West and Central Africa's Regional trend analysis in the supply and availability of reproductive health products at service-delivery points

Period of study: 2017-2023

United Nations Population Fund West and Central Africa Regional Office

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ACRONYMS AND ABBREVIATIONS

DMPA-SC	Depot medroxyprogesterone acetate in its subcutaneous form
FP	Family planning
HFs	Health facilities
IUD	Intra Uterine Device
LMIS	Logistics management information systems
PPFP	Postpartum family planning
RH	Reproductive health
SDG	Sustainable Development Goal
SDP	Service Delivery Point
UNFPA	United Nations Population Fund
WCA	West and Central Africa
WCARO	West and Central Africa Office
WHO	World Health Organisation

Foreword

Regional Director's Message

The right to sexual and reproductive health is a fundamental human right. It is essential for individuals, families, and communities to thrive. However, in many parts of the world, this right is not being fulfilled. Millions of people still lack access to quality sexual and reproductive health services and commodities.

The situation is particularly dire in West and Central Africa. The region is home to the world's highest maternal mortality ratio and unmet need for family planning. There are many factors that contribute to this, including poverty, gender inequality, insecurity, and weak health systems. But one of the biggest challenges is the lack of access to quality-assured essential sexual and reproductive health products at every service delivery point.

In 2022, UNFPA launched the third phase of the UNFPA Supplies Partnership to address this challenge. Initiated in 2008, this partnership is a global initiative that aims to ensure that everyone has access to the sexual and reproductive health products they need. In West and Central Africa, the partnership has been working in 20 eligible countries to expand methods for modern contraception, strengthen their national health systems including supply chains, advocate for policies and enhanced domestic resources that support sexual and reproductive health so that countries can move from funding to funding and financing, and collect data for informed decisions.

One of the key activities of the partnership is to conduct annual surveys of health facilities to assess the availability of sexual and reproductive health products at the service delivery points and to assess the quality of services through interviews with clients. This report presents the results of different national surveys conducted in West and Central Africa from 2017 to 2023. The report's findings are clear: there is a critical need to improve the availability of sexual and reproductive health products in West and Central Africa across all levels of the health pyramids.

I urge all stakeholders to use this report to improve commodity security in the region. We must work together to ensure that everyone has access to the sexual and reproductive health products they need. This is essential for achieving the Sustainable Development Goals and for ensuring the health and well-being of all people in West and Central Africa.

I believe that by working together, we can make a difference in the lives of millions of women and girls in West and Central Africa so that no woman should die while giving birth, every pregnancy is by choice, not a chance; and every young person's potential is fulfilled.

Thank you for your commitment to this important issue.

Dr Sennen Houton,
Regional Director, UNFPA WCARO

Aknowledgement

This report was written under the supervision of Patrick Gaparayi, Regional Advisor and Team Lead, Commodity Management at UNFPA WCARO, supported by Dr. Chilanga Asmani, Regional Advisor, Family Planning Policy and Programming, UNFPA WCARO, and Dr. Saliyou Sanni, Regional Advisor, Maternal Health and Health Systems Strengthening, UNFPA WCARO.

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Summary

This work aimed to conduct an analysis of the situation of the securing of reproductive health products during the period from 2017 to 2023. Based on periodic surveys on the supply and availability of contraceptive methods and vital maternal health medicines in health facilities (HFs) in the different countries of the UNFPA Supplies Partnership programme in West and Central Africa.

To do this, sixty-two (62) survey reports conducted from 2017 to 2023 in the HFs of the twenty (20) beneficiary countries[1] of the programme were used to extract the results of the main indicators of the supply and availability of reproductive health (RH) products. These indicators were extracted by year and by country as reported in the reports. The extracted data were then pooled to estimate regional averages. The analysis of the reports and the extracted data made it possible to identify findings and generate results at several levels.

In terms of supply and availability of RH products

- At least three and five methods are offered in 95% and 78% of health facilities in the countries of the region, respectively. Depending on the location, 95% of health facilities in urban and rural areas offer at least three methods, and 80% and 78% offer all five methods.
- Indicators of availability of contraceptive methods to be improved in the HFs of the countries of the region. Indeed:

On the day of the survey:

- 43.2% of FOSA had all the modern contraceptive methods they are expected to offer;
- 79.5% had at least three of these contraceptive methods;
- 74.5% had at least five of these contraceptive methods.

During the last three months:

- 39.6% of HFs had permanent stock of all contraceptive methods they are expected to offer;
- 77.5% of HFs have permanently available in stock at least three of the contraceptive methods they are expected to offer;
- 76% of HFs have permanently available in stock at least five of the contraceptive methods they are expected to offer.

[1]These are 16 West African countries (Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal and Sierra Leone, Togo) and seven (7) Central African countries (Cameroon, Central African Republic, Congo-Brazzaville, Gabon, Equatorial Guinea, Sao Tome & Principe, Chad)

Unlike the indicators of the supply of methods, those of the availability of these methods both on the day of the survey and during the last three months appear to be relatively weaker in rural areas than in urban areas.

- Indicators of availability of vital maternal health medicines to be improved in health facilities providing delivery services.

  - 83.1% of HFs had injectable magnesium sulfate; 94.2% had oxytocin and 60.4% had misoprostol.

  - 71% of HFs had at least seven (7) maternal health medicines in stock, including magnesium sulfate and oxytocin at the time of the survey.

- High proportions of avoidable causes of stock shortages at HFs level, such as delays in replenishment requests, and delays in delivery from supply sources, to which we can add the low need or absence of demand from customers.

- High levels of unfulfilled RH product orders in health facilities in the region: just under one in two health facilities (49.5% on average) saw their last RH product order fully fulfilled (min = 25.5% in 2021 and max = 60.1% in 2023)

On the training of staff responsible for stock management in health facilities

- A relatively average percentage of health facilities with staff trained in the management of the logistics management information system (LMIS) at the regional level, but with disparities between countries. Indeed, 66.3% of health facilities had staff trained in the supply chain LMIS. Some countries such as Congo (41.4%), Chad (44%), Central Africa (46%) and to a lesser extent Gambia (53.73%), remain at low average proportions of health facilities with staff trained in LMIS.
- A high percentage of health facilities with personnel trained in the provision of modern methods of contraception at the regional level, with disparities between countries. This average percentage was 86.3% in the region. Training included the insertion and removal of implants in 82% of cases and the insertion and removal of the IUD in 70% of cases.

On the tools for assisting and guiding RH service provision

Availability of guidelines or protocols, checklists and tools to support RH service delivery, necessary to ensure the quality of services to be improved at the level of health facilities (between 60 and 70% of HFs had them, depending on the type of document).

On billing for services and products (contraceptives and RH medications)

- FP service consultations are billed in 36.7% of the region's HFs, and FP inputs in 44% of the HFs surveyed.
- Consultations for maternal and child health services are billed in 30 to 45%. As for FP inputs and RH drugs, they are billed in at least 40-50% of the HFs in the region.

The billing of these services reported by the HFs was also confirmed by the customers interviewed during the surveys. It is noted that some countries are the exception with very low proportions of HFs in which these services are billed both according to the data of the establishments and according to those provided by customers. These are Sao Tome and Principe where free service seems to be completely free, and Niger.

On customers' perception of FP services

- The vast majority (97%) of customers are generally satisfied with the FP services received on the day of the surveys (including the technical, organizational and relational aspects of the service offer). However, there is dissatisfaction with the waiting time before the service. Indeed, the waiting time was considered long by almost one in three customers (32%).

In conclusion, this analysis provides an overview of the indicators of supply and availability of RH products in the UNFPA WCARO area over a previous period. Securing these products requires interventions that address both structural deficiencies in the supply chain and demand shortfalls contributing to stockouts. The UNFPA regional office, through its leadership in the field of reproductive health, and particularly in FP, has a key role to play, in particular by supporting initiatives aimed at improving access to RH services and products, improving stock management through functional and reliable logistics information systems, and stimulating demand for products and services. It will have to continue, if not strengthen, its technical and financial support to countries in:

1. Advocacy for policies of universal access to a wide range of products including new self-administered long-acting reversible methods, such as subcutaneous DMPA.

2. Improving availability and accessibility through last-mile distribution initiatives. The last-mile distribution strategy currently being tested in the seven countries of the region (Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mauritania, Niger, Chad)[2] should be supported and evaluated to better capitalize on its impact on the availability of products and services with a view to its expansion.

[2] UNFPA WCARO Annual Report 2023

3. The extension of the digitalization of logistics information of national supply chains for greater visibility of the status of product stocks, the analysis and adequate routine exploitation of logistics information throughout the supply chain. Since the control of logistics information lies at the heart of the supply chain, this support, adapted and contextualized according to the needs identified by each country, should ultimately make it possible to anticipate and prevent product shortages at the national, intermediate and peripheral levels.

4. Capacity building of human resources in the supply chain (training and retraining as appropriate on LMIS management) especially for the benefit of the least equipped countries in the region such as Congo, Chad, Central Africa, and Gambia.

5. Performance monitoring through periodic surveys is essential for evidence-based and up-to-date decision-making. For greater visibility of performance recorded at the regional level, it is recommended that the twenty beneficiary countries of the UNFPA Supplies Partnership Programme be organized into two groups for the conducting of annual surveys on the supply and availability of RH products at regular intervals between the groups. This set-up will allow the regional office to have regional indicators each year from a first representative group of 10 countries, and each country to have said indicators at the national level every two years. This set-up will also have the advantage of providing each year an overall analysis of the combined databases of the different countries, and a good estimate of the regional indicators.

6. Support for specific investigations of supply chain factors that affect RH commodity availability in countries. UNFPA Supplies Partnership periodic surveys of commodity supply and availability provide indicators at the service delivery point, but do not provide insight into specific factors in the upstream national supply chain that could influence availability at the dispensation point. Further studies targeting the end-to-end national supply chain (selection, quantification of needs, acquisition or purchase, storage, distribution, and finally dispensation) would help to better identify strengths and weaknesses upstream.

Finally, given the limitations of this report, which provides an overall picture of the average level of indicators for the period 2017 to 2023, and the dynamics of reproductive health programme actions in countries, we recommend that UNFPA WCARO conduct a specific analysis of survey data from 2024 to better understand the real level of performance. A comparison could be made with data from surveys conducted in 2023 to measure progress. In addition, it will provide greater visibility of regional data and better monitoring of trends from one year to the next.

For the different countries in the region, the recommendations made are those considered relevant for improving product safety but may not be relevant for some countries given the dynamics of actions regularly undertaken by countries in terms of RH. They have been grouped into six sections, addressing the improvement of service provision, product availability, logistics information, and human resource capacities, and finally the improvement of monitoring of indicator performance through surveys in health facilities.

I. INTRODUCTION

The population of the West and Central Africa region, estimated at 503 million in 2023, is expected to reach one billion in 2050 [1]. This population is particularly young with 33% of the population aged 10 to 24 years [2]. Although this constitutes a very strong human capital for regional and national socio-economic transformation, West and Central Africa (WCA) has experienced slow progress in key indicators related to maternal mortality, contraception and fertility, and the region is well behind globally in achieving key Sustainable Development Goals (SDGs) by 2030 [3]. It is recognized that the adequate use of contraceptive methods reduces maternal mortality by almost 44% [4]. However, supply and demand challenges remain among the most significant barriers to access and use of these commodities in several countries. Despite some modest improvements, many countries in the region still face challenges in governance, peace, gender equality, security, public sector management and public financial management [5].

In addition, the West and Central Africa region is increasingly experiencing severe humanitarian crises such as armed conflict and terrorism, in addition to the alarming impacts of climate change and other emergencies in which sexual and reproductive health rights and choices are threatened. As of July 2023, seven countries (Burkina Faso, Cameroon, Chad, Central African Republic, Mali, Niger, Nigeria) in West and Central Africa were in humanitarian crisis [6]. UNFPA, through its UNFPA Supplies Partnership programme, works with partners to ensure reliable regular supplies and appropriate use of quality contraceptive methods and other sexual and reproductive health commodities by strengthening national health systems, advocating for policies and resources that support sexual and reproductive health, including family planning, and collecting data to support this work [7].

To ensure that these commodities reach their intended customers, UNFPA Supplies Partnership programme requires all its beneficiary countries to conduct annual service delivery point surveys to assess the impact of the commodities procured on service availability. The reports of these surveys are very useful in assessing the reach of commodities in beneficiary countries and in advocating for increased resources. It is in this context that the UNFPA Regional Office for West and Central Africa (UNFPA/WCARO) has undertaken to review the national survey reports and thus develop an analysis of regional trends in commodity supply, availability and utilization during the period 2017 to 2023 and formulate country-specific recommendations for the planning and future implementation of commodity security plans.

II. GOALS

This work aims to support West and Central Africa in carrying out a situation analysis on the securing of reproductive health products (contraceptive methods and maternal health medicines) during the period from 2017 to 2023, as assessed by annual surveys in health facilities in the different countries of the UNFPA Supplies Partnership programme.

Specifically, this involved (i) examining country-specific trends in service delivery point (SDP) survey reports; (ii) identifying factors that contribute to improving commodity security, including in humanitarian and fragile contexts, with a focus on new and less used contraceptive methods; (iii) analyzing the effects of major trends on the availability and use of sexual and reproductive health commodities and services; (iv) identifying strategies to mitigate stockouts or overstocks of FP commodities; (v) developing innovative solutions to improve the availability of and access to sexual and reproductive health commodities and services up to the last mile; and (vi) finally, proposing feasible regional and national recommendations to improve commodity security and the extension of family planning services to communities.

III. METHODOLOGY

III.1. Approach and framework of the analysis

The methodological approach consisted of extracting data from survey reports conducted from 2017 to 2023 in West and Central African countries benefiting from the UNFPA Supplies Partnership programme. These are 15 West African countries (Benin, Burkina Faso, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal and Sierra Leone, Togo) and 5 Central African countries (Cameroon, Central African Republic, Congo-Brazzaville, Sao Tome & Principe, Chad). In addition, the quantitative analysis was supplemented by a documentary review.

III.2. Data sources

III.2.1. Annual RH Product Surveys

The data were extracted mainly from periodic survey reports carried out in the various countries of West and Central Africa (WCA) from 2017 to 2023. Repeated cross-sectional surveys were conducted in health facilities with the aim of measuring indicators of the supply and availability of modern contraceptive methods and maternal health medicines at the national level. The contraceptive methods taken into account in the various surveys are the male condom, the female condom, contraceptive pills, emergency contraception, injectable contraceptives, the IUD or coil, implants, tubal ligation, vasectomy. As for RH drugs, they are (i) Oxytocin, ii) Misoprostol, iii) Sodium Chloride, iv) Sodium Lactate Solution (Ringer Lactate), v) Magnesium Sulfate, vi) Calcium Gluconate, vii) Hydralazine, viii) Methyldopa, ix) Ampicillin, x) Gentamicin, xi) Metronidazole Injection, xii) Mifepristone, xiii) Azithromycin, xiv) Cefixime, xv) Benzathine Benzylpenicillin, xvi) Nifedipine, xvii) Dexamethasone, xviii) Betamethasone, and ixx) Tetanus Toxoid Vaccine (TTV)[3][8].

