# Contraceptive Financial Sustainability Tool User's Manual

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 8 | TABLE A - Use this table if only commitments by source of funding is available | | | | | | |
| 9 | Funding Commitments by Source and YEAR | | | | | | |
| 10 | | | | | | | |
| 11 | List ministries, donors, etc. who have committed funds towards contraceptive financing ⬇ | 2010 | 2011 | 2012 | 2013 | 2014 | Total |
| 12 | Government | | | | | | |
| 13 | Ministry of Health | $ 50,000 | $ - | $ - | $ - | $ - | $ 50,000 |
| 14 | Other | $ - | $ - | $ - | $ - | $ - | $ - |
| 15 | | | | | | | $ - |
| 16 | | | | | | | $ - |
| 17 | Donors/Non-profit | | | | | | |
| 18 | UNFPA | $ 100,000 | $ - | $ - | $ - | $ - | $ 100,000 |
| 19 | USAID | $ 270,000 | $ - | $ - | $ - | $ - | $ 270,000 |
| 20 | IPPF | $ 79,000 | $ - | $ - | $ - | $ - | $ 79,000 |
| 21 | NGO | $ 157,000 | $ - | $ - | $ - | $ - | $ 157,000 |
| 22 | Social marketing | $ 130,000 | $ - | $ - | $ - | $ - | $ 130,000 |

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**Abstract**

By looking at various contraceptive scenarios, countries can begin to understand the financing resources needed to plan ahead for their needs. This manual includes guidance on how to use the Microsoft Excel-based Contraceptive Financial Sustainability Tool to identify any funding gaps by developing scenarios and determining financing requirements and commitments. The scenarios are the starting point for devising strategic options to fill any gap between need and availability; the goal is always to improve the country's financial sustainability.

Cover photo: Clockwise from top left—Woman in Mali holding a condom, WEI; various currencies, Turbophoto.com; woman in Bangladesh receiving contraceptive pills, DELIVER project; screenshot from the Contraceptive Financial Sustainability Tool, USAID | DELIVER PROJECT.

# Contents

Tables

# Acronyms

| | |
|---|---|
| BCC | behavior change communication |
| COC | combined oral contraceptive |
| CPR | contraceptive prevalence rate |
| CPT | contraceptive procurement table |
| CS | contraceptive security |
| CYP | couple-years of protection |
| DFID | Department for International Development |
| DHS | Demographic Health Survey |
| HMIS | health management information system |
| IEC | information, education, and communication |
| IPPF | International Planned Parenthood Federation |
| IUD | intrauterine device |
| KfW | *Kreditanstalt für Wiederaufbau* |
| LMIS | logistics management information system |
| MICS | Multi-Indicator Cluster Surveys |
| MOH | Ministry of Health |
| NGO | nongovernmental organization |
| POP | progestin only pills |
| PRSP | poverty reduction strategy paper |
| PSM | Procurement and Supply Management |
| RH | reproductive health |
| RHI | Reproductive Health Interchange |
| RHS | Reproductive Health Survey |
| SPA | service provision assessment |
| SPARHCS | Strategic Pathway to Reproductive Health Commodity Security |
| UNFPA | U.N. Population Fund |
| USAID | U.S. Agency for International Development |

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# Introduction

As countries work to improve the availability of health commodities, many are challenged with finding sufficient and sustainable financing for contraceptives. To understand the resources needed to plan ahead, countries can use this manual and the easy-to-use Microsoft Excel-based *Contraceptive Financial Sustainability Tool* to look at various financing options and scenarios. By creating different scenarios, the tool can estimate financing requirements and determine any subsequent funding gap.

The tool is ideal for program managers, financial planners or managers, and technical assistance providers who are interested in developing different financing scenarios. To improve financial sustainability, the scenarios are the starting point for developing strategic options to fill any gap between need and availability. It can help answer your questions: What are my country's future contraceptive needs and what are the estimated financing needs? What is the financial impact for different contraceptive prevalence rate growth projections? What are the financial consequences of various strategic options for future markets?

This user's manual will help you understand your country's current contraceptive financing context and will provide directions on how to identify and obtain the necessary data to build different financing scenarios. You will find step-by-step guidance on using the Excel-based tool to—

- determine different contraceptive growth rates, by method

- project contraceptive commodity unit and financing requirements

- determine the financing gap

- understand potential market option scenarios and the financial impact.

The tool only explicitly considers direct commodity costs, but you can adapt it to include other associated program costs, such as landed costs.

Use this manual with *Contraceptive Financial Sustainability: A Primer*. The primer describes different options to increase resources for financing contraceptives and describes the strengths and limitations of those options, including country examples. It describes the types of options that are available for contraceptive financing if you need to increase the sustainability or amount of financing for contraceptives. The primer also provides examples of countries that are implementing the various financing options described. It has a section on strategic development and implementation, describes a strategic plan, and provides guidance on how to develop a plan, including implementation issues.

# General Guidelines for Using the Tool

This tool can be used to build multi-year contraceptive financing scenarios that look at many different commodity projections for modern methods and enable you to model different contraceptive prevalence rate (CPR) growth rates for each method, over time. The scenarios can reflect potential changes in CPR, based on historical trends from demographic and consumption data, to meet national CPR targets, or information from stakeholder interviews. The scenarios can show different rates of CPR growth: slow, medium, or aggressive.

The tool will help generate commodity projections, cost projections, prevalence, and market share outputs in separate worksheets. The financing tool uses two types of worksheets: *Input* and *Results*. You insert specific data into five different Input worksheets:

1. Input – Background Information
2. Input – Scenarios & Projections
3. Input – Contraceptive Forecast
4. Input – Unit Price
5. Input – Funding.

The inputs generate a number of results or outputs into the following *Results* worksheets:

A. Results – Commodity Projection
B. Results – Summary Tables
C. Scenario – Market Share (You must insert some data in this worksheet and provide outputs in the same worksheet.)

This guide takes you through the required data that you will enter into each of the *Input* worksheets. The references to cells are the financial sustainability tool sample file, which is populated with sample data. The cell references also apply to the blank version of the tool. After you complete all the inputs, the results are automatically calculated in the Results worksheets. You will find many different outputs on these worksheets.

## Entering Data into the Input Worksheets

You must enter data in the *Input* worksheets. The following are general guidelines for entering data into the tool:

- In the blue figure (see below), you will see instructions that explain how to enter data into the tool.

**✋ Enter background information into worksheet: *1. Input – Background Info***

- Enter data in the grey filled cells only.

- Do *not* adjust or delete cells that are *not* highlighted in grey.

- Do *not* adjust or delete white or colored cells; they contain formulas and they are linked to other cells between the Input and Results worksheets throughout the tool.

- Use the comments feature in Excel to record sources of information, inputs, references, assumptions, and data points for you and for others who may work with the data in the tool (to insert a comment, place the cursor on the cell, right-click on the cell, and select *Insert Comment*). If the tool is used by more than one person, consider adding an initial and date to the comments.

The Results worksheets contain the results generated from the data that you enter in the Input worksheets. All the data in this guide are illustrative sample data only; the data show how the linkages between the worksheets function and allows you to learn how to use the tool and to see the results. The sample data enable you to populate the cells that will show the inputs and results of each worksheet. The sample data is from 2010–2014.

## Building Scenarios Using the Tool

Table 1 displays a summary of the different steps required to build the scenarios, including a list of suggested tools and resources to help you navigate through the worksheets. Each step is explained in detail in the following pages. Note that the steps below may be concurrent (e.g., part of assessing the current market will be to discuss future financing options with stakeholders). Also, the level of effort involved in each step will vary depending on how much work has been done recently using an existing contraceptive security (CS) assessment or contraceptive forecast. For example, if you had a CS assessment recently, the assessment step may be very different from the step you would need to take if an assessment has not been done recently, or if you have limited secondary data available. See appendix B for a table of resources.

**Table 1. Summary of Process to Build Financial Sustainability Scenarios**

| Steps | Actions | Tools and Resources | Corresponding Input or Results Worksheet |
|---|---|---|---|
| 1. Assessing the country's current contraceptive context | 1.1. Assessing the overall contraceptive context<br>1.2. Determining contraceptive financing<br>1.3. Assessing the total market | • *Strategic Pathway to Reproductive Health Commodity Security (SPARHCS)* or other *CS* assessment<br>• Demographic Health Survey (DHS)/other heath surveys (Multi-Indicator Cluster Survey [MICS], Reproductive Health Survey [RHS])<br>• market segmentation analysis<br>• Reproductive Health Interchange (RHI)<br>• poverty reduction strategy papers (PRSPs)<br>• Global Fund to Fight AIDS, Tuberculosis and Malaria proposals<br>• national health strategies and plans<br>• reproductive health subaccounts<br>• stakeholder interviews with reproductive health, family planning, donors, social marketing sector<br>• procurement planning and monitoring reports | These activities are completed outside the tool:<br>• literature review<br>• secondary analysis<br>• supplementary in-country interviews, meetings, site visits, as needed<br>• if necessary, formal assessment of contraceptive situation focusing on financing and future trends |
| 2. Estimating contraceptive commodities, unit price and available financing | 2.1. Projecting commodity needs and unit prices | These may include—<br>• existing contraceptive procurement tables (CPTs) and forecasts<br>• SPECTRUM (demographic forecast tool)<br>• Reality Check (demographic forecast | *1. Input – Background Information*<br><br>*2. Input – Scenarios & Projections*<br><br>*3. Input – Contraceptive Forecast* |

| Steps | Actions | Tools and Resources | Corresponding Input or Results Worksheet |
|---|---|---|---|
| | | tool) <br> • PipeLine (procurement planning tool) <br> • logistics management information system (LMIS) data <br> • health service statistics | *4. Input – Unit Price* |
| | 2.2. Estimating financing available from different sources for financing contraceptives | • interviews <br> • procurement records <br> • donor financial record <br> • RHI <br> • CPTs | *5. Input – Funding* |
| 3. Quantifying the financing gap: results | 3.1. Estimate contraceptive requirements and financing costs | | *A. Results – Commodity Projection* <br> *B. Results – Summary Tables* <br> *C. Scenario – Market Share* |
| 4. Future strategy development and implementation | 4.1. Prepare strategic plan to implement financing options. <br> 4.2. Approve strategic plan. <br> 4.3. Begin implementation. <br> 4.4. Monitor and revise plan, as needed. | • Meetings with stakeholders <br> • Stakeholder strategic planning workshop | See Future Strategy Development and Implementation section in the *Primer* |

# Assessing the Country's Current Contraceptive Context

To develop options for contraceptive financial sustainability, you must first assess the country's current contraceptive context. To do this, you must—

- understand the overall contraceptive context

- determine the current sources of contraceptive financing

- assess the total market for contraceptive products.

This step is not a complete assessment that generates primary data on the availability and accessibility of contraceptives; instead, you will use this step to gather and analyze *existing* data and information.

It is recommended that the assessment phase include—

- a literature review of existing documents and secondary data

- key informant interviews: individually, or in a workshop setting, or both

- site visits.

The extent of the assessment needed depends on the availability of data, how recently a previous assessment (e.g., a Strategic Pathway to Reproductive Health Commodity Security [SPARHCS] or reproductive health [RH] commodity security assessment) was complete, the quality of the data and previous assessments, and whether there are major gaps in information. The key informant interviews can effectively validate previous findings and data. The site visits will help you to understand the situation better; and typically, avoid a quantitative assessment of product availability. If during this step, major information gaps are identified, you may need to do a more comprehensive assessment and data collection. See appendix B for a table of key resources and links.

## Understanding the Overall Contraceptive Context

A review of both qualitative and quantitative data will help you understand the overall family planning context in the country and will help answer the following questions:

- What is the current family planning situation in a country?

- What are future trends in family planning; what types and quantities of commodities will you need to support these trends?

- Do any programmatic strategies, contextual factors, or other factors influence the trend and could impact financing needs?

Qualitative data from RH assessments, such as a SPARHCS assessment, a review of existing policies and strategies related to contraceptives, and key informant interviews will provide insight into likely future family planning program trends and the potential to influence future preferences. They will

also help you determine the type and quantity of commodities needed in the future. For example, some countries may be trying to increase awareness and use of long-term and permanent methods, such as implants, which will have an impact on the required financing. Speaking with organizations regarding their program objectives pertaining to information, education, and communication (IEC)/behavior change communication (BCC) campaigns can show you how contraceptive use may change among clients, in terms of method and source. Existing RH policies and strategies may have CPR goals, or other related targets, that can guide the development of the financial sustainability scenarios. Quantitative data from Demographic Health Survey (DHS) reports provide current CPR, method mix, unmet demand, and source of contraceptives by users.

Several other components inform, influence, and shape the overall context in which contraceptives are financed and used by clients. These include commitment, coordination, capacity, and context (policy and socioeconomic environment). For a complete description of these components, and more information on what they include, please see the SPARHCS tool and the SPARHCS process guide (Hare et al. 2004; Rao et al. 2008).

You can use the SPARHCS tool to frame your assessment and to provide specific assessment questions. A SPARHCS process guide includes information on how to use the SPARHCS tool and how to conduct an assessment. Several SPARHCS and reproductive health assessments have been conducted; you can access them on the USAID | DELIVER PROJECT website at www.deliver.jsi.com or the RHSC website at http://www.rhsupplies.org.

# Determining Contraceptive Financing

To plan for financing, you should understand how contraceptives are currently financed, who provides the various financing sources for contraceptives, and the future intentions and commitments of these sources. Public sector contraceptives can be financed by a combination of government and donor funds; and also by households, if a cost recovery system is in place. Although the focus of financial sustainability is long-term national financing, private sector financing can help diversify funding sources for the government and increase the number of options for contraceptive financing. While it can be difficult to estimate private-sector expenses for households, this information can provide a more complete picture of total financing of contraceptives in the country and can strengthen your understanding of the potential for out-of-pocket options. If the country had a reproductive health subaccount, you should be able to access data on out-of-pocket expenditures on contraceptives.

