	97.8%
Ghana	3	2014	Sep-14	Dec-14	100	241	231	95.9%
	4	2015	May-15	Jun-15		239	233	97.5%
	5	2016	Aug-16	Nov-16		169	156	92.3%
	6	2017	Sep-17	Nov-17		199	183	92.0%
Kenya	2	2014	Nov-14	Dec-14	120	354	324	91.5%
	3	2015	Jun-15	Jul-15		358	348	97.2%
	4	2015	Nov-15	Dec-15		358	338	94.4%
	5	2016	Nov-16	Dec-16	151	428	410	95.8%
Niger: Niamey	1	2015	Jun-15	Aug-15	33	33	31	93.9%
	2	2016	Mar-16	May-16		33	33	100.0%
	3	2016	Nov-16	Dec-16		31	27	87.1%
	4	2017	May-17	Sep-17		32	32	100.0%
Nigeria: Kaduna	1	2014	Sep-14	Oct-14	66	137	135	98.5%
	2	2015	Sep-15	Oct-15		153	149	97.4%
	3	2016	May-16	Jul-16		146	142	97.3%
	4	2017	Apr-17	May-17		167	165	98.8%
Nigeria: Lagos	1	2014	Sep-14	Oct-14	39	94	87	92.6%
	2	2015	Sep-15	Oct-15	52	132	123	93.2%
	3	2016	May-16	Jul-16		132	124	93.9%
	4	2017	Apr-17	May-17		125	117	93.6%
Uganda	2	2014	Jan-15	Feb-15	110	369	360	97.6%
	3	2015	Aug-15	Sep-15		378	362	95.8%
	4	2016	Mar-16	Apr-16		378	350	92.6%
	5	2017	Apr-17	May-17		348	335	96.3%

*The number of EAs increased substantially in select countries either to improve precision (Burkina, Ethiopia, Lagos, Nigeria) or to increase the number of sampling strata (Kenya).

3.2 MEASURES

We provide data on the following measures: availability of five individual methods at SDPs, availability of multiple methods including LARC methods, and service readiness for provision of LARCs. We assessed methods (e.g. injectable), not products (e.g. 3- or 6-month injectable, and intramuscular or subcutaneous injectables). We aligned our measures with definitions of core indicators used in FP2020 monitoring: indicators 10, 11a, and 11b. (FP2020 2015, n.d.; Track20 n.d.).

To study availability of individual methods, we categorized SDPs that offer family planning into four groups: not offering the method; offering the method but currently out of stock of the method (i.e. on the day of the assessment); offering the method, which is currently available but with history of stock-outs in the last three months; and offering the method, which is currently available with no history of stock-outs in the last three months. For the purpose of this study, we focused on five methods that are commonly used in the region, based on method mix data available from population-based surveys. These methods include: intrauterine devices (IUD), implants, injectables, pills, and male condoms. In select countries where subcutaneous injectables have been introduced at scale, PMA2020 has measured the availability of intramuscular injectables (known by its commercial name, Depo Provera®) and subcutaneous injectables (known by its commercial name, Sayana Press®) rather than injectables in general. In these cases, we present information on the two injectable methods separately.

The availability of multiple methods indicates access to contraceptive choices. To measure this, we adopted the indicator definitions used in FP2020's annual monitoring framework (FP2020 2015). We generated a binary variable to identify primary level SDPs, regardless of whether the SDP provides family planning, with three or more methods available on the day of assessment. Available methods include methods for which the commodity was in stock and male and female sterilization if the facility offered the procedure. Among secondary and tertiary level facilities, we created another binary variable to identify SDPs with five or more methods. As previously indicated, each country survey asks about different methods depending on method availability in the country. For both variables, we assessed the number of method types, irrespective of different delivery modes (e.g. intramuscular or subcutaneous injectables) or active ingredients (e.g. combined or progestin-only oral pills).

When facilities had three or more methods available, we determined what percent of those facilities had one or more LARC methods available. For secondary and tertiary level facilities that had five or more methods available, we determined the percent of facilities with two LARC methods available.

Finally, to assess service readiness, we calculated the percent of facilities offering implants and IUDs that had the contraceptive method in stock, had trained personnel available to insert and remove the method, and had all equipment and supplies available for method insertion and removal. The

equipment and supplies minimally required for the implant include six items: clean gloves, antiseptic, sterile gauze pad or cotton wool, local anesthetic, surgical blade, and a sealed implant pack. For the IUD, there are three minimally required items: sponge-holding forceps, speculum, and tenaculum. Often, having a contraceptive in stock at an SDP is tracked as an indicator of method availability. A more comprehensive definition of availability, however, should encompass service readiness with respect to required trained personnel and supplies for clinical methods.

For the background characteristics of SDPs, the surveys collected information on the managing authority (public and non-public) and the facility type. Detailed categories for the managing authority and facility types vary by country due to differing health systems. For this report, SDPs were classified into two sectors (public and non-public) and three levels (primary, secondary, and tertiary). Appendix 2 presents detailed information on facility types by level in each country.

3.3 ANALYSIS

The unit of analysis was the SDP. All analyses were conducted by individual survey, and results were compared across survey rounds and countries. For availability of individual methods, we assessed the percent distribution of SDPs offering family planning – including both formal and non-formal SDPs – by the four previously mentioned availability categories. For availability of multiple methods (i.e. three or more methods and five or more methods), we calculated percent of formal facilities – excluding pharmacy, drug shop and other non-formal health facilities – that met the criteria regardless of whether or not they provide family planning.

In our study settings, the number of private SDPs per EA did not exceed three in most cases, with a few exceptions such as Kinshasa, DRC.[4] Thus, all eligible SDPs (i.e. all public SDPs designated to serve EAs and up to three private SDPs located within the EAs) are included in the surveys, and there are no sampling weights associated with the sample design. For summary statistics, we calculated unweighted averages of estimates across the surveys and geographies. In general, we first present the level of measures in the most recent survey round, then compare measures across rounds, and finally compare measures for public and private facilities combined to public facilities only.

4. In countries with relatively prevalent non-public sector SDPs, some urban EAs had three or more non-public SDPs within the boundary. Although the sampling protocol is to select up to three private SDPs per EA, there are some exceptions in the data. Based on the most recent survey across the nine geographies studied in this report, a total of 860 EAs were surveyed and 84 EAs (10%) had three or more non-public SDPs within the EA. Of those, 33 EAs are in Kinshasa, DRC. As noted above, the distinction between public and non-public facilities in the DRC health system is not clear, which explains the relatively large number of EAs in Kinshasa that are classified as private in the data.

4. Results

4.1 Characteristics of SDP sample

The SDP sample size varies across countries as does the sample composition in terms of the managing authority sector (i.e. public versus private) and facility level (e.g. primary, secondary, or tertiary, and pharmacy or shop, etc.). Table 2 outlines the number of completed facility surveys by sector and level for each country-round.

In Burkina Faso, the number of SDPs with completed surveys ranges from about 100 SDPs in Rounds 1 and 2 to about 130 SDPs in Rounds 3 and 4. The increase in sample size is due to the expansion from 53 to 83 EAs between Rounds 2 and 3. Across survey rounds, about 85% of SDPs surveyed are public. Half of the facilities are primary level, about 40% are secondary or tertiary level, and the remaining 10% are pharmacies or shops.

In Kinshasa, DRC, the SDP sample size ranges from 228 to 247 SDPs in Rounds 3 and 4, and decreases to 171 to 177 SDPs in Rounds 5 and 6. The decline in the number of SDPs sampled in Kinshasa, DRC is due to a change in the sampling approach between Round 4 and 5. EAs prior to Round 5 were relatively large compared to EAs in other PMA2020 geographies. In Round 5, PMA2020 decreased the geographic area of each EA to the standard of about 200 households. As a result, fewer SDPs fell within the boundaries of the EAs and thus fewer SDPs were sampled. Across rounds, approximately 85% of SDPs are classified as private sector SDPs. However, the distinction between public and non-public management in this setting is not clear. Many SDPs receive financial support from both public and non-public sources, and this may change over time. In contrast, categorizing SDPs into levels is straightforward. In the Kinshasa, DRC SDP samples included in this report, roughly half are primary level, 10% are secondary or tertiary level, and the remaining 40% are pharmacies or shops.

The PMA2020 SDP sample in Ethiopia is the largest compared to the other geographies included in this report. In Round 2 the sample included about 400 SDPs. Due to the expansion from 200 to 221 EAs between Rounds 2 and 3, the number of SDPs in Rounds 3 through 5 is about 450. Most SDPs (about 85%) are public. Approximately 30% of SDPs are primary level SDPs while about two-thirds are secondary or tertiary level SDPs. The remaining 5% are pharmacies or shops. Most geographies included in this report have a higher percentage of primary level facilities. The relatively low percentage of primary facilities in the Ethiopia sample is due to the fact that urban EAs usually do not have a health post (a primary level facility) that serves the area.

In Ghana, 156 to 233 SDPs were surveyed in Rounds 3 through 6. About two-thirds of facilities are public. In Ghana, health clinics, Community-Based Health Planning and Services (CHPSs), health

centers, and district hospitals are considered primary level facilities, regional hospitals are considered secondary level facilities, and teaching hospitals are considered tertiary level facilities. The PMA2020 Ghana questionnaires did not distinguish between various hospital types in the country; thus, separating district, regional, and teaching hospitals is not possible. We speculate, however, that only a small number of hospitals surveyed in PMA2020 Ghana are secondary or tertiary. There are only 15 regional and teaching hospitals in the country and it is unlikely that they are all included in the PMA2020 sample. Therefore, of the 68 to 82 hospitals included in each survey round, most were likely district hospitals (primary level). In sum, facilities in the sample were predominantly primary level facilities (i.e. health clinics, CHPSs, health centers, and district hospitals). Therefore, for analytical purposes, in this report we assumed all SDPs were primary level facilities as defined by the Ghana Health Services, even though a small number of the hospitals may have been either secondary or tertiary level facilities.

The number of SDPs in the Kenya sample is 324 to 348 SDPs in Rounds 2 through 4. The sample size increased to 410 in Round 5. The increase in sample size is the result of the PMA2020 program expanding to new counties in Round 5 and adding 31 EAs to the sample. About 80% of SDPs in the Kenya sample are public. Approximately 40% of facilities are primary level SDPs, just under half are secondary or tertiary, and slightly over 10% are pharmacies or shops.

In Niamey, Niger, PMA2020 has the smallest SDP sample among the geographies in this report. The sample size ranges from 27 to 33 SDPs, about 80% of which are public. Two-thirds of facilities in the samples are primary, about 10% are secondary or tertiary, and 15% to 20% are pharmacies or shops.

In Kaduna State, Nigeria the sample size ranges from 135 to 165 SDPs in Rounds 1 through 4. About half of these facilities are public. The proportion of facilities that are pharmacies or shops, 40% to 50%, is relatively high compared to that of other geographies in this report. About 40% of facilities are primary level SDPs and about 15% are secondary or tertiary level facilities.

In Lagos State, Nigeria the SDP sample is 87 in Round 1. Due to the expansion from 39 to 52 EAs prior to Round 2, the sample size is about 120 in Rounds 2 through 4. Slightly over half (about 55% to 60%) of facilities are public. Roughly 45% are primary level, 20% are secondary or tertiary level, and about a third are pharmacies or shops.

Finally, in Uganda the SDP sample size ranges from 335 to 362 SDPs. The majority (about 65%) are public. Half of the facilities in the sample are primary level, 30% are secondary or tertiary level, and 20% are pharmacies or shops.