In each country, a sample of health facilities that offer reproductive health services (including family planning and/or delivery services) were identified for inclusion in the survey, using a stratification method in primary, secondary and tertiary level facilities. Within each stratum, health facilities were randomly sampled across the country in both urban and rural areas. The surveys were conducted following a standardised protocol and questionnaire proposed by the UNFPA Supplies Partnership programme.

[3]According to the WHO Priority life-saving medicines for women and children, 2012; the priority medicines are: i) Oxytocin, ii) Misoprostol, iii) Sodium chloride, iv) Sodium lactate compound solution, v) Magnesium sulphate, vi) Calcium gluconate, vii) Hydralazine, viii) Methyldopa, ix) Ampicillin, x) Gentamicin, xi) Metronidazole, xii) Mifepristone, xiii) Azithromycin, xiv) Cefixime, xv) BenzathineBenzylpenicillin, xvi) Nifedipine, xvii) Dexamethasone, xviii)

Data collection was carried out in health facilities using questionnaires over a period of 2 to 4 weeks depending on the country by trained collection agents. A paper questionnaire was used in 2017 and from 2018, UNFPA Supplies Partnership programme collaborated with Systmapp to create an online digital tool for data collection using tablets. In its content, the digital questionnaire is identical to the paper questionnaire used previously. At the end of the collection, the data were analysed according to a reporting plan proposed by UNFPA. The determination of the different indicators of supply, availability, as well as those relating to stockouts of products in the countries was done taking into account the level of care at which a product should be available according to national guidelines.

III.2.2. General presentation of the investigation reports

The general outline of the country reports devoted to the results of the surveys is structured around the description of the HFs (classification, location and type of manager); the supply, availability and stockouts of modern contraceptive methods, and vital maternal health medicines. In addition to this information on the supply and availability of RH products, the reports also present aspects related to the supply chain, information on staff training, the existence of guidelines, checklists and working tools in health facilities, billing for RH services (including consultations, inputs and medicines) and the assessment by customers of the family planning services received on the day of the survey. Finally, the last part of the reports deals with the conclusions and main recommendations based on the results obtained.

III.3. Data extraction procedure

Data extraction was done manually using a pre-designed framework, drawn from the main indicators of supply and availability presented in the various successive reports. The extracted data were entered directly into an Excel file drawn from the main indicators of supply and availability presented in the various reports. The indicators filled in with the various data by country, and by year of survey were used to present the results in the form of tables and figures, which were commented on.

III.4. Documentary review

In addition to country survey reports on RH products, data from various sources available on the internet (study reports, scientific articles, etc.) were examined to support the results, especially in aspects not covered by the surveys, such as the use of contraceptive methods in relation to availability. The information collected from different sources was triangulated in order to cross-check quantitative and qualitative data. Other documents such as" *Relevant International Conference on Population and Development (ICPD) country reviews* [9], *the "Sustainability Readiness Assessment Tool (SRAT) findings"* [10], *"UNFPA Strategic Plan"* [11,12], *"UNFPA Business Model"* [13], *"UNFPA FP strategy, UNFPA WCA Acceleration papers"* [14], *UNFPA supplies partnership annual reports* [15], etc.

III.5. Data processing and analysis

The data extracted from the reports using Excel files were transferred to Stata 18 software for processing and analysis. The analysis consisted of simple average calculations of the indicators provided by the reports of the different surveys by country, and the overall averages for the region. The analysis of trends in country indicators was done by simple linear regression for countries that conducted at least two surveys during the period. Two levels of analysis were considered. These are the overall analysis at the regional level and the analysis by country. The different analyses were stratified according to the characteristics of the HFs (HFs level (primary, secondary, tertiary), location (urban, rural), when data availability allowed.

The results were presented in the form of tables and figures to facilitate visualisation, especially at the regional level, and comparison between countries.

III.6. Data quality assurance mechanism

In order to ensure good data quality, various quality control measures were observed throughout the data collection and processing. These measures include in particular the prior validation of the data extraction framework, the report frameworks and the analysis plan by the mission monitoring managers at UNFPA WCARO. The data were extracted in duplicate from the reports by two pairs of assistants, then compared and verified by the consultant and biostatistician. In the event of differences, the report was reviewed to find the correct value to be entered in the extraction framework. A data extraction report was produced specifying the missing or unfilled data for each country report. In addition, discussions with the mission monitoring manager at UNFPA made it possible to take into account the guidelines throughout the process.

III.7. Limitations of the data analysed

This analysis was made from the data reported in the various survey reports conducted in the countries at varying intervals (first annual, then biannual or triannual), and some countries had only conducted two surveys and others five during the period in question. Added to this are the missing data, mainly because some countries did not follow the standard reporting plan proposed by UNFPA Supplies Partnership programme as part of the annual surveys. This limits a good analysis of trends and a rigorous comparison of progress recorded between countries, the calculation of weighted indicators to take into account the weight of the countries in the sample. The averages presented are in fact unweighted raw results.

Also, the available data do not allow a link to be established between the supply of services or the availability of contraceptive products and their use by users, the surveys not having taken into account the matter of the use of the methods, but rather the perceptions and opinions of family planning customers about the services.

Despite these limitations, the extracted data provided results that could guide the regional office as to the average level of the main indicators of supply and availability of RH products in the region. These guidelines could be consolidated by a direct analysis of the raw databases generated by the 2024 surveys in the different countries of the region.

IV. RESULTS

IV.1. Mapping of surveys carried out from 2017 to 2023 in FOSA in WCA

From 2017 to 2023, sixty-two (62) surveys on the supply and availability of reproductive health products (modern methods of contraception and vital maternal health medicines) at service delivery points were conducted in twenty (20) of the twenty-three (23) countries of intervention of the UNFPA Regional Office for West and Central Africa under the UNFPA Supplies Partnership programme. The number of surveys conducted per country during the period varies from two (2) to five (5), and per year varies from four (4) in 2021 to 14 in 2018.

Three countries, including one in West Africa (Cape Verde) and two in Central Africa (Gabon and Equatorial Guinea), did not conduct a survey during the period indicated.

Table 1 shows the number of surveys carried out from 2017 to 2023 as well as the average numbers of HFs included per survey by country.

TABLE 1: Number of surveys carried out by country from 2017 to 2023 as well as the average number of health facilities (HFs) included by country

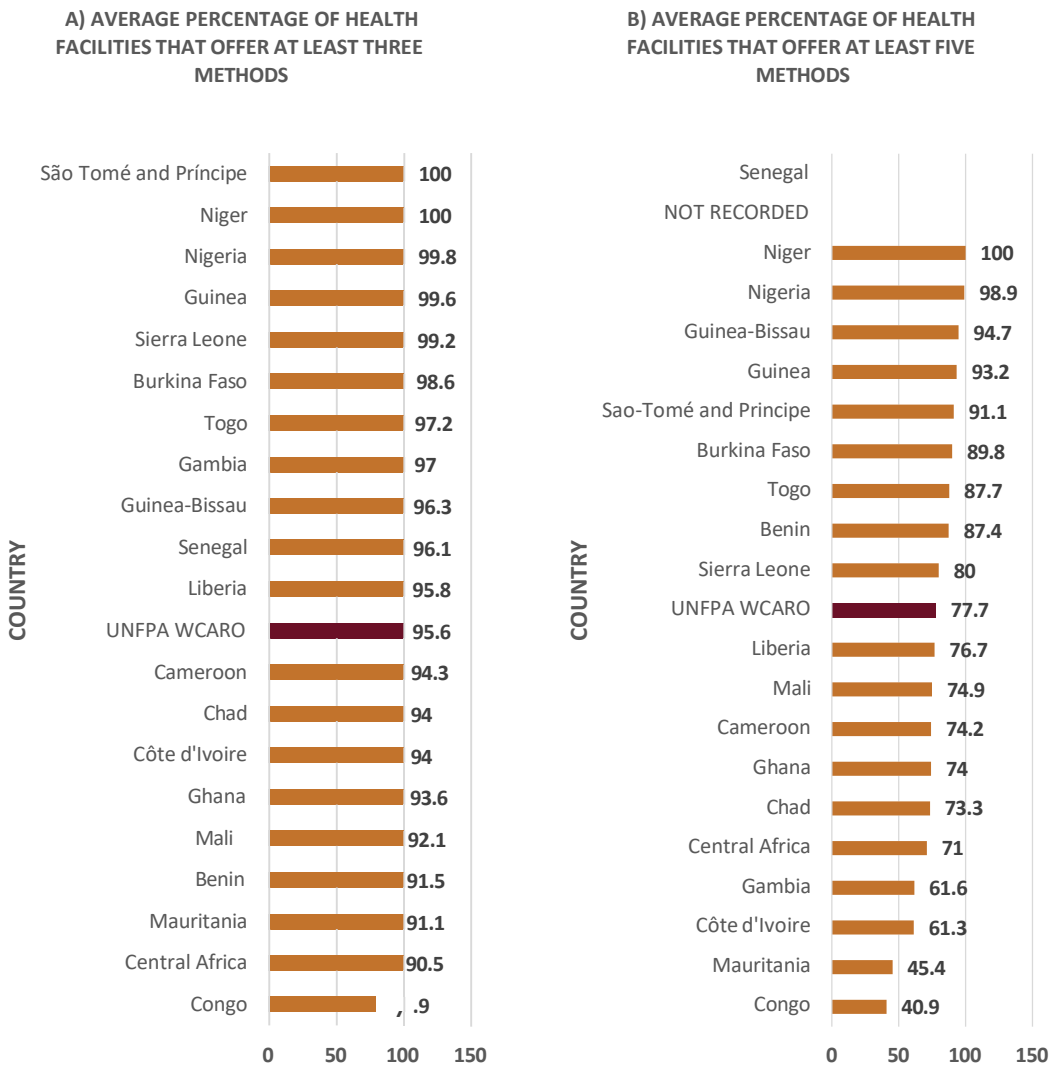
	Number of surveys conducted between 2017 and 2023	Years of investigations (reports)	Average number of FOSA per survey
Benign	3	2017, 2019, 2022	175
Burkina Faso	5	2017, 2018, 2019, 2020, 2023	411
Cameroon	3	2018, 2020, 2022	283
Central Africa	2	2019, 2022	165
Congo	2	2019, 2021	405
Côte d'Ivoire	3	2017, 2028, 2020	478
Gambia	3	2018, 2020, 2022	144
Ghana	2	2017, 2022	365
Guinea	4	2017, 2018, 2020, 2022	221
Guinea-Bissau	3	2017, 2018, 2019	96
Liberia	4	2017, 2018, 2010, 2022	134
Mauritania	4	2017, 2018, 2010, 2022	144
Mali	2	2017, 2019	199
Niger	4	2017, 2018, 2021, 2023	136
Nigeria	4	2017, 2018, 2019, 2021	1096
Sao Tome and Principe	4	2017, 2018, 2019, 2022	39
Senegal	2	2018, 2022	376
Sierra Leone	2	2018, 2022	128
Togo	3	2018, 2020, 2023	309
Chad	3	2017, 2020, 2023	224
UNFPA WCARO	**62**	**2017 to 2023**	**283**

IV.2. Offer of RH products in HFs, 2017-2023

Analysis of regional data from 2017 to 2023 shows that 95.6% and 77.7% of health facilities in the region offered at least three and five modern contraceptive methods, respectively, according to national guidelines. These average performances in the region hide disparities between countries, with half of the countries being below the regional averages as shown in Figure 1. These are Congo, Central African Republic, Cameroon, Chad, Mauritania, Mali, Côte d'Ivoire, Ghana, and Gambia.

Considering as a target, 85% of health facilities offering at least three contraceptive methods [10], we see that the regional average is above this target (Figure 1), and only one country, namely Congo, is below the target. However, there is a need to expand the number of contraceptive methods offered in several countries mentioned above to improve customers' choice of methods. The comparison with the billing of family planning services shows that these countries are those in which these services are billed the most (Figure 9, page 26), compared to countries with higher indicators of the supply of methods.

FIGURE 1: Average supply of at least three (A) and at least five (B) modern contraceptive methods at the regional level from 2017 to 2023



Indicators of the supply of contraceptive methods in health facilities in the region between 2017 and 2023 have changed little, especially with regard to the supply of at least three methods. However, there was a decline in 2021 for this indicator, probably due to the COVID-19 pandemic. It should be noted, however, that only three countries reported survey data during 2021 (Congo, Niger, Nigeria). Overall, the comparison between urban and rural areas for the supply of at least three (3) contraceptive methods does not show any noticeable differences, as does that of at least five methods (Table 2).

TABLE 2: Offer of at least three and five contraceptive methods according to the type and location of the HFs

Offer according to national guidelines or protocols	Years								Trend
	2017	2018	2019	2020	2021	2022	2023	Together	
n	3590	3801	2652	2454	1711	2200	1128	2505	
HFs offering at least three modern contraceptive methods	%	%	%	%	%	%	%	%	
Regional	95.6	97.5	95.0	94.6	91.7	95.3	96.6	95.6	-0.213
Type of HFs									
Primary level HFs	96.0	97.1	95.1	91.7	91.4	94.5	97.4	95.1	-0.372
Secondary level HFs	97.3	98.2	93.6	95.6	94.0	95.6	96.7	96.1	-0.380
Tertiary level HFs	94.4	98.1	92.9	99.3	86.7	96.3	91.7	95.3	-0.190
Implementation environment									
Urban	94.2	96.0	94.0	96.2	93.3	95.0	95.4	95.0	0.0393
Rural	95.6	97.7	95.9	92.0	90.2	95.6	97.2	95.3	-0.231
HFs offering at least FIVE modern contraceptive methods	%	%	%	%	%	%	%	%	
Regional	87.0	77.8	76.8	68.7	71.9	74.3	87.0	77.9	-1.16
Type of HFs									
Primary level HFs	83.4	73.3	75.9	58.9	70.5	68.5	80.0	73.0	-2,223
Secondary level HFs	92.6	82.8	81.5	73.2	87.1	81.8	89.1	84.0	-1,213
Tertiary level HFs	85.6	89.0	77.7	92.3	86.7	91.9	87.7	87.3	0.920
Implementation environment									
Urban	88.3	79.4	75.9	75.5	75.8	76.5	86.2	79.8	-0.862
Rural	77.9	76.4	74.5	60.2	68.2	64.2	87.1	77.9	-1,001

IV.3. Availability of modern contraceptive methods in health facilities, 2017-2023

IV.3.1. Availability of contraceptive methods on the day of the survey

The average availability of all modern contraceptive methods according to the national guidelines of the countries at the regional level is 43.2% (38.4% in 2019 and 60.2% in 2021). The analysis of this availability of all methods on the day of the survey by country shows that Côte d'Ivoire had the least in stock with 4.17% (4.2% in 2017, 4.7% in 2018 and 3.8% in 2020). It is followed by other countries below the regional average such as Ghana (11.35%), Central African Republic (14.7%), Chad (19.67%), Congo (15.7%), Cameroon (24.8%), Burkina Faso (26.6%) and Benin (29.8%). Some countries, notably Senegal (95.8%) and Sao Tome and Principe (92.4%), reported the availability of all contraceptive methods expected to be offered in more than 90% of their health facilities.