# Assessing the Total Market

An objective of financial sustainability is to look at strategic options; it is also important to understand the *total* market for providing contraceptives. This means that you should look at all the sectors that provide contraceptive service—the public sector, social marketing sources, nongovernmental organizations (NGOs), and the commercial sector (non-subsidized sector that does not receive any outside financial or commodity assistance). Estimating the percentage of the contraceptive market, by method, for each sector, is helpful if you want to understand market trends and client preferences; it also helps develop options for market changes. This data will be used in the C. Scenario – Market Share worksheet.

# Estimating Contraceptive Commodities, Unit Price, and Available Financing

After the general assessment and data collection is complete, you can begin entering data into the tool. You enter the data into five specific *Input* worksheets. The instructions to enter data are grouped into two parts in this section: *Projecting Commodity Needs* and *Estimating Financing Availability*—

**Projecting Commodity Needs:** You determine current contraceptive use and enter the inputs for CPR growth for the scenarios, select and enter current commodity data, and enter unit costs.

Projecting commodity needs input worksheets:
1. Input – Background Information

2. Input – Scenarios & Projections

3. Input – Contraceptive Forecast

4. Input – Unit Price

**Estimating Financing Availability:** Determines current and likely future financing availability.

Estimating financing available input worksheet:
5. Input – Funding

After you enter data into the *Input* worksheets, the *Results* worksheets in the tool will display the commodity and financing requirements. See section 3, Quantifying the Financing Gap.

## Projecting Commodity Needs

### 1. Input – Background Information

Collect the following background information to set the baseline information for the different scenarios. Enter this information into the grey cells of the *1. Input – Background Information* worksheet (see figure 1):

🖐 **Enter background information into worksheet: 1. Input – Background Info**

**Figure 1. Input – Background Information Screen**

| | A | B | C |
|---|---|---|---|
| 1 | **Instructions:** | | |
| 2 | 1) Fill in the requested background information into the grey cells and make any notes as necessary for reference purposes | | |
| 3 | | | |
| 4 | **GENERAL INFORMATION** | **Background** | **Notes (References)** |
| 5 | 1. Baseline year | 2009 | |
| 6 | 2. Starting year | 2010 | |
| 7 | 3. Last year of projection | 2014 | |
| 8 | 4. Currency in which the results are displayed | US$ | |
| 9 | 5. Currency conversion | Schillings | |
| 10 | 6. Exchange rate (if applicable). **Insert date of rate in 'Notes' column.** 1US$ = | 2356 | |

**1. Current baseline year:** Enter the baseline year for the scenario. The baseline year is the year for which you have the latest forecast information.

**2. Starting year:** This can correspond to other activities, strategies, or funding cycles. For example, if a CS strategy is being developed for five years, starting in 2009; this exercise will determine what costs are possible for different scenarios; enter *2009* as the starting year.

**3. Last year of projection:** The difference between the first year of the project and the last year of the project represents the time horizon for the analysis.

• The country should determine which time horizon to consider. Shorter time frames may be more realistic but may decrease the usefulness of the analysis. The longer the time frame, the more uncertainty is introduced because commitments by the government, donors, and technical assistance providers will be less reliable in three to five years.

• An additional consideration is if the country has an existing CS or RH strategic plan, which typically spans five years. It may be of more value if the period of the financial sustainability plan time frame is the same, so it can complement these strategies.

While in-country policymakers should make the final decision as to the time frame, they should set a time frame that is realistic and relevant to the country context, always considering the current health sector or economic plans and length of donor commitments.

**4. Currency in which data is displayed:** Enter the currency type. Display data using this currency throughout the worksheets.

**5. Currency conversion:** If you want to convert the data into a different currency after the results are produced, enter the name abbreviation and include the full name in the Notes (reference) cell. For example, if data was originally entered in U.S. dollars and the user would like to convert it into *schillings,* enter *schillings* in cell B9.

**6. Exchange rate:** For reference, enter the exchange rate. In cell B10, enter the exchange rate to convert U.S. dollars into schillings. U.S. dollars are used in the sample data in the guide; it is the default currency.

## 2. Input – Scenarios and Projections

In this worksheet, enter baseline CPR rates by method and year, the population increase of women of reproductive age, and the projected increase; including a descriptive name for three different scenarios.

✎ **Create your scenarios and percentage increase in worksheet: 2. Input – Scenarios & Projections**

**1. Baseline CPR:** To generate the baseline CPR, follow these steps:

In cells D12 to L12, make sure that you enter all the modern contraceptive methods used in the country (to the right of *Adjust contraceptives as needed*). The template includes most of the major methods. However, if additional methods are used in the country, add them in the grey cells only. Enter the name of the additional method in cells K14 and L14. Enter the CPR in the cells directly below. Also enter the couple-years of protection (CYP) for the added methods. The CYP is in the 3. Input – Contraceptive Forecast worksheet, starting in column C52.

- In cell C15, record the data source for CPR and the year the data source was published.

- Insert the latest national CPR data for each method in cells D15 to L15 to the right of Source and Year. You will find CPR data in the most recent DHS report.

**Note:** The CPR for each method will be automatically totaled in the far right column (M14). Figure 2 should correspond to the total CPR for modern methods, based on the data source used.

**Figure 2. Current Contraceptive Prevalence Rate**

| Contraceptive Prevalence Rate | | | | | | | | | | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Adjust contraceptives as needed →** **Enter source and year ↓** | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | other | other | Total |
| DHS, 2006 | 8.0% | 10.0% | 9.0% | 1.0% | 2.0% | 3.0% | 0.0% | | | 33% |

**2. Population Increase of Women of Reproductive Age:** You must consider population growth of women of reproductive age when estimating commodity projections. Each year, the cohort of women of reproductive age will change in a country. You can either use all women of reproductive age, or married women of reproductive age, to make the projection. Using SPECTRUM, you can generate this data, or you can find the information in the U.N. World Population Prospects online database at http://esa.un.org/unpp.

Cut and paste the population figures for married women of reproductive age into the Total Population column in this table. You can find it in SPECTRUM under *display – family planning (famplan) – family planning – women of reproductive age*.

To enter data into figure 3, Population Increase of Women of Reproductive Age—
- In cell J21, specify if the population growth is for *All* or *Married* women of reproductive age.

- In cell J22, indicate the data source for women of reproductive age.

- In cells C23 to C28, in the *Total Population* column, enter the number of women of reproductive age or married women of reproductive age; in cells B23 to B28, enter the corresponding year in the *Year* column.

**Figure 3. Population Increase of Women of Reproductive Age**



The population increase will be considered as part of the overall increase for each method, which are shown on the two tables in worksheet *2. Input – Scenarios & Projections*. The increase will be added to the totals on worksheet *A. Results – Commodity Projection*.

(1) Based on the population growth information entered, the additional users represented by population growth are calculated for each method, based on the current CPR. (2) That figure is converted into the number of units needed for each method, based on the CYP. (3) The number of units is distributed among the different sectors in the *A. Results – Commodity Projection* worksheet, based on the *Market share by sector by method* table in the *3. Input – Contraceptive Forecast* worksheet.

For example, in table 2—

**Table 2. Example illustrating allocation of new users**

**2010— Because of population growth, 32,889 women of reproductive age were added to the population.**

CPR per method for the additional population = 32,889 × current CPR for each method

| | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD |
|---|---|---|---|---|---|---|
| Current CPR | 8.0% | 10.0% | 9.0% | 1.0% | 2.0% | 3.0% |
| Number of new users for each method | 2,631 | 3,289 | 2,960 | 329 | 658 | 987 |
| CYP | 15.00 | 4.00 | 120.00 | 120.00 | 0.29 | 1 |
| Additional units needed based on CYP | 39,467 | 13,156 | 355,201 | 39,467 | 188 | 987 |

Note:
CYP for IUDs is .286. However, to convert users into the number of units needed, the practice is to use a one-to-one ratio (FPLM 2000a).

**3. Projected Increase in CPR:** Figure 4 displays the *projected increase in contraceptive prevalence rate by method* for each scenario. Note the projections in this figure do not represent a new CPR rate for each method. However, to arrive at the projections, you must develop an estimate of the anticipated increase in CPR for each method. An increase in population is already factored into the calculations, based in the information input in figure 3, *Population increase of women of reproductive age.* You must project the increase in CPR and enter that figure in figure 4.

For example, if the current CPR in 2009 for injectables is 10 percent, and the projected increase in 2010 is 5 percent, the 5 percent is considered to be the projected increase. The projected increase in CPR could result from several factors—ranging from IEC/BCC campaigns, increased service provider training, or a national strategy focusing on particular methods.

A few guidelines for approximate increases in method use are the following:

- Increase in contraceptive use can be determined during discussions with stakeholders who are familiar with the family planning program and who have some knowledge of past CPR trends. Remember the scenarios are best guesses or informed estimates; they are a guide to develop possible financing options and program decisions. They are not the same as a forecast, which requires more accurate estimates.

- The projected increases depend on the current CPR, overall demand, and other factors; the projected increase in demand will vary widely from country to country. Growth will be slower for lower prevalence methods; or methods that require additional support, such as injectables, implants, and intrauterine devices (IUDs). The growth rates must reflect the trends in the country, both prevalence and method mix, for more realistic scenarios.

- You should determine how much increase is expected for a method from year to year, for a particular method. For example, the baseline CPR for injectables is 10 percent. In the slow scenario, it is projected that injectable use will increase by 5 percent. In the medium scenario, injectable use will increase by 10 percent. In the aggressive scenario, it will increase by 20 percent.

- The scenarios presented in this guide are labeled slow, medium, and aggressive growth. You can create other scenarios; for example, to look at the cost impact of increasing the use of a particular method, such as long-term methods. Or, for different scenarios, where the projected increase remains the same, but you change the unit price to see the impact on overall financing needs.

To insert data to reflect estimated increase in growth, populate figure 4.

1. In figure 4, in column C, enter a name for each scenario. Figure 4 shows figures for three different scenarios: slow, medium, and aggressive growth.

2. In the grey cells, enter the projected percentage growth increase in CPR for each scenario's method and year.

**Figure 4. Projected Increase in CPR**

| | | 2010 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Enter name for each scenario ↓ | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | other |
| Scenario 1 | slow growth | 5.0% | 5.0% | 5.0% | 0.5% | 1.0% | 2.0% | 0.0% | 0.0% |
| Scenario 2 | medium | 10.0% | 10.0% | 10.0% | 5.0% | 3.0% | 5.0% | 0.0% | 0.0% |
| Scenario 3 | aggressive | 20.0% | 20.0% | 20.0% | 10.0% | 10.0% | 8.0% | 0.0% | 0.0% |

The increase in CPR per method represented in figure 4 is added to the increase because of the population growth; it is included in the totals calculated in worksheet *A: Results – Commodity Projection.*

# 3. Input – Contraceptive Forecast

The next step in estimating commodity and financing needs for financial sustainability planning is to enter the data from a current contraceptive quantification or forecast. While the terms *forecasting* and *quantification* are often used interchangeably, strictly speaking, they refer to different steps in the quantification process:

- *Forecast* estimates future contraceptive demand, for a given population, over a given time period.

- *Quantification* is the entire process of estimating how many contraceptives are needed; part of this estimate is forecasting for future demand. By its nature, quantification is usually closely linked to procurement planning—determining what to buy and when.

The financial sustainability tool considers the latest forecast or quantification to estimate financing costs and requirements, based on the various scenarios.

As a first step in determining contraceptive supply and financing needs, determine if a country has had a recent contraceptive forecast and, subsequent, procurement quantification. If so, use this data as the basis for entering data into the *3. Input – Contraceptive Forecast* worksheet. If the country has *not* had a recent forecast and procurement quantification for contraceptives, you should conduct a forecast and quantification and use those figures in the tool. See appendix C for more guidance.

After you have the contraceptive forecast or quantification data, you can begin entering this information into the tool.

✎ **Enter data into worksheet: 3. Input – Contraceptive Forecast**

**1. Current forecast:** Enter the data into the grey cells of the *Input – Contraceptive Forecast* worksheet:

a. Adjust the sector headings in the grey cells under *Public Sector and Private Non-Profit* sections, based on what commodity data is available in the country. Insert information only in the grey cells in row 11.

b. Insert commodity quantities, either from logistics, service statistics, or demographic data into the grey cells in columns C and D, and F through J.

Figure 5 is an example of a completed current forecast table.

**Figure 5. Example of Current Forecast Table**

| | | MOH | 0 | Total Public Sector | NGO | IPPF | Social Marketing | MSI | Commerical | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | **Public Sector** | | | **Private Non-Profit** | | | |
| | | | | | | | **2009** | | | |
| | Adjust sectors as needed and enter forecast data ➔ | | | | | | | | | |
| Pills | | 222,000 | - | 222,000 | 24,000 | 12,000 | 84,000 | - | - | 342,000 |
| Injectables | | 390,000 | - | 390,000 | 130,000 | 30,000 | - | 27,000 | - | 577,000 |
| Condoms (male) | | 620,000 | - | 620,000 | 215,000 | 466,000 | 430,000 | 190,000 | - | 1,921,000 |
| Condoms (female) | | - | - | - | 3,000 | - | - | - | - | 3,000 |
| Implants | | 2,500 | - | 2,500 | - | - | - | - | - | 2,500 |
| IUD | | 5,000 | - | 5,000 | - | - | - | - | - | 5,000 |
| Emergency Contraceptives | | - | - | - | - | - | - | - | - | - |
| other | | | - | - | - | - | - | - | - | - |
| 0 | | | 0 | - | 0 | 0 | 0 | 0 | 0 | - |

The following are notes and guidelines for completing the table in figure 5:

- The headings for Ministry of Health (MOH), Total Public Sector, Social Marketing, and Commercial Sector are already included as default headings; do *not* move the headings because they are linked to other tables in the tool.