Table 2. Number of complete facility surveys by sector and level, by country and round

	Public	Non-public	**Total**	Public	Non-public	**Total**	Public	Non-public	**Total**	Public	Non-public	**Total**
Burkina Faso		2014 Round 1			2015 Round 2			2016 Round 3			2016 Round 4	
Secondary & tertiary	42	3	**45**	39	4	**43**	47	5	**52**	49	4	**53**
Primary	47	5	**52**	47	2	**49**	62	8	**70**	61	6	**67**
Pharmacy & other	0	9	**9**	0	8	**8**	1	9	**10**	4	5	**9**
Total	**89**	**17**	**106**	**86**	**14**	**100**	**110**	**22**	**132**	**114**	**15**	**129**
DRC: Kinshasa		2015 Round 3			2015 Round 4			2016 Round 5			2017 Round 6	
Secondary & tertiary	11	13	**24**	14	9	**23**	13	11	**24**	13	9	**22**
Primary	15	113	**128**	14	85	**99**	11	79	**90**	11	97	**108**
Pharmacy & other	4	91	**95**	3	103	**106**	0	57	**57**	0	47	**47**
Total	**30**	**217**	**247**	**31**	**197**	**228**	**24**	**147**	**171**	**24**	**153**	**177**
Ethiopia		2014 Round 2			2015 Round 3			2016 Round 4			2017 Round 5	
Secondary & tertiary	257	0	**257**	288	0	**288**	301	0	**301**	295	2	**297**
Primary	85	30	**115**	96	34	**130**	94	35	**129**	97	24	**121**
Pharmacy & other	0	26	**26**	1	25	**26**	0	26	**26**	1	23	**24**
Total	**342**	**56**	**398**	**385**	**59**	**444**	**395**	**61**	**456**	**393**	**49**	**442**
Ghana		2014 Round 3			2015 Round 4			2016 Round 5			2017 Round 6	
Primary, secondary & tertiary*	144	22	**166**	142	24	**166**	112	23	**135**	121	22	**143**
Pharmacy & other	2	63	**65**	2	65	**67**	0	21	**21**	0	40	**40**
Total	**146**	**85**	**231**	**144**	**89**	**233**	**112**	**44**	**156**	**121**	**62**	**183**
Kenya		2014 Round 2			2015 Round 3			2015 Round 4			2016 Round 5	
Secondary & tertiary	135	20	**155**	140	29	**169**	139	21	**160**	156	18	**174**
Primary	129	6	**135**	125	9	**134**	130	7	**137**	181	7	**188**
Pharmacy & other	0	34	**34**	1	44	**45**	1	40	**41**	2	46	**48**
Total	**264**	**60**	**324**	**266**	**82**	**348**	**270**	**68**	**338**	**339**	**71**	**410**
Niger: Niamey		2015 Round 1			2016 Round 2			2016 Round 3			2017 Round 4	
Secondary & tertiary	4	0	**4**	4	0	**4**	2	0	**2**	3	0	**3**
Primary	21	0	**21**	22	0	**22**	20	1	**21**	22	1	**23**
Pharmacy & other	0	6	**6**	1	6	**7**	0	4	**4**	0	6	**6**
Total	**25**	**6**	**31**	**27**	**6**	**33**	**22**	**5**	**27**	**25**	**7**	**32**
Nigeria: Kaduna		2014 Round 1			2015 Round 2			2016 Round 3			2017 Round 4	
Secondary & tertiary	24	3	**27**	17	1	**18**	17	2	**19**	23	3	**26**
Primary	49	5	**54**	61	5	**66**	52	4	**56**	57	5	**62**
Pharmacy & other	0	54	**54**	0	65	**65**	2	65	**67**	0	77	**77**
Total	**73**	**62**	**135**	**78**	**71**	**149**	**71**	**71**	**142**	**80**	**85**	**165**
Nigeria: Lagos		2014 Round 1			2015 Round 2			2016 Round 3			2017 Round 4	
Secondary & tertiary	14	5	**19**	14	12	**26**	15	10	**25**	14	12	**26**
Primary	39	1	**40**	53	2	**55**	53	4	**57**	53	1	**54**
Pharmacy & other	0	28	**28**	0	42	**42**	0	42	**42**	0	37	**37**
Total	**53**	**34**	**87**	**67**	**56**	**123**	**68**	**56**	**124**	**67**	**50**	**117**
Uganda		2014 Round 2			2015 Round 3			2016 Round 4			2017 Round 5	
Secondary & tertiary	90	15	**105**	93	13	**106**	85	14	**99**	86	12	**98**
Primary	141	44	**185**	137	42	**179**	139	32	**171**	133	37	**170**
Pharmacy & other	0	70	**70**	0	77	**77**	0	80	**80**	0	67	**67**
Total	**231**	**129**	**360**	**230**	**132**	**362**	**224**	**126**	**350**	**219**	**116**	**335**

*In Ghana, the number of hospitals (which could not be identified for their level) was 82 in Round 3, 82 in Round 4, 68 in Round 5, and 75 in Round 6.

4.2 COMMODITY AVAILABILITY BY INDIVIDUAL METHOD

We first assessed availability of the five select methods – IUD, implant, injectable, pill, and male condom – among sampled SDPs that offer family planning. Figure 4 displays the percent distribution of SDPs according to commodity availability by country and round for these five methods. Across the nine geographies, injectables, pills, and condoms were offered on average in 86%, 92%, and 92% of SDPs, respectively, according to the latest survey round in each geography (see Appendix 3a). In Burkina Faso, Ethiopia, Kenya, and Uganda, over 90% of SDPs offered the injectable, while at least 70% of SDPs offered the injectable in the remaining geographies. Pills and condoms were offered in at least 75% of SDPs across geographies. In many geographies, including Burkina Faso, Ethiopia, Ghana, Kenya, and Lagos, Nigeria, at least 90% of SDPs offered pills and condoms. The percent of SDPs offering injectables, pills, and condoms remained fairly stable over the rounds studied in all geographies except Kinshasa, DRC). In Kinshasa, DRC the percent of SDPs offering injectables, pills, and condoms increased by 24, 18, and nine percentage points, respectively, from the first to the latest round.

We also assessed stock-outs among SDPs offering specific methods. According to the latest survey round in each geography, among SDPs offering injectables, pills, and condoms, on average 16%, 20%, and 13%, respectively, had a stock-out currently (i.e. at the time of the survey) or in the three months prior to the survey (see Appendix 3a). Stock-outs of the injectable ranged from 0% (Niamey, Niger) to 30% (Uganda) of SDPs offering the method in all geographies, while stock-outs of pills ranged from 2% (Burkina Faso) to 47% (Uganda), and stock-outs of condoms ranged from 3% (Burkina Faso) to 23% (Kinshasa, DRC). Stock-outs of these methods varied by round. For example, stock-outs of injectables among SDPs offering the method varied by at least 20 percentage points across rounds in Ethiopia, while stock-outs of pills varied by the same amount in Burkina Faso and Uganda. In Niamey, Niger, stock-outs of all three short-acting methods varied 22 to 28 percentage points across rounds.

Compared to short-acting methods, IUDs and implants were offered at lower levels with greater variation across geographies. According to the latest round survey in each geography, an average of 58% of all SDPs offered the IUD (range: 35% in Kaduna, Nigeria to 85% in Burkina Faso) and 72% offered the implant (range: 44% in Kaduna, Nigeria to 95% in Burkina Faso). While IUD availability decreased or remained stable in five geographies and increased in four states, implant availability increased across the board, on average nine percentage points between the first and latest round.

In terms of stock-outs of LARCs, an average of 11% and 18% of SDPs were stocked out of the IUD or implant, respectively, at the time of the most recent survey or in the three months prior to the survey, among SDPs providing IUD and implants. Stock-outs of the IUD ranged from 0% (Niamey, Niger) to 27% (Kinshasa, DRC) of facilities offering the IUD, while stock-outs of implants ranged from 4% (Burkina Faso) to 31% (Kaduna, Nigeria) of facilities offering the method.

There was less variation across rounds in stock-outs of IUDs and implants compared to short-acting methods. The only geographies with fluctuations in stock-outs at or above 20 percentage points across rounds were in Niamey, Niger (IUD stock-outs varied 33 percentage points and implant stock-outs varied 26 percentage points) and Uganda (implant stock-outs varied 20 percentage points).

In nearly all cases, the percentage of public SDPs offering each method was greater than that of public and non-public SDPs combined (see Appendix 3b). Differences were largest in the geographies with relatively high percentages of private SDPs, including Kinshasa in DRC, Ghana, Kaduna State in Nigeria, Lagos State in Nigeria, and Uganda. In these geographies, the percentage of public SDPs offering the IUD, implant, and injectables was significantly higher than that of public and non-public SDPs. For the latest round studied across these five geographies, the average of the difference between public versus public and non-public combined was 23, 27, and 19 percentage points, respectively. When looking at stock-outs among SDPs offering each method, differences in levels between public-only and public and non-public combined were negligible.

Appendices 3a and 3b provide detailed information and tables on individual commodity availability for each geography.

Figure 4. Distribution of SDPs by commodity availability of five methods among those providing family planning services: by country and round