Regarding the availability of at least three methods and at least five methods at the regional level, they were 79.5% (69.3% in 2022 and 94.2% in 2021) and 74.45% (59.2% in 2017 and 81.7% in 2023), respectively. These methods were generally less available in rural areas than in urban areas, as shown in the table below (Table 3).

TABLE 3: Regional trend in the availability of contraceptive methods on the day of the survey

Indicators (According to national guidelines or protocols)									
	%	%	%	%	%	%	%	%	
n	3590	3801	2652	2454	1711	2200	1128	2505	
HFs in which all contraceptive methods were available on the day of the survey									
Regional	39.6	50.9	38.4	38.4	60.2	35.0	53.1	43.2	-0.170
Type of HFs									
Primary level HFs	39.0	52.6	46.6	37.5	57.7	36.6	44.9	43.8	-0.795
Secondary level HFs	37.7	48.5	40.9	40.0	64.6	33.0	53.5	42.3	0.064
Tertiary level HFs	45.0	56.9	49.8	54.5	50.4	41.3	32.5	48.8	-1,743
Implementation environment									
Urban	35.6	46.8	43.4	42.6	64.8	30.6	57.9	42.5	0.735
Rural	32.6	47.2	33.8	33.6	55.3	27.6	48.9	37.7	-0.202
HFs having at least THREE contraceptive methods in stock on the day of the survey									
Regional	80.8	77.3	87.3	79.8	94.2	69.3	82.0	79.5	-0.883
Type of HFs									
Primary level HFs	77.6	84.1	88.5	77.6	92.5	68.2	86.8	80.4	-0.954
Secondary level HFs	73.1	77.7	78.0	81.2	96.4	68.3	84.3	76.8	0.318
Tertiary level HFs	78.0	83.7	69.8	87.2	68.0	83.9	90.7	80.5	1,274
Implementation environment									
Urban	77.3	76.8	86.4	80.7	70.1	86.9	79.1	77.3	-0.024
Rural	71.5	74.0	83.9	78.6	70.4	85.7	76.7	71.5	0.744
HFs having at least FIVE contraceptive methods in stock on the day of the survey									
Regional	59.3	79.3	79.8	76.9	81.5	81.7	65.3	74.5	1,569
Type of HFs									
Primary level HFs	60.6	78.9	78.6	73.9	74.3	79.0	68.1	74.0	1,038
Secondary level HFs	73.8	85.3	74.3	78.9	90.3	85.1	58.8	78.4	-0.649
Tertiary level HFs	70.4	85.4	67.3	89.3	78.0	91.5	64.8	79.3	1,073
Implementation environment									
Urban	68.2	68.2	68.2	68.2	68.2	68.2	68.2	68.2	-0.520
Rural	52.5	79.5	75.1	74.3	78.3	68.1	72.7	52.5	1,533

OBSERVATIONS

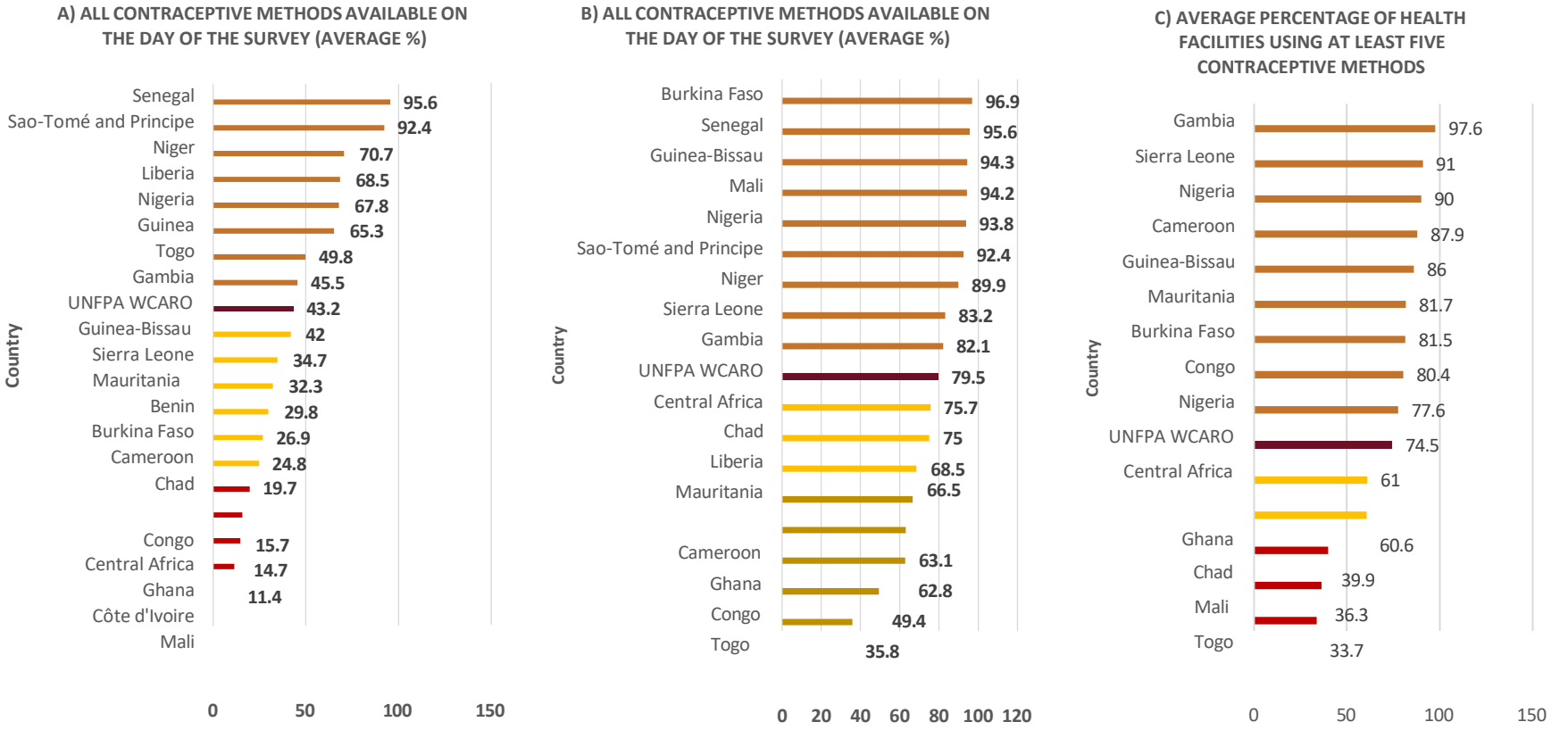
Examination of the data reported on the availability of at least three methods and at least five methods seems to show inconsistencies in the reports from certain countries such as Gambia, Sierra Leone, Niger, Cameroon, Mauritania and Congo. All these countries reported a higher percentage of availability of at least five methods (C) than at least three methods (B) at national level. In principle, this is not logical, as a health facility that has at least five contraceptive methods in stock will necessarily have at least three.

This inconsistency could be explained by the fact that some countries may have misinterpreted and therefore wrongly estimated the availability of the five methods.

It would therefore be advisable to harmonise countries' understanding of these estimates in order to ensure a better appraisal of the data at both national and regional level.

More than half of the 20 countries covered by the programme had availability above the regional average for both the three methods (79.5%) and the five methods (74.45%). Togo, Congo, Chad, Ghana, Cameroon and Mauritania had the lowest availability of at least the three methods (less than 75%), while Burkina Faso (97%), Mali (94.2%), Nigeria (93.8%), and Guinea-Bissau (94.3%) reported an average availability of more than 90%. For the five contraceptive methods, only 33.7%, 36.3% and 39.9% of health facilities in Togo, Mali and Chad respectively had them at the time of the surveys, much lower than the regional average (74.45%) (Figure 2).

FIGURE 2: Average percentage of health facilities stocking all contraceptive methods (A) and at least three contraceptive methods expected (B) and at least five contraceptive methods expected to be offered according to national guidelines (C)



IV.3.2. Availability of contraceptive methods in the last three months

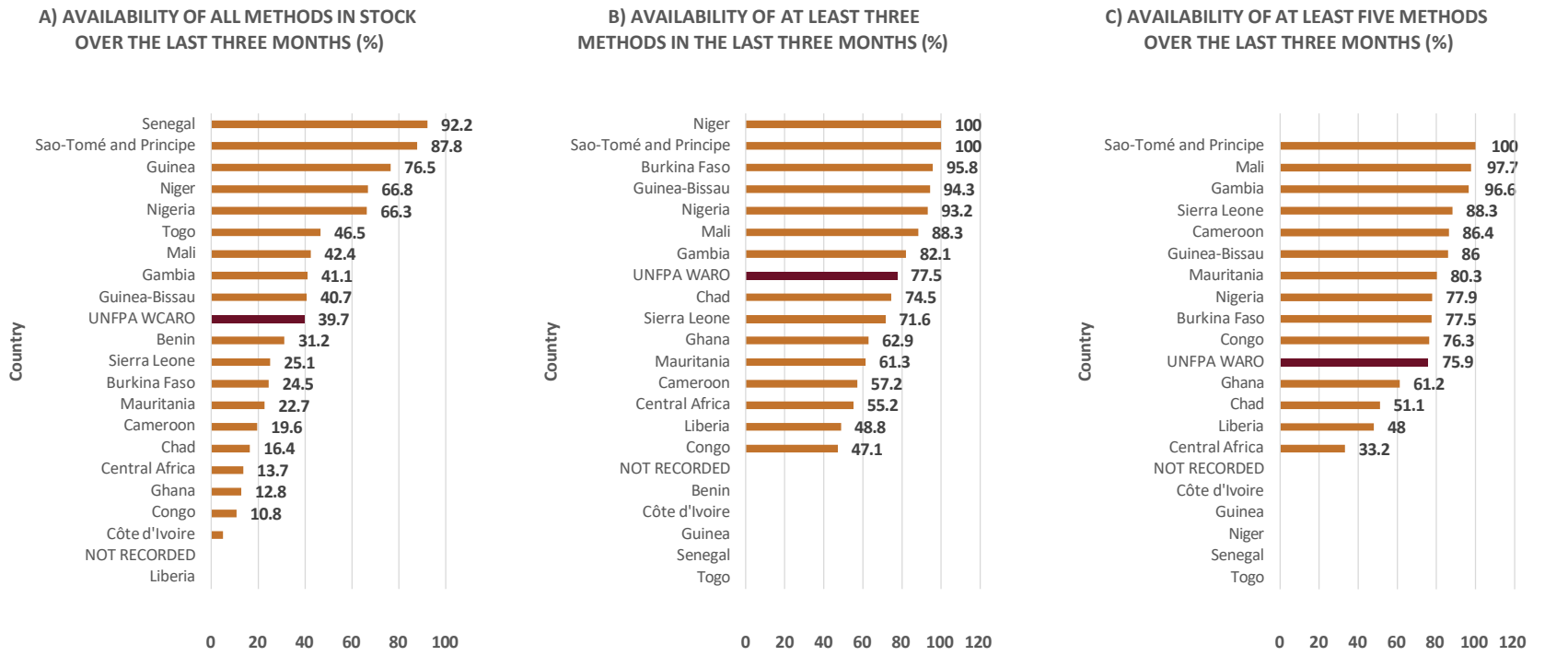
The regional average for the availability of all contraceptive methods expected to be offered in the last three months in health facilities is estimated at 39.6% during the period from 2017 to 2023, but with fluctuations depending on the year. Indeed, these average percentages were 30.4% in 2020, 29.4% in 2022 against 46.1% in 2018. When we look at the availability of at least three of the methods, and that of at least five methods, the average percentages at the regional level are respectively 77.5% and 75.9% during the last three months. In general, there are almost equal levels of availability of contraceptive methods between urban and rural areas at the regional level (Table 4).

TABLE 4: Regional trend in availability of contraceptive methods expected to be offered in the last three months

Indicators (According to national guidelines or protocols)	Years							Total	Trend
	2017	2018	2019	2020	2021	2022	2023		
n	3590	3801	2652	2454	1711	2200	1128	2505	
%	%	%	%	%	%	%	%	%	
HFs not having experienced a stock shortage of any contraceptive method during the last 3 months									
Regional	**40.3**	**46.1**	**43.4**	**30.4**	**40.9**	**29.4**	**44.9**	**39.6**	**-1.474**
Type of HFs									
Primary level HFs	40.3	46.8	43.6	28.9	38.7	28.9	38.4	38.6	-2.423
Secondary level HFs	36.7	49.4	34.4	36.8	61.7	25.2	43.8	38.8	-1.643
Tertiary level HFs	49.5	56.7	51.6	43.6	47.0	23.8	31.3	45.4	-4.883
Implementation environment									
Urban	43.6	43.1	46.4	33.6	46.6	28.7	49.0	40.6	-1.332
Rural	45.6	44.6	41.2	29.9	51.3	30.0	41.6	39.9	-1.959
HFs not having experienced a stock shortage for AT LEAST THREE contraceptive methods during the last three months									
Regional	**76.4**	**78.3**	**81.7**	**74.8**	**92.2**	**67.6**	**88.5**	**77.5**	**-0.150**
Type of HFs									
Primary level HFs	74.0	79.2	82.8	73.9	91.1	71.9	89.0	77.8	0.412
Secondary level HFs	75.7	73.7	70.7	75.7	93.6	68.6	84.7	74.2	0.268
Tertiary level HFs	79.9	81.1	71.8	79.9	87.0	80.1	90.7	79.9	0.951
Implementation environment									
Urban	71.1	72.1	75.9	75.6	69.5	87.5	74.2	71.1	0.890
Rural	67.6	68.2	81.3	74.5	68.8	88.7	73.4	67.6	1,437
HFs not having experienced a stock shortage for AT LEAST FIVE modern contraceptive methods during the last three months									
Regional	**65.5**	**78.2**	**79.1**	**73.1**	**83.3**	**83.5**	**70.8**	**75.9**	**1,905**
Type of HFs									
Primary level HFs	59.0	78.4	76.0	71.6	77.0	83.1	75.9	74.0	2,671
Secondary level HFs	70.9	76.2	72.1	74.1	91.0	82.5	74.9	75.5	1,467
Tertiary level HFs	77.3	73.6	78.8	78.5	88.0	93.0	82.6	80.7	2,742
Implementation environment									
Urban	60.5	74.4	82.3	73.2	84.3	76.0	75.5	60.5	2,735
Rural	52.2	75.9	76.0	73.7	83.0	75.8	73.2	52.2	3,544

Looking at the country indicators of method availability in the last three months, it appears that the countries in which all the contraceptive methods expected to be offered were not always available during the last three months are basically those mentioned above, namely Côte d'Ivoire (4.10%), Congo (10%), Ghana (12.7%), Central African Republic (13.7%), Chad (16.7%), Cameroon (19.7%), Mauritania (22.7%), and Burkina Faso (24.5%). On the other hand, the indicators of availability of at least three methods and at least five methods during the last three months were better for most countries in the region, ranging from 47.1% in Congo to 100% in Sao Tome and Principe and Niger, and from 33.1% in Central African Republic to 100% in Sao Tome & Principe (Figure 3).

