



FP_{WATCH} RESEARCH BRIEF

The DRC 2015 FPwatch Survey: Findings from a contraceptive commodity and service assessment among public and private sector outlets



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Background

The Democratic Republic of the Congo (DRC) aims to achieve a contraceptive prevalence rate (CPR) of 19% by 2020 and to reach an additional 2.1 million women with modern contraceptive methods to achieve its national FP2020 commitments.

FAMILY PLANNING ENVIRONMENT IN THE DRC

The DRC's 2015 population was estimated at over 80 million people, with 45% of the population under age 15, a total fertility rate of 5.9 children per woman and a projected annual population growth of 2.7 percent.¹ The high growth rate, legacy of political instability and wide ranging cultural and geographical contexts present considerable challenges toward meeting the population's health and family planning (FP) needs. Less than half of the DRC's health zones provide public FP services and 28% of married women of reproductive age in the DRC have an unmet need for contraception.² According to the most recent Demographic and Health Survey (DHS 2013), 8.1% of DRC women (approximately 1.4 million women) are currently using a modern contraceptive method, with slow change and wide variation by geography and sociodemographic group.³ Traditional FP methods are used by more than half of women reporting using a contraceptive method. Among women using any modern method, more than half rely on condoms and other short-acting methods. There is low use of long-acting reversible contraceptive (LARC) or permanent methods (LARC/PMs).³

SECTOR ROLES IN CONTRACEPTIVE PROVISION

The public sector in the DRC has been weakened by political conflict and access to care is severely limited. Approximately 70% of health service costs in the public sector are covered by the user.² The private sector in the DRC extends throughout the country and has in many areas filled the gaps left by a struggling public sector. The pharmaceutical sector is largely unregulated with a large proportion of pharmacies unregistered and many products circulating without commercial authorization.² In addition to the public and private sectors, non-profit organizations also run clinics and hospitals throughout the country. In 2013, approximately half of DRC women received FP commodities and services from private sector sources, one-third from public sector sources and about 6% from not-for-profit sources.³

KEY STRATEGIES TO DATE

The Congolese government has demonstrated leadership in recent national efforts to improve FP and reproductive health (RH). **In 2012, DRC committed to the London Summit on Family Planning's FP2020 Initiative goals.**⁴ In 2014, the Ministry of Health (MoH) adopted the National Strategic Plan for Family Planning for 2014-2020.⁵ The two primary objectives of the plan are to increase modern contraceptive prevalence, estimated at 6.5% in 2013, to at least 19.0% by 2020; and to increase access to and use of modern contraceptive methods for at least 2.1 million additional women by 2020.⁵ The plan is organized around six focus areas, including government commitment for family planning, increasing access to services, improving service quality, promoting demand generation, enhancing contraceptive logistics systems management, and evaluating to measure results.⁵

KEY INTERVENTIONS

The DRC government and partners have taken a number of actions to address the high unmet need in the country and to improve contraceptive choice. These actions are designed to:⁵

- Obtain effective and concrete commitments of the government to support family planning products and services;
- Improve access for men and women to FP services in the public and private sectors, with an emphasis on access for youth;
- Increase the quality of family planning services;
- Generate demand for family planning;
- Develop and strengthen an efficient logistical system to manage contraceptives; and
- Implement a reliable evaluation system to measure results

References on this page:

¹The World Health Organization (WHO). 2015. *Democratic Republic of the Congo: WHO Statistical Profile*. Accessed on 8 June 2015 from: <http://www.who.int/gho/countries/cod.pdf?ua=1>.

²Mukaba T., et al. 2015. Family Planning Policy Environment in the DRC: Levers of Positive Change and Prospects for Sustainability. *Glob Health Sci Pract* 3(2): 163-73.

³Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) et ICF International, 2014. Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014. Rockville, Maryland, USA: MPSMRM, MSP et ICF International.

⁴FP2020. 2016. The DRC. Accessed on 1 September 2016 from: <http://www.familyplanning2020.org/entities/85/resources>.

⁵Secrétaire Général à la Santé, MSP. *DRC Family Planning: National Multisectoral Strategic Plan (2014-2020)*. Kinshasa, DRC: MSP.

FPwatch at a glance

WHAT IS FPWATCH?