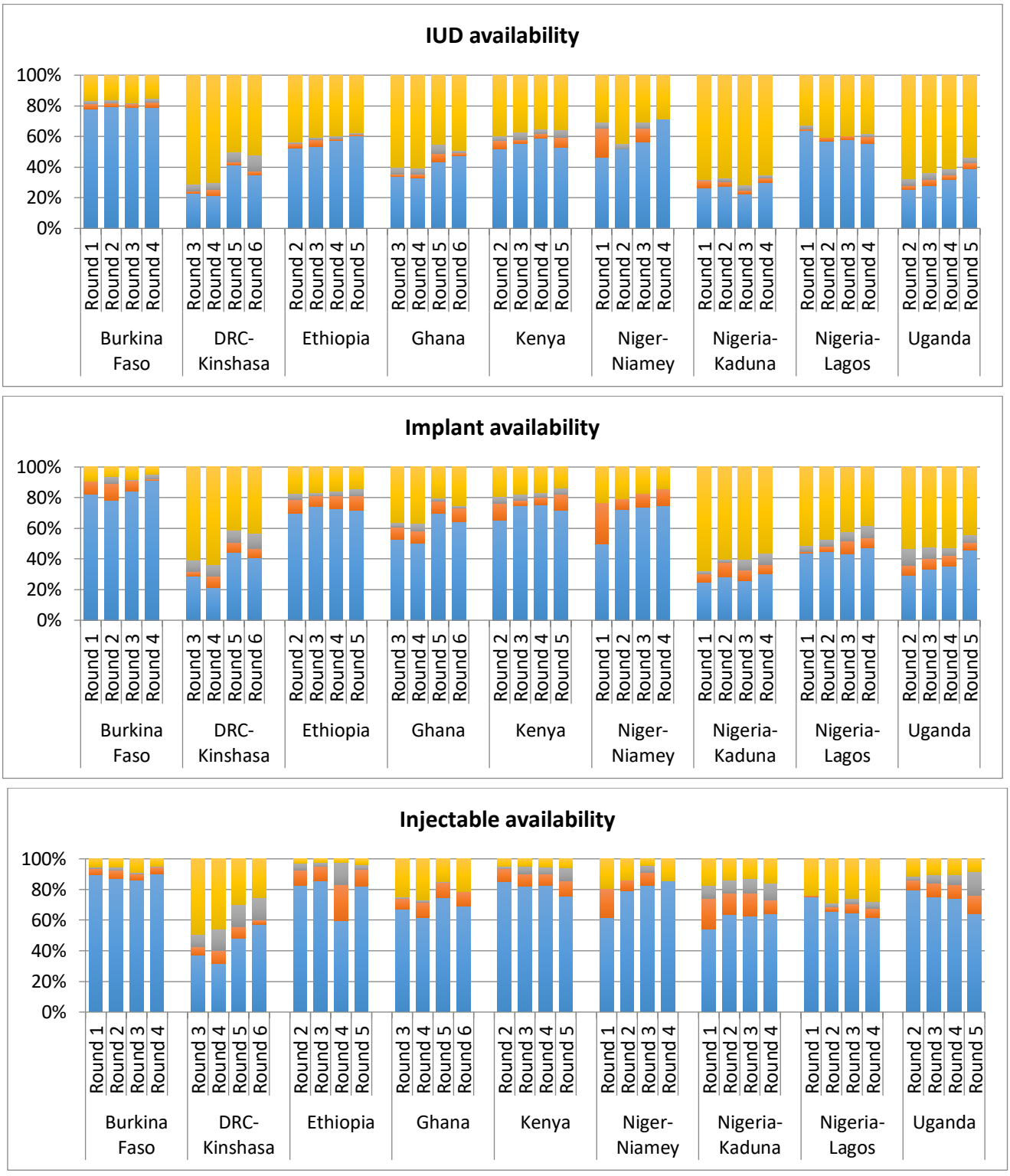
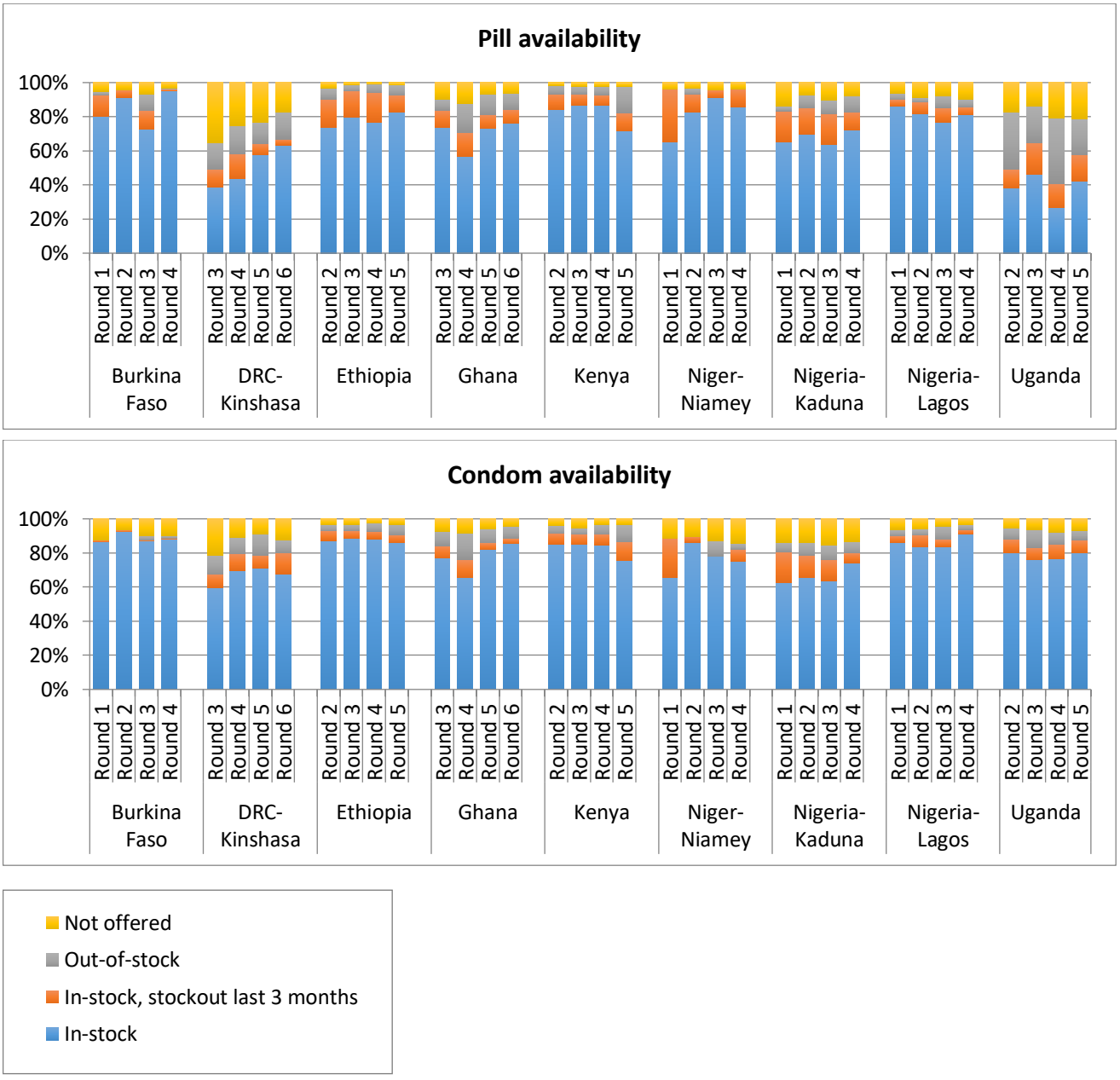


Figure 4. (continued)



4.3 AVAILABILITY OF THREE AND FIVE METHODS AND OF LARCS

Next, we assessed the availability of three or more and five or more methods of family planning, regardless of method type – among formal health facilities. Figure 5 shows trends in method availability at primary level facilities and Figure 6 show trends in method availability at secondary and tertiary level facilities for each country. In the most recent survey round in each geography, on average 81% of primary SDPs had three or more methods (range: 42% in Kinshasa, DRC to 96% in Lagos, Nigeria and Niamey, Niger). In Burkina Faso, Ghana, Kenya, Niamey, Niger, and Lagos, Nigeria, at least 90% of primary level SDPs had three or more contraceptive methods available at the time of the survey. Availability of three or more methods did not consistently change across rounds in the nine geographies. Availability of five or more methods among higher level SDPs was 83% on average (range: 59% in Kinshasa, DRC to 96% in Burkina Faso) in the latest survey round across geographies, an increase of six percentage points on average over the four rounds.

Geographies that have a high percentage of primary level facilities with three or more methods also tended to have a high percentage of primary level facilities with one or more LARCs. Among primary SDPs with three or more methods, an average of 86% had at least one LARC method across the geographies (range: 65% in Ethiopia to 100% in Burkina Faso) in the latest survey round. In Burkina Faso, Ghana, Kenya, Niamey, Niger, and Lagos, Nigeria 92% to 100% of facilities with three or more methods had at least one LARC method available. Among facilities with five or more methods available in the latest survey round, an average of 88% had two LARC methods available (range: 77% in Kinshasa, DRC to 92% in Burkina Faso and Kenya). Over the rounds and geographies studied, availability of LARCs increased. From the first to last round studied, the average increase of primary level facilities with three or more methods offering one LARC was eight percentage points, while the average increase for higher level facilities with five or more methods offering two LARCs was four percentage points.

Availability of multiple methods and LARCs at public facilities (see Appendix 4b) is fairly similar to availability at public and non-public facilities combined. For most geographies, the percentage of public facilities offering three or more methods, five or more methods, and LARC methods was the same as or a few percentage points higher than that of public and non-public facilities combined. One exception is Kinshasa, DRC where primary level public facilities were much more likely to offer at least three methods than were public and non-public facilities combined (the difference ranged from 31 to 54 percentage points across the four rounds). Another exception is Lagos, Nigeria where higher level public facilities were significantly more likely to offer at least five methods than were public and non-public facilities combined (the difference ranged from 11 to 27 percentage points across four rounds).

Appendices 4a and 4b presents detailed information and tables on availability of multiple methods for each geography.

Figure 5. Trends in the percent of public and non-public primary level facilities with three or more methods available and availability of LARC methods among them: by country and round

*Ghana: Graph represents primary, secondary, and tertiary level facilities combined.

Figure 6. Trends in the percent of public and non-public secondary/tertiary level facilities with five or more methods available and availability of LARC methods among them: by country and round

Note: Due to small sample size for secondary/tertiary level facilities in Niamey, Niger, the graph for this geography is not shown. In Ghana, facility level distinction among hospitals is not possible in the dataset, and thus, Ghana results are not presented in this figure.

4.4 SERVICE READINESS FOR IMPLANTS AND IUD

Finally, we assessed service readiness of facilities in terms of having in place commodities, equipment, supplies, and personnel required for implant and IUD insertion and removal (see Appendix 5a). In the latest survey round, readiness to provide IUD services ranged between 15% in Kinshasa, DRC and 96% in Lagos, Nigeria with an average of 73% across geographies. Implant service readiness was higher than IUD service readiness, ranging from 50% in Niamey, Niger to 91% in Ghana, with an average of 75% across geographies. Results from the latest round in each geography are presented further in Figure 7. There is no clear pattern of any single element – personnel, equipment and supplies, or commodity – affecting the readiness score across countries.

Since commodity availability is an element of service readiness that is more widely monitored than service readiness as a whole, we compared the percent of facilities that have commodity availability with the percent of SDPs that have service readiness using this broader definition. On average, examining the latest survey round across the nine geographies, the percent of SDPs offering the IUD that are fully ready to provide the service is 23 percentage points below the percent that have the IUD commodity in stock. This difference ranges from one percentage point in Lagos, Nigeria to 71 percentage points in Kinshasa, DRC. For implants, on average, the percent of SDPs offering the method that are fully ready to provide the service is 18 percentage points below the percent of SDPs that have the implant commodity in stock. This difference ranges from seven percentage points in Ghana to 50 percentage points in Niamey, Niger. Figure 8 presents the comparison of commodity availability and service readiness for the IUD and implant.

Figure 7. Percent of facilities with components of and overall service readiness to provide implants and IUDs among facilities providing implants and IUDs: the most recent round by country