FIGURE 3: Average percentages of health facilities that had in stock during the last three months all contraceptive methods (A) and at least three contraceptive methods (B) and at least five contraceptive methods expected to be offered according to national guidelines (C)



(NB: Several countries such as Liberia (A), Benin, Côte d'Ivoire, Guinea, Senegal, Togo (B and C) and Niger (B) do not have indicators at the national level in their reports. There are also discrepancies in the availability of the five methods which remain higher than that of the three methods, particularly in Cameroon, Congo, Gambia, Mali, Mauritania, Sierra Leone.)

IV.3.3. Supply and availability of subcutaneous DMPA

Subcutaneous depot medroxyprogesterone acetate commonly referred to as DMPA-SC is a new injectable contraceptive method that offers the potential to expand access to contraception and improve women's contraceptive autonomy through its self-injection option [20,21]. It was introduced in surveys from 2023. Only two reports, including that of Burkina Faso and Chad in 2023, reported data on the supply and availability of this method. This supply was 81.8% and 33.0% of health facilities in Burkina Faso and Chad, respectively. In health facilities offering this method, the product was available (in stock on the day of the survey) in 88.0% of them in Burkina Faso, and in 91.5% in Chad. Its availability during the last three (3) months was 85% in the health facilities concerned (Table 5).

TABLE 5: Supply and availability of subcutaneous DMPA at the national level

Country indicators	2023 (%)
DMPA-SC Offer	
Burkina Faso (n= 406)	**81.80**
Chad (n=248)	**33.00**
Total (n=654)	**57.40**
Offer to customers for self-injection	
Burkina Faso (n=349)	**47.00**
Chad (n=82)	**15.90**
Total (n=431)	**31.45**
Availability of DMPA on the day of the survey	
Burkina Faso (n=349)	**88.00**
Chad (n=82)	**91.50**
Total (n=431)	**89.75**
Availability in the last 3 months	
Burkina Faso (n=349)	**84.90**
Chad (n=82)	**85.40**
Total (n=431)	**85.15**

While in both countries, DMPA-SC is mainly offered by health professionals, surveys report that some health facilities, a minority (less than one in five health facilities offering DMPA-SC) are experimenting with the distribution of this product by community health workers on the one hand, and self-injection by the customers themselves on the other.

IV.3.4. Reasons for stockouts of contraceptive methods on the day of the survey

There are several reasons why contraceptive methods are not available at service delivery points [16-19]. During the surveys, the most commonly cited reasons were mainly "Delays in delivery" attributable to the main source of resupply (institution/warehouse); "Low demand for the product by customers in the health facility" and "Delays in requests for resupply from the health facility" attributable to the stock manager. The lack of trained personnel to offer methods, particularly implants and IUDs, as a justification for the unavailability of these methods only accounts for 12% and 17% of the reasons (Table 6). While the lack of personnel trained in the provision of long-acting methods such as implants and IUDs remains less involved in stock shortages of these products on a regional scale, it justifies their unavailability in at least 25% of stock shortages in Ghana, Burkina Faso, Côte d'Ivoire, Cameroon, Congo and Central Africa.

TABLE 6: Main reasons for stockouts of injectables, implants and IUDs on the day of the survey at the regional level

		Years							Total
		2017	2018	2019	2020	2021	2022	2023	
Reasons for stock shortages		%	%	%	%	%	%	%	%
Delay in delivery from primary replenishment source (institution/warehouse)	Injectables	30.77	24.26	44.37	30.90	42.90	48.86	38.85	**35.73**
	Implants	23.15	27.76	8.00	18.06	75.00	35.12	30.63	**25.77**
	IUD	11.78	6.80	15.55	15.86	0.00	28.26	12.67	**14.61**
Delay in request for replenishment from the HFs	Injectables	19.80	27.40	11.95	8.56	34.95	5.68	19.78	**16.90**
	Implants	8.25	14.18	8.85	12.78	12.50	18.44	19.70	**13.44**
	IUD	9.30	11.34	14.28	4.96	28.60	3.22	12.20	**9.60**
Unavailability of the product on the market preventing the HFs from obtaining it	Injectables	10.93	2.08	15.48	18.95	14.20	2.90	2.43	9.17
	Implants	4.23	16.00	6.33	4.13	12.50	3.26	9.70	7.10
	IUD	3.33	1.64	15.27	6.36	0.00	5.28	4.43	5.00
Low or no demand/need for the product in the HFs	Injectables	28.20	17.06	10.83	3.08	2.00	11.68	9.45	**13.68**
	Implants	33.73	17.84	20.77	12.98	0.00	27.88	19.38	**21.88**
	IUD	37.15	36.46	18.63	34.06	42.80	38.82	32.08	**33.84**
Lack of staff trained in offering this product in the HFs	Injectables								
	Implants	23.83	12.62	15.00	17.00	0.00	5.34	1.40	12.78
	IUD	33.70	17.50	19.20	0.00	28.60	8.90	9.73	17.63
Lack of equipment to dispense this contraceptive	Injectables								
	Implants	1.92	13.75	11.17	16.63	0.00	3.83	0.87	7.13
	IUD	2.65	5.83	0.27	0.15	0.00	1.10	5.90	2.57
Others	Injectables	10.30	8.60	7.47	3.72	9.50	28.02	9.13	11.33
	Implants	6.43	8.02	12.95	10.02	0.00	20.16	9.93	10.83
	IUD	2.15	25.25	14.25	22.24	0.00	16.42	11.70	14.26

IV.4. Availability of maternal health medicines

IV.4.1. Availability of magnesium sulfate, oxytocin and misoprostol

Overall, the regional availability of injectable oxytocin varied between 89.4% and 97.1% depending on the year, and that of injectable magnesium sulfate between 71.2% and 85.9% (Table 7). Considering the data for the year 2023 with 85% as a target, they are achieved for oxytocin (93.1%) and magnesium sulfate (90.5%), but not for misoprostol (67.6%). The trend in the availability of these two products from 2017 to 2023 seems regressive (-0.266 for magnesium sulfate and -0.789 for oxytocin). On the other hand, the availability of misoprostol tablets has grown from 2017 to 2023 (+1.171) and this growth is particularly marked in rural areas (+6.572) over the period. However, it should be noted that there has been an uneven development for each of the three drugs concerned.

TABLE 7: Regional availability of magnesium sulfate, oxytocin and misoprostol

Indicators (Vital Maternal Health Medicines)	Years							Trend
	2017	2018	2019	2020	2021	2022	2023	
n	3590	3801	2652	2454	1711	2200	1128	
%	%	%	%	%	%	%	%	
Magnesium sulfate injection								
Regional	85.9	85.1	77.5	85.1	71.2	82.7	90.5	-0.266
Type of HFs								
Primary level HFs	75.4	89.9	68.8	85.2	66.0	66.7	87.0	-0.844
Secondary level HFs	86.5	96.8	81.4	95.8	87.6	81.8	95.2	-0.096
Tertiary level HFs	86.0	86.0	86.0	86.0	86.0	86.0	86.0	0.583
Implementation environment								
Urban	83.3	97.6	81.5	93.8	-	83.0	88.5	-0.162
Rural	86.7	97.9	67.9	85.6	-	79.0	92.2	-0.196
Injectable oxytocin								
Regional	94.4	96.5	97.1	94.8	89.4	90.9	93.1	-0.789
Type of HFs								
Primary level HFs	91.4	96.8	93.5	94.9	88.3	84.2	91.9	-0.948
Secondary level HFs	94.6	99.5	85.3	99.0	91.8	90.2	94.2	-0.550
Tertiary level HFs	96.5	100.0	83.2	95.9	90.7	91.7	98.8	-0.340
Implementation environment								
Urban	94.4	98.7	87.4	97.3	-	88.2	95.2	-0.406
Rural	92.3	99.8	85.1	96.8	-	90.1	91.4	-0.436
Misoprotol tablet								
Regional	55.8	65.8	57.8	48.8	60.8	66.4	67.6	1,171
Type of HFs								
Primary level HFs	39.8	65.9	53.1	45.2	54.3	50.6	56.5	0.808
Secondary level HFs	61.5	91.0	68.5	83.6	77.6	73.7	84.6	1,723
Tertiary level HFs	76.0	97.1	79.1	90.6	72.5	83.3	91.0	0.380
Implementation environment								
Urban	44.7	81.9	75.7	79.9	75.6	66.9	69.7	2,415
Rural	23.2	51.1	63.2	43.3	70.2	70.1	52.5	6,572

AVAILABILITY OF INJECTABLE MAGNESIUM AT COUNTRY LEVEL

The analysis of the availability of magnesium between the editions of the surveys by country according to the available data shows that Senegal (+6.77) and Togo (+3.4) and Niger (+1.99), are the countries that have experienced a positive trend in the availability of magnesium. The other countries have either remained stable with more or less high availability percentages, but evolving in a sawtooth pattern. Seven (7) countries, led by Sao Tome and Principe (100%), have good availability of magnesium compared to the regional average (Figure 4). On the other hand, the availability of this product remains particularly low in health facilities in Congo (39.9%), which is also one of the countries with poor availability indicators for maternal health medicines.

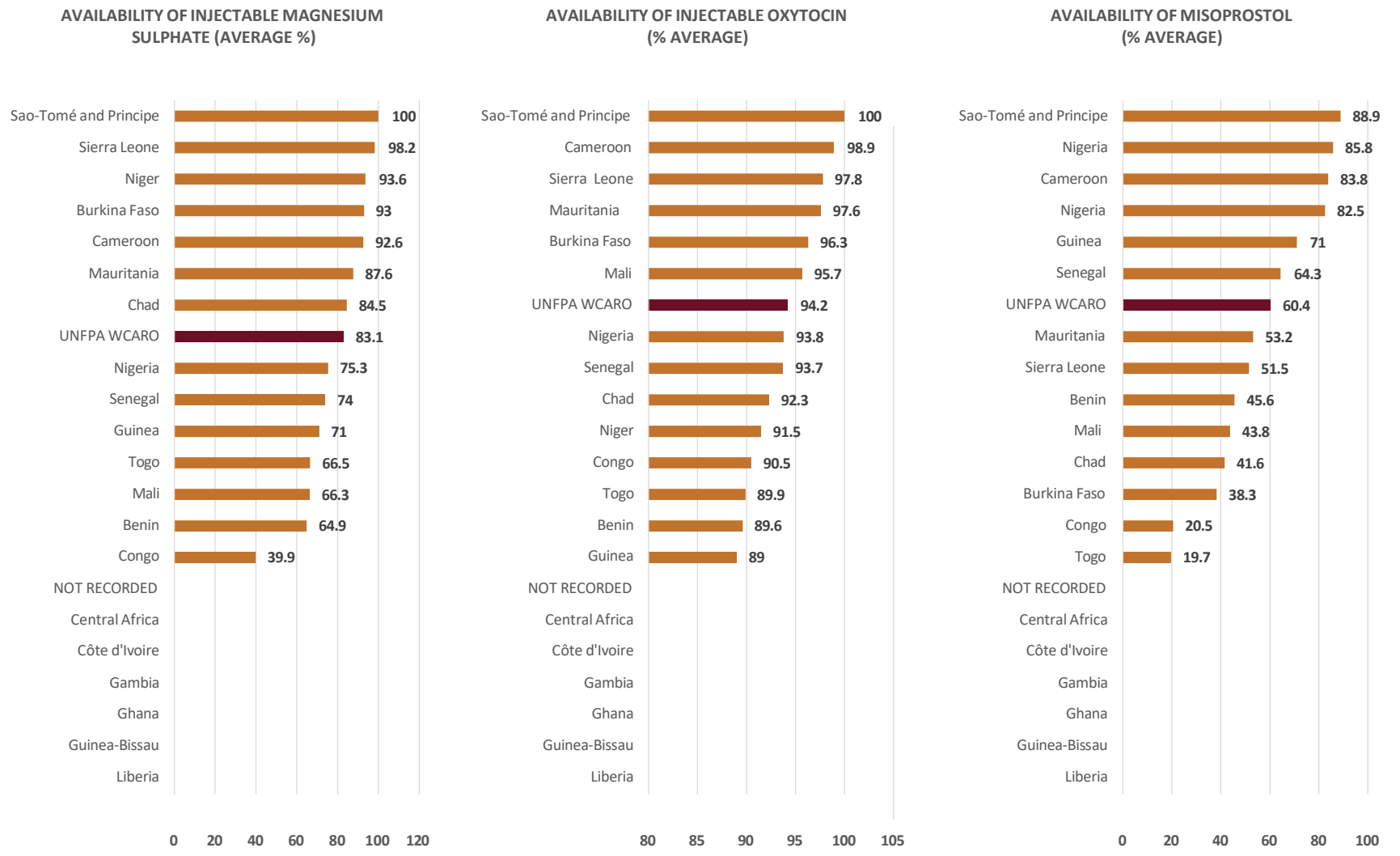
AVAILABILITY OF INJECTABLE OXYTOCIN AT COUNTRY LEVEL

Injectable oxytocin was available in at least 85% of the countries' health facilities from 2017 to 2023, except Benin in 2022 which recorded an availability of only 76.9% while it had it in 96% of its health facilities in 2017 and 2019.

AVAILABILITY OF MISOPROSTOL TABLET AT COUNTRY LEVEL

The availability of misoprostol tablets in health facilities has shown a positive trend over the surveys in several countries, including Sao Tome and Principe (+16.7%) between 2017 (68%) and 2019 (100%), Burkina Faso (+6.3%) which increased from 19.4% in 2017 to 59.5% in 2023, and Senegal (+7.9%) which reported 40.4% in 2018 and 80.2% in 2022. The unavailability of product is particularly marked in Congo, with only 20.5% in 2021, followed by Mali with 43% in the last survey in 2019, and Chad 45.5% in 2023.