- Under *public sector*, in addition to a column for MOH, an additional column is provided if you want to further disaggregate the public sector (i.e., MOH and Ministry of Finance).

- Figure 5 includes the commercial sector, which shows the possibility of including this sector (if estimates for the commercial are not available, you do not need to include it as part of the projection—leave it blank).

- Figure 5 also shows a number of different private non-profit entities. If entries are only for the public sector, leave the other cells blank.

**2. Market share:** Data from the current consumption table will automatically generate the *market share by sector by method* table, in a separate table, within the same worksheet (see figure 6).

**Figure 6. Market Share by Sector by Method**

| | MOH | 0 | Total Public Sector | NGO | IPPF | Social Marketing | MSI | Commerical | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | **Public Sector** | | | **Private Non-Profit** | | | |
| Pills | 65% | 0% | 65% | 7% | 4% | 25% | 0% | 0% | 100% |
| Injectables | 68% | 0% | 68% | 23% | 5% | 0% | 5% | 0% | 100% |
| Condoms (male) | 32% | 0% | 32% | 11% | 24% | 22% | 10% | 0% | 100% |
| Condoms (female) | 0% | 0% | 0% | 100% | 0% | 0% | 0% | 0% | 100% |
| Implants | 100% | 0% | 100% | 0% | 0% | 0% | 0% | 0% | 100% |
| IUD | 100% | 0% | 100% | 0% | 0% | 0% | 0% | 0% | 100% |
| Emergency Contraceptives | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| other | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| 0 | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

The contraceptive market varies in each country. In some countries, the commercial sector is still in the early stages of development; it will play a very small role in financing and providing contraceptives. In other countries, with a more mature private sector, households can sustain contraceptives sold commercially, while social marketing further increases the availability of contraceptives at prices that a wider range of clients may find more appealing.

This worksheet determines the current market; it is a starting point to make market adjustments later in the *Scenario – Market Share* worksheet.

**3. Couple-years of protection (CYP):** CYP is the estimated contraceptive protection provided for one couple for one year. The data entered in the *current forecast* table automatically generates a second table. The *CYP Share by Sector* calculates the CYP provided by each method. To calculate CYP, the quantity of each method required to protect a couple (a conversion factor) is converted for a one-year period. CYP can indicate the amount of contraceptive protection that different programs provide. The conversion factors can be adjusted if there is specific country data; otherwise, the conversion factors shown in table 2 are hardcoded into the formula. These are internationally used and accepted conversion factors (USAID 2010). Table 2 is an example of conversion factors used by the tool.

**Table 3. Couple-Years of Protection Conversion Factor**

| Method | CYP per Unit | Conversion (multiply or divide) |
|---|---|---|
| Oral contraceptives | 15 cycles per CYP | / |
| Condoms | 120 units per CYP | / |
| Female condoms | 120 units per CYP | / |
| Vaginal foaming tablets | 120 units per CYP | / |
| Depo-Provera injectable | 4 doses (ml) per CYP | / |
| Noristerat injectable | 6 doses per CYP | / |
| Cyclofem monthly injectable | 13 doses per CYP | / |
| Copper-T 380-A IUD | .286 (3.5 CYP per IUD inserted) | / |
| Norplant implant | .286 (3.5 CYP per IUD inserted) | / |
| Implanon implant | .5 (2.0 CYP per implant) | / |
| Jadelle implant | .286 (3.5 CYP per IUD inserted) | / |
| Emergency contraceptive pills | 20 doses per CYP | / |
| Natural family planning (i.e., standard days method) | 2 CYP per trained, confirmed adopter | / |
| Sterilization (male and female)* • Asia • Latin America • Africa | .1 (10 CYP) .1 (10 CYP) .125 (8 CYP) .125 (8 CYP) | / |

| Method | CYP per Unit | Conversion (multiply or divide) |
|---|---|---|
| • Near East/North Africa | | |
| **\*The CYP conversion factor** for sterilization varies because it depends on when the sterilization is performed in the reproductive life of the individual. For more specific data on CYPs and sterilization, consult the national Demographic and Health Survey and Centers for Disease Control and Prevention reproductive health survey records, which may provide a historical calculation, based on a specific country's context. | | |

## Figure 7. Breakdown of CYP Coverage by Sector

| CYP Share by Sector | Public Sector | | | Private Non-Profit | | | | Commerical | Total |
|---|---|---|---|---|---|---|---|---|---|
| | MOH | 0 | Total Public Sector | NGO | IPPF | Social Marketing | MSI | | |
| Pills | 14,800 | - | 14,800 | 1,600 | 800 | 5,600 | - | - | 22,800 |
| Injectables | 97,500 | - | 97,500 | 32,500 | 7,500 | - | 6,750 | - | 144,250 |
| Condoms (male) | 5,167 | - | 5,167 | 1,792 | 3,883 | 3,583 | 1,583 | - | 16,008 |
| Condoms (female) | - | - | - | 25 | - | - | - | - | 25 |
| Implants | 8,741 | - | 8,741 | - | - | - | - | - | 8,741 |
| IUD | 17,483 | - | 17,483 | - | - | - | - | - | 17,483 |
| Emergency Contraceptives | - | - | - | - | - | - | - | - | - |
| other | - | - | - | - | - | - | - | - | - |
| 0 | - | - | - | - | - | - | - | - | - |
| Total | 128,890 | - | 128,890 | 34,317 | 11,383 | 3,583 | 8,333 | - | 186,507 |
| As a % of Total CYP | 69% | 0% | 69% | 18% | 6% | 2% | 4% | 0% | 100% |

Using the information from figure 7, the worksheet automatically creates a pie chart that shows the CYP coverage, by sector.

**Figure 8. Coverage by Couple-Years of Protection**

**Coverage by CYP**
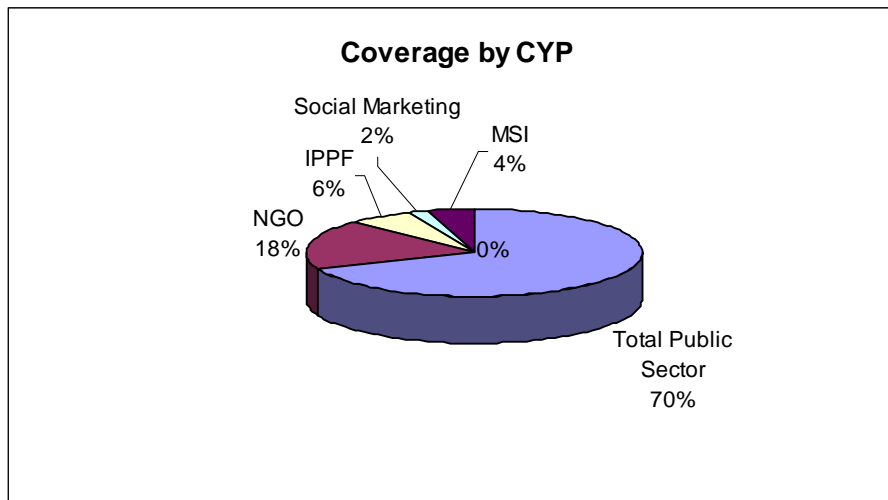


## 4. Input – Unit Price

Next, you will enter the unit price for the contraceptives, either by method or, if information is available, by brand, into the *4. Input – Unit Price* worksheet. As part of this exercise, you should determine who is procuring the contraceptives for the country (e.g., the MOH; developing partners; social marketing; international NGOs, such as International Planned Parenthood Federation [IPPF] or IPPF affiliates; or the commercial sector), because their unit prices will differ.

For the public sector, enter the procurement unit price into the table. At times, the government will use either its own national resources or a procurement agent (i.e., the United Nations Population Fund [UNFPA]) to procure the contraceptives. If the government uses its own funds to finance contraceptives, the unit prices must be under the public heading.

If you include the commercial sector in the scenario, enter the procurement cost of the contraceptive for the commercial sector into the table. Obtaining procurement prices from commercial companies may be difficult because this information is sensitive and is rarely shared. Additionally, several commercial retailers may sell contraceptives in the market. In this case, enter the average unit price for the method (see example in figure 9). For other private non-profit sectors—organizations similar to IPPF, social marketing, and NGOs—it may be difficult to obtain procurement prices. If procurement unit prices are not accessible, then you can enter retail prices. Use the comments feature in Microsoft Excel to note that you used this data, so the source of the projected commodity and financing costs in the scenarios is clear.

You can use the following resources to access data on contraceptive unit prices.

- USAID | DELIVER PROJECT website: www.deliver.jsi.com for USAID prices

- My Commodities page (if you have a login): http://deliver.jsi.com/dhome/mycommodities

- Reproductive Health Interchange (http://rhi.rhsupplies.org) provides detailed contraceptive shipment information for USAID, UNFPA, IPPF, Crown Agents, World Bank, etc. (when acting as a procurement agent for Department for International Development [DFID]), including costs.

- Management Sciences for Health Price Guide:
  http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=Dmp&language=English

Enter data into the grey cells of the *4. Input – Unit Price* worksheet:

1.  In the grey cells only, in column A, add brands, if applicable, under each method.

2.  Enter the unit price for each brand in the cell that corresponds to that method and funding source.

Notes and guidelines for entering data:

- The contraceptive methods are set up in the column on the left-hand side of the table. However, in the cells below the method, enter the contraceptive brands for each method. Note the unit or pack size next to the brand name (see examples in figure 9).

- Enter the brands and unit prices into the grey cells only.

- If desired, list just one unit price for each method, or list the brands and the respective unit prices separately.

Based on the unit prices entered, the system will calculate an *average* unit price for each method; this figure is then linked to the *A. Result – Commodity Projection* worksheet (to the *2 – Projected Costs* table) to estimate the projected contraceptive costs for each of the three scenarios.

Figure 9 is an example of the worksheet, *4. Input – Unit Price* table. Please note, the unit prices are examples only.

**Figure 9. Example of the Worksheet, *4. Input – Unit Price***

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 7 | Unit price (for all methods list specific brands and note presentation/pack size) | | | | | | | |
| 8 | | Organization Procuring or Selling Contraceptives | | | | | | |
| 9 | | Public | | Private Non-Profit | | | | |
| 10 | Add brands as needed for each method⬇ | MOH | 0 | NGO | IPPF | Social Marketing | MSI | Commerical |
| 11 | **Oral Pill** | | | | | | | |
| 12 | COC | | | | | | | |
| 13 | Oralcon-F. (one cycle) | $ 0.30 | | | $ 0.50 | $ 0.60 | $ 0.48 | |
| 14 | Duofem (one cycle) | $ 0.25 | | | | | | |
| 15 | Microgynon (per pack) | | | $ 0.25 | | | | |
| 16 | private sector average | | | | | | | $ 2.00 |
| 17 | Average | $ 0.28 | $ - | $ 0.25 | $ 0.50 | $ 0.60 | $ 0.48 | $ 2.00 |
| 18 | POP | | | | | | | |
| 19 | Excluton (per pack) | | | | $ 0.38 | $ - | | |
| 20 | Microlut (one cycle) | $ 0.26 | | $ 0.25 | | | $ 0.38 | |
| 21 | average private sector price | | | | | | | $ 4.48 |
| 22 | | | | | | | | |
| 23 | Average | $ 0.26 | $ - | $ 0.25 | $ 0.38 | $ - | $ 0.38 | $ 4.48 |
| 24 | Oral Pill Average | $ 0.27 | $ - | $ 0.25 | $ 0.44 | $ 0.60 | $ 0.43 | $ 3.24 |
| 25 | **Injectables** | | | | | | | |
| 26 | Depo-provera | $ 0.90 | $ - | $ 0.90 | | $ 1.17 | | $ 1.43 |
| 27 | 2 month | | | | $ 0.85 | | $ 0.90 | |
| 28 | | | | | | | | |
| 29 | Average | $ 0.90 | $ - | $ 0.90 | $ 0.85 | $ 1.17 | $ 0.90 | $ 1.43 |
| 30 | **Male condoms (list all brands)** | | | | | | | |
| 31 | Generic brand | $ 0.02 | $ 0.00 | $ 0.04 | $ 0.04 | $ 0.05 | $ 0.08 | |
| 32 | private sector brand | | | | | | | $ 0.25 |
| 33 | | | | | | | | |
| 34 | | | | | | | | |
| 35 | | | | | | | | |
| 36 | Average | $ 0.02 | $ 0.00 | $ 0.04 | $ 0.04 | $ 0.05 | $ 0.08 | $ 0.25 |
| 37 | **Female Condom** | | | | | | | |
| 38 | Generic brand | $ - | $ - | $ 0.85 | $ - | $ - | $ 0.90 | $ 0.56 |
| 39 | private sector average | | | | | | | |
| 40 | Average | $ - | $ - | $ 0.85 | $ - | $ - | $ 0.90 | $ 0.56 |
| 41 | **Implant** | | | | | | | |
| 42 | Jadelle | $ 21.00 | $ - | | $ - | $ - | $ - | $ - |
| 43 | Implanon | | | $ 22.97 | | | | |
| 44 | Sinoplant | | | | | | | |
| 45 | private sector average | | | | | | | |
| 46 | Average | $ 21.00 | $ - | $ 22.97 | $ - | $ - | $ - | $ - |
| 47 | **IUD** | | | | | | | |
| 48 | Copper - T | $ 0.90 | $ - | $ 0.98 | $ 0.54 | $ 0.53 | $ 2.35 | $ 10.40 |
| 49 | | | | | | | | |
| 50 | private sector average | | | | | | | |
| 51 | Average | $ 0.90 | $ - | $ 0.98 | $ 0.54 | $ 0.53 | $ 2.35 | $ 10.40 |
| 52 | **Emergency contraceptives** | | | | | | | |
| 53 | | $ - | $ - | $ - | $ - | $ - | $ - | $ - |

After you enter all the unit prices, use the tool to calculate the estimated costs for contraceptives for a five-year period, for each scenario, by sector and by method, as shown in the *A. Results – Commodity Projection* and *B. Results – Summary Table*.