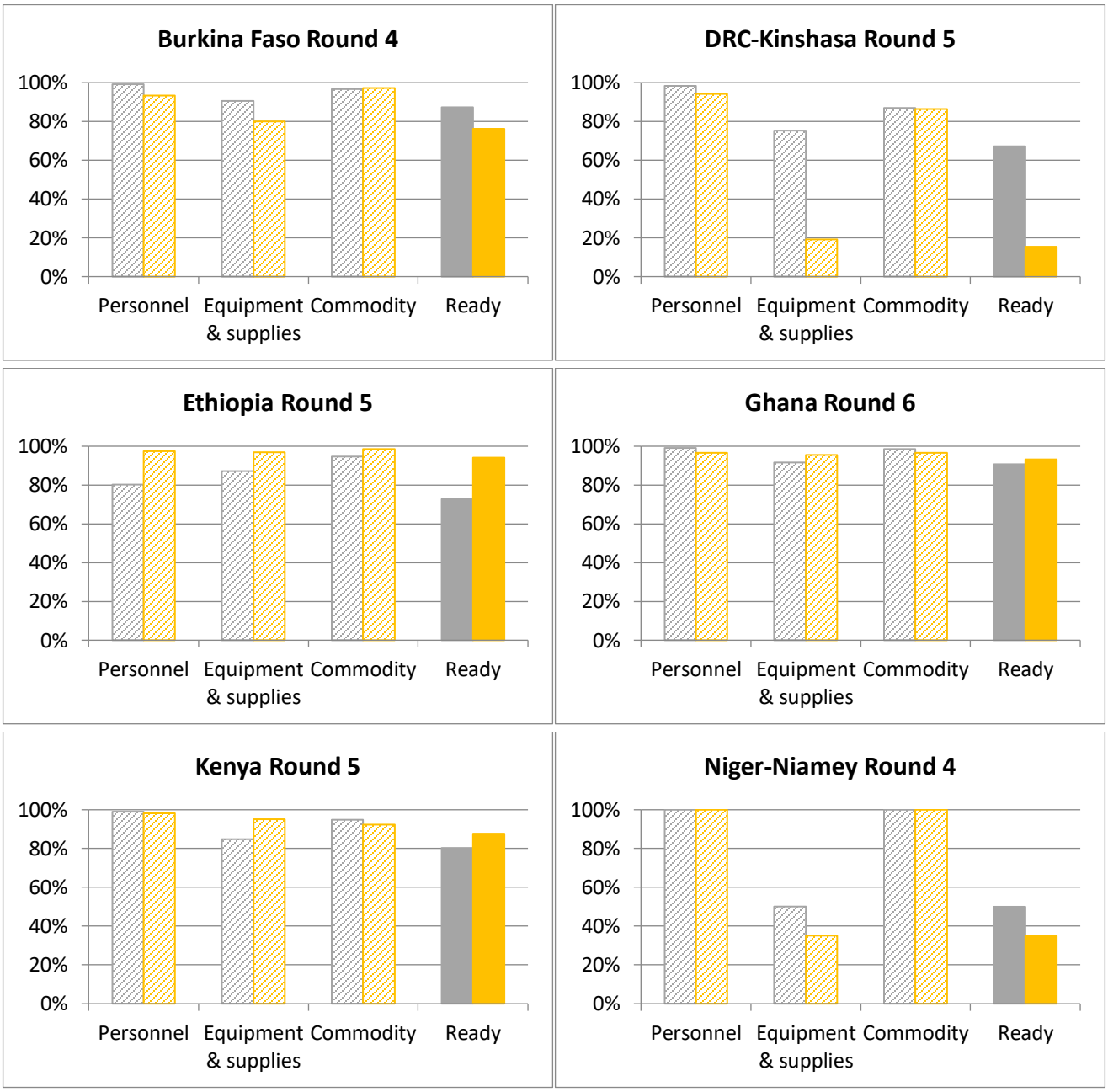
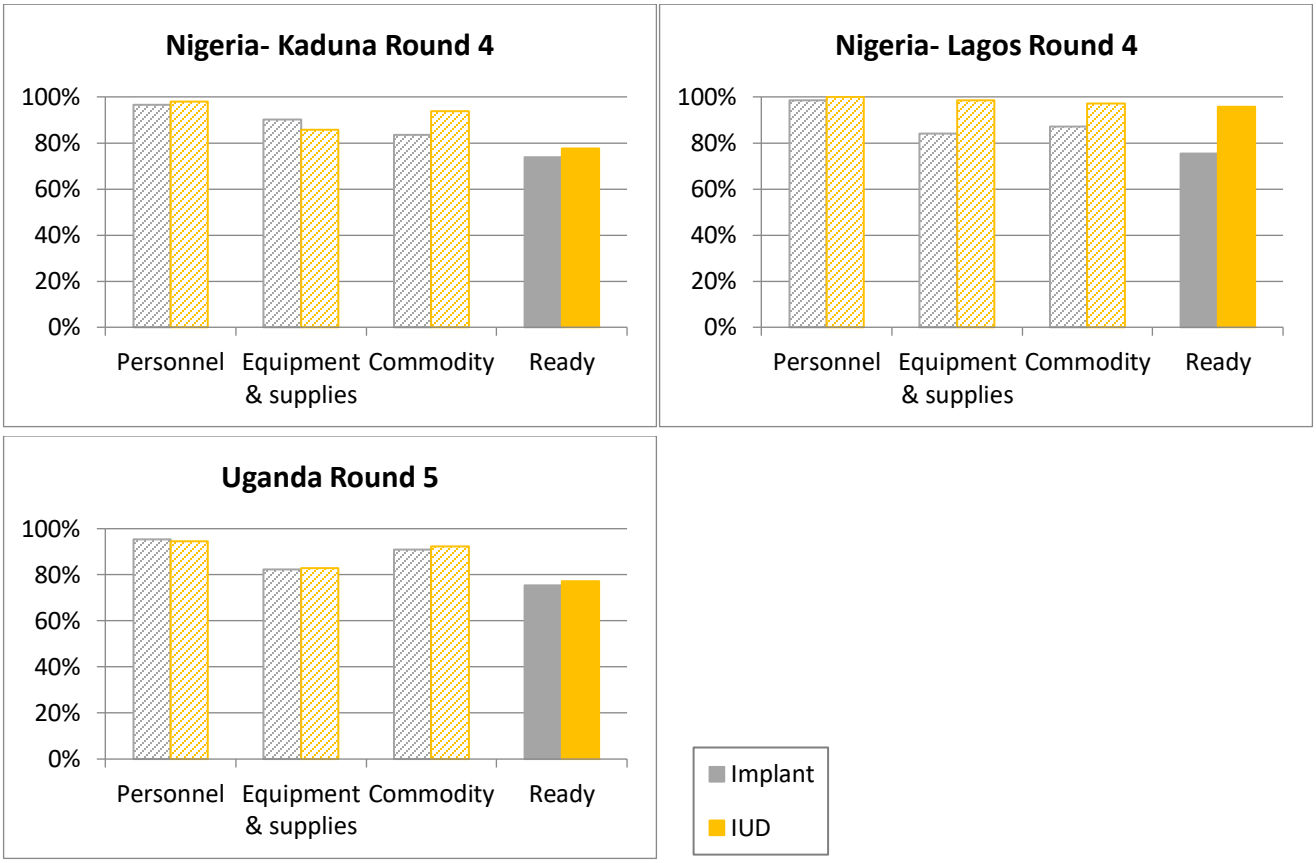
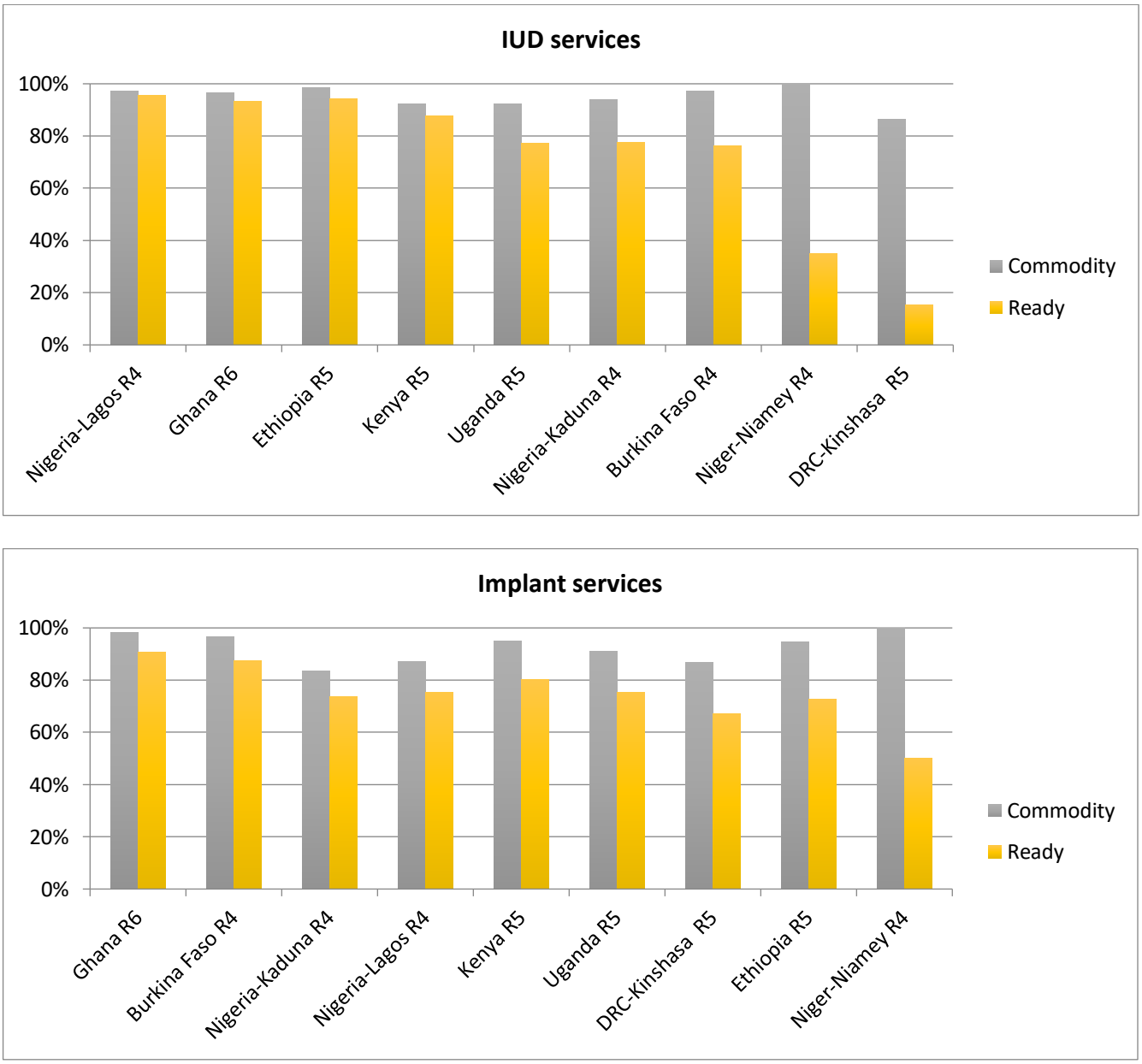


Figure 7. (continued)



Note: Service readiness to provide implant and IUD refers to the percent of facilities offering implants and IUDs, respectively, that had the contraceptive method in stock; had trained personnel available to insert and remove the method; and had all equipment and supplies available for method insertion and removal. The equipment and supplies minimally required for the implant include six items: clean gloves, antiseptic, sterile gauze pad or cotton wool, local anesthetic, surgical blade, and a sealed implant pack. Three items are required for the IUD: sponge-holding forceps, speculums, and tenaculum.

Figure 8. Comparison of SDPs with commodity vs. SDPs ready to provide services*: the most recent round by country



*Service readiness: based on availability of trained personnel, essential equipment and supplies, and commodity.

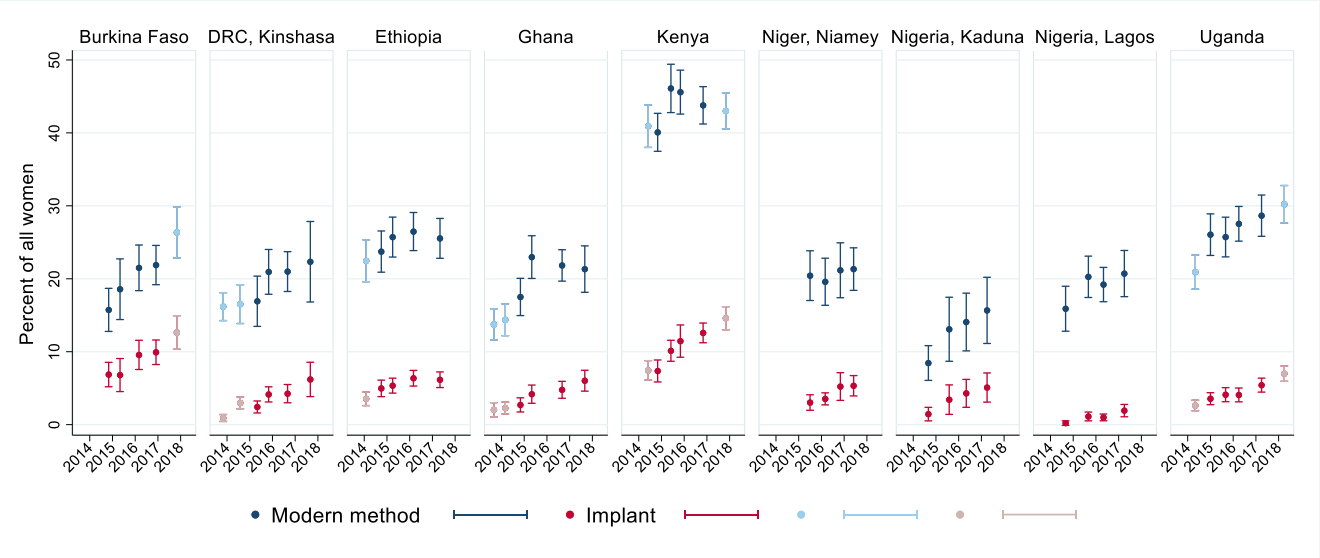
Figure 9 shows trends in implant and IUD service readiness for each country. For IUD service readiness, there was a 25 percentage point increase between Rounds 1 and 4 in Burkina Faso. There was little change in the other geographies except Kinshasa, DRC and Niamey, Niger where there was a 14 to 15 percentage point decrease in IUD provision service readiness across four rounds. Service readiness for implant provision increased by 13 percentage points or more in Burkina Faso, Lagos, Nigeria, and Uganda over the survey rounds included in this report. In the other geographies there was little change except for Niamey, Niger where there was a 21 percentage point decrease in readiness – though careful interpretation is needed in consideration of the small denominator.

There was little difference in service readiness when comparing public facilities (see Appendix 5b) to public and non-public facilities combined (see Appendix 5a). The difference in service readiness was often close to zero and no greater than seven percentage points. One exception is Kinshasa, DRC where 84% of public facilities in Round 5 were ready to provide implant services compared to 67% of public and non-public facilities combined. See Appendices 5a bad 5b for more detailed information and tables on service readiness for each geography.