FIGURE 4: Availability of magnesium sulfate, oxytocin and misoprostol in health facilities by country



IV.4.2. Availability of at least seven (7) vital maternal health medicines (including magnesium sulfate and oxytocin)

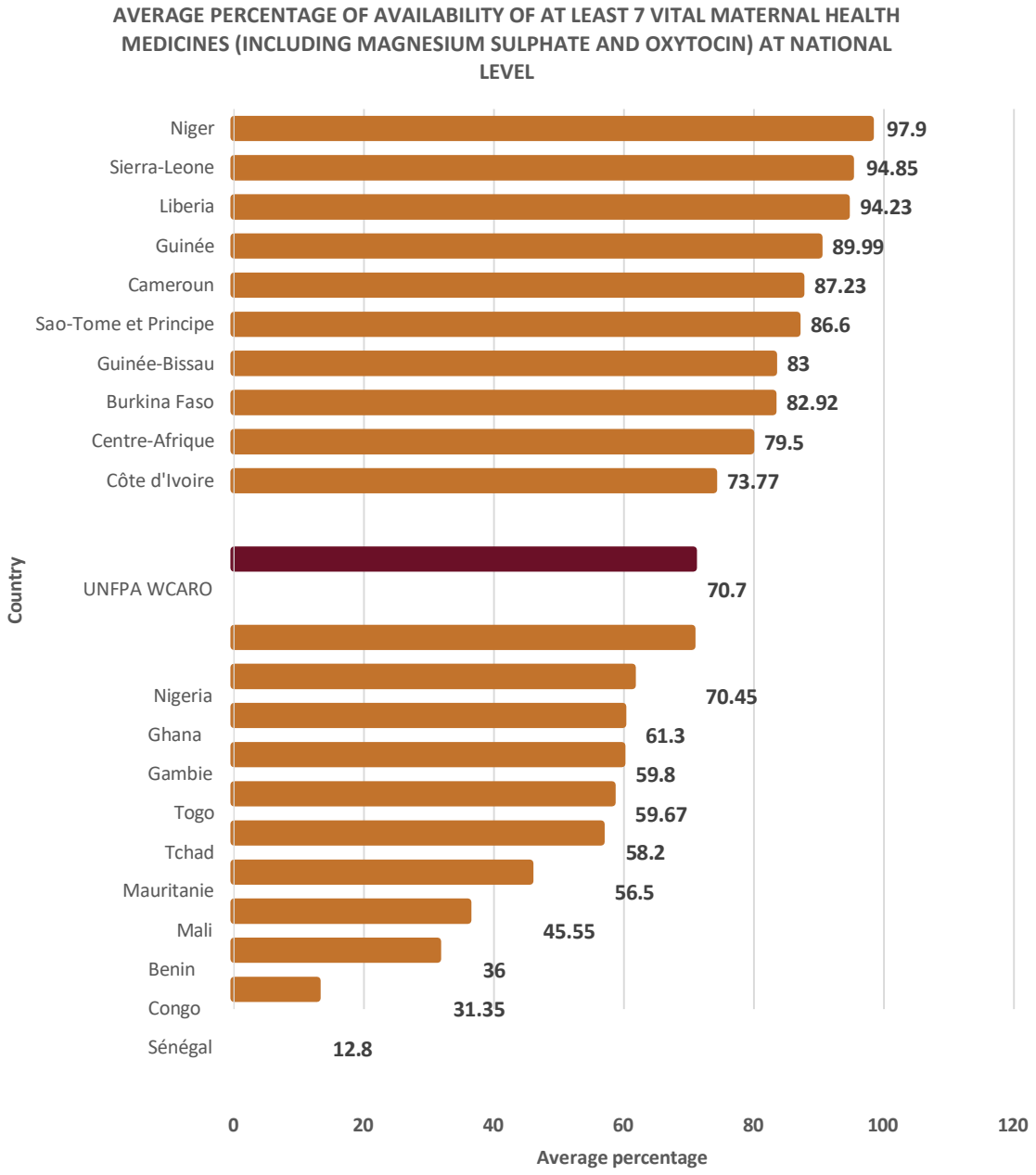
At the regional level, the average availability of at least seven (7) maternal health medicines including magnesium sulfate and oxytocin in health facilities is 70.7%. While overall the trend in this availability between 2017 and 2023 is positive (+1.687), there are significant fluctuations depending on the year. Indeed, from 61.9% in 2017, then 75.7% in 2018, there is a decrease in 2019 (70.3%), then in 2021 (51.4%) followed by an increase from 2022 (75.4%) which continued in 2023 (81.3%) (Table 8).

TABLE 8: Trend in availability of at least seven (7) vital maternal health medicines (including magnesium sulfate and oxytocin)

Indicators HFs having at least 7 vital maternal health medicines (including magnesiu sulfate and oxytocin) on the day of the survey	Years							Trend
	2017	2018	2019	2020	2021	2022	2023	
n	3590	3801	2652	2454	1711	2200	1128	
%	%	%	%	%	%	%	%	
Regional	**61.9**	**75.7**	**70.3**	**71.0**	**51.4**	**75.4**	**81.2**	**1,687**
Type of HFs								
Primary level HFs	50.5	73.1	65.9	71.3	41.4	65.6	76.9	1,756
Secondary level HFs	66.9	81.0	76.4	81.2	76.5	84.0	92.4	2,840*
Tertiary level HFs	87.7	77.8	77.5	80.6	87.6	88.1	94.9	1,273
Implementation environment								
Urban	60.3	78.7	76.3	76.5	64.2	77.8	86.3	2,392
Rural	51.7	69.9	66.0	65.3	40.8	73.6	77.5	2,600

Considering the regional average of availability of at least seven maternal health medicines including magnesium sulfate and oxytocin (70.7%), nine of the twenty countries (9/20) remain below this average, some at a particularly low level such as Senegal (12%), Congo (31%) and Benin (36% on average, with a significant drop from 55.9% in 2019 to 5.0% in 2022). Unlike the latter, Niger, Sierra Leone, Liberia, Guinea, Cameroon, Burkina Faso, Guinea-Bissau record availability of at least 80% for this indicator (Figure 5).

FIGURE 5: Average percentage of availability of at least 7 vital maternal health medicines (including magnesium sulfate and oxytocin) at the national level



The analysis of trends in the availability of maternal health medicines shows that some countries such as Mali (+19.4), Guinea-Bissau (+9.5), Central Africa (+8.93), Mauritania (+8.31), Chad (+7.27), Togo (+4.6) and Côte d'Ivoire (+4.31) show a positive trend between the different surveys. Other countries, on the other hand, seem to have evolved in a negative trend. This is the case of Benin (which goes from 55.9% for the 2020 survey to 5.0% for the 2023 survey), and Sao Tome and Principe which goes from 100% in 2019 to 71.4% in 2022 (Table 9).

TABLE 9: Availability of at least 7 vital maternal health medicines (including magnesium sulfate and oxytocin) at the national level and by survey year

Country	Year								Trend
	2017	2018	2019	2020	2021	2022	2023	Total	
Benign	**47.10**		**55.90**			**5.00**		**36.00**	**-9.09**
Burkina Faso	74.20	87.60	83.70	91.20			77.90	82.92	**0.05**
Cameroon		85.80		86.80		89.10		87.23	**0.82**
Central Africa			66.10			92.90		79.50	**8.93**
Congo			**28.90**		**33.80**			**31.35**	**2.45**
Côte d'Ivoire	62.70	80.30		78.30				73.77	**4.31**
Gambia		77.80		20.50		81.10		59.80	**0.82**
Ghana	61.30							61.30	
Guinea	82.40	94.00		87.34		96.23		89.99	**1.85**
Guinea-Bissau	71.00	88.00	90.00					83.00	**9.5**
Liberia	92.10	96.80		93.80				94.23	**0.27**
Mauritania	30.90	55.10		62.00		78.00		56.50	**8.31 ***
Mali	26.10		65.00					**45.55**	**19.45**
Niger							97.90	97.90	
Nigeria	66.60	73.20	72.90		69.10			70.45	**0.26**
Sao Tome and Principe	100.00	75.00	100.00			71.40		86.60	**-4.34**
Senegal		12.80						**12.80**	
Sierra Leone		100.00				89.70		94.85	**-2.58**
Togo		57.60		44.30			77.10	59.67	**4.46**
Chad	28.30			74.40			71.90	58.20	**7.27**
Total	**61.89**	**75.69**	**70.31**	**70.96**	**51.45**	**75.43**	**81.20**	**70.70**	**1,687**

IV.5. Main reasons for stockouts of maternal health medicines

The main reasons for stockouts of maternal health medicines, as reported for contraceptive methods, are “delays in delivery by the supply source”, “delays in requesting replenishment”, “low demand or need for the medicine in the health facility”. The data show that “delays in replenishment by the supply source” caused nearly 40% of stockouts of magnesium sulfate, oxytocin and misoprostol in 2023. The same is true for stockouts of oxytocin in 2017 (32.8%), 2019 (43.8%), and 2021 (33.9%) (Table 10).

TABLE 10: Main reasons for stockouts of maternal health medicines

		Years							
		2017	2018	2019	2020	2021	2022	2023	Total
Reasons for stock shortages	Medicines	%	%	%	%	%	%	%	%
Delay in delivery from primary replenishment source (institution/warehouse)	Injectable magnesium sulfate	24.02	7.12	15.35	12.22	5.35	21.47	**43.77**	**19.21**
	Injectable oxytocin	32.8	11.10	43.83	11.88	33.90	23.08	37.17	**27.00**
	Misoprostol tablet	13.8	14.35	9.48	11.27	12.75	28.71	38.35	**18.73**
Delay in request for replenishment from the HFs	Injectable magnesium sulfate	25.6	21.94	13.58	12.48	36.90	23.64	12.27	**20.08**
	Injectable oxytocin	31.8	5.57	22.87	0.00	20.80	0.00	27.70	**16.03**
	Misoprostol tablet	22.5	11.45	9.53	9.30	16.20	24.34	10.48	**15.28**
Unavailability of the drug on the market preventing the HFs from obtaining it	Injectable magnesium sulfate	16.2	7.92	14.66	18.06	1.80	2.97	12.17	11.46
	Injectable oxytocin	16.8	11.60	3.55	23.30	25.00	1.92	0.00	12.04
	Misoprostol tablet	16.2	12.13	19.00	31.48	22.25	15.28	12.38	17.95
Low or no demand/need for the medicine in the HFs	Injectable magnesium sulfate	18.0	30.48	24.80	18.04	38.10	29.49	13.28	**23.48**
	Injectable oxytocin	14.3	1.87	7.47	21.03	7.75	13.33	8.00	**11.30**
	Misoprostol tablet	26.5	41.45	54.60	27.75	27.15	22.93	25.78	**32.26**
Lack of staff trained in this medicine in the HFs	Injectable magnesium sulfate	6.68	9.84	7.58	5.72	5.35	9.27	1.38	6.75
	Injectable oxytocin	10.44	0.00	3.55	0.00	0.00	0.00	0.00	2.82
	Misoprostol tablet	7.65	7.60	14.30	5.02	5.25	2.36	10.75	7.73
Others	Injectable magnesium sulfate	7.18	22.64	15.53	16.50	12.50	16.05	2.33	13.63
	Injectable oxytocin	7.72	36.57	32.15	14.78	12.50	53.33	16.90	23.06
	Misoprostol tablet	13.35	13.00	19.13	16.62	16.40	13.23	6.67	13.91

IV.6. Fulfilment of HFs orders for RH products over the last three months

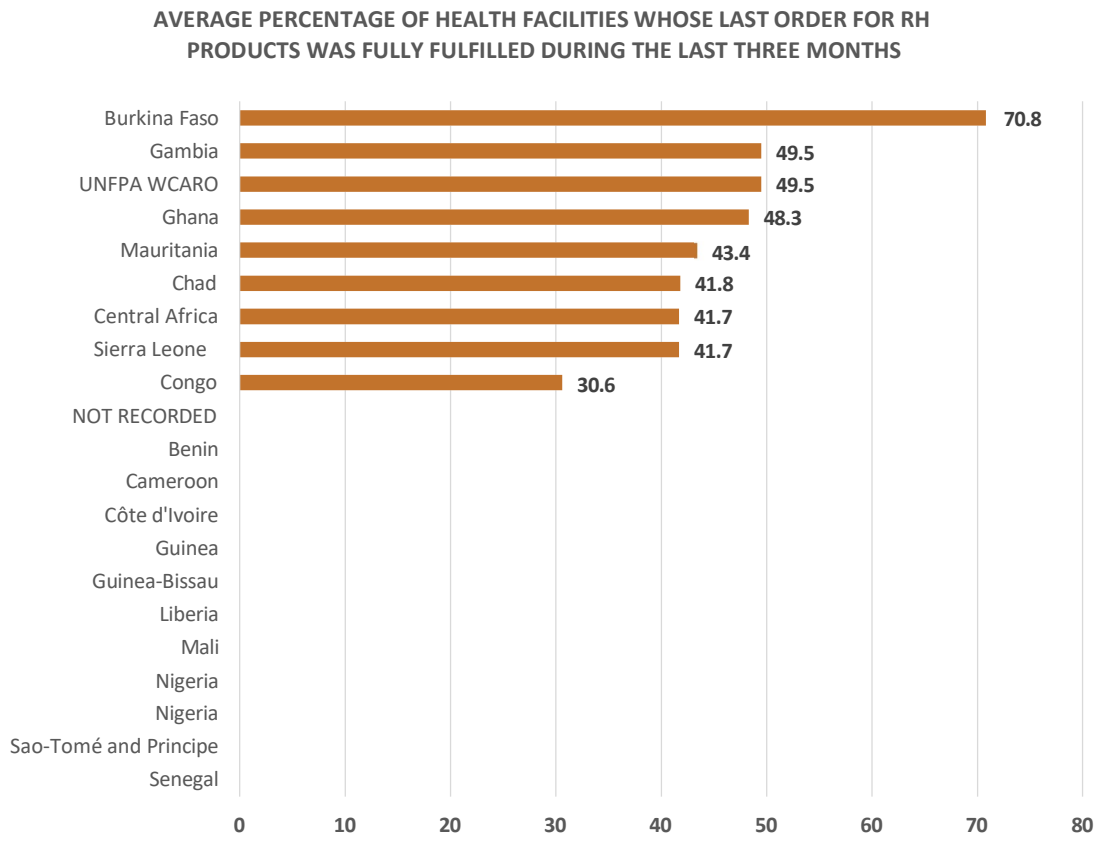
One of the target indicators for securing products under the UNFPA Supplies Partnership programme is to reach at least 75% of countries with their latest orders for RH products fully fulfilled [10]. The results of the regional analyses show that slightly less than one in two health facilities (49.5% on average) had their latest order for RH products fully fulfilled (min = 25.5% in 2021 and max = 60.1% in 2023). This observation remains valid regardless of the type of health facility or the location (urban-rural), with an overall negative trend (-3.34) as shown in Table 11. This situation attributable to the source of supply is detrimental to the availability of products at service delivery points, and would benefit from improvement.

TABLE 11: HFs with the last order for products fully fulfilled over the last three months

Indicators	Years							Total	Trend
	2017	2018	2019	2020	2021	2022	2023		
HFs whose orders have been fulfilled: Last order for products has been fully fulfilled	%	%	%	%	%	%	%	%	
n	3590	3801	2652	2454	1711	2200	1128		
Regional	58.3	64.0	52.6	39.0	**25.5**	42.5	60.1	49.5	-2,545
Type of HFs									
Primary level HFs	59.5	62.7	54.0	41.7	**25.2**	43.1	62.3	50.5	-2,391
Secondary level HFs	54.8	67.0	46.6	39.6	**26.3**	44.8	53.4	49.1	-2,362
Tertiary level HFs	60.3	44.1	63.5	57.7	**33.3**	55.6	49.6	55.2	-0.892
Implementation environment									
Urban	56.0	47.1	56.8	33.0	**29.6**	42.4	60.6	47.1	-1,144
Rural	58.8	70.5	48.4	35.1	**21.1**	40.5	58.7	49.0	-3,340

Regarding this indicator by country, only eight (8) of the twenty (20) beneficiaries of the programme reported it in their survey reports (Figure 6). Among these countries, Burkina Faso (70.8%) and Gambia (49.5%) are those that reported a percentage at least equal to the regional percentage, and Congo the lowest percentage (30.6%). When analysing the trend of this fulfilment during the various surveys by country, it remains negative for most of those that reported data (Burkina Faso, Central African Republic, Congo, Gambia, Ghana, Mauritania), except for Chad (+3.5) which goes from 25.6% in 2019 to 60.1% in 2023, and Sierra Leone (+0.22) which maintains almost the same percentage level according to the data from the 2018 (41.2%) and 2022 (42.1%) reports.