# Estimating Financing Availability

By taking the final steps—entering data into the tool—you will identify financing gaps, which will determine the future financing for contraceptives. You can use four main types of sources to fund contraceptives:

- donors and other non-profit organizations

- national governments

- households (out-of-pocket spending)

- third parties (usually insurance organizations or private organizations).

However, the main focus for the tools is to determine the availability of national government, donor, and non-profit organizations—they are responsible for procuring contraceptives for the public sector (if information on the commercial sector is available, you can enter this information into the tool). For additional information on using these funding sources to increase financing, see, *Contraceptive Financial Sustainability: A Primer,* in the first section, Options for Increasing Financing Sustainability of Contraceptives (deliver.jsi.com).

**Donor and other non-profit organizations:** You will need to determine future commitments for donors and other organizations from in-country interviews or contraceptive procurement table (CPT) reports. Donors may include USAID, UNFPA, Crown Agents, *Kreditanstalt für Wiederaufbau* (KfW), DFID, and Japan International Cooperation Agency. Other multilateral donors may include other UN agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Also collect financing commitments from NGOs.

Most donors will only be able to commit to funding for a short period of time (one year or less), but they may be able to indicate their longer-term funding. In many cases, the organizations cannot state exactly what their future funding commitments will be for contraceptive commodities. Therefore, it is important to collect historical data, not only to understand the current situation, but also to help predict the future funding levels. If current and future information is not available, using historical commitments and projecting these costs forward can be a temporary solution.

You can obtain historical procurement information through the Reproductive Health Interchange (RHI) website (rhi.rhsupplies.org). The database contains many of the major contraceptive procurers—USAID, UNFPA, IPPF, and Crown Agents—when it acts as a procurement agent for DFID and others. You must validate RHI data through interviews with in-country representatives. For instance, RHI data may include times where an agency acted as a third-party procurement agent and not as the funding source. For example, UNFPA often acts as a procurement agent for national governments.

**National governments:** Governments can support commodities through their own internally generated funds (e.g., from tax revenues); or they can use donor funds or credits given as direct or ear-marked budget support, or basket funds. You should verify this type of financing through budget and/or procurement records. Be careful that you do not double-count funds (e.g., count donations provided as ear-marked funds to a national budget under government spending).

If possible, verify anecdotal stakeholder information on funding through original records, such as procurement records. It is possible that the stakeholders will report amounts that were budgeted or allocated rather than the amount actually spent or used to procure commodities.

## 5. Input – Funding

Enter data in the grey cells. You will need to select either table A or B, depending on the information you have available. Only complete *one* table.

1.  Select table A or B in the worksheet:

    a.  Table A: If you only know commitments by funding source, enter funding commitments in table A for each year data is available.

    b.  Table B: If you know the funding commitments by funding source and method, enter data in table B for each year data is available.

    **Note:** Table B is a series of tables, each representing funding commitments for one year. Fill out as many years as possible, based on reliable funding commitment information.

2.  List the funding sources in the left-hand column in the grey cells.

*   Column A in table A

*   Column I in table B.

See the following completed samples of tables A and B:

In table A, you can disaggregate government funding sources—for example, the MOH and other national resources—World Bank credits, loans, or basket funds. Under the donor and other non-profit organizations section, funding commitments are known for 2010; beyond 2010, it is unlikely that you will have known commitments. Table A totals the commitments by year, as well as a cumulative total over the five-year period.

**Figure 10. Table A - Funding Commitments by Source and Year**

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 8 | TABLE A - Use this table if only commitments by source of funding is available | | | | | | |
| 9 | Funding Commitments by Source and YEAR | | | | | | |
| 10 | | | | | | | |
| 11 | List ministries, donors, etc. who have committed funds towards contraceptive financing ⬇ | 2010 | 2011 | 2012 | 2013 | 2014 | Total |
| 12 | Government | | | | | | |
| 13 | Ministry of Health | $ 50,000 | $ - | $ - | $ - | $ - | $ 50,000 |
| 14 | Other | $ - | $ - | $ - | $ - | $ - | $ - |
| 15 | | | | | | | $ - |
| 16 | | | | | | | $ - |
| 17 | Donors/Non-profit | | | | | | |
| 18 | UNFPA | $ 100,000 | $ - | $ - | $ - | $ - | $ 100,000 |
| 19 | USAID | $ 270,000 | $ - | $ - | $ - | $ - | $ 270,000 |
| 20 | IPPF | $ 79,000 | $ - | $ - | $ - | $ - | $ 79,000 |
| 21 | NGO | $ 157,000 | $ - | $ - | $ - | $ - | $ 157,000 |
| 22 | Social marketing | $ 130,000 | $ - | $ - | $ - | $ - | $ 130,000 |
| 23 | MSI | $ 58,000 | $ - | $ - | $ - | $ - | $ 58,000 |
| 27 | Total (by source) | $ 844,000 | $ - | $ - | $ - | $ - | $ 844,000 |

Use table B if you have a breakdown of funding, by funding source, and method for different years (see the following example). In table B, the totals are listed for each method, by funding source.

## Figure 11. Table B – Funding Commitments by Source and Method

| | I | J | K | L | M | N | O | P | Q | S |
|---|---|---|---|---|---|---|---|---|---|---|
| 8 | TABLE B - Use this table if a breakdown of funding by method and funding source is available. Complete a table for each year data is available | | | | | | | | | |
| 9 | Funding Commitments by Source and METHOD | | | | | | | | | |
| 10 | | | | | Amount Committed for 2010 | | | | | |
| 11 | | | | If possible, breakdown by contraceptive OR enter aggregate amount for each organization in 'Total' row highlighted in yellow | | | | | | |
| 12 | | | | | | | | | | |
| 13 | List ministries, donors, etc. who have committed funds towards contraceptive financing ⬇ | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | other | Total |
| 14 | Government | | | | | | | | | |
| 15 | Ministry of Health | $ 60,000 | $ 40,000 | $ - | | | | | | $ 100,000 |
| 16 | Other | | | | | | | | | $ - |
| 17 | | | | | | | | | | |
| 18 | Donors/Non-profit | | | | | | | | | |
| 19 | UNFPA | $ 90,000 | $ 200,000 | $ 15,000 | $ - | $ 55,000 | $ 2,000 | | | $ 362,000 |
| 20 | USAID | $ 16,000 | $ 38,000 | $ 15,000 | | $ - | $ - | | | $ 69,000 |
| 21 | IPPF | $ 30,000 | $ 27,000 | | | | | | | $ 57,000 |
| 22 | NGO | $ 18,000 | $ 125,000 | | $ 3,000 | | | | | $ 146,000 |
| 23 | MSI | $ 13,000 | $ 34,000 | | | | | | | $ 47,000 |
| 27 | | | | | | | | | | $ - |
| 28 | Total (by method) | $ 247,000 | $ 464,000 | $ 73,000 | $ 3,000 | $ 55,000 | $ 2,000 | $ - | $ - | $ 844,000 |

# Quantifying the Financing Gap: Results

## Estimate the Contraceptive Requirements and Financing Costs

After you populate the five Input worksheets, combine the inputs and present them in the two results worksheets: A. Results – Commodity Projection and B. Results – Summary Tables.

The *A. Results – Commodity Projection* worksheet provides the following results:

- Units Projected presents the quantity of contraceptives or units required for each sector, by scenario and year:

  - Aggregated Total Commodities by Year (row 53): Cumulative commodities required by scenario and method for each sector and year

  - Aggregated Total – All 5 Years (row 61): Cumulative commodities required by method for the entire period (in the sample data, this period covers five years)

  - Aggregation by Scenario (row 67): Cumulative quantities estimated by method and year for each scenario.

- Projected Costs presents the cost of each sector presented by scenario and year:

- Aggregated Total Costs by Method and Year (row 128): The total cost required by scenario and method for each year

- Aggregated Total Financing Costs – All 5 Years (row136): The total cost of commodities for the entire five-year period

- Finance Costs by Sector, Scenario, Year (row 187): A summary of costs for each sector by scenario and year.

The *B. Results – Summary Tables* worksheet provides the following results:

- Aggregated Contraceptive Requirements by Year (row 3): Cumulative commodities required by year and method

- Aggregated Contraceptive Financing Costs by Year (row 8): Cumulative costs by year and method

- Contraceptive Financing Needs by Scenario (row 24): For each scenario, costs are summarized by year and scenario

- Funding commitments by source and year (row37): The table summarizes the funding commitments by year and source

- Funding Gap/Surplus (row 57): For each scenario, displays funding gap/surplus by year

- Funding commitments by method and year – From table B (row 62): Displays funding commitments by year and method
- Funding Gap/Surplus (row75): Summarizes the funding gaps by year for each method
- Total Contraceptive Financing Costs by Method and Scenario (row 88): Summarizes costs by each scenario for each year.

# A. Results – Commodity Projection

## Units Projected

The *A. Results – Commodity Projection* worksheet calculates the projected commodities required for each sector, by method, over the five-year period. To do this, the projected demand increase for each method was taken from the 2. Input – Scenarios & Projections sheet and multiplied by the contraceptive forecast data from 3. Input – Contraceptive Forecast sheet.

Figure 12 is an example of the projected commodities for only the MOH for 2010. Cell C7 shows the projected amount for pills will be 258,719 pills for scenario 1 in 2010. The full table showing the projected commodities for each of the sectors, by method and year, are in the Excel file, Sample File.

**Figure 12. Projected Commodities by Source, Scenario, and Year**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | A. Results - Commodity Projection | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | 1. Units Projected | | | | | | | | | |
| 4 | | | 2. Scenarios & Projections * 3. Contraceptive Forecast | | | | | | | |
| 5 | | | | | | 2010 | | | | |
| 6 | MOH | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | Total |
| 7 | Scenario 1 | slow growth | 258,719 | 418,392 | 765,641 | – | 2,713 | 6,087 | – | 1,451,551 |
| 8 | Scenario 2 | medium | 269,819 | 437,892 | 796,641 | – | 2,763 | 6,237 | – | 1,513,351 |
| 9 | Scenario 3 | aggressive | 292,019 | 476,892 | 858,641 | – | 2,938 | 6,387 | – | 1,636,876 |

The aggregate of all the projected commodities, adding all the sectors, is calculated in the Aggregated Total Commodities by Year (row 53) table, which shows the quantities needed for each method, by year. Figure 13 shows the total needed for only 2010. This table can be useful to show what the total contraceptive needs are for each year, by scenario.

**Figure 13. Aggregate Commodities by Scenario, Year and Method**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 53 | **Aggregated Total Commodities by Year** | | | | | | | | | |
| 54 | | | | | | | **2010** | | | |
| 55 | | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | Total |
| 56 | Scenario 1 | slow growth | 398,567 | 619,006 | 2,372,251 | 42,482 | 2,713 | 6,087 | – | 3,441,105 |
| 57 | Scenario 2 | medium | 415,667 | 647,856 | 2,468,301 | 42,617 | 2,763 | 6,237 | – | 3,583,440 |
| 58 | Scenario 3 | aggressive | 449,867 | 705,556 | 2,660,401 | 42,767 | 2,938 | 6,387 | – | 3,867,915 |

Also included in the *A. Results – Commodity Projection* worksheet is a cumulative summary of commodity needs over the entire five-year projection, by method, for each scenario. The Aggregated Total – All 5 Years (row 61) table presents what the total contraceptive needs would be, based on the projected demand increase from the 2. Input – Scenarios & Projections worksheet (see figure 14).

**Figure 14. Aggregated Total—All 5 Years**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 61 | **Aggregated Total - All 5 Years** | | | | | | | | | |
| 62 | | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | Scenario Total |
| 63 | Scenario 1 | slow growth | 2,584,629 | 3,514,812 | 16,631,352 | 611,488 | 15,690 | 41,748 | – | 23,399,719 |
| 64 | Scenario 2 | medium | 2,935,934 | 4,048,778 | 18,751,386 | 641,954 | 16,504 | 44,272 | – | 26,438,828 |
| 65 | Scenario 3 | aggressive | 3,779,036 | 5,340,147 | 23,814,560 | 688,039 | 19,759 | 47,544 | – | 33,689,085 |

An aggregation for each scenario is also provided by year and method (row 67). Figure 15 shows the commodity requirements for scenario 1.

**Figure 15. Aggregation of Commodity Requirements by Scenario and Year**

| | A | B | C | D | E | F | G | H | I |
|---|---|---|---|---|---|---|---|---|---|
| 67 | **Aggregation by Scenario** | | | | | | | | |
| 68 | | Scenario 1 | | | | | | | |
| 69 | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | other |
| 70 | 2010 | 398,567 | 619,006 | 2,372,251 | 42,482 | 2,713 | 6,087 | 0 | 0 |
| 71 | 2011 | 457,670 | 663,014 | 2,843,441 | 81,869 | 2,927 | 7,188 | 0 | 0 |
| 72 | 2012 | 519,944 | 709,295 | 3,340,123 | 121,669 | 3,143 | 8,316 | 0 | 0 |
| 73 | 2013 | 575,345 | 743,841 | 3,798,551 | 162,080 | 3,349 | 9,478 | 0 | 0 |
| 74 | 2014 | 633,103 | 779,656 | 4,276,986 | 203,388 | 3,558 | 10,680 | 0 | 0 |

## Projected Costs

After you project the commodities, the costs for each scenario are presented in the 2. Projected Costs section (row 78) within the A. Results – Commodity Projection worksheet. The projected commodity costs are calculated by linking the 4. Input – Unit Price worksheet with the projected commodities. Figure 16 is an example of the projected contraceptive costs for the MOH for 2010. The table shows the annual total for each scenario for the MOH.