Figure 9. Trends in the percent of facilities with personnel, equipment and supplies, and contraceptive commodity to provide implants and IUDs among facilities providing implants and IUDs: by country and round

*Data for Kinshasa, DRC Round 6 not available due to an inconsistent skip pattern in the questionnaire.

Figure 10. Trends of percent of all women using modern contraceptive methods and implant by geography



Source: Authors' calculation using PMA2020 surveys

Dark blue and red symbols represent survey rounds analyzed in this report.

5. Discussion

Using data from PMA2020 SDP surveys in nine geographies, we conducted comparative and trend analyses on contraceptive method availability as well as service readiness to provide LARC methods. The EA-SDP linked design in PMA SDP surveys provides unique data that allow researchers to understand the service environment that is geographically and administratively accessible to a sampled population. This linked design provides uniquely relevant data to investigate the impact of service environment on service utilization among the population. However, in countries where the geographic distribution of SDPs does not align with the geographic distribution of the population, the SDP sample may not represent the SDPs in the country. In addition, as in any analysis of international SDP survey data, careful interpretation is required for comparative analyses across countries because of vastly different health systems, especially in the composition of SDPs by managing authority and facility level.

Our findings indicate that the percent of facilities offering IUDs and implants ranged widely across geographies, while short-acting method availability was high overall. About three-quarters or more of facilities in most geographies offered pills, condoms, and the injectable. Facilities offering the IUD ranged from 30% to 85% and facilities offering implants ranged from 30% to 95%. Within geographies, availability of individual methods remained fairly stable over time except for implants, which increased universally. This observation tracks with increases in implant use among the surveyed population that are also revealed in PMA2020 trend data (see Figure 10). In all geographies except Kinshasa, DRC availability of any one method fluctuated 17 percentage points or less.

Many geographies included in this study had a high percentage (about 90% or more) of primary level facilities with three or more methods available, and many of those facilities had at least one LARC method. While no clear trends in improvement of three or more methods at primary level facilities were apparent within countries, this report does provide evidence of increases in the availability of five or more methods at secondary and tertiary level facilities in all geographies studied.

Finally, service readiness results illustrate that method availability is essential but not sufficient for facilities' capacity to provide LARC services, and cross-country variation in service readiness is greater than variation in method availability. We believe service readiness measures provide a more accurate picture of access, as they go beyond contraceptive availability alone and include availability of trained providers and required supplies for LARC services. Using this definition of service readiness results in a significant reduction in access that averages 18 percentage points for implants and 23 percentage points for IUDs across the nine geographies covered in this report. Though currently unavailable, new

client exit surveys in future PMA SDP surveys will provide additional data on service provision and quality of care.

In conclusion, surveys provide important and useful data on contraceptive method availability beyond service volume data from routine health information systems and supply chain information from logistics and management information systems. This research demonstrates that SDP survey data can and should be used to monitor levels and trends of method availability and service readiness and to inform program management.

References

Babazadeh, S. et al. 2018. “Assessing the Contraceptive Supply Environment in Kinshasa, DRC: Trend Data from PMA2020.” *Health Policy and Planning*.

Campbell, Oona M. R. et al. 2015. “Who, What, Where: An Analysis of Private Sector Family Planning Provision in 57 Low- and Middle-Income Countries.” *Tropical Medicine & International Health*.

FP2020. 2015. *FP2020 Commitment to Action 2014-2015: Measurement Annex*. Retrieved (http://progress.familyplanning2020.org/).

FP2020. n.d. “Data and Measurement Hub: What We Measure.” Retrieved (http://www.familyplanning2020.org/microsite/measurement-hub/whatwemeasure).

Georges, Guiella, Turke Shani, Coulibaly Hamadou, and Scott Radloff. 2018. “Rapid Uptake of the Subcutaneous Injectable in Burkina Faso : Evidence From PMA2020 Cross-Sectional Surveys.” *Global Health: Science and Practice*.

Hawes, Meagan et al. 2017. “Response Patterns on Behavioral Outcomes in Relation to Use of Resident Enumerators over Multiple Survey Rounds.”

PMA2020. 2017. “PMA2020 Survey Methodology - Questionnaires.” Retrieved (https://www.pma2020.org/questionnaires).

Shiferaw, Solomon et al. 2017. “Does Proximity of Women to Facilities with Better Choice of Contraceptives Affect Their Contraceptive Utilization in Rural Ethiopia?” *PLoS ONE*.

Track20. n.d. “FP2020 Core Indicators.” Retrieved (http://track20.org/pages/data_analysis/core_indicators/overview.php).

Tsui, Amy O., Win Brown, and Qingfeng Li. 2017. “Contraceptive Practice in Sub-Saharan Africa.” *Population and Development Review*.

Zimmerman, Linnea, Hannah Olson, PMA2020 Principal Investigators Group, Amy Tsui, and Scott Radloff. 2017. “PMA2020: Rapid Turn-Around Survey Data to Monitor Family Planning Service and Practice in Ten Countries.” *Studies in Family Planning* 48(3):293–303.

Appendix 1. List of contraceptive methods assessed for their service availability and stock in PMA2020 SDP surveys, by country

Country	Methods
Burkina	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, beads, foam/jelly, and diaphragm
DRC: Kinshasa	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, beads, foam/jelly, and diaphragm
Ethiopia	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, and beads. In addition, progestin pills was included in in Rounds 2 and 4, and 'other modern method' was included in in Rounds 1 and 5.
Ghana	IUD, implants, 1-month injectables, 3-month injectables, pills, male condoms, female condoms, emergency contraception, beads, foam/jelly, and diaphragm. In addition, 'other modern method' was included in Rounds 5 and 6, and N-tablet was included in Rounds 2 through 6.
Kenya	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, beads, foam/jelly, and diaphragm.
Niger: Niamey	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, and beads.
Nigeria: Kaduna & Lagos	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, beads, foam/jelly, and diaphragm.
Uganda	IUD, implants, injectables, pills, male condoms, female condoms, emergency contraception, beads, foam/jelly, and diaphragm. In addition, 'other modern method' was included in Rounds 5.

Note: Starting from the following surveys in each country, PMA2020 SDP surveys assessed DMPA-IM (Depo Provera®) and DMPA-SC (Sayana Press®) separately, instead of single assessment on injectables: Burkina Faso Round 3, Kinshasa/DRC Round 3, Niamey/Niger Round 4, Nigeria Round 4, and Uganda Round 5.

Appendix 2. List of SDPs assessed in PMA2020 SDP surveys and analytical categorization by facility-level, by country

	Secondary & Tertiary facilities	Primary facilities	Pharmacy, shop, other
Burkina	National hospital Teaching hospital Regional hospital Medical center w/ surgical branch Private hospital/polyclinic/clinic	Health center Private health center	Bulk pharmacy Pharmacy Pharmaceutical shop Other
DRC: Kinshasa	Hospital	Health center Health clinic Health post	Pharmacy/Chemist Ligablo Other
Ethiopia	Hospital Health center	Health post Health clinic	Pharmacy Retail Other
Ghana	-	Hospital* Health center Health clinic CHPS	Pharmacy Chemist Retail Other
Kenya	Hospital Health center Health clinic	Dispensary	Pharmacy Nursing maternity home Other
Niger: Niamey	National hospital District hospital Central maternity	Integrated health center	Private practice Bulk pharmacy Pharmacy Other
Nigeria: Kaduna & Lagos	Hospital Maternity clinic	Health center/ PHC Health clinic/ post	Pharmacy Chemist/ Patent medical store Other
Uganda	Hospital Health center 4	Health center 3 Health center 2 Health clinic	Pharmacy Chemist Other

* In Ghana, district, regional, and teaching hospitals are considered primary, secondary, and tertiary level facilities, respectively. The PMA2020 SDP questionnaire does not distinguish between various hospital types, thus separating district, regional, and teaching hospitals is not possible. Nevertheless, based on the number and distribution of regional and teaching hospitals in the country, a majority of hospitals included are likely primary level, district hospitals.

Appendix 3. Among SDPs offering family planning, distribution of method availability status among five main methods, by country and round

a) Public and non-public facilities

Round	n		IUD	Implants	Injectables		Pills	Condoms
Burkina Faso								
1	96	In-stock, and no stockout last 3 months	78.1	82.3	89.6		80.2	86.5
		In-stock, but stockout last 3 months	3.1	8.3	4.2		12.5	1.0
		Out-of-stock	2.1	0.0	1.0		2.1	0.0
		Not offered	16.7	9.4	5.2		5.2	12.5
2	93	In-stock, and no stockout last 3 months	79.6	78.5	87.1		91.4	92.5
		In-stock, but stockout last 3 months	2.2	10.8	5.4		4.3	1.1
		Out-of-stock	2.2	4.3	2.2		0.0	0.0
		Not offered	16.1	6.5	5.4		4.3	6.5
			IUD	Implants	DMPA-	DMPA-	Pills	Condoms
3	122	In-stock, and no stockout last 3 months	78.7	84.4	86.1	36.1	73.0	86.9
		In-stock, but stockout last 3 months	2.5	6.6	4.1	6.6	10.7	0.8
		Out-of-stock	0.8	0.8	0.8	3.3	9.8	2.5
		Not offered	18.0	8.2	9.0	54.1	6.6	9.8
4	124	In-stock, and no stockout last 3 months	79.0	91.1	90.3	65.3	95.2	87.9
		In-stock, but stockout last 3 months	3.2	0.8	4.0	6.5	0.8	0.8
		Out-of-stock	2.4	3.2	0.8	8.9	0.8	1.6
		Not offered	15.3	4.8	4.8	19.4	3.2	9.7
DRC: Kinshasa								
Round	n		IUD	Implants	DMPA-	DMPA-	Pills	Condoms
3	167	In-stock, and no stockout last 3 months	22.8	28.7	37.1	0.0	38.9	59.9
		In-stock, but stockout last 3 months	1.8	3.0	5.4	0.0	10.2	7.8
		Out-of-stock	4.2	7.8	8.4	0.0	15.6	10.8
		Not offered	71.3	60.5	49.1	100.0	35.3	21.6
4	146	In-stock, and no stockout last 3 months	21.2	21.2	31.5	8.2	43.8	69.9
		In-stock, but stockout last 3 months	4.1	7.5	8.9	0.7	14.4	9.6
		Out-of-stock	4.8	7.5	13.7	3.4	16.4	9.6
		Not offered	69.9	63.7	45.9	87.7	25.3	11.0
5	104	In-stock, and no stockout last 3 months	41.3	44.2	48.1	14.4	57.7	71.2
		In-stock, but stockout last 3 months	1.9	6.7	7.7	1.0	6.7	7.7
		Out-of-stock	6.7	7.7	14.4	7.7	12.5	12.5
		Not offered	50.0	41.3	29.8	76.9	23.1	8.7
6	115	In-stock, and no stockout last 3 months	34.8	40.9	57.4	25.2	63.5	67.8
		In-stock, but stockout last 3 months	2.6	6.1	2.6	2.6	3.5	12.2
		Out-of-stock	10.4	9.6	14.8	9.6	15.7	7.8
		Not offered	52.2	43.5	25.2	62.6	17.4	12.2

Appendix 3. (continued)