FIGURE 6: Order or request for contraceptives by the HFs fully fulfilled over the last three months at the national level



IV.7. Staff training on the logistics management information system

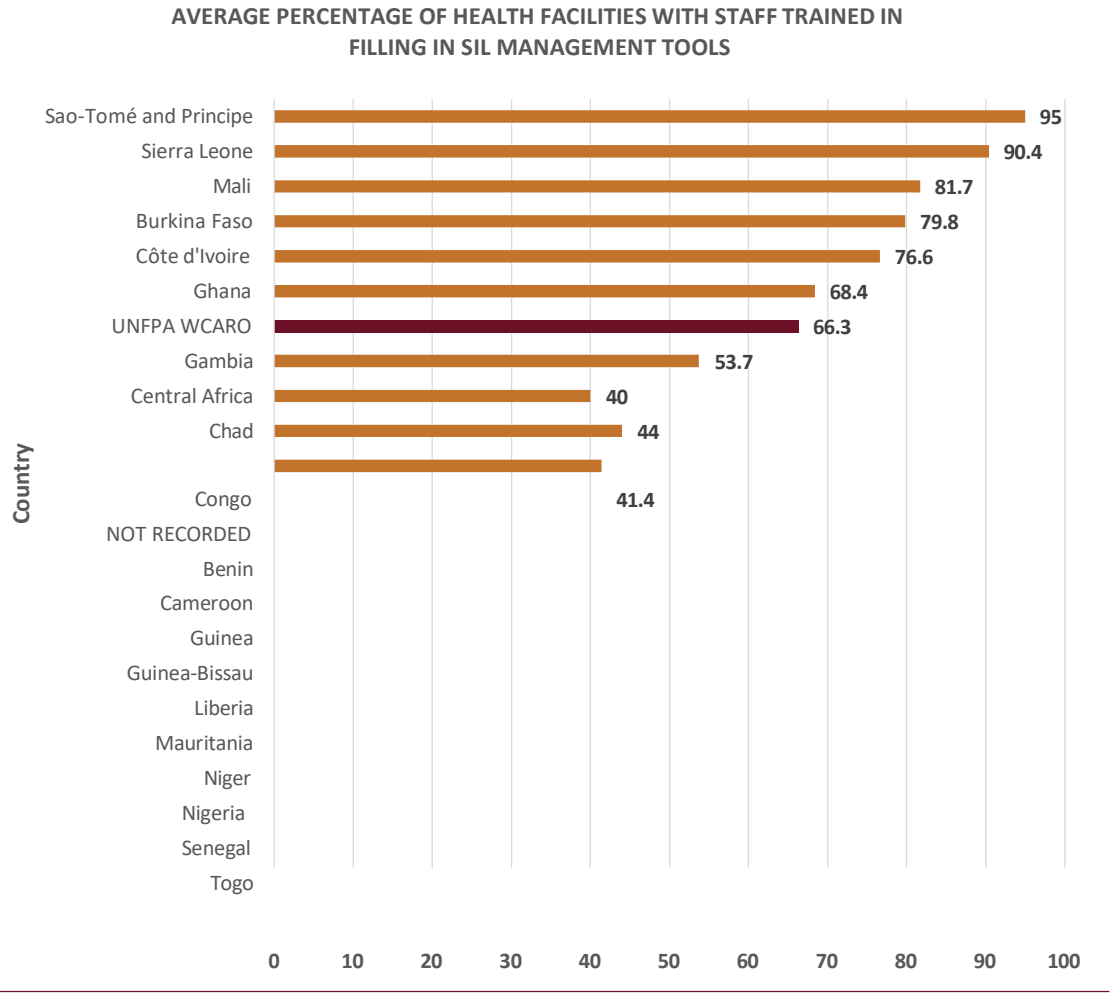
Capacity building of human resources involved in supply chain management is one of the keys to securing reproductive health commodities. On average in the UNFPA WCARO region, more than 65% (47% to 90%) of health facilities have staff trained in logistics management information systems (LMIS). More specifically, 68.2% have staff trained in filling out logistics management tools, 66.25% in establishing stock levels (including knowledge of minimum and maximum stock), 66.8% in making a request or order for replenishment, and 68.2% in the proper maintenance of physical stocks of commodities (Table 12).

TABLE 12: HFs with staff trained in LMIS management at the regional level

Indicators (HFs equipped with personnel trained in the management of logistics management information systems (LMIS))	**Years**							**Trend**
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	
n	3590	3801	2652	2454	1711	2200	1128	
%	%	%	%	%	%	%	%	
On filling out logistics management tools, distribution registers or providing services to customers	72.6	76.2	64.4	56.7	43.6	74.5	64.8	-0.900
Proper maintenance of physical product stocks (minimum stock and maximum stock)	73.0	75.6	63.3	57.3	42.0	74.9	66.4	-0.730

The overall level of the region, however, hides disparities between countries. Indeed, the examination of the data available in the country reports shows that Congo (41.4%), Chad (44%), Central Africa (46%) and to a lesser extent Gambia (53.73%), remain at low average proportions of health facilities with staff trained in LMIS management. On the other hand, more than 95% of health facilities in Sao Tome and Principe, as well as 90% of those in Sierra Leone, have staff trained in LMIS management. Mali and Burkina Faso report around 80% of health facilities with staff trained in LMIS tool management (Figure 7).

FIGURE 7: Percentage of health facilities per country with personnel trained in the management of logistics management information systems (LMIS) for products



Training in managing the logistics information system includes record keeping (including filling in logistics management tools, distribution records or providing services to customers), establishing stock levels (including knowledge of minimum and maximum stock levels), making requests or orders for replenishment, and proper maintenance of physical stocks of products.

Several countries (**Benin, Cameroon, Guinea, Guinea-Bissau, Liberia, Mauritania, Niger, Nigeria, Senegal and Togo**) did not provide this information in their survey reports.

IV.8. Training of staff in the provision of modern methods of contraception

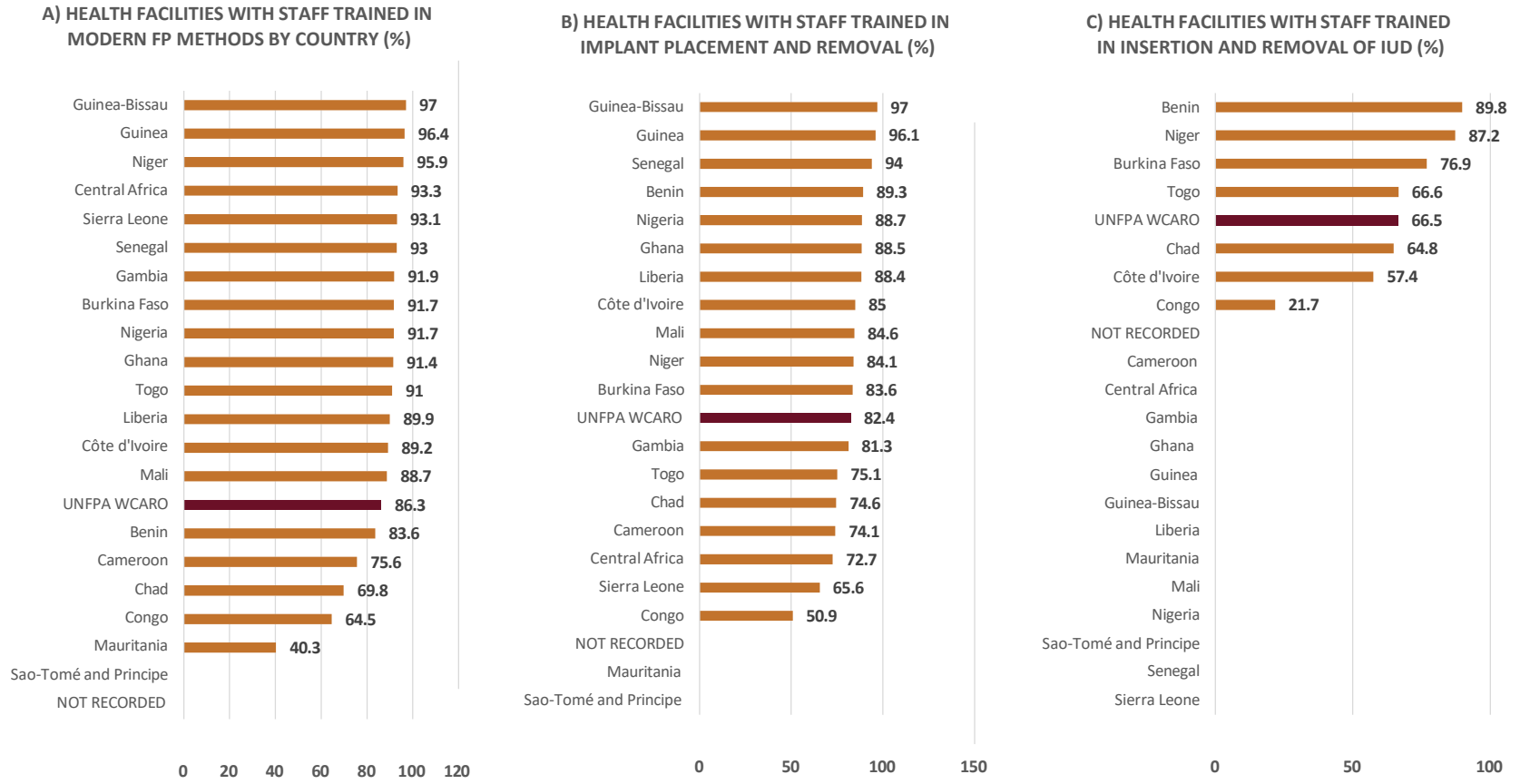
The vast majority (86.3%) of health facilities offering family planning services in the region, whether primary (85.6%), secondary (89%) or tertiary (92.7%), and regardless of their location, have staff trained in providing modern contraceptive methods in general. These training courses include the insertion and removal of contraceptive implants in more than 80% of cases, and the insertion and removal of IUDs in approximately 70% of cases. It should be noted, however, that these percentages remain relatively lower for primary health facilities than for secondary or tertiary facilities. The same is true for those located in rural areas compared to those in urban areas (Table 13).

TABLE 13: HFs with staff trained in the provision of modern methods of contraception at the regional level

Indicators	Years							Total	Trend
	2017	2018	2019	2020	2021	2022	2023		
n	3590	3801	2652	2454	1711	2200	1128	2505	
	%	%	%	%	%	%	%	%	
HFs equipped with personnel trained in the provision of modern methods of contraception									
Regional	**88.8**	**90.6**	**89.1**	**83.5**	**81.9**	**78.8**	**89.8**	**86.3**	**-1,550**
Type of HFs									
Primary level HFs	88.3	88.8	89.3	79.4	79.4	82.3	88.8	85.6	-1,191
Secondary level HFs	92.7	91.5	90.6	85.7	88.6	82.7	88.7	88.9	-1,572
Tertiary level HFs	96.7	92.8	92.2	94.5	94.4	85.7	93.5	92.7	-1,224
Implementation environment									
Urban	92.1	92.7	91.9	86.5	87.8	87.8	90.6	90.1	-0.888
Rural	85.9	87.7	87.3	83.9	76.3	86.5	88.4	85.8	-0.267
HFs equipped with personnel trained in the installation and removal of implants									
Regional	**84.7**	**78.5**	**81.8**	**79.3**	**78.0**	**89.7**	**87.4**	**82.4**	**0.861**
Type of HFs									
Primary level HFs	77.1	75.3	80.8	75.3	73.9	81.2	90.9	78.3	1,232
Secondary level HFs	91.9	89.4	85.9	82.7	87.3	88.2	96.9	88.6	-0.214
Tertiary level HFs	95.9	91.3	96.8	93.1	94.4	83.3	100.0	92.7	-1,056
Implementation environment									
Urban	90.3	86.8	87.7	81.9	85.6	87.2	91.9	87.2	-0.143
Rural	80.6	77.1	75.5	76.6	70.1	84.0	84.2	78.6	0.641
HFs equipped with personnel trained in the insertion and removal of IUDs									
Regional	**69.5**	**66.8**	**60.3**	**63.7**	**54.6**	**78.8**	**66.5**	**69.5**	**0.899**
Type of HFs									
Primary level HFs	63.3	59.9	57.4	51.0	48.4	83.3	60.1	63.3	1,444
Secondary level HFs	79.4	83.8	70.3	62.6	68.5	92.1	75.3	79.4	0.326
Tertiary level HFs	95.5	96.7	79.6	87.8	91.7	89.6	90.0	95.5	-1,011
Implementation environment									
Urban	80.9	84.6	68.1	67.7	63.8	88.0	76.0	80.9	-0.037
Rural	55.7	57.5	54.0	51.4	44.8	72.3	56.3	55.7	1,701

Figure 8 presents the average percentages of health facilities with staff trained to provide modern methods of contraception (A), implant insertion and removal (B), and IUD insertion and removal (C). Compared to the regional averages for these indicators, and according to available data, four countries (Mauritania, Congo, Chad, Benin, and Cameroon) have relatively low levels of health facilities with staff trained to provide modern methods of contraception.

FIGURE 8: Average percentages of HFs with staff trained in providing modern methods of contraception (A), implant insertion and removal (B), and IUD insertion and removal (C)



IV.9. Existence of guidelines, checklists and work tools in the HFs

Guidelines, protocols, checklists, or provider guides are tools for assistance, provider orientation, and standardisation in the provision of reproductive health care. They provide technical information to help health care providers effectively and adequately provide methods and services, and are essential for quality assurance of services. On average, at the regional level, these tools are available in 60 to 70% of health facilities according to country survey reports, regardless of the year between 2017 and 2023 (Table 14). The lowest availability of these tools is observed in 2021, a year in which only three countries conducted surveys (Congo, Niger, Nigeria); this weakness during this year seems attributable to Congo, which has proportions varying from 25 to 35% depending on the type of tool.

Examination of the availability of these tools over the course of the surveys shows a notable regression of the trend in several countries including Sao Tome, Mali, Côte d'Ivoire, Congo, sometimes reaching -75 from one survey to another for certain documents.

TABLE 14: Existence of guidelines, checklists and working tools at regional level

Existence of guidelines, checklists and working tools	Years							Total
	2017	2018	2019	2020	2021	2022	2023	
n	3590	3801	2652	2454	1711	2200	1128	
%	%	%	%	%	%	%	%	%
Family planning guidelines (national or WHO)	79.2	65.2	59.2	71.9	46.0	72.5	71.8	**69.5**
Family planning checklists and/or job aids	81.1	57.9	62.4	71.3	50.3	67.5	58.9	**66.5**
Antenatal care guidelines (national or WHO)	78.3	70.7	58.5	73.8	48.0	74.8	71.8	**71.1**
Prenatal care checklists and/or job aids	73.1	65.4	61.9	73.6	50.8	70.3	72.2	**68.8**
Guidelines for the management of biomedical waste	71.9	57.7	50.0	62.5	50.9	64.7	64.8	**61.8**

IV.10. Billing for consultation services and reproductive health inputs/medications

At the regional level, the billing of consultations and inputs/medications relating to RH services is effective in about a third of the health facilities visited during the surveys. Taken individually, consultations for services related to maternal and child health are billed in 30 to 45% and the billing of inputs/medications relating to them in at least 40-50% of the HFs in the region. There is a general downward trend in the proportion of facilities billing for family planning consultations between 2017 and 2023 (-1,272), unlike that of HFs billing for HIV-related care, which is increasing (+5,182).