**Figure 16. Example of Projected Contraceptive Costs by Source, Scenario and Year**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 78 | **2. PROJECTED COSTS** | | | | | | | | | |
| 79 | | | **Units Projected * 4. Unit Price** | | | | | | | |
| 80 | | | | | | | 2010 | | | |
| 81 | MOH | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contrace | Scenario Total |
| 82 | Scenario 1 | slow growth | $ 69,207 | $ 376,553 | $ 15,313 | $ - | $ 56,972 | $ 5,478 | $ - | $ 523,523 |
| 83 | Scenario 2 | medium | $ 72,177 | $ 394,103 | $ 15,933 | $ - | $ 58,022 | $ 5,613 | $ - | $ 545,847 |
| 84 | Scenario 3 | aggressive | $ 78,115 | $ 429,203 | $ 17,173 | $ - | $ 61,697 | $ 5,748 | $ - | $ 591,935 |

The worksheet summarizes the aggregated costs for all the sectors, by scenarios, for each projected year. You may find this table (row 128) useful because it shows the total contraceptives costs across all sectors. Figure 17 displays the aggregated projected cost for 2010.

**Figure 17. Aggregated Projected Costs by Scenario, Year, and Method**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 128 | **Aggregated Total Costs by Method and Year** | | | | | | | | | |
| 129 | | | | | | | 2010 | | | |
| 130 | | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Scenario Total |
| 131 | Scenario 1 | slow growth | $ 141,089 | $ 555,496 | $ 94,273 | $ 36,110 | $ 56,972 | $ 5,478 | $ - | $ 889,417 |
| 132 | Scenario 2 | medium | $ 147,142 | $ 581,386 | $ 98,090 | $ 36,224 | $ 58,022 | $ 5,613 | $ - | $ 926,477 |
| 133 | Scenario 3 | aggressive | $ 159,249 | $ 633,166 | $ 105,724 | $ 36,352 | $ 61,697 | $ 5,748 | $ - | $ 1,001,935 |

Additionally, the aggregated cumulative cost, by each sector and scenario, is calculated for the five-year period. This information can be useful for advocacy purposes by bringing attention to the total future funding required to meet the expected contraceptive demand.

**Figure 18. Aggregated Contraceptive Financing Costs—All Five Years**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 136 | **Aggregated Contraceptive Financing Costs - All 5 Years** | | | | | | | | | |
| 137 | **MOH** | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Total |
| 138 | Scenario 1 | slow growth | $ 448,796 | $ 2,138,127 | $ 107,355 | $ – | $ 329,490 | $ 37,573 | $ – | $ 3,061,341 |
| 139 | Scenario 2 | medium | $ 509,797 | $ 2,462,948 | $ 121,040 | $ – | $ 346,579 | $ 39,845 | $ – | $ 3,480,208 |
| 140 | Scenario 3 | aggressive | $ 656,193 | $ 3,248,512 | $ 153,722 | $ – | $ 414,940 | $ 42,790 | $ – | $ 4,516,158 |
| 141 | Total | | $ 1,614,786 | $ 7,849,588 | $ 382,117 | $ – | $ 1,091,009 | $120,208 | $ – | $ 11,057,707 |
| 142 | | | | | | | | | | |
| 149 | **Total Public Sector** | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Total |
| 150 | Scenario 1 | slow growth | $ 448,796 | $ 2,138,127 | $ 107,355 | $ – | $ 329,490 | $ 37,573 | $ – | $ 3,061,341 |
| 151 | Scenario 2 | medium | $ 509,797 | $ 2,462,948 | $ 121,040 | $ – | $ 346,579 | $ 39,845 | $ – | $ 3,480,208 |
| 152 | Scenario 3 | aggressive | $ 656,193 | $ 3,248,512 | $ 153,722 | $ – | $ 414,940 | $ 42,790 | $ – | $ 4,516,158 |
| 153 | Total | | $ 1,614,786 | $ 7,849,588 | $ 382,117 | $ – | $ 1,091,009 | $120,208 | $ – | $ 11,057,707 |
| 154 | | | | | | | | | | |
| 155 | **NGO** | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Total |
| 156 | Scenario 1 | slow growth | $ 45,344 | $ 712,709 | $ 74,456 | $ 519,765 | $ – | $ – | $ – | $ 1,352,274 |
| 157 | Scenario 2 | medium | $ 51,508 | $ 820,983 | $ 83,947 | $ 545,661 | $ – | $ – | $ – | $ 1,502,099 |
| 158 | Scenario 3 | aggressive | $ 66,299 | $ 1,082,837 | $ 106,614 | $ 584,833 | $ – | $ – | $ – | $ 1,840,583 |
| 159 | Total | | $ 163,151 | $ 2,616,529 | $ 265,017 | $1,650,259 | $ – | $ – | $ – | $ 4,694,956 |
| 160 | | | | | | | | | | |
| 161 | | | | | | | | | | |
| 162 | **IPPF** | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Total |
| 163 | Scenario 1 | slow growth | $ 39,903 | $ 155,334 | $ 161,379 | $ – | $ – | $ – | $ – | $ 356,616 |
| 164 | Scenario 2 | medium | $ 45,327 | $ 178,932 | $ 181,950 | $ – | $ – | $ – | $ – | $ 406,209 |
| 165 | Scenario 3 | aggressive | $ 58,343 | $ 236,003 | $ 231,079 | $ – | $ – | $ – | $ – | $ 525,425 |
| 166 | Total | | $ 143,573 | $ 570,269 | $ 574,408 | $ – | $ – | $ – | $ – | $ 1,288,250 |
| 167 | | | | | | | | | | |
| 168 | **Social Marketing** | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Total |
| 169 | Scenario 1 | slow growth | $ 380,893 | $ – | $ 186,140 | $ – | $ – | $ – | $ – | $ 567,032 |
| 170 | Scenario 2 | medium | $ 432,664 | $ – | $ 209,867 | $ – | $ – | $ – | $ – | $ 642,531 |
| 171 | Scenario 3 | aggressive | $ 556,911 | $ – | $ 266,535 | $ – | $ – | $ – | $ – | $ 823,445 |
| 172 | Total | | $ 1,370,467 | $ – | $ 662,541 | $ – | $ – | $ – | $ – | $ 2,033,009 |
| 173 | | | | | | | | | | |
| 174 | **MSI** | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contra | Total |
| 175 | Scenario 1 | slow growth | $ – | $ 148,024 | $ 131,596 | $ – | $ – | $ – | $ – | $ 279,620 |
| 176 | Scenario 2 | medium | $ – | $ 170,512 | $ 148,371 | $ – | $ – | $ – | $ – | $ 318,883 |
| 177 | Scenario 3 | aggressive | $ – | $ 224,897 | $ 188,434 | $ – | $ – | $ – | $ – | $ 413,331 |
| 178 | Total | | $ – | $ 543,433 | $ 468,401 | $ – | $ – | $ – | $ – | $ 1,011,834 |

The Financing Costs by Sector, Scenario and Year summarizes each sector's financing needs, by year and scenario. Only the MOH is shown in figure 19.

**Figure 19. Financing Costs by Sector, Scenario and Year**

| | A | B | C | D | E | F | G | H | I | L |
|---|---|---|---|---|---|---|---|---|---|---|
| 187 | **Financing costs by Sector, Scenario and Year** | | | | | | | | | |
| 188 | MOH | Scenario 1 | | | | | | | | |
| 189 | | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | Total |
| 190 | | 2010 | $ 69,207 | $ 376,553 | $ 15,313 | $ - | $ 56,972 | $ 5,478 | $ - | $ 523,523 |
| 191 | | 2011 | $ 79,470 | $ 403,324 | $ 18,354 | $ - | $ 61,459 | $ 6,469 | $ - | $ 569,076 |
| 192 | | 2012 | $ 90,283 | $ 431,478 | $ 21,560 | $ - | $ 66,013 | $ 7,485 | $ - | $ 616,818 |
| 193 | | 2013 | $ 99,903 | $ 452,493 | $ 24,520 | $ - | $ 70,323 | $ 8,530 | $ - | $ 655,768 |
| 194 | | 2014 | $ 109,932 | $ 474,279 | $ 27,608 | $ - | $ 74,724 | $ 9,612 | $ - | $ 696,155 |
| 195 | | | | | | | | | | $ 3,061,341 |
| 196 | MOH | Scenario 2 | | | | | | | | |
| 197 | | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | Total |
| 198 | | 2010 | $ 72,177 | $ 394,103 | $ 15,933 | $ - | $ 58,022 | $ 5,613 | $ - | $ 545,847 |
| 199 | | 2011 | $ 86,197 | $ 441,457 | $ 19,802 | $ - | $ 63,680 | $ 6,775 | $ - | $ 617,910 |
| 200 | | 2012 | $ 101,656 | $ 493,590 | $ 24,071 | $ - | $ 69,529 | $ 8,000 | $ - | $ 696,845 |
| 201 | | 2013 | $ 116,700 | $ 541,148 | $ 28,308 | $ - | $ 74,900 | $ 9,136 | $ - | $ 770,192 |
| 202 | | 2014 | $ 133,068 | $ 592,651 | $ 32,926 | $ - | $ 80,448 | $ 10,321 | $ - | $ 849,414 |
| 203 | | | | | | | | | | $ 3,480,208 |
| 204 | MOH | Scenario 3 | | | | | | | | |
| 205 | | | Pills | Injectables | Condoms (male) | Condoms (female) | Implants | IUD | Emergency Contraceptives | Total |
| 206 | | 2010 | $ 78,115 | $ 429,203 | $ 17,173 | $ - | $ 61,697 | $ 5,748 | $ - | $ 591,935 |
| 207 | | 2011 | $ 100,540 | $ 522,987 | $ 22,883 | $ - | $ 71,784 | $ 7,089 | $ - | $ 725,284 |
| 208 | | 2012 | $ 127,488 | $ 635,572 | $ 29,748 | $ - | $ 82,901 | $ 8,543 | $ - | $ 884,252 |
| 209 | | 2013 | $ 157,347 | $ 758,045 | $ 37,415 | $ - | $ 93,514 | $ 9,951 | $ - | $ 1,056,273 |
| 210 | | 2014 | $ 192,702 | $ 902,706 | $ 46,503 | $ - | $ 105,044 | $ 11,459 | $ - | $ 1,258,414 |
| 211 | | | | | | | | | | $ 4,516,158 |

# B. Results – Summary Tables

Additional results are presented in figure 20, *B. Results – Summary Tables*. The projected quantities and costs from the *A. Results – Commodity Projection* worksheet are aggregated into annual commodity requirements and costs, by scenario, as shown in the following two tables. You can use these tables to show a macro-level example of the commodity requirements and costs needed annually, based on different demand increases (i.e., slow, medium, and aggressive growth). The aggregation of contraceptive requirements is only provided to show how costs were determined. More helpful information on contraceptive requirements is provided in the *A. Results – Commodity Projections* worksheet.

**Figure 20. Summary Tables by Commodity Requirements and Cost**

## Summary Tables

### Aggregated contraceptive requirements by year

| | | 2010 | 2011 | 2012 | 2013 | 2014 | Total |
|---|---|---|---|---|---|---|---|
| Scenario 1 | slow growth | 3,806,771 | 4,091,601 | 4,393,678 | 4,630,410 | 4,879,155 | 21,801,615 |
| Scenario 2 | medium | 3,983,476 | 4,480,473 | 5,035,046 | 5,557,469 | 6,133,249 | 25,189,713 |
| Scenario 3 | aggressive | 4,336,451 | 5,310,194 | 6,497,487 | 7,820,300 | 9,411,414 | 33,375,846 |
| | Total | 12,126,698 | 13,882,267 | 15,926,212 | 18,008,179 | 20,423,819 | 80,367,175 |
| | | | | | | | 80,367,175 |

### Aggregated contraceptive financing costs by year

| | | 2010 | 2011 | 2012 | 2013 | 2014 | Total |
|---|---|---|---|---|---|---|---|
| Scenario 1 | slow growth | $ 1,402,212 | $ 1,504,787 | $ 1,599,446 | $ 1,378,650 | $ 1,772,984 | $ 7,658,078 |
| Scenario 2 | medium | $ 1,465,792 | $ 1,644,575 | $ 1,827,745 | $ 1,646,739 | $ 2,217,877 | $ 8,802,728 |
| Scenario 3 | aggressive | $ 1,594,156 | $ 1,945,667 | $ 2,352,701 | $ 2,307,228 | $ 3,388,996 | $ 11,588,748 |
| | Total | $ 4,462,159 | $ 5,095,028 | $ 5,779,893 | $ 5,332,617 | $ 7,379,857 | $ 28,049,554 |

After you know the cost of the contraceptives, the information is linked to the funding commitments information entered in the 5. Input – Funding worksheet, and a funding gap or surplus is generated. Depending on whether table A or table B was completed in the *5. Input – Funding* worksheet, the subsequent tables will produce the funding gap or surplus in the *B. Results – Summary Tables* worksheet (see figure 21). Funding gaps are shown in parentheses. The following sample image shows the funding gap, by source and year, for scenario 1.