Round	n		IUD	Implants	Injectables	Pills	Condoms
Ethiopia							
2	387	In-stock, and no stockout last 3 months	52.5	69.8	82.7	73.9	87.3
		In-stock, but stockout last 3 months	2.8	8.8	10.1	16.5	5.7
		Out-of-stock	1.0	4.1	4.4	6.5	3.6
		Not offered	43.7	17.3	2.8	3.1	3.4
3	433	In-stock, and no stockout last 3 months	53.6	74.1	85.5	79.7	88.5
		In-stock, but stockout last 3 months	4.4	6.9	9.5	15.5	4.6
		Out-of-stock	1.6	2.1	2.8	3.7	3.7
		Not offered	40.4	16.9	2.3	1.2	3.2
4	444	In-stock, and no stockout last 3 months	57.4	73.0	59.9	76.8	88.3
		In-stock, but stockout last 3 months	1.1	8.3	23.4	17.3	4.5
		Out-of-stock	1.8	2.9	14.4	5.2	4.7
		Not offered	39.6	15.8	2.3	0.7	2.5
5	435	In-stock, and no stockout last 3 months	60.2	71.7	82.3	82.8	86.0
		In-stock, but stockout last 3 months	1.1	9.4	10.6	9.9	4.6
		Out-of-stock	0.9	4.6	3.4	6.0	6.2
		Not offered	37.7	14.3	3.7	1.4	3.2
Ghana							
Round	n		IUD	Implants	Injectables	Pills	Condoms
3	216	In-stock, and no stockout last 3 months	33.8	52.8	67.1	73.6	76.9
		In-stock, but stockout last 3 months	1.4	7.9	6.9	10.2	7.4
		Out-of-stock	4.6	3.2	0.9	6.5	8.3
		Not offered	60.2	36.1	25.0	9.7	7.4
4	220	In-stock, and no stockout last 3 months	32.7	50.5	61.8	56.8	65.5
		In-stock, but stockout last 3 months	2.7	7.7	10.0	14.1	10.5
		Out-of-stock	4.1	5.0	1.4	16.8	15.5
		Not offered	60.5	36.8	26.8	12.3	8.6
5	149	In-stock, and no stockout last 3 months	43.6	69.8	74.5	73.2	81.9
		In-stock, but stockout last 3 months	5.4	8.1	10.1	8.1	4.0
		Out-of-stock	6.0	2.0	0.7	12.1	8.1
		Not offered	45.0	20.1	14.8	6.7	6.0
6	167	In-stock, and no stockout last 3 months	47.4	64.2	69.4	76.3	85.5
		In-stock, but stockout last 3 months	1.7	9.2	9.2	8.1	2.9
		Out-of-stock	1.7	1.2	0.0	9.2	6.9
		Not offered	49.1	25.4	21.4	6.4	4.6

Appendix 3. (continued)

Kenya

Round	n		IUD	Implants	Injectables	Pills	Condoms
2	315	In-stock, and no stockout last 3 months	52.1	65.4	85.1	84.1	85.1
		In-stock, but stockout last 3 months	5.1	11.1	8.6	9.2	6.3
		Out-of-stock	3.2	4.1	1.3	5.1	4.4
		Not offered	39.7	19.4	5.1	1.6	4.1
3	339	In-stock, and no stockout last 3 months	55.2	74.6	82.0	86.7	85.0
		In-stock, but stockout last 3 months	2.9	3.5	8.3	6.5	5.9
		Out-of-stock	4.7	4.1	5.0	4.7	3.8
		Not offered	37.2	17.7	4.7	2.1	5.3
4	329	In-stock, and no stockout last 3 months	58.7	75.4	82.7	86.6	84.8
		In-stock, but stockout last 3 months	3.0	4.9	7.3	6.1	6.1
		Out-of-stock	3.3	3.0	4.6	5.2	5.8
		Not offered	35.0	16.7	5.5	2.1	3.3
5	406	In-stock, and no stockout last 3 months	52.7	71.9	75.9	71.7	75.4
		In-stock, but stockout last 3 months	6.7	10.1	9.9	10.3	11.1
		Out-of-stock	4.9	4.4	8.4	15.8	10.1
		Not offered	35.7	13.5	5.9	2.2	3.4

Niger

Round	n		IUD	Implants	Injectables	Pills	Condoms
1	26	In-stock, and no stockout last 3 months	46.2	50.0	61.5	65.4	65.4
		In-stock, but stockout last 3 months	19.2	26.9	19.2	30.8	23.1
		Out-of-stock	3.8	0.0	0.0	0.0	0.0
		Not offered	30.8	23.1	19.2	3.8	11.5
2	29	In-stock, and no stockout last 3 months	51.7	72.4	79.3	82.8	86.2
		In-stock, but stockout last 3 months	0.0	6.9	6.9	10.3	3.4
		Out-of-stock	3.4	0.0	0.0	3.4	0.0
		Not offered	44.8	20.7	13.8	3.4	10.3
3	23	In-stock, and no stockout last 3 months	56.5	73.9	82.6	91.3	78.3
		In-stock, but stockout last 3 months	8.7	8.7	8.7	4.3	0.0
		Out-of-stock	4.3	0.0	4.3	0.0	8.7
		Not offered	30.4	17.4	4.3	4.3	13.0

Round	n		IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
4	28	In-stock, and no stockout last 3 months	71.4	75.0	85.7	10.7	85.7	75.0
		In-stock, but stockout last 3 months	0.0	10.7	0.0	0.0	10.7	7.1
		Out-of-stock	0.0	0.0	0.0	0.0	0.0	3.6
		Not offered	28.6	14.3	14.3	89.3	3.6	14.3

Appendix 3. (continued)

Nigeria: Kaduna

Round	n		IUD	Implants	Injectables		Pills	Condoms
1	109	In-stock, and no stockout last 3 months	26.6	24.8	54.1		65.1	62.4
		In-stock, but stockout last 3 months	4.6	5.5	20.2		18.3	18.3
		Out-of-stock	0.9	1.8	8.3		2.8	5.5
		Not offered	67.9	67.9	17.4		13.8	13.8
2	121	In-stock, and no stockout last 3 months	27.3	28.1	63.6		69.4	65.3
		In-stock, but stockout last 3 months	3.3	9.9	14.0		15.7	13.2
		Out-of-stock	2.5	1.7	8.3		7.4	7.4
		Not offered	66.9	60.3	14.0		7.4	14.0
3	116	In-stock, and no stockout last 3 months	22.4	25.9	62.9		63.8	63.8
		In-stock, but stockout last 3 months	2.6	6.9	14.7		18.1	12.1
		Out-of-stock	3.4	6.9	9.5		7.8	8.6
		Not offered	71.6	60.3	12.9		10.3	15.5
			IUD	Implants	DMPA-	DMPA-	Pills	Condoms
4	140	In-stock, and no stockout last 3 months	30.0	30.0	64.3	12.9	72.1	74.3
		In-stock, but stockout last 3 months	2.9	6.4	8.6	1.4	10.7	5.7
		Out-of-stock	2.1	7.1	11.4	5.0	9.3	6.4
		Not offered	65.0	56.4	15.7	80.7	7.9	13.6

Nigeria: Lagos

Round	n		IUD	Implants	Injectables		Pills	Condoms
1	80	In-stock, and no stockout last 3 months	63.7	43.8	75.0		86.2	86.2
		In-stock, but stockout last 3 months	1.2	1.2	1.2		3.8	3.8
		Out-of-stock	2.5	3.8			3.8	3.8
		Not offered	32.5	51.2	23.8		6.2	6.2
2	114	In-stock, and no stockout last 3 months	57.0	44.7	65.8		81.6	83.3
		In-stock, but stockout last 3 months	2.6	3.5	2.6		7.0	7.0
		Out-of-stock	0.0	4.4	2.6		2.6	3.5
		Not offered	40.4	47.4	28.9		8.8	6.1
3	116	In-stock, and no stockout last 3 months	57.8	43.1	64.7		76.7	83.6
		In-stock, but stockout last 3 months	2.6	8.6	6.0		8.6	4.3
		Out-of-stock	0.0	6.0	3.4		6.9	7.8
		Not offered	39.7	42.2	25.9		7.8	4.3
			IUD	Implants	DMPA-	DMPA-	Pills	Condoms
4	112	In-stock, and no stockout last 3 months	55.4	47.3	61.6	0.9	81.2	91.1
		In-stock, but stockout last 3 months	4.5	6.2	6.2	0.9	4.5	2.7
		Out-of-stock	1.8	8.0	4.5	3.6	4.5	2.7
		Not offered	38.4	38.4	27.7	94.6	9.8	3.6

Appendix 3. (continued)

Uganda

Round	n		IUD	Implants	Injectables		Pills	Condoms
2	342	In-stock, and no stockout last 3 months	25.4	29.2	79.5		38.0	80.1
		In-stock, but stockout last 3 months	2.6	6.7	6.4		11.1	7.9
		Out-of-stock	4.4	10.8	2.9		33.6	6.4
		Not offered	67.5	53.2	11.1		17.3	5.6
3	338	In-stock, and no stockout last 3 months	28.1	33.4	75.4		46.4	76.0
		In-stock, but stockout last 3 months	3.8	6.8	8.9		18.3	7.1
		Out-of-stock	4.4	7.7	5.3		21.6	10.7
		Not offered	63.6	52.1	10.4		13.6	6.2
4	331	In-stock, and no stockout last 3 months	32.0	35.3	74.0		26.9	76.4
		In-stock, but stockout last 3 months	2.7	6.9	9.4		13.9	8.8
		Out-of-stock	3.9	5.1	6.3		38.4	6.9
		Not offered	61.3	52.6	10.3		20.8	7.9
			IUD	Implants	DMPA-	DMPA-	Pills	Condoms
5	314	In-stock, and no stockout last 3 months	38.9	45.9	64.3	12.7	42.0	79.9
		In-stock, but stockout last 3 months	3.8	4.8	11.8	2.9	15.6	7.6
		Out-of-stock	3.5	5.1	15.3	5.1	21.0	5.7
		Not offered	53.8	44.3	8.6	79.3	21.3	6.7

Appendix 3. (continued)

b) Public facilities

Burkina Faso

Round	n	Method availability status	IUD	Implants	Injectables		Pills	Condoms
1	89	In-stock, and no stockout last 3 months	82.0	86.5	94.4		85.4	91.0
		In-stock, but stockout last 3 months	3.4	7.9	4.5		11.2	1.1
		Out-of-stock	1.1	0.0	0.0		1.1	0.0
		Not offered	13.5	5.6	1.1		2.2	7.9
2	86	In-stock, and no stockout last 3 months	82.6	81.4	90.7		96.5	97.7
		In-stock, but stockout last 3 months	2.3	11.6	5.8		2.3	1.2
		Out-of-stock	1.2	3.5	2.3		0.0	0.0
		Not offered	14.0	3.5	1.2		1.2	1.2
			IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
3	109	In-stock, and no stockout last 3 months	85.3	92.7	94.5	39.4	78.9	90.8
		In-stock, but stockout last 3 months	2.8	7.3	3.7	7.3	10.1	0.9
		Out-of-stock	0.9	0.0	0.9	3.7	10.1	1.8
		Not offered	11.0	0.0	0.9	49.5	0.9	6.4
4	114	In-stock, and no stockout last 3 months	85.1	97.4	95.6	70.2	99.1	90.4
		In-stock, but stockout last 3 months	3.5	0.9	4.4	7.0	0.9	0.9
		Out-of-stock	0.9	1.8	0.0	9.6	0.0	1.8
		Not offered	10.5	0.0	0.0	13.2	0.0	7.0

DRC: Kinshasa

Round	n	Method availability status	IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
3	25	In-stock, and no stockout last 3 months	64.0	68.0	56.0	0.0	32.0	60.0
		In-stock, but stockout last 3 months	4.0	4.0	16.0	0.0	16.0	4.0
		Out-of-stock	8.0	20.0	12.0	0.0	16.0	8.0
		Not offered	24.0	8.0	16.0	100.0	36.0	28.0
4	28	In-stock, and no stockout last 3 months	57.1	60.7	67.9	25.0	53.6	71.4
		In-stock, but stockout last 3 months	7.1	10.7	3.6	3.6	25.0	10.7
		Out-of-stock	10.7	14.3	14.3	3.6	10.7	14.3
		Not offered	25.0	14.3	14.3	67.9	10.7	3.6
5	22	In-stock, and no stockout last 3 months	77.3	81.8	72.7	27.3	77.3	77.3
		In-stock, but stockout last 3 months	0.0	0.0	9.1	0.0	0.0	13.6
		Out-of-stock	4.5	4.5	9.1	27.3	13.6	4.5
		Not offered	18.2	13.6	9.1	45.5	9.1	4.5
6	20	In-stock, and no stockout last 3 months	55.0	65.0	80.0	25.0	65.0	70.0
		In-stock, but stockout last 3 months	5.0	5.0	5.0	0.0	0.0	0.0
		Out-of-stock	15.0	20.0	10.0	25.0	15.0	20.0
		Not offered	25.0	10.0	5.0	50.0	20.0	10.0