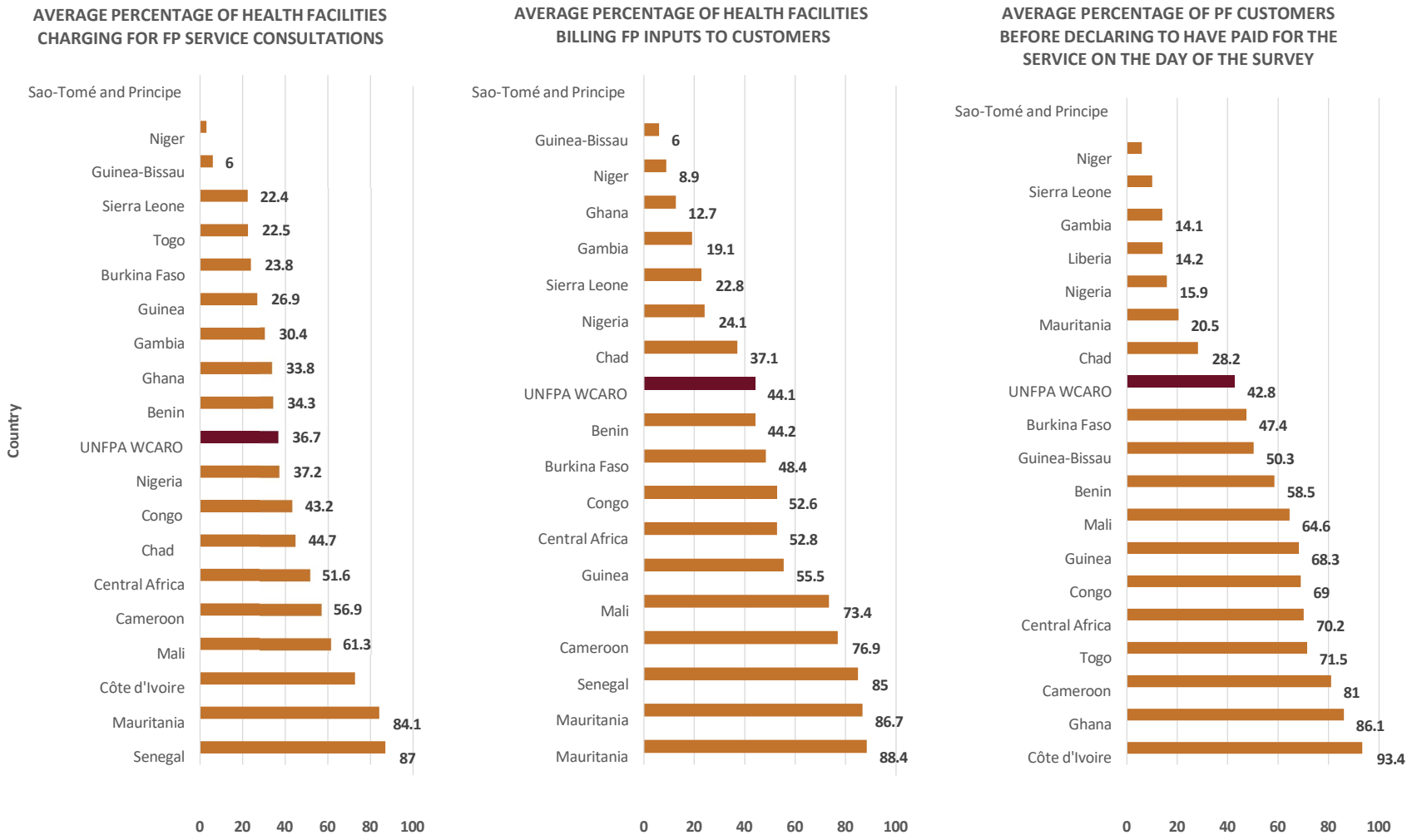
TABLE 15: Billing for consultation services and RH inputs/medications

	Years							Total
	2017	2018	2019	2020	2021	2022	2023	
n	3590	3801	2652	2454	1711	2200	1128	
%	%	%	%	%	%	%	%	%
Billing for RH consultations								
Family planning service	39.6	41.4	36.0	30.9	22.9	40.1	32.7	36.7
Antenatal care service	32.2	40.1	43.9	33.9	39.8	45.3	32.8	38.6
Maternity service	35.6	47.2	44.2	34.0	45.7	44.9	45.9	42.2
Postnatal care service	37.1	38.9	42.4	29.7	40.9	46.9	34.7	38.6
Newborn Care Service	31.3	38.8	43.5	33.6	37.5	44.3	30.7	37.4
Care of childhood illnesses in children under 5 years old	31.4	28.8	47.1	36.8	42.2	32.6	13.7	33.2
HIV care (screening, ART, consultation)	28.4	27.2	25.3	24.6	33.9	45.6	68.4	33.0
Billing for RH products/medications								
Family planning inputs	46.33	49.47	47.81	51.70	26.13	33.48	28.60	44.09
Medicines for maternal health	38.26	42.87	52.54	49.30	43.20	31.20	38.10	42.61
Medicines for children's health	38.89	35.67	50.89	55.22	44.06	26.20	26.20	40.55
Other medications	44.36	56.37	56.22	55.45	54.50	28.80	48.67	49.34
Customers who indicated that they paid for the FP service	46.60	41.89	39.51	46.40	31.21	50.35	24.80	42.81

Figure 9 presents the average percentage of HFs by country in which consultation services (A) and family planning inputs (B) give rise to billings to customers, as well as the average percentage of customers who reported having paid for the service (C). It shows that the countries that report the least billings for FP consultations and inputs to customers are Sao Tome and Principe (0.0%), Niger and Guinea-Bissau (6%), while Senegal, Mauritania, Côte d'Ivoire, Mali and Cameroon are those in which these services are most billed in HFs. This trend for these countries is confirmed by the percentages of customers who reported having paid for the service on the day of the survey (Figure 9. C).

Analysing the data from 2017 to 2023 by country, we see a decline in the percentages of customers reporting having paid for FP services in some countries. This is the case of Burkina Faso (-13.71) which goes from more than 85% in 2017 to 9.8% in 2023; Guinea (88% in 2018 to 48.1% in 2022), Guinea-Bissau (71% in 2017 to 33% in 2019), Chad (43% in 2020 to 23% in 2023), and Togo which goes from 88% in 2018 to 61% in 2023. On the other hand, the Central African Republic and Congo recorded an increase in customers declaring having paid for the FP service, going from 41% in 2019 to 99.2% in 2022; and from 60% in 2018 to 71% in 2020, respectively.

FIGURE 9: Billings for consultation services (A), family planning inputs (B) and percentage of customers reporting paying for the service (C) by country



IV.11. Clients' perception of FP services

IV.11.1. FP Customer Profile

The perception of FP services was assessed among customers leaving the service on the day of the surveys. The average number of FP service customers surveyed each year from 2017 to 2023 is 970 at the regional level (with extremes of 711 in 2021 and 1270 in 2023). While the number of customers surveyed from one survey to another remains little variable within countries, there is a large disparity between countries. Indeed, the average number of customers surveyed varies from 77 in Guinea-Bissau to 3879 in Côte d'Ivoire. However, the profile of customers remains more or less comparable between countries. They are mainly women (97%) and live with their partner in more than 75% of cases (69% to 90%).

IV.11.2. Customers' opinions on family planning service

Analysis of regional data by year shows that at least 90 to 98% of FP customers participating in exit interviews in health facilities benefited from the contraceptive method of their choice, and service providers took into account their preference and wish in the vast majority of cases (93 to 98%). The proportion of customers who learned to use the method received on the day of the survey varied from 87 to 96% during the period with a negative trend. The technical aspect of the service provision least taken into account by the provider on the day of the survey was that of the common side effects of the method, which were only mentioned by 85% of customers (Table 16).

In terms of the organisation of the service, customers also express their satisfaction in the vast majority of cases, with the cleanliness of the premises (93 to 97%), with the privacy in the examination rooms (90 to 99%) and with the time devoted to them by the service provider (91 to 98%). However, there is a relatively high level of dissatisfaction with the waiting time before benefiting from the FP service reported by almost a third of customers, or 32% (29.4% to 49.1% depending on the year).

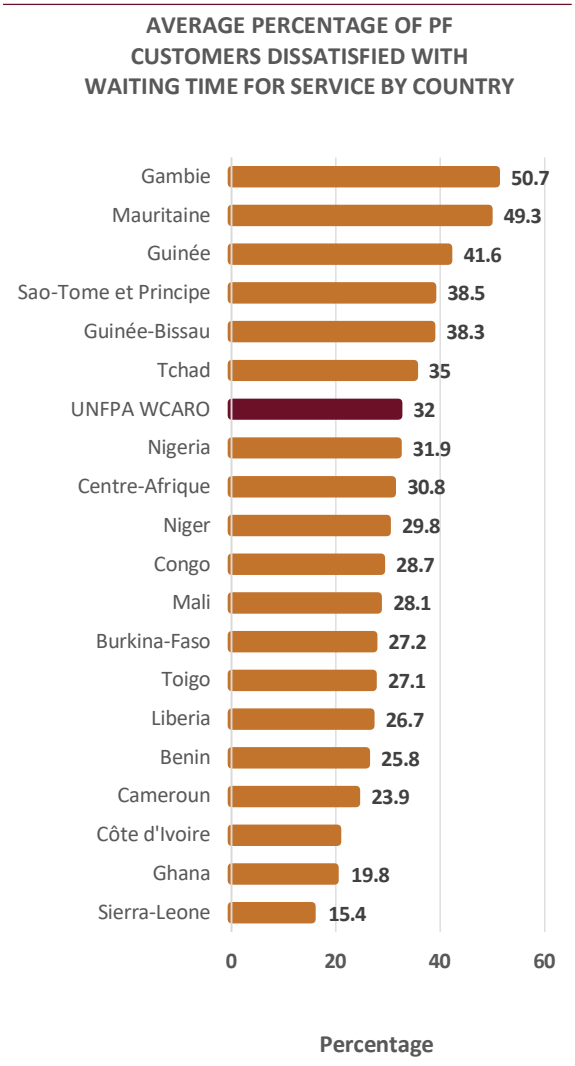
The examination of the reported data shows that, in general, 23% of customers had been obliged or forced by providers to accept a contraceptive method. However, the vast majority (an average of more than 95% regardless of the country) of FP customers are generally satisfied with the service received on the day of the various surveys (Table 16).

TABLE 16: Customer opinions on the technical, organisational and relational aspects of the FP service

Indicators	Years							Total
	2017	2018	2019	2020	2021	2022	2023	
n								
	%	%	%	%	%	%	%	%
Customers' opinions on the technical aspects of the FP service								
Service delivered using the method of their choice	97.5	93.9	95.3	97.1	90.9	97.0	98.0	96.0
The service provider took into account the customer's preferences and wishes	93.2	97.7	94.9	94.6	94.5	95.2	95.8	95.2
The customer learned how to use the method	91.2	91.8	86.9	87.4	92.1	88.4	95.7	90.1
The customer was informed of the common side effects of the method	85.5	85.5	87.2	85.1	87.2	85.7	84.0	85.7
An appointment was made for the customer at the HFs for a check-up and/or delivery of additional supplies	90.6	89.5	85.1	88.7	92.9	92.6	82.7	89.2
Customers' opinions on organisational aspects of the FP service								
The customer considers the waiting time too long	30.25	31.46	32.24	32.01	49.11	30.72	29.37	32.03
The customer is satisfied with the cleanliness of the establishment	94.71	93.78	95.99	93.23	97.24	94.85	96.52	94.68
The customer is satisfied with the privacy provided in the examination room	96.14	95.92	97.03	89.79	94.32	95.60	98.60	95.23
The customer is satisfied with the time devoted to them	95.83	91.07	97.91	96.87	96.32	96.56	98.50	95.61
Customer opinions on the relational aspects of the FP service								
The customer states they were treated with courtesy and respect by the HFs staff	97.0	94.7	97.8	97.1	97.6	98.1	99.1	97.0
The customer states they were forced to accept a family planning method or were coerced by the provider into accepting it	22.2	25.3	27.3	12.3	39.7	16.8	30.7	22.9
The customer is satisfied with the overall attitude of the healthcare provider towards them	97.5	98.3	97.8	97.6	94.6	97.8	98.3	97.8
The customer is generally satisfied with the service received on the day of the survey	97.6	98.3	98.0	97.8	96.2	98.3	96.1	97.8
The customer is generally satisfied with the service received on the day of the survey	97.61	98.34	97.98	97.82	96.21	98.33	96.08	97.77
The customer will return to this HFs	96.94	97.93	98.31	97.08	96.79	97.58	94.35	97.27
The customer would recommend this HFs to their family or friends	94.63	97.53	96.71	96.39	96.19	95.86	86.92	95.50
Waiting times and receipt of services	21.1	33.9	58.7	40.1	135.0	30.9	36.5	40.8

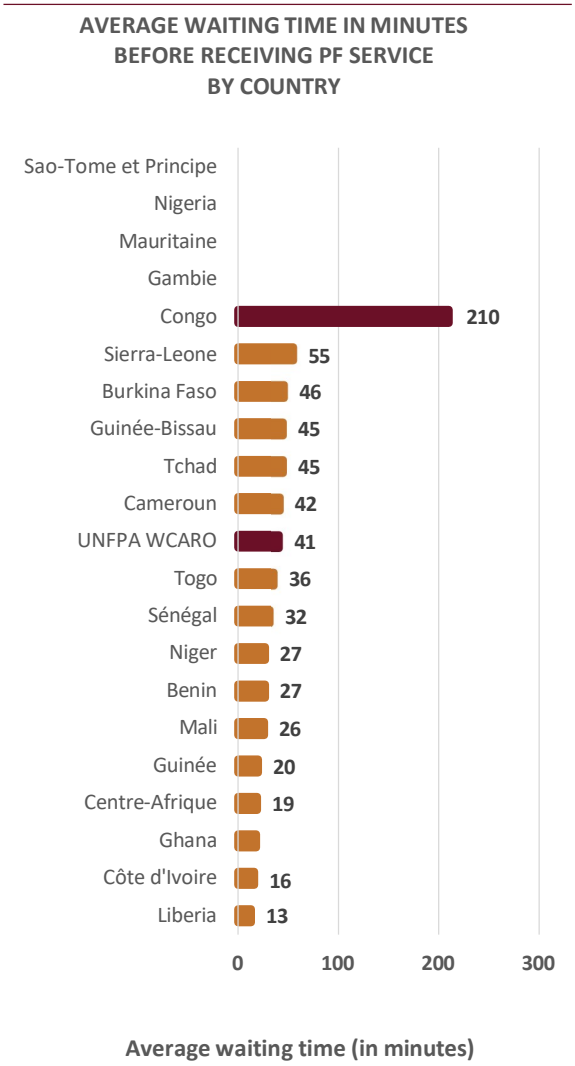
The percentage of customers dissatisfied with waiting time also varies by country, reaching 50.7% in Gambia, compared to 15.4% in Sierra Leone (Figure 10). However, the available data do not allow a link to be established between this customer dissatisfaction and the time actually spent by the customer before receiving the service. At the regional level, the average waiting time in minutes to receive the service is 41 minutes at the regional level (minimum = 13 minutes and maximum = 210 minutes). This average time seems significantly higher in Congo with an average waiting time of 210 minutes (180 to 240 minutes), or 3 to 4 hours, while the rate of customer dissatisfaction in relation to this wait remains lower than the regional average. The same observation is made to a lesser extent for Sierra Leone, Burkina Faso, Cameroon which, with waiting times relatively higher than the regional average, record less customer dissatisfaction than some countries. Countries such as Liberia, Côte d'Ivoire, Ghana, Central African Republic, Guinea, Mali, Benin and Niger report waiting times of between a quarter and a half hour (13 minutes to 27 minutes).