**Figure 21. Contraceptive Financing Needs by Scenario by Source and Year**

## Contraceptive Financing Needs by Scenario

| Scenario 1 | 2010 | 2011 | 2012 | 2013 | 2014 | Total for 5 Years | As % of Total |
|---|---|---|---|---|---|---|---|
| Pills | $ 141,089 | $ 162,011 | $ 184,056 | $ 203,667 | $ 224,113 | $ 914,936 | 16% |
| Injectables | $ 555,496 | $ 594,989 | $ 636,522 | $ 667,524 | $ 699,663 | $ 3,154,194 | 56% |
| Condoms (male) | $ 94,273 | $ 112,998 | $ 132,736 | $ 150,953 | $ 169,966 | $ 660,925 | 12% |
| Condoms (female) | $ 36,110 | $ 69,589 | $ 103,418 | $ 137,768 | $ 172,880 | $ 519,765 | 9% |
| Implants | $ 56,972 | $ 61,459 | $ 66,013 | $ 70,323 | $ 74,724 | $ 329,490 | 6% |
| IUD | $ 5,478 | $ 6,469 | $ 7,485 | $ 8,530 | $ 9,612 | $ 37,573 | 1% |
| Emergency Contraceptives | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| other | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| 0 | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| TOTAL | $ 889,417 | $ 1,007,515 | $ 1,130,228 | $ 1,238,765 | $ 1,350,958 | $ 5,616,883 | 100% |
| | | | | | | TRUE | |

## Funding Commitments by SOURCE and YEAR

| Scenario 1 | 2010 | 2011 | 2012 | 2013 | 2014 | Total | Total |
|---|---|---|---|---|---|---|---|
| Government | | | | | | | |
| Ministry of Health | $ 50,000 | $ - | $ - | $ - | $ - | $ 50,000 | 6% |
| Other | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| 0 | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| 0 | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| Donors/Non-profit | | | | | | | |
| UNFPA | $ 100,000 | $ - | $ - | $ - | $ - | $ 100,000 | 12% |
| USAID | $ 270,000 | $ - | $ - | $ - | $ - | $ 270,000 | 32% |
| IPPF | $ 79,000 | $ - | $ - | $ - | $ - | $ 79,000 | 9% |
| NGO | $ 157,000 | $ - | $ - | $ - | $ - | $ 157,000 | 19% |
| Social marketing | $ 130,000 | $ - | $ - | $ - | $ - | $ 130,000 | 15% |
| MSI | $ 58,000 | $ - | $ - | $ - | $ - | $ 58,000 | 7% |
| Commerical | | | | | | | |
| 0 | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| 0 | $ - | $ - | $ - | $ - | $ - | $ - | 0% |
| TOTAL | $ 844,000 | $ - | $ - | $ - | $ - | $ 844,000 | 100% |
| | | | | | | $ 844,000 | $ - |

## Funding Gap/Surplus

| Scenario 1 | 2010 | 2011 | 2012 | 2013 | 2014 | Gap/Surplus | |
|---|---|---|---|---|---|---|---|
| Total Gap/Surplus | $ (45,417) | $ (1,007,515) | $ (1,130,228) | $ (1,238,765) | $ (1,350,958) | $ (4,772,883) | |

The following sample, figure 22, shows the funding gap, by method and year, for scenario 1.

**Figure 22. Contraceptive Financing Needs by Scenario by Method and Year**

### Contraceptive Financing Needs by Scenario

| Scenario 1 | | 2010 | | 2011 | | 2012 | | 2013 | | 2014 | | Total for 5 Years | As % of Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pills | $ | 381,275 | $ | 409,871 | $ | 426,188 | $ | 143,745 | $ | 473,355 | $ | 1,834,435 | 24% |
| Injectables | $ | 741,794 | $ | 797,429 | $ | 856,439 | $ | 902,656 | $ | 951,222 | $ | 4,249,540 | 55% |
| Condoms (male) | $ | 213,952 | $ | 229,998 | $ | 247,018 | $ | 260,348 | $ | 274,356 | $ | 1,225,672 | 16% |
| Condoms (female) | $ | 6,093 | $ | 6,276 | $ | 6,458 | $ | 6,645 | $ | 6,836 | $ | 32,309 | 0% |
| Implants | $ | 54,390 | $ | 56,294 | $ | 58,208 | $ | 59,894 | $ | 61,619 | $ | 290,404 | 4% |
| IUD | $ | 4,707 | $ | 4,919 | $ | 5,135 | $ | 5,361 | $ | 5,596 | $ | 25,718 | 0% |
| Emergency Contraceptives | $ | - | $ | - | $ | - | $ | - | $ | - | $ | - | 0% |
| Other | $ | - | $ | - | $ | - | $ | - | $ | - | $ | - | 0% |
| Other | $ | - | $ | - | $ | - | $ | - | $ | - | $ | - | 0% |
| TOTAL | $ | 1,402,212 | $ | 1,504,787 | $ | 1,599,446 | $ | 1,378,650 | $ | 1,772,984 | $ | 7,658,078 | 100% |

### Funding commitments by METHOD and YEAR - From Table B

| Scenario 1 | | 2010 | | 2011 | | 2012 | | 2013 | | 2014 | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pills | $ | 347,000 | $ | 185,000 | $ | - | $ | - | $ | - | $ | 532,000 |
| Injectables | $ | 564,000 | $ | 345,000 | $ | - | $ | - | $ | - | $ | 909,000 |
| Condoms (male) | $ | 73,000 | $ | 55,000 | $ | - | $ | - | $ | - | $ | 128,000 |
| Condoms (female) | $ | 3,000 | $ | - | $ | - | $ | - | $ | - | $ | 3,000 |
| Implants | $ | 55,000 | $ | 60,000 | $ | - | $ | - | $ | - | $ | 115,000 |
| IUD | $ | 2,000 | $ | 5,000 | $ | - | $ | - | $ | - | $ | 7,000 |
| Emergency Contraceptives | $ | - | $ | - | $ | - | $ | - | $ | - | | |
| Other | $ | - | $ | - | $ | - | $ | - | $ | - | | |
| Other | $ | - | $ | - | $ | - | $ | - | $ | - | $ | - |
| TOTAL | $ | 1,044,000 | $ | 650,000 | $ | - | $ | - | $ | - | $ | 1,694,000 |

### Funding Gap/Surplus

| Scenario 1 | | 2010 | | 2011 | | 2012 | | 2013 | | 2014 | | Total Gap/Surplus |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pills | $ | (34,275) | $ | (224,871) | $ | (426,188) | $ | (143,745) | $ | (473,355) | $ | (1,302,435) |
| Injectables | $ | (177,794) | $ | (452,429) | $ | (856,439) | $ | (902,656) | $ | (951,222) | $ | (3,340,540) |
| Condoms (male) | $ | (140,952) | $ | (174,998) | $ | (247,018) | $ | (260,348) | $ | (274,356) | $ | (1,097,672) |
| Condoms (female) | $ | (3,093) | $ | (6,276) | $ | (6,458) | $ | (6,645) | $ | (6,836) | $ | (29,309) |
| Implants | $ | 610 | $ | 3,706 | $ | (58,208) | $ | (59,894) | $ | (61,619) | $ | (175,404) |
| IUD | $ | (2,707) | $ | 81 | $ | (5,135) | $ | (5,361) | $ | (5,596) | $ | (18,718) |
| Other | $ | - | $ | - | $ | - | $ | - | $ | - | $ | - |
| Total Gap/Surplus | $ | (358,212) | $ | (854,787) | $ | (1,599,446) | $ | (1,378,650) | $ | (1,772,984) | $ | (5,964,078) |

Figure 22 shows a funding gap starting in 2010 and a growing gap in 2011 to 2014 for scenario 1. You can use the data in the Funding Gap/Surplus table as a starting point to begin discussions with the government, donors, NGOs, social marketing organizations, and the private sector to fill the funding gap and, also, to determine financing options and next steps.

After you present all the results, you will need to decide how to use this information to strengthen financing for contraceptives. You may want to review the financing scenarios with colleagues and

select the scenario that is the most realistic. From there, you can use the financing strategies presented in the *Contraceptive Financial Sustainability: A Primer* (in the first section called Options for Increasing Financing Sustainability of Contraceptives) (http://deliver.jsi.com) to help you decide which options to implement and to help you develop a strategy to operationalize these into actions. The Future Strategy Development and Implementation chapter in the primer provides additional information on the process of developing a strategic plan for contraceptive financial sustainability.

# Strategic Options for Future Markets

This section includes background information that you can use when you look at different market share possibilities and how to calculate different scenarios using the worksheet in the tool, *Scenario1 – Market Share.*

Governments who want to diversify and share the responsibility in providing contraceptives may want to determine how financing can be changed if market shares change. One possible next step after completing the estimated projections and determining the funding gap is to look at the current contraceptive market and find potential areas for change in the market. Making adjustments to decrease or increase the provision of methods between sectors can demonstrate the impact this will have on cost. For example, in Albania, the public sector would like to focus more government funding toward longer-term methods and shift individuals who can pay to the private sector or social marketing sources. To understand the cost impact of this change, adjustments were made to move more users of injectables to the public sector and to increase the share of resupply methods— for example, condoms—to the other sectors. The tool can show just how much of a difference in cost this would have on all of the sectors.

This tool enables you to try out different sector mixes to estimate how these changes will impact the budget of each sector in the *Scenario1 – Market Share* worksheet for each of the scenarios (there is a market share worksheet for each scenario: *Scenario1 – Market Share, Scenario2 – Market Share*, and *Scenario3 – Market Share*). For example, there could be a growing commercial sector market that will absorb more demand from contraceptive users. Adjustments can be made to increase the percentage f the commercial sector market share to see how this will affect cost. Another example could be donor phaseout of public sector contraceptives and the need to understand the financial impact this will have on the government as they prepare to absorb more of the financial responsibility in providing public-sector contraceptives. Trying out these changes to see the impact on cost can help inform decisions and can also be used for advocacy purposes to mobilize resources and increase awareness of how changes in the market can affect cost.

The tool enables you to adjust the market share for each method. It shows the cost comparisons between the current and adjusted markets. Each scenario will have its own worksheet for adjustments. Each worksheet contains the projected commodities generated from the *A. Results – Commodity Projection* worksheet. The market adjustments are made based on the estimated commodities.

The markets are grouped into three categories: Public, Private Non-Profit, and Commercial Sector; see the following example.

 **Enter data into worksheet: Scenario1 – Market Share**

To use this worksheet—

• Enter new market share percentages for each method and sector in the grey cells in the Market Share table (this table will already include the current market share taken from the forecast of the baseline year from the *3. Inputs – Contraceptive Forecast* worksheet).

In the following sample table, new percentages were entered to (1) incrementally increase the share of private non-profits for pills from 35 percent in 2009 to 53 percent in 2014 and (2) decrease the public provision of injectables from 68 percent to 55 percent (the new percentages are shown in red) (figure 23).

**Figure 23. Example of Adjusting Market Share**

| | | Market Share | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Pills | | | | Injectables | | | |
| | | | | Priv | | | | Priv | | |
| | | Public | NonProf | Commercial | Total | Public | NonProf | Commercial | Total |
| INPUT | Adjust market share for each method as desired → | 2009 | 65% | 35% | 0% | 100% | 68% | 32% | 0% | 100% |
| | | 2010 | 60% | 40% | 0% | 100% | 65% | 35% | 0% | 100% |
| | | 2011 | 55% | 42% | 3% | 100% | 60% | 35% | 5% | 100% |
| | | 2012 | 50% | 45% | 5% | 100% | 58% | 37% | 5% | 100% |
| | | 2013 | 45% | 50% | 5% | 100% | 55% | 40% | 5% | 100% |
| | | 2014 | 40% | 53% | 7% | 100% | 55% | 40% | 5% | 100% |

As shown in figure 24, these changes result in an increase in the private non-profit cost of pills from U.S.$53,142[1] to $68,553 in one year (2010) when the share changes from 35 percent to 40 percent. The cost for public sector injectables decreases from $376,553 to $362,118 in 2010, when the public sector share changes from 68 percent to 65 percent. The total cost of injectables across all sectors for 2010 increases from $568,139 to $569,021. This information can give you an idea of how costs will increase when one sector increases or decreases their provision of contraceptives.

The worksheet includes a table of the costs in the current market and a table of the adjusted market costs. The following sample table (see figure 24) shows the cost comparison between the current and adjusted market (highlighted in light blue) for pills and injectables.

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[1] From this point forward, all dollar amounts are U.S. dollars.