Appendix 3. (continued)

Ethiopia

Round	n	Method availability status	IUD	Implants	Injectables	Pills	Condoms
2	338	In-stock, and no stockout last 3 months	59.2	78.1	84.6	74.9	87.9
		In-stock, but stockout last 3 months	3.0	9.8	9.8	15.7	5.0
		Out-of-stock	1.2	4.7	4.4	6.2	3.6
		Not offered	36.7	7.4	1.2	3.3	3.6
3	378	In-stock, and no stockout last 3 months	60.6	83.1	87.8	80.2	89.7
		In-stock, but stockout last 3 months	5.0	7.7	8.5	15.1	4.0
		Out-of-stock	1.9	2.4	2.6	3.7	3.7
		Not offered	32.5	6.9	1.1	1.1	2.6
4	388	In-stock, and no stockout last 3 months	64.4	81.4	59.8	78.1	88.9
		In-stock, but stockout last 3 months	1.0	9.3	23.2	16.2	3.9
		Out-of-stock	1.8	3.1	16.0	5.4	5.2
		Not offered	32.7	6.2	1.0	0.3	2.1
5	391	In-stock, and no stockout last 3 months	66.0	78.5	86.4	83.1	87.5
		In-stock, but stockout last 3 months	1.0	10.2	10.0	9.7	4.6
		Out-of-stock	1.0	4.9	3.3	6.4	6.4
		Not offered	32.0	6.4	0.3	0.8	1.5

Ghana

Round	n	Method availability status	IUD	Implants	Injectables	Pills	Condoms
3	145	In-stock, and no stockout last 3 months	49.0	73.8	92.4	81.4	81.4
		In-stock, but stockout last 3 months	1.4	10.3	6.9	6.9	4.1
		Out-of-stock	6.9	4.8	0.7	5.5	10.3
		Not offered	42.8	11.0	0.0	6.2	4.1
4	143	In-stock, and no stockout last 3 months	47.6	72.7	86.0	58.0	68.5
		In-stock, but stockout last 3 months	3.5	11.2	11.9	14.0	8.4
		Out-of-stock	6.3	5.6	1.4	19.6	19.6
		Not offered	42.7	10.5	0.7	8.4	3.5
5	112	In-stock, and no stockout last 3 months	51.8	83.0	87.5	80.4	85.7
		In-stock, but stockout last 3 months	7.1	9.8	11.6	7.1	2.7
		Out-of-stock	7.1	2.7	0.9	11.6	8.9
		Not offered	33.9	4.5	0.0	0.9	2.7
6	115	In-stock, and no stockout last 3 months	61.2	82.6	87.6	77.7	87.6
		In-stock, but stockout last 3 months	2.5	12.4	12.4	9.9	2.5
		Out-of-stock	1.7	1.7	0.0	10.7	8.3
		Not offered	34.7	3.3	0.0	1.7	1.7

Appendix 3. (continued)

Kenya

Round	n	Method availability status	IUD	Implants	Injectables	Pills	Condoms
2	262	In-stock, and no stockout last 3 months	61.1	75.6	90.5	88.2	87.0
		In-stock, but stockout last 3 months	5.0	11.8	7.6	8.0	6.5
		Out-of-stock	3.4	4.2	1.1	3.8	4.2
		Not offered	30.5	8.4	0.8	0.0	2.3
3	263	In-stock, and no stockout last 3 months	66.2	88.2	89.0	91.3	90.5
		In-stock, but stockout last 3 months	3.0	3.0	5.7	3.4	4.2
		Out-of-stock	4.9	4.9	4.6	4.6	3.0
		Not offered	25.9	3.8	0.8	0.8	2.3
4	267	In-stock, and no stockout last 3 months	69.3	88.4	89.5	89.9	87.6
		In-stock, but stockout last 3 months	2.6	4.9	6.0	5.6	5.6
		Out-of-stock	3.4	3.4	3.7	3.7	6.0
		Not offered	24.7	3.4	0.7	0.7	0.7
5	339	In-stock, and no stockout last 3 months	59.6	81.7	80.8	71.7	75.5
		In-stock, but stockout last 3 months	7.4	10.9	10.0	10.3	11.8
		Out-of-stock	5.3	4.7	8.0	16.8	11.5
		Not offered	27.7	2.7	1.2	1.2	1.2

Niger

Round	n	Method availability status	IUD	Implants	Injectables	Pills	Condoms
1	21	In-stock, and no stockout last 3 months	57.1	61.9	76.2	76.2	66.7
		In-stock, but stockout last 3 months	23.8	33.3	23.8	23.8	23.8
		Out-of-stock	4.8	0.0	0.0	0.0	0.0
		Not offered	14.3	4.8	0.0	0.0	9.5
2	24	In-stock, and no stockout last 3 months	62.5	87.5	91.7	91.7	95.8
		In-stock, but stockout last 3 months	0.0	8.3	8.3	8.3	0.0
		Out-of-stock	4.2	0.0	0.0	0.0	0.0
		Not offered	33.3	4.2	0.0	0.0	4.2
3	19	In-stock, and no stockout last 3 months	63.2	84.2	89.5	100.0	78.9
		In-stock, but stockout last 3 months	5.3	10.5	10.5	0.0	0.0
		Out-of-stock	5.3	0.0	0.0	0.0	10.5
		Not offered	26.3	5.3	0.0	0.0	10.5

Round	n	Method availability status	IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
4	23	In-stock, and no stockout last 3 months	82.6	87.0	100.0	4.3	87.0	78.3
		In-stock, but stockout last 3 months	0.0	13.0	0.0	0.0	13.0	4.3
		Out-of-stock	0.0	0.0	0.0	0.0	0.0	4.3
		Not offered	17.4	0.0	0.0	95.7	0.0	13.0

Appendix 3. (continued)

Nigeria: Kaduna

Round	n	Method availability status	IUD	Implants	Injectables		Pills	Condoms
1	67	In-stock, and no stockout last 3 months	41.8	38.8	70.1		73.1	68.7
		In-stock, but stockout last 3 months	7.5	7.5	17.9		20.9	22.4
		Out-of-stock	1.5	3.0	3.0		0.0	3.0
		Not offered	49.3	50.7	9.0		6.0	6.0
2	70	In-stock, and no stockout last 3 months	45.7	47.1	77.1		80.0	78.6
		In-stock, but stockout last 3 months	5.7	15.7	15.7		14.3	12.9
		Out-of-stock	1.4	2.9	2.9		2.9	2.9
		Not offered	47.1	34.3	4.3		2.9	5.7
3	68	In-stock, and no stockout last 3 months	38.2	42.6	79.4		80.9	77.9
		In-stock, but stockout last 3 months	4.4	11.8	8.8		11.8	7.4
		Out-of-stock	4.4	11.8	5.9		5.9	10.3
		Not offered	52.9	33.8	5.9		1.5	4.4
			IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
4	77	In-stock, and no stockout last 3 months	51.9	49.4	79.2	18.2	81.8	81.8
		In-stock, but stockout last 3 months	5.2	11.7	9.1	1.3	6.5	5.2
		Out-of-stock	3.9	13.0	11.7	5.2	10.4	7.8
		Not offered	39.0	26.0	0.0	75.3	1.3	5.2

Nigeria: Lagos

Round	n	Method availability status	IUD	Implants	Injectables		Pills	Condoms
1	51	In-stock, and no stockout last 3 months	88.2	62.7	98.0		98.0	92.2
		In-stock, but stockout last 3 months	2.0	2.0	2.0		2.0	2.0
		Out-of-stock	3.9	0.0	0.0		0.0	2.0
		Not offered	5.9	35.3	0.0		0.0	3.9
2	65	In-stock, and no stockout last 3 months	86.2	70.8	93.8		96.9	93.8
		In-stock, but stockout last 3 months	1.5	4.6	3.1		1.5	3.1
		Out-of-stock	0.0	6.2	3.1		1.5	3.1
		Not offered	12.3	18.5	0.0		0.0	0.0
3	67	In-stock, and no stockout last 3 months	86.6	64.2	85.1		85.1	88.1
		In-stock, but stockout last 3 months	3.0	13.4	7.5		6.0	3.0
		Out-of-stock	0.0	10.4	4.5		7.5	7.5
		Not offered	10.4	11.9	3.0		1.5	1.5
			IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
4	65	In-stock, and no stockout last 3 months	81.5	73.8	89.2	0.0	92.3	93.8
		In-stock, but stockout last 3 months	7.7	9.2	9.2	0.0	4.6	3.1
		Out-of-stock	1.5	10.8	1.5	3.1	0.0	3.1
		Not offered	9.2	6.2	0.0	96.9	3.1	0.0

Appendix 3. (continued)

Uganda

Round	n	Method availability status	IUD	Implants	Injectables		Pills	Condoms
2	228	In-stock, and no stockout last 3 months	34.6	39.0	93.4		31.1	88.2
		In-stock, but stockout last 3 months	3.9	8.8	3.5		11.4	4.8
		Out-of-stock	5.3	13.2	1.3		46.1	5.7
		Not offered	56.1	39.0	1.8		11.4	1.3
3	227	In-stock, and no stockout last 3 months	40.1	45.4	86.8		39.2	82.8
		In-stock, but stockout last 3 months	5.3	9.3	6.2		22.5	4.4
		Out-of-stock	6.2	10.1	2.6		27.8	8.8
		Not offered	48.5	35.2	4.4		10.6	4.0
4	223	In-stock, and no stockout last 3 months	44.4	46.6	87.9		23.3	83.4
		In-stock, but stockout last 3 months	4.0	10.3	5.8		9.4	7.2
		Out-of-stock	5.8	7.2	2.7		49.3	4.5
		Not offered	45.7	35.9	3.6		17.9	4.9
			IUD	Implants	DMPA-IM	DMPA-SC	Pills	Condoms
5	219	In-stock, and no stockout last 3 months	52.5	61.6	79.9	16.4	38.8	91.8
		In-stock, but stockout last 3 months	4.6	5.5	9.6	4.1	16.0	5.0
		Out-of-stock	5.0	7.3	9.6	7.3	24.7	1.8
		Not offered	37.9	25.6	0.9	72.1	20.5	1.4

Appendix 4. Percent of SDPs that have multiple methods and percent of SDPs with multiple methods that have long-acting reversible methods, by facility type, survey and round

a) Public and non-public facilities

Country and survey round	Primary level facilities			Secondary and tertiary facilities			
	n	% with 3+ methods	Among those with 3+ methods, % with one or more LARC	n	% with 5+ methods	Among those with 5+ methods, % with one or more LARC	Among those with 5+ methods, % with two or more LARC
Burkina Faso							
1	52	92.3	88.9	45	88.9	100.0	97.5
2	49	98.0	95.8	43	90.7	97.4	97.4
3	70	88.6	100.0	52	90.4	100.0	100.0
4	67	91.0	100.0	53	96.2	98.0	92.2
DRC: Kinshasa							
3	128	28.9	91.9	24	54.2	100.0	61.5
4	99	31.3	83.9	23	65.2	100.0	73.3
5	90	40.0	94.4	24	75.0	94.4	88.9
6	108	41.7	82.2	22	59.1	92.3	76.9
Ethiopia							
2	115	79.1	64.8	257	84.4	100.0	90.8
3	130	83.8	67.9	288	88.9	100.0	94.9
4	129	79.8	69.9	301	87.7	99.6	91.7
5	121	86.0	65.4	297	91.6	99.6	90.4
Ghana							
3	166	87.3	91.0				
4	166	81.9	92.6				
5	135	90.4	96.7				
6	143	92.3	95.5				
Kenya							
2	135	96.3	85.4	155	80.0	100.0	90.3
3	134	94.0	92.1	169	82.8	98.6	88.6
4	137	94.9	94.6	160	86.2	98.6	89.1
5	188	89.9	97.6	174	86.8	99.3	92.1
Niger							
1	21	95.2	100.0	4	-	-	-
2	22	100.0	95.5	4	-	-	-
3	21	90.5	100.0	2	-	-	-
4	23	95.7	100.0	3	-	-	-
Nigeria: Kaduna							
1	54	75.9	46.3	27	66.7	100.0	83.3
2	66	74.2	69.4	18	83.3	100.0	80.0
3	56	85.7	52.1	19	84.2	100.0	75.0
4	62	79.0	67.3	26	88.5	100.0	82.6
Nigeria: Lagos							
1	40	95.0	89.5	19	89.5	100.0	94.1
2	55	92.7	92.2	26	73.1	100.0	84.2
3	57	91.2	94.2	25	72.0	100.0	94.4
4	54	96.3	92.3	26	76.9	95.0	90.0
Uganda							
2	185	70.8	40.5	105	72.4	93.4	73.7
3	179	72.6	46.2	106	68.9	95.9	78.1
4	171	56.7	55.7	99	73.7	100.0	90.4
5	170	60.0	74.5	98	81.6	100.0	91.2