FIGURE 10: Pourcentage moyen de client insatisfaits du temps d'attente au service de FP



NB : informations manquantes pour le Sénégal

FIGURE 11: Temps moyen avant de bénéficier du service de FP



NB : informations manquantes pour la Gambie, Mauritanie,

Nigéria, et Sao-Tomé&Principe

IV.12. Contributing factors to improving commodity security

Based on the main causes of RH product stockouts in health facilities, which are essentially delivery delays attributable to the supply source, delays in requesting replenishment attributable to health facilities, and low or absent demand, several factors could contribute to improving the safety of these products. These include:

- The availability of products at the supply sources of health facilities as well as that of means of transport up to the last mile: delays in delivery on the part of the supply source could be explained on the one hand by the absence of the product at the time of the order, but also by the insufficiency of the logistical means for the transport of the products to the place of delivery when this aspect is the responsibility of the latter.

- Anticipation of replenishment requests by health facilities. This requires the effective application of the skills of actors trained in logistics management, regular analysis of logistics management data on the consumption of contraceptive products and RH drugs at all operational levels (intermediate and peripheral) for better visibility of stocks, and better estimation of needs over time.

- The promotion of social marketing for the improvement of the demand of products by customers, throughout the community world, but especially professionals offering services in health facilities [22]. The lack of customer knowledge of certain methods could be the source of the absence or weakness of demand causing their stockout in health facilities in favour of the most requested methods.

IV.13. Effects of availability on the use of sexual and reproductive health products and services

The data available in the survey reports do not allow for measurement of the effect of availability on contraceptive method use. However, several studies report a correlation between the availability of contraceptive methods and their use, due to the choice offered to customers. Indeed, in a review of the introduction of six methods in 113 countries, the authors reported that the addition of a method accessible to at least half of the population is correlated with an increase of 4 to 8 percentage points in the total use of the six modern methods. These authors conclude that it is possible to increase contraceptive use by expanding the availability of current methods, improving the characteristics of current methods, or introducing new methods. Access to a wider choice of methods also helps to better meet the individual needs of women and couples, and to ensure the continuity of contraception [23]. Furthermore, according to FP-2023 reporting data from Demographic and Health Surveys (DHS), between 7 and 27% of women stop using a contraceptive method for reasons related to the service environment, including quality of services, availability of sufficient choice of methods, stockouts among others [24].

IV.14. Strategies for mitigating stockouts or overstocks of FP products

Analysis of available data highlights the multidimensional nature of the issue of stockouts of contraceptive products and RH medicines, influenced by both structural supply and demand factors. These stockouts can be attributed to failures in national supply chains (including weak and inadequate logistics information systems (LIS), insufficient storage space, lack of trained, motivated and dedicated staff for supply chain management, and inadequate financing of stocks). However, the implementation of an effective LMIS and the involvement of public and private actors, particularly in the distribution chain, have led to a reduction in stockout rates of medical products [16,18,19,25,26]. Therefore, several strategies can be considered depending on the contexts at the national level to mitigate these stockouts or overstocks of reproductive health products, including contraceptive methods.

IV.14.1. For the mitigation of stock shortages

- Financing the upgrading of initial stocks of products in health facilities with a transfer of ownership of stocks as a trunk stock of the establishments. This strategy is however only productive when it is accompanied by good stock management guaranteeing among other things the minimum and maximum stocks observable at each level of the chain.

- Improving inventory visibility by gradually replacing manual management of the product logistics management information system with computerised management.

- The establishment of a mechanism to facilitate or improve the periodic and regular collection of logistics information, including the processing of information on consumption and the status of available stocks at the national and intermediate level (administrative regions or districts).

- Strengthening the capacity to forecast and quantify product needs, mainly at the intermediate and peripheral levels. This necessarily requires good control of the quantities consumed, which can only be obtained at the service delivery points (HFs) level.

- The establishment of an alert system for stock shortage threats and expired products (Control of minimum and maximum stock levels) at the national, intermediate and peripheral levels. The integration of this alert system into the routine LMIS within the framework of a project in Guinea-Bissau would contribute to an improvement in the availability of health products throughout the supply chain, thanks to the implementation of various mechanisms: management and reporting tools, information system, supervision mechanisms, performance bonus mechanisms, etc. [19].

- Standardisation of the monitoring and evaluation system of supply and availability indicators for better use and exploitation of information at all levels.

- The separation of service provision and logistics management, especially in peripheral health facilities, for greater efficiency and autonomy in supply chain management.

- The accountability and involvement of stakeholders in the dispensing chain at intermediate and peripheral levels in the monitoring and use of product consumption data.
- Taking into account the management of the supply chain of RH products in the package of periodic and regular supervisions of health facilities.
- The establishment of a mentoring system in the management of supplies and stocks at intermediate and peripheral levels for the sharing of good practices in securing products.
- The qualitative and quantitative improvement of product storage spaces in health facilities would also facilitate stock management, contributing to compliance with the principle of minimum and maximum stocks in particular.

IV.14.2. For the mitigation of product overstocks

- The establishment of groups (especially WhatsApp) for instant communication and information on inventory management between supply chain actors at national and intermediate levels.
- The development and implementation of a stock shortage and overstock management plan (PGRS) at the national and intermediate levels. The format of this PGRS may be defined at the regional level by the UNFPA office.

IV.15. Innovative solutions to improve product availability, access and usage

IV.15.1. a. Improved product availability

Availability and access to products implies that they are made available to end consumers at the last mile. To achieve this, solutions have been developed to improve the transport of products from the source of supply to health facilities, but also to increase the availability of different methods. These include, among others:

- The provision of intermediate level logistics resources (vehicles) to ensure delivery to peripheral health facilities.
- Contractualisation of the transport of products with private transporters while guaranteeing the quality of said products and securing contracts through sustainable financing.
- The use of humanitarian convoys or even military convoys for the transport of products in areas with security challenges such as Burkina Faso, Mali, Niger, and Central Africa, etc.
- The use of medical drones is currently being tested in certain countries, particularly in Côte d'Ivoire, for the delivery of emergency products.

Several countries in the region, including Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mauritania, Niger and Chad are in the pilot experimentation phase of last-mile distribution [27].

IV.15.2. b. Improving access to and use of services

In addition, other initiatives to improve access to family planning services and the use of contraceptive methods by customers have been developed in several countries in the region. These include:

- Eliminating specific barriers to access to long-acting methods, including financial and logistical barriers such as lack of providers trained in IUD insertion and removal, implant insertion and removal, lack of insertion and removal equipment [25,28].

- Exposure of customers to family planning awareness and contraceptive methods could contribute to increased demand and utilisation of services. This exposure to the FP awareness message contributed to an increase in contraceptive method use among women of reproductive age from 5.7 to 7.7% in Central Africa according to one study [29]. In addition to exposure through health care providers, traditional or digital media and social marketing campaigns on family planning are essential avenues for improving access to and utilisation of services.

- The provision of family planning services through advanced health posts, or by community health workers: Community distribution of contraceptive methods including injectables is a well-documented innovation in the literature that improves the accessibility and use of these methods [25,30-32].

- The recent introduction and ongoing popularisation of subcutaneous DMPA in several countries in the region offers a practical alternative, including easier administration and the possibility of self-injection by women when they are trained [33,34].

- The introduction of postpartum family planning (PPFP) in delivery services [35,36].

V. RECOMMENDATIONS

V.1. Regional Office recommendations

Securing commodities requires interventions that address both structural deficiencies and demand shortfalls that contribute to stockouts. The UNFPA regional office, through its leadership in reproductive health, and particularly in FP, has a key role to play. It will need to continue, if not strengthen, its technical and financial support to countries in:

7. Advocacy for policies of universal access to a wide range of products including new self-administered long-acting reversible methods, such as subcutaneous DMPA.

8. Improving availability and accessibility through last-mile distribution initiatives. The last-mile distribution strategy currently being tested in the seven countries of the region (Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mauritania, Niger, Chad)[4] should be supported and evaluated to better capitalize on its impact on the availability of products and services with a view to its expansion.

9. The extension of the digitalisation of logistics information of national supply chains for greater visibility of the status of product stocks, the analysis and adequate routine exploitation of logistics information throughout the supply chain. Since the control of logistics information lies at the heart of the supply chain, this support, adapted and contextualised according to the needs identified by each country, should ultimately make it possible to anticipate and prevent product shortages at the national, intermediate and peripheral levels.

10. Capacity building of human resources in the supply chain (training and retraining as appropriate on LMIS management) especially for the benefit of the least equipped countries in the region such as Congo, Chad, Central Africa, and Gambia.

11. Performance monitoring through periodic surveys that are essential for evidence-based and up-to-date decision-making. For greater visibility of performance recorded at the regional level, it is recommended that the twenty beneficiary countries of the UNFPA Supplies Partnership programme be organised into two groups for the conducting of annual surveys on the supply and availability of RH products at regular intervals between the groups. This set-up will allow the regional office to have regional indicators each year from a first representative group of 10 countries, and each country to have said indicators at the national level every two years. This set-up will also have the advantage of providing each year an overall analysis of the combined databases of the different countries, and a good estimate of the regional indicators.

[4]UNFPA WCARO Annual Report 2023

12. Support for specific investigations of supply chain factors that affect RH commodity availability in countries. UNFPA Supplies Partnership programme periodic surveys of commodity supply and availability provide indicators at the service delivery point, but do not provide insight into specific factors in the upstream national supply chain that could influence availability at the dispensation point. Further studies targeting the national supply chain as a whole (selection, quantification of needs, acquisition or purchase, storage, distribution, and finally dispensation) would help to better identify strengths and weaknesses upstream.

Finally, given the limitations noted in this report, which provides an overall picture of the average level of indicators for the period 2017 to 2023, we strongly recommend that UNFPA WCARO conduct a specific analysis of the 2024 survey data to better understand the real level of performance. A comparison could be made with the data from the surveys conducted in 2023 to measure progress. In addition, it will provide greater visibility of regional data and better monitoring of trends from one year to the next.

V.2. Country-level recommendations

For the different countries in the region, the recommendations made are those considered relevant for improving product safety, but may not be relevant for some countries given the dynamics of the actions regularly undertaken by countries in terms of RH. They have been grouped into five components, addressing in particular the improvement of the service offer, product availability, logistics information, and human resource capacities. In these product-specific components, recommendations have been made to countries for improving the monitoring of indicator performance.

For the improvement of demand

1. Develop and implement social marketing programs aimed at increasing demand for family planning methods, in addition to exploring ways to promote appropriate use of these methods through the media. This recommendation could primarily target countries where low demand is a major reason for stockouts (IUDs, implants, emergency contraception, etc.),

For the improvement of the offer, services and access to services

2. Expand the range of contraceptive methods and RH medications to be offered at each level of service in accordance with national guidelines. Expanding the range of methods offered by HFs could help provide more choice to customers. This is all the more justified since the review of reported data shows that 23% of customers had been forced or coerced by providers to accept a contraceptive method,

3. Implement policies to improve the financial accessibility of services and exempt populations from payments for RH services. The implementation of these policies should be accompanied by means of monitoring their effectiveness on the ground (particularly in Senegal, Mauritania, Côte d'Ivoire, Mali and Cameroon).

4. Strengthen the availability of guidelines, protocols, checklists, or provider guides for providers in health facilities. These tools provide assistance, guidance for providers and standardisation in the provision of reproductive health care at the national level.

5. Develop strategies aimed at reducing customer waiting times at service delivery points (particularly in Gambia, Mauritania, Sohag and Principe, Guinea, Guinea Bissau, Chad, Congo).

For the improvement of product availability

6. Support health facilities (HFs) in upgrading initial stocks of products with a transfer of ownership of stocks as the establishments' rolling stock. This must be accompanied by good stock management guaranteeing, among other things, the minimum and maximum stocks observable at each level of the chain.

7. Develop targeted strategies that address each facility's challenges to mitigate stockouts of contraceptives and target RH drugs. This may include strengthening routine (weekly or monthly) monitoring of RH stockouts at health facilities, regional depots, and central purchasing offices at different levels.

8. Set up an alert system for threats of stock shortages and expired products (control of minimum and maximum stock levels) at national, intermediate and peripheral levels.

9. Standardise product storage spaces in health facilities to facilitate the management of minimum and maximum stocks.

10. Develop strategies to reduce product delivery times in warehouses at national and intermediate levels.

For the improvement of logistics information

11. Establish mechanisms to facilitate or improve the periodic and regular collection of logistics information, including the processing of information on consumption and the status of available stocks at the intermediate level (administrative regions or districts), then national level.

12. Strengthen access to information at all stages of the supply chain by setting up a system for sharing logistics information at the national and intermediate levels on stock flows, stock shortages and overstocks. This sharing could be done through consultation frameworks or through electronic communication channels, which increasingly facilitate access to information on product availability for supply chain stakeholders.

13. Promote the use of the electronic logistics information management system (E-LMIS) of the supply chain at the national and then intermediate level in order to improve the visibility of stocks in real time.

For the improvement of human resources capacities

14. Strengthen the capacities of HFs in terms of forecasting and quantifying product needs mainly at the intermediate and peripheral levels, especially in countries such as Congo, Chad, Central Africa, and Gambia;
15. Take into account the management of the supply chain of RH products in the package of periodic and regular supervisions of health facilities;
16. Establish a mentoring system in supply and inventory management at intermediate and peripheral levels for sharing good product security practices,
17. Establish a system for recycling service providers for the supply and dispensing of long-acting reversible contraceptive methods (IUDs, Implants, etc.).

For the improvement of the quality of monitoring reports on RH product security indicators

18. Standardise the frequency of surveys to monitor indicators of the supply and availability of RH products in countries in order to better assess the effects of the actions undertaken,
19. Ensure compliance with the survey data reporting plan proposed by the programme in order to better assess of indicators between countries,
20. Ensure the calculation methods for certain product availability indicators are followed, in particular indicators relating to the availability of at least five contraceptive methods. Indeed, the interpreting the "percentage of HFs that have at least five methods in stock" as meaning "percentage of HFs that do not have a stock shortage of five methods" could be a source of errors for certain indicators. HFs that do not have a stock shortage of five methods are sometimes considered to have at least five methods, when it would be enough to be short of four methods, to only have 4 others in stockout of the eight (8) contraceptive methods on the list. The second clarification to be provided to the teams responsible for conducting the surveys concerns the absence of stock shortages during the last three months. In principle, a product that is not available on the day of the survey should be considered as not having always been available during the last three months. This does not appear to be the case in several reports, resulting in a percentage of availability during the last three months higher than that on the day of the survey.

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