**Figure 24. Example of Comparison of Current and Adjust Market Share and Cost**

**OUTPUT**

## Current market share and cost

### Current Commodity Costs

| | | Pills | | | | Injectables | | |
|---|---|---|---|---|---|---|---|---|
| | Public | Private Non Profit | Commercial | Total | Public | Private Non Profit | Commercial | Total |
| 2009 | $ 59,385 | $ 45,600 | $ - | $ 104,985 | $ 351,000 | $ 178,585 | $ - | $ 529,585 |
| 2010 | $ 69,207 | $ 53,142 | $ - | $ 122,350 | $ 376,553 | $ 191,586 | $ - | $ 568,139 |
| 2011 | $ 79,470 | $ 61,023 | $ - | $ 140,493 | $ 403,324 | $ 205,207 | $ - | $ 608,531 |
| 2012 | $ 90,283 | $ 69,326 | $ - | $ 159,609 | $ 431,478 | $ 219,531 | $ - | $ 651,009 |
| 2013 | $ 99,903 | $ 76,713 | $ - | $ 176,616 | $ 452,493 | $ 230,223 | $ - | $ 682,716 |
| 2014 | $ 109,932 | $ 84,414 | $ - | $ 194,346 | $ 474,279 | $ 241,308 | $ - | $ 715,588 |
| | $ 448,796 | $ 344,617 | $ - | $ 793,413 | $ 2,138,127 | $ 1,087,856 | $ - | $ 3,225,982 |

## Adjusted Commodity Projections

### Adjusted Market Commodity Costs

| | | Pills | | | | Injectables | | |
|---|---|---|---|---|---|---|---|---|
| | Public | Private Non Profit | Commercial | Total | Public | Private Non Profit | Commercial | Total |
| 2009 | $ 59,385 | $ 51,600 | $ - | $ 110,985 | $ 351,000 | $ 178,585 | $ - | $ 529,585 |
| 2010 | $ 63,970 | $ 68,553 | $ - | $ 132,523 | $ 362,118 | $ 206,903 | $ - | $ 569,021 |
| 2011 | $ 67,335 | $ 82,655 | $ 44,486 | $ 194,476 | $ 358,028 | $ 221,613 | $ 47,406 | $ 627,046 |
| 2012 | $ 69,542 | $ 100,609 | $ 84,231 | $ 254,383 | $ 370,252 | $ 250,629 | $ 50,715 | $ 671,596 |
| 2013 | $ 69,257 | $ 123,699 | $ 93,206 | $ 286,162 | $ 368,202 | $ 284,147 | $ 53,185 | $ 705,534 |
| 2014 | $ 67,742 | $ 144,284 | $ 143,588 | $ 355,614 | $ 385,930 | $ 297,829 | $ 55,745 | $ 739,504 |
| | $ 337,846 | $ 519,801 | $ 365,510 | $ 1,223,158 | $ 1,844,529 | $ 1,261,121 | $ 207,050 | $ 3,312,700 |

The cost comparisons can be viewed in two other ways. The first table, Comparison of Market Costs: By Sector and Year, illustrates a side-by-side comparison of aggregated costs for each sector. The second table, Comparison of Old and Adjusted Market Costs by Sector and Method, presents a cumulative side-by-side comparison by sector and method. Both tables give you and stakeholders a quick view of the cost impact when you make changes to the market share. When the public sector decreases their provision of pills and injectables, the first table shows a decrease in yearly total costs for the public sector.

The second table shows what the cumulative change in costs would be for public sector injectables ($2.1 million to $1.8 million). Because the share of pills increased in the private non-profit sector, there was an overall increase in the potential financing of pills in the private non-profit sector, from $344,617 to $519,801. See figure 25.

**Figure 25. Comparison of Current and Adjusted Market Share**

## Tables - Comparison of Current and Adjusted Market Share

### Comparison of market costs: By Sector and Year

| | Public | | Private Non Profit | | Commercial | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Adjusted | Current | Adjusted | Current | Adjusted | Current | Adjusted | Current |
| 2010 | $ 494,706 | $ 515,867 | $ 354,976 | $ 366,247 | $ 134,552 | $ - | $ 984,234 | $ 882,113 |
| 2011 | $ 500,684 | $ 559,900 | $ 408,519 | $ 438,966 | $ 264,781 | $ - | $ 1,173,983 | $ 998,866 |
| 2012 | $ 521,976 | $ 606,039 | $ 481,063 | $ 514,078 | $ 347,602 | $ - | $ 1,350,641 | $ 1,120,116 |
| 2013 | $ 526,188 | $ 643,509 | $ 562,336 | $ 583,816 | $ 397,131 | $ - | $ 1,485,655 | $ 1,227,325 |
| 2014 | $ 549,128 | $ 682,352 | $ 622,094 | $ 655,758 | $ 489,494 | $ - | $ 1,660,715 | $ 1,338,110 |
| Total | $ 2,592,683 | $ 3,007,666 | $ 2,428,988 | $ 2,558,864 | $ 1,633,558 | $ - | $ 6,655,228 | $ 5,566,530 |
| As % of Total | 39% | 54% | 36% | 46% | 25% | 0% | 100% | 100% |

### Comparison of old and adjusted market costs by sector and method

| | Public | | Private Non Profit | | Commercial | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Adjusted | Current | Adjusted | Current | Adjusted | Current | Adjusted | Current |
| Pills | $ 337,846 | $ 448,796 | $ 519,801 | $ 344,617 | $ 365,510 | $ - | $ 1,223,158 | $ 793,413 |
| Injecta | $ 1,844,529 | $ 2,138,127 | $ 1,261,121 | $ 1,087,856 | $ 207,050 | $ - | $ 3,312,700 | $ 3,225,982 |
| Condoms | $ 43,244 | $ 53,680 | $ 471,499 | $ 591,339 | $ 831,568 | $ - | $ 1,346,310 | $ 645,020 |
| Condoms | $ - | $ - | $ 176,567 | $ 535,052 | $ 229,430 | $ - | $ 405,997 | $ 535,052 |
| Impla | $ 329,490 | $ 329,490 | $ - | $ - | $ - | $ - | $ 329,490 | $ 329,490 |
| IUD | $ 37,573 | $ 37,573 | $ - | $ - | $ - | $ - | $ 37,573 | $ 37,573 |
| Emergency Contr | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| other | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Total | $ 2,592,683 | $ 3,007,666 | $ 2,428,988 | $ 2,558,864 | $ 1,633,558 | $ - | $ 6,655,228 | $ 5,566,530 |
| As % of Total | 39% | 54% | 36% | 46% | 25% | 0% | 100% | 100% |

Additionally, the worksheet shows the changes for each sector, for each method, in a graph, as shown in figure 26. The current market share shows that the public sector provides 100 percent of IUDs and implants; they will continue do so through 2014. The public sector's provision of pills will decrease from 65 percent in 2009 to 49 percent by 2014; while the private non-profit and commercial sectors will increase the pills they will provide from 35 percent to 47 percent and 0 percent to 4 percent, respectively.

**Figure 26. Current and Adjusted CYP Market Share**
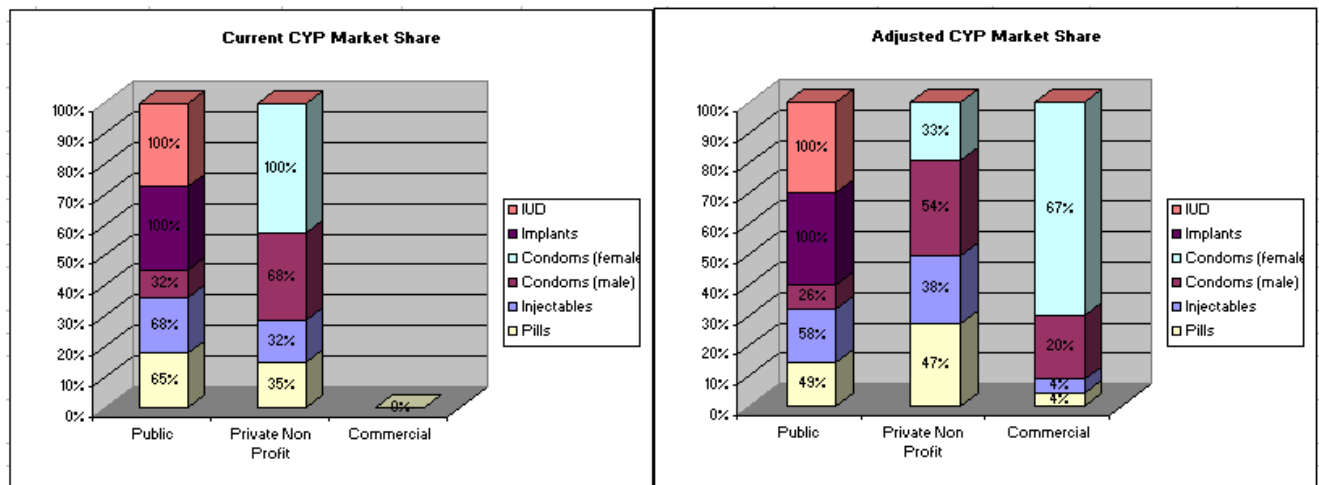


After you generate the costs for each of the scenarios, you can use the findings to consider, anticipate, and plan for financial sustainability. For example, if one scenario was to increase government financing of contraceptives over the next five years, the tool shows what this might cost over five years; the results will enable the government to devise options and develop a financial sustainability strategy to ensure that they have sufficient financing. One of the financial sustainability activities in the strategy could be to advocate for a budget line specifically for procuring contraceptives. To save resources, another activity could be to seek access to less expensive commodity costs, enabling the government to procure additional contraceptives.

Another scenario could have the social marketing sector provide more resupply methods. The tool could be used to increase the percentage of contraceptives that they provide to determine the impact on financing for both the public and social marketing sectors. The results could be used to advocate for increasing engagement with social marketing organizations to share the financing burden of contraceptives. A case study in appendix A is an example of how the tool was used to develop scenarios and look at their financial impact.

After you share the results with the stakeholders and everyone agrees on which scenario to pursue, another important phase begins—preparing a strategic plan and beginning implementation.

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## Appendix A

# Fictitious Case Study— Translating Costing Results into Strategy

## Introduction

Modern contraceptive use in Nayabel continued to grow at a steady, rapid pace—the contraceptive prevalence rate (CPR) for modern methods was at 8 percent in 2005; it increased to 15 percent by 2007. Modern methods made up the largest increase between 2005 and 2007, with traditional methods falling, correspondingly, from 67 percent to 38 percent. It is anticipated that modern method use will continue to grow, especially for condoms, oral pills, and injectables. The 2008 National Contraceptive Security Strategy emphasizes and highlights the importance of the availability of contraceptives. The Ministry of Health (MOH) has demonstrated a commitment toward providing family planning products by setting a goal to achieve contraceptive independence by 2015, when all public sector contraceptives will be financed 100 percent by the Government of Nayabel. Currently, only one donor is providing contraceptives in Nayabel; as 2015 approaches, that donor will become the procurement agent for the MOH.

## Background

As the use of modern contraceptives increases, and as a large segment of a growing population reach reproductive age, more financial resources are needed to meet demand. To achieve contraceptive independence, the country is looking beyond the public sector, toward the private sector—which is made up of social marketing and commercial providers—to become partners in providing and financing contraceptives in Nayabel. The private sector already plays a major role in procuring and distributing contraceptives. SOMA, the only social marketing organization providing contraceptives in Nayabel, makes up 36 percent of the market for couple-years of protection (CYP) coverage; the commercial market provides 30 percent and the public sector provides 34 percent.

## Looking at Different Financing Scenarios

To understand the contraceptive financing in Nayabel, the country used the financial sustainability tool to do a financial sustainability analysis; they looked at the current demand and projected future needs, developed various scenarios, and estimated their costs for all sectors. The tool enabled the country to look at a number of possible contraceptive scenarios to determine how changes in demand for modern methods from 2009 to 2013 might affect financing. This first step was done by a smaller financial sustainability technical working group comprising staff from the MOH. The three

modern methods in this analysis included three resupply methods: condoms, oral contraceptives, and injectables; and one long-acting permanent method (LAPM), IUDs. After the group entered the required data in the input sheets, three different scenarios were created to reflect possible changes in CPR growth in the country: slow, medium, and aggressive. Consumption data from the Institute of Public Health, social marketing, and commercial sectors were used as the contraceptive baseline for the projections. From these results, one scenario was chosen as the financial sustainability model that the group agreed would be the most realistic and feasible to implement.

Scenario 3, with aggressive CPR growth, was selected as the most likely scenario for financial sustainability; the demand for modern methods would increase from 22 percent to 37 percent, with more aggressive growth in resupply methods and modest growth in IUDs by 2013. The cumulative five-year financial cost (inclusive of the public sector, social marketing, and commercial sector) of this scenario would be $8.46 million. It would cost the public sector $506,500 in the absence of any market, or unit cost changes, over a five-year period. The total financial costs for the other two scenarios would be $7.06 million and $8.50 million.

## Changing Market Share and the Impact on Financing

The government wants to focus more of its financial resources on long-term methods rather than resupply methods. The MOH would also like to continue providing free contraceptives for anyone unable to pay, especially those residing in rural areas. To determine the impact on costs through 2013, the next step in the analysis was to look at how making adjustments reflected the desired changes (by the MOH) in the market, in each of the sectors. They used the Market Share worksheet to estimate the impact of increasing the public share of long-term methods, while increasing the private sector's share of resupply methods (by shifting the public sectors share of resupply methods to the private sector).

They made following changes to the current market share:

- Condoms:
  - The public sector would maintain the current share of 11 percent of condoms through 2013.
  - The commercial sector's condom market would increase from 31 percent to 50 percent to meet both the increasing demand for contraceptives and the users' preference to easily access these methods at numerous retail sites.

- Oral pills: The public sector would decrease their provision of oral pills from 30 percent to 25 percent. To balance this reduction, social marketing's share of oral pills would increase from 21 percent to 40 percent by 2013, mainly by introducing a new oral pill, priced between *Femna* and *Microgyon.* Femna is the least expensive and only affordable oral pill on the market for all income quintiles. Microgynon, the second most expensive pill, is affordable to only 20 percent of couples.

- Injectables: The private sector share of injectables would increase from 0 percent to 10 percent. Injectables would be more accessible if the commercial sector is encouraged to begin offering this method to those willing to pay higher costs; and if they are willing to diversify the source of injectables from the public sector, who provide approximately 70 percent of this method at this time.

- IUDs: To help expand the use of LAPMs, IUDs could be introduced and sold through the commercial sector, increasing their share from 8 percent to 13 percent. Currently, more than 90 percent of IUDs are accessible only at public sector health facilities. This will to provide more sources for users and will give those who can afford commercial sector prices a choice in buying this method from the private sector.