Appendix 4. (continued)

b) Public facilities

Country and survey round	Primary level facilities			Secondary and tertiary facilities			
	n	% with 3+ methods	Among those with 3+ methods, % with one or more LARC	n	% with 5+ methods	Among those with 5+ methods, % with one or more LARC	Among those with 5+ methods, % with two or more LARC
Burkina Faso							
1	47	100.0	93.6	42	92.9	100.0	97.4
2	47	100.0	95.7	39	97.4	97.4	97.4
3	62	98.4	100.0	47	97.9	100.0	100.0
4	61	100.0	100.0	49	100.0	100.0	93.9
DRC Kinshasa							
3	15	60.0	100.0	11	63.6	100.0	71.4
4	14	85.7	66.7	14	85.7	100.0	83.3
5	11	90.9	100.0	13	76.9	90.0	80.0
6	11	72.7	87.5	13	53.8	85.7	71.4
Ethiopia							
2	85	78.8	76.1	257	84.4	100.0	90.8
3	96	86.5	79.5	288	88.9	100.0	94.9
4	94	83.0	80.8	301	87.7	99.6	91.7
5	97	87.6	75.3	295	91.5	99.6	90.4
Ghana							
3	144	93.8	91.1				
4	142	89.4	93.7				
5	112	98.2	96.4				
6	121	99.2	95.8				
Kenya							
2	129	97.7	85.7	135	86.7	100.0	93.2
3	125	95.2	91.6	140	90.0	99.2	91.3
4	130	96.9	94.4	139	93.5	98.5	89.2
5	181	90.6	98.2	156	89.1	99.3	92.1
Niger							
1	21	95.2	100.0	4	-	-	-
2	22	100.0	95.5	4	-	-	-
3	20	90.0	100.0	2	-	-	-
4	22	95.5	100.0	3	-	-	-
Nigeria Kaduna							
1	49	79.6	46.2	24	70.8	100.0	82.4
2	61	77.0	68.1	17	82.4	100.0	85.7
3	52	90.4	53.2	17	88.2	100.0	80.0
4	57	80.7	69.6	23	95.7	100.0	86.4
Nigeria Lagos							
1	39	94.9	89.2	14	100.0	100.0	100.0
2	53	94.3	92.0	14	100.0	100.0	85.7
3	53	94.3	94.0	15	93.3	100.0	92.9
4	53	96.2	92.2	14	100.0	92.9	85.7
Uganda							
2	141	74.5	44.8	90	78.9	93.0	73.2
3	137	73.0	51.0	93	75.3	95.7	78.6
4	139	58.3	60.5	85	80.0	100.0	91.2
5	133	68.4	75.8	86	89.5	100.0	92.2

Appendix 4 note: All sampled SDPs in Ghana were considered primary level facilities for analytical purposes. Results for secondary or tertiary facilities are not presented in Niamey/Niger due to small sample sizes.

Appendix 5. Percent of SDPs providing IUD and implant services that have essential trained personnel, equipment and supplies, and commodity, by country and round

a) Public and non-public facilities

	IUD					Implant				
	n	Personnel	Equipment & supplies	Commodity	**Ready**	n	Personnel	Equipment & supplies	Commodity	**Ready**
Burkina Faso										
1	80	97.5	53.8	97.5	**51.2**	87	95.4	75.9	100.0	**71.3**
2	78	98.7	55.1	97.4	**55.1**	87	98.9	69.0	95.4	**65.5**
3	101	96.0	59.4	98.0	**56.4**	113	99.1	77.9	98.2	**75.2**
4	105	93.3	80.0	97.1	**76.2**	118	99.2	90.7	96.6	**87.3**
DRC Kinshasa										
3	48	93.8	41.7	85.4	**29.2**	66	93.9	84.8	80.3	**71.2**
4	44	97.7	18.2	84.1	**15.9**	53	96.2	79.2	79.2	**60.4**
5	52	94.2	19.2	86.5	**15.4**	61	98.4	75.4	86.9	**67.2**
6	55	n/a	21.8	78.2	**n/a**	65	n/a	84.6	83.1	**n/a**
Ethiopia										
2	218	95.4	97.7	98.2	**92.2**	320	77.2	85.6	95.0	**71.6**
3	258	96.5	95.7	97.3	**91.1**	360	79.2	85.0	97.5	**73.3**
4	268	95.5	97.4	97.0	**91.0**	374	80.2	86.9	96.5	**73.8**
5	271	97.4	97.0	98.5	**94.1**	373	80.2	87.1	94.6	**72.7**
Ghana										
3	86	96.5	98.8	88.4	**84.9**	138	96.4	92.8	94.9	**84.1**
4	87	96.6	98.9	89.7	**85.1**	139	96.4	89.9	92.1	**83.5**
5	82	97.6	97.6	89.0	**86.6**	119	97.5	90.8	97.5	**87.4**
6	88	96.6	95.5	96.6	**93.2**	129	99.2	91.5	98.4	**90.7**
Kenya										
2	190	96.8	95.3	94.7	**87.4**	254	96.5	79.9	94.9	**75.6**
3	213	98.6	94.4	92.5	**87.8**	279	97.5	84.2	95.0	**79.2**
4	214	98.1	96.7	94.9	**90.7**	274	98.9	90.5	96.4	**86.9**
5	261	98.1	95.0	92.3	**87.7**	351	98.9	84.9	94.9	**80.3**
Niger-Niamey										
1	18	94.4	50.0	94.4	**50.0**	21	100.0	71.4	100.0	**71.4**
2	16	100.0	31.2	93.8	**31.2**	23	91.3	82.6	100.0	**73.9**
3	16	81.2	12.5	93.8	**6.2**	19	73.7	57.9	100.0	**47.4**
4	20	100.0	35.0	100.0	**35.0**	24	100.0	50.0	100.0	**50.0**
Nigeria Kaduna										
1	35	94.3	82.9	97.1	**80.0**	35	91.4	74.3	94.3	**71.4**
2	40	100.0	85.0	92.5	**77.5**	48	97.9	81.2	95.8	**79.2**
3	33	100.0	84.8	87.9	**78.8**	46	97.8	89.1	82.6	**76.1**
4	49	98.0	85.7	93.9	**77.6**	61	96.7	90.2	83.6	**73.8**
Nigeria Lagos										
1	54	100.0	98.1	96.3	**94.4**	39	97.4	69.2	92.3	**59.0**
2	68	98.5	95.6	100.0	**95.6**	60	95.0	76.7	91.7	**70.0**
3	70	100.0	95.7	100.0	**95.7**	67	98.5	79.1	89.6	**71.6**
4	69	100.0	98.6	97.1	**95.7**	69	98.6	84.1	87.0	**75.4**
Uganda										
2	111	97.3	85.6	86.5	**74.8**	160	95.6	79.4	76.9	**62.5**
3	123	97.6	86.2	87.8	**76.4**	162	98.8	73.5	84.0	**61.1**
4	128	97.7	85.2	89.8	**75.0**	157	97.5	73.9	89.2	**68.2**
5	145	94.5	82.8	92.4	**77.2**	175	95.4	82.3	90.9	**75.4**

Appendix 5. (continued)

b) Public facilities

	IUD					Implant				
	n	Personnel	Equipment & supplies	Commodity	**Ready**	n	Personnel	Equipment & supplies	Commodity	**Ready**
Burkina Faso										
1	77	97.4	54.5	98.7	**51.9**	84	95.2	76.2	100.0	**71.4**
2	74	98.6	56.8	98.6	**56.8**	83	98.8	68.7	96.4	**65.1**
3	97	95.9	58.8	99.0	**55.7**	109	99.1	77.1	100.0	**76.1**
4	102	93.1	81.4	99.0	**77.5**	114	99.1	90.4	98.2	**88.6**
DRC Kinshasa										
3	19	100.0	31.6	89.5	**26.3**	23	100.0	95.7	78.3	**78.3**
4	21	95.2	23.8	85.7	**19.0**	24	91.7	83.3	83.3	**62.5**
5	18	100.0	22.2	94.4	**22.2**	19	100.0	89.5	94.7	**84.2**
6	15	n/a	13.3	80.0	**n/a**	18	n/a	66.7	77.8	**n/a**
Ethiopia										
2	214	95.3	97.7	98.1	**92.1**	313	77.3	85.9	94.9	**71.9**
3	255	96.5	96.1	97.3	**91.4**	352	78.7	84.7	97.4	**72.7**
4	261	95.8	98.1	97.3	**92.0**	364	79.9	86.8	96.7	**73.6**
5	266	97.4	97.0	98.5	**94.0**	366	79.8	86.9	94.8	**72.4**
Ghana										
3	83	96.4	98.8	88.0	**84.3**	129	96.9	94.6	94.6	**86.0**
4	82	96.3	100.0	89.0	**85.4**	128	96.9	93.0	93.8	**85.9**
5	74	97.3	97.3	89.2	**86.5**	107	97.2	89.7	97.2	**86.0**
6	79	96.2	96.2	97.5	**93.7**	117	100.0	91.5	98.3	**90.6**
Kenya										
2	182	97.3	95.6	95.1	**87.9**	240	97.1	79.2	95.4	**75.4**
3	195	99.0	94.9	93.3	**89.2**	253	98.0	83.8	94.9	**79.1**
4	201	98.0	97.0	95.5	**91.5**	258	98.8	90.7	96.5	**87.2**
5	245	98.8	97.1	92.7	**89.4**	330	99.7	85.5	95.2	**80.9**
Niger-Niamey										
1	18	94.4	50.0	94.4	**50.0**	21	100.0	71.4	100.0	**71.4**
2	16	100.0	31.2	93.8	**31.2**	23	91.3	82.6	100.0	**73.9**
3	14	85.7	14.3	92.9	**7.1**	18	72.2	61.1	100.0	**50.0**
4	19	100.0	36.8	100.0	**36.8**	23	100.0	52.2	100.0	**52.2**
Nigeria Kaduna										
1	34	94.1	82.4	97.1	**79.4**	33	90.9	75.8	93.9	**72.7**
2	37	100.0	83.8	97.3	**81.1**	46	97.8	80.4	95.7	**78.3**
3	32	100.0	87.5	90.6	**81.2**	45	97.8	88.9	82.2	**75.6**
4	47	97.9	85.1	93.6	**76.6**	57	96.5	89.5	82.5	**71.9**
Nigeria Lagos										
1	48	100.0	97.9	95.8	**93.8**	33	97.0	63.6	100.0	**60.6**
2	57	98.2	94.7	100.0	**94.7**	53	94.3	73.6	92.5	**67.9**
3	60	100.0	95.0	100.0	**95.0**	59	98.3	76.3	88.1	**67.8**
4	59	100.0	98.3	98.3	**96.6**	61	98.4	83.6	88.5	**75.4**
Uganda										
2	100	97.0	85.0	88.0	**76.0**	139	96.4	77.7	78.4	**62.6**
3	117	98.3	86.3	88.0	**76.1**	147	99.3	74.1	84.4	**61.9**
4	121	97.5	84.3	89.3	**73.6**	143	98.6	72.7	88.8	**67.1**
5	136	97.8	86.0	91.9	**80.1**	163	98.8	85.3	90.2	**77.9**

Appendix 5 note: Personnel and service readiness results for Kinshasa/DRC Round 6 are not presented due to an inconsistent skip pattern in the questionnaire.