After these adjustments are made, the cost to the public sector from 2009 to 2013 would be $471,000, which is less than the current cost of $506,465. The reduction is due to the following:

- The number of condoms and injectables in the public sector do not increase and orals pills offered by the public sector do decrease.

- The public sector continues to provide IUDs and injectables, which are lower cost resupply methods per CYP than pills and condoms. Additionally, the MOH can obtain these at significantly lower costs than other sectors because they purchase through the procurement agent. IUDs are the most affordable of all the modern methods over the long term.

- Shifting condoms and pills to the social marketing commercial sector also decreases the overall financing of the public sector.

To secure buy-in from the public- and private-sector stakeholders, a stakeholder workshop was held to discuss the results and recommendations for implementing the changes, increasing the public sector's provision of longer-term methods, and shifting more of the resupply methods to the private sectors. The participants developed an financial sustainbability plan, based on the feedback and recommendations they received at the stakeholder workshop. The recommendations to achieve financial sustainability included relaxing regulations to enable more private-sector organizations to sell contraceptives and to have private practices for clients who prefer to obtain their contraceptives from this sector. Another recommendation was to change the regulatory policy to exempt condoms and pills from being taxed, thereby encouraging more pharmacies to have these products available for clients. The financial sustainability implementation plan offered a number of other steps and actions for the Contraceptive Security Technical Working Group to improve contraceptive financial sustainability in Nayabel.

# Appendix B

# Key Resources to Assess the Current Contraceptive Context

**Table 26: Key Resources**

| Resource | Information Provided | Source |
|---|---|---|
| Demographic Surveys : <br> • DHS <br> • Multi-Indicator Cluster Survey (MICS) <br> • Reproductive Health Survey (RHS) | • Contraceptive prevalence rate (CPR) <br> • Method mix <br> • Unmet need <br> • Reasons for not using <br> • Future using intentions <br> • Fertility preferences <br> • Source of supply preferences <br> • Sector shares (may be incomplete) | Demographic and Health Survey: available at www.measuredhs.com <br> MICS: available at http://www.childinfo.org <br> RHS: available at http://www.cdc.gov/reproductivehealth/surveys/index.htm <br><br> Sources for other socio-demographic data: <br> http://apps.who.int/whosis/data/ <br> http://www.prb.org/datafinder.aspx |
| National strategies and reports: health, reproductive health (RH), family planning, HIV and AIDS | • Strategies, priorities, health indicators <br> • Goals and targets for CPR, fertility | Available in-country from MOH |
| Program reports: annual reports, strategies, marketing plans (nongovernmental organizations [NGOs], small and medium enterprises, faith-based organizations) | • May include service, commodity, and financial data, source of funds, current coverage, growth plans, etc. | From program or organization websites |
| Facility surveys (e.g., service provision assessments) | • Information on extent and quality of services | Service provision assessments (SPAs) available online at www.measuredhs.com |

**Table 26: Key Resources**

| Resource | Information Provided | Source |
|---|---|---|
| Poverty Reduction Strategy Paper (PRSP) | • Commitment: place of RH and family planning as a national priority<br><br>• Goals for CPR, fertility, etc. | Available at http://www.imf.org/external/np/prsp/prsp.aspx or in-country from MOH or World Bank |
| Global Fund to Fight AIDS, Tuberculosis and Malaria:<br>• Proposals<br>• Procurement and supply management (PSM) plan | • Proposals:<br>  – Background information on health system and supply chain<br>  – Extent of support for RH and family planning from HIV and AIDS<br>• Procurement and supply management (PSM): procurement plans for condoms and other RH commodities | Proposals and PSMs available at http://www.theglobalfund.org/<br>More recent reports available in-country from Country Coordinating Mechanisms, Principal Recipient, MOH, or the National AIDS Coordinating Agency |
| Contraceptive Procurement Tables (CPTs) | • Current contraceptive quantification (may include logistics, demographic data) | MOH, USAID Mission, USAID \| DELIVER PROJECT (available at http://deliver.jsi.com) |
| PipeLine database | • Contraceptive quantification, procurement plan, historical consumption | MOH, USAID Mission, USAID \| DELIVER PROJECT (available at http://deliver.jsi.com) |
| RHI database | • Historical and upcoming shipment data for contraceptives from USAID, UNFPA, and IPPF | Available at http://rhi.rhsupplies.org/rhi/index.do |
| RH subaccounts | • Spending by sector, by financing source, financing agent on RH commodities | Available at http://www.who.int/nha/en/ or http://www.hs2020.org/section/topics/finance/nha |
| Stock status surveys (e.g., logistics indicators assessment tool) | • Historical stock status information at various levels of supply chain | In-country; may be available at www.deliver.jsi.com |
| Key informant interviews (MOH, RH commodity security committee members, donors, | • Insight into activities aiming to increase contraceptive use either overall or for a specific method(s) | In-country field office or assessment reports should have list of key RH technical assistance providers |

**Table 26: Key Resources**

| Resource | Information Provided | Source |
|---|---|---|
| organizations promoting or providing RH use and services, other technical assistance providers) | • Future commitments on financing of contraceptives | |
| SPARHCS | • Assessment reports and strategic plans | Available at www.deliver.jsi.com |
| Reproductive health information | • Country reports, data, surveys | Reproductive Health Supplies Coalition: www.rhsupplies.org<br><br>Supplies Information Database: http://www.rhsupplies.org/resources-tools/supplies-information-database-sid.html |

# Appendix C

# Contraceptive Forecasting

If you have not completed a contraceptive forecast or quantification, you will need to complete this step before entering data into the 3. Input – Contraceptive Forecast worksheet to produce the commodity requirements and costs for financial sustainability.

The starting point for estimating commodity and financing needs for financial sustainability planning should be the current contraceptive quantification and forecast. While the terms *quantification* and *forecasting* are often used interchangeably; strictly speaking, a forecast estimates future contraceptive demand for a given population and a given period of time, while a quantification estimates the actual quantity of contraceptives needed for the time period, considering the forecast, quantities of product on hand and already on order, safety/buffer stocks, lead time stocks, and desired stock level at the end of the period. Quantification refers to the entire process of estimating how many contraceptives are needed; part of this is the forecasting for future demand. Quantification is usually closely linked to procurement planning—determining what to buy and when. If a reliable quantification is not available, you may need to prepare one. If a reliable quantification is available, you can use it for this next step.

The differences between a quantification for financial sustainability planning and a quantification for procurement planning are as follows:

- For sustainability planning, you can prepare several quantification scenarios, based on different projections of contraceptive prevalence, different method mixes, different sector shares, and different commodity costs, etc. For procurement planning, the exact quantities to be procured will be determined.

- The timing for procurement planning is typically short- to medium-term, usually one to three years. For sustainability planning, the time may be longer, possibly up to five years. Beyond a period of five years, the quality of the forecast will be much lower because of increased uncertainty.

- Quantifications for financial sustainability planning, because of their hypothetical nature, are not linked to a procurement plan.

Three main types of data can be used to conduct a contraceptive forecast:

1. Demographic data, based on population surveys of contraceptive use, including the following software for demographic-based forecasting methodologies:

    – The SPECTRUM software and manual are available at http://www.futuresinstitute.org/Pages/Spectrum.aspx. The two most useful SPECTRUM applications for these purposes are Dem-Proj (population projections) and FamPlan (program costs).

- The Reality Check software user's guide is available at http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/RC-User_s-Guide-FINAL_updated.pdf.

2. Logistics data, based on the actual quantities of commodities obtained from a logistics management information system (LMIS).

3. Service statistics, based on client service statistics, typically from a health management information system (HMIS).

Table 2 describes each data source in greater detail and provides a summary of their respective strengths and weaknesses. Each type of data has its own strengths and weaknesses, and their availability and reliability will depend not only on their inherent characteristics, but also on the country and programmatic context. The best data for quantification is the data that is closest to the actual consumption of a product, by a client, in real time. Demographic data, due to its infrequent collection and sampling limitations, and because it is based on client responses from memory, has inherent flaws in forecasting. Service statistics data for contraceptives also has inherent flaws as it usually does not track actual quantities of products. Logisticians prefer consumption data—provided the data are of sufficient quality. If a country or program has a functioning health management information system (HMIS) and a weak or non-functioning logistics management information system (LMIS), then you should use the service statistic data. If both sources are unavailable, then demographic data obtained from the latest DHS or related source can be used to make commodity projections.

The following are suggestions for choosing data and methodology to use for a forecast:

- To determine which methodology and data source to use as the basis for determining contraceptive supply, you must evaluate the respective data. To do so, collect data from as many of these sources as possible to determine what exactly the data are based on and how reliable they are. Often, data from more than one source is combined to balance the limitations of each.

- If possible, use all three types of data, comparing the forecasts with actual consumption to determine forecast accuracy. While, in theory, each type of data should give the same answer in terms of quantities of commodities required; in practice, they rarely do. For example, a logistics-based forecast may provide an estimate of a financing need of $2 million, while a demographic quantification will estimate a need of only $1 million. There may be several reasons for this, which are related to the quality of different datasets and how current the datasets are. There are no easy answers on to how to deal with this situation.

- If different methodologies give similar answers (usually within 10 percent) for financial sustainability planning, demographic data may be the best to use as it is easier to link data to prevalence, and because national or program goals are usually expressed in terms of contraceptive use or unmet need. However, if the methodologies produce very different answers, you must use your best judgment as to which is best.

- Another important consideration for this work is that using demographic data makes it easier to use various demographic forecasting software programs, in particular SPECTRUM; but also Reality Check,[2] which enables you to easily change a number of variables, including

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[2] Reality Check is an Excel-based demographic forecasting and modeling software that is based on SPECTRUM. While simpler and easier to use than SPECTRUM, it is not as flexible.

contraceptive prevalence, fertility rate, method mix, and sector share. While you can translate commodity-based logistics data into prevalence and enter it in the software; in practice, this is cumbersome and is not recommended.

- You must decide whether to use demographic-based quantification or commodity-based quantification in developing scenarios. You can translate a commodity-based quantification into demographic prevalence, and vice versa; but it is advisable to only use SPECTRUM if you are using demographic data. However, you can use Excel worksheets, or a similar program, with any type of data.

- If you are using demographic data, enter all of the required inputs into the chosen software to generate the commodity quantities needed for each scenario. Remember that you may not be able to distinguish and disaggregate the data for the public sector from the various procurers (i.e., USAID, DFID, KfW, or UNFPA). The software will give commodity projections for the public sector, and you must disaggregate this further into commodity source, such as MOH, donor, etc.

- If you include the social marketing programs, you will produce a more complete forecast. Some countries will want to categorize social marketing under the public sector because social marketing organizations often depend on the government or developing partners for commodities, and public sector forecasts may have already included the amount to be set aside for social marketing. Therefore, take care that you do not double-count the commodities for these two sectors. To reflect the country context, enter the table headings in the *3. Input – Contraceptive Forecast* worksheet.

> See the references list for more details on forecasting methodology and the types of data that can be used and their comparative advantages (FPLM 2000a) (FPLM 2000b).
>
> Both documents are available at www.deliver.jsi.com.

- It may also be difficult to obtain consumption or forecast data from the private sector because the information is not always shared publicly. You may need to use assumptions based on survey data, or qualitative information from key informants, about the size of the private sector. If you use these, carefully document these assumptions in the notes section of the 3. Input – Contraceptive Forecast.

**Table 27. Types of Data for Quantifications and Forecasts**

| Type | Data | Source | Strengths | Weaknesses |
|---|---|---|---|---|
| Logistics | Records of quantities of commodities distributed to clients | • LMIS<br>• PipeLine<br>• Logistics records from various levels<br>• Sales records | • Actual commodity-based<br>• Data will include wastage, pipeline filling, etc.<br>• Data are brand-specific<br>• If logistics data linked to regular ordering, then may be more timely than service data | • Data quality and availability may vary from program to program<br>• Data may be incomplete (i.e., some facilities may not report)<br>• Often difficult to have reliable logistics data from the lowest level—quantities dispensed to users—and higher level issues data often does not accurately reflect consumption or demand (e.g., may reflect stockpiling)<br>• Stockouts may cause under-reporting<br>• Sales data (e.g., from social marketing organizations) may not reflect actual sales to users but higher-level sales/distribution figures |
| Service Statistics | Number of clients at facilities (new and continuing users) | • HMIS data | • May include logistics data<br>• In certain situations, data may be higher quality than logistics data | • Reliability and availability may vary from program to program<br>• Data often not brand-specific or even specific for all methods (e.g., progestin only pills (POP) and combined oral contraceptive (COC) conflated)<br>• Service data usually refers to new and continuing users and not consumption<br>• May need to draw inferences to translate client users to commodities (e.g., standard dispensing protocols); these may not be reliable<br>• Service data tend not to account for discontinuation leading to overestimates<br>• Data may be more difficult to access<br>• Often data not as timely as logistics data (more than one year after fact) |

| Type | Data | Source | Strengths | Weaknesses |
|------|------|--------|-----------|------------|
| Demographic | Population-based survey data | • DHS<br>• MICS<br>• RHS<br>• Other surveys | • Covers entire market<br>• Data usually readily available<br>• Provides information on all methods and not just supply-based ones (e.g., sterilization and traditional methods) | • Data not commodity-based; consumption inferred from responses<br>• Data usually not brand-specific<br>• Data may be several years old<br>• Estimate usage only; need to make separate estimation of waste, etc.<br>• Assumptions used to translate use into commodities may not be valid; more reliable for some methods than others<br>• If use of particular methods is low, significant sampling errors in data may occur<br>• Data based on respondent's memory and responses given |

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