FPwatch is a multi-country research project implemented by Population Services International (PSI) with funding from the Bill and Melinda Gates Foundation (BMGF) and the Three Millennium Development Goal (3MDG) Fund. Standardized tools and approaches are employed to provide comparable data across countries and over time. FPwatch is a response to the Family Planning 2020 (FP2020) goal to **enable 120 million additional women and girls to have informed choice and access to family planning information and a range of modern contraceptive methods.**⁶ Launched in 2015, FPwatch is designed to provide timely, relevant and high-quality FP market information. Research methods implemented include outlet surveys and interviews with national FP experts.

GOAL

The FPwatch project aims to inform and monitor national and global policy, strategy and funding decisions for improving informed choice and access to FP information and a range of modern contraceptive methods.

RELEVANCE

FPwatch is an expansion of PSI's ACTwatch research initiative⁷ and is designed to deliver high-quality evidence on modern contraceptive availability, price and relative market share, as well as contraceptive service availability and readiness through outlet surveys in the proposed countries. FPwatch market evidence will complement other FP research and monitoring that is heavily reliant on

population-based studies and modeling. The data gathered and analyzed through FPwatch will provide the FP community with relevant evidence to support the strategic decision making necessary for reaching women and girls who are in need of FP information, services and contraceptives.

The DRC 2015 FPwatch survey complements concurrent data collection focused on tracking FP2020 progress, including surveys conducted by the Performance Monitoring and Accountability 2020 (PMA2020) project in the DRC.⁸ The 2015 DRC FPwatch assessment supplements and builds upon these surveys by conducting a full contraceptive commodity audit and service provider questionnaire providing information on contraceptive commodity and service availability, price, volume and service readiness for all public and private outlets.

FPwatch market monitoring in the DRC in 2015 was implemented in the context of national strategies⁹ designed to improve access to modern contraceptive methods.

OUTLET SURVEYS

Outlet surveys are the core component of the FPwatch project. The outlet survey in the DRC is designed to monitor key FP market indicators at the regional level in urban and rural areas within two key regions: Kinshasa and Katanga.

This summary report presents cross-sectional data from the 2015 outlet survey.

5

Number of FPwatch outlet surveys implemented internationally from 2015-2016

+25,000

Total number of outlets screened in 2015 outlet surveys

+6,500

Number of outlets interviewed in 2015 outlet surveys

References on this page:

⁶FP2020. 2016. *FP2020*. Accessed on 8 June 2015 from: <http://www.familyplanning2020.org/>.

⁷ACTwatch Group. 2016. *ACTwatch: Evidence for Malaria Medicine Policy*. Accessed on 1 September 2016 from: <http://www.actwatch.info/>.

⁸PMA2020. 2016. *PMA2020: The DRC*. Accessed on 1 September 2016 from: <http://www.pma2020.org/program-countries/democratic-republic-congo>.

⁹Secrétaire Général à la Santé, MSP. *DRC Family Planning: National Multisectoral Strategic Plan (2014-2020)*. Kinshasa, DRC: MSP.

What questions are answered by the outlet survey?



What types of outlets in the public and private sectors are carrying modern contraceptive methods?



What proportion of public and private sector outlets are stocking selected modern contraceptive commodities and providing a range of methods?



What is the relative market share for each contraceptive method and for each outlet type?



What is the consumer price of modern contraceptive methods among private sector outlets?



What proportion of public and private sector outlets are providing selected modern contraceptive services, and what is the readiness of selected outlet types for performing contraceptive services?

The FPwatch Countries, 2015 -2016



Methods

FPwatch implements standardized methods and questionnaires that allow for comparisons within and between countries. Together, a full census of all outlets providing contraceptive methods, a full audit of all available contraceptive commodities and a provider interview on contraceptive services give a complete picture of the FP commodity and services market.

HOW IS THE SAMPLING CONDUCTED?

A probability-proportional-to-size (PPS) cluster design was used to select clusters within each stratum, with cluster population serving as the measure of size. The cluster unit used was the *health area*, the lowest government health administrative unit, comprised of approximately 10,000-15,000 inhabitants. In Kinshasa, 17 urban and 17 rural health areas were selected, while 20 urban and 60 rural health areas were selected in Katanga. All outlets providing contraceptive products and services directly to consumers were audited in the selected health areas.

A booster sample was selected to increase the sample size for public health facilities and registered pharmacies. All public health facilities were included for health zones in which sampled health areas were located. The facilities surveyed included private and not-for-profit facilities that represent the government in areas without a public facility. All registered pharmacies within Kinshasa and Katanga were also included in the census.

WHAT TYPES OF OUTLETS ARE SURVEYED?

The main types of outlets sampled included public health facilities, community health workers (CHWs), not-for-profit facilities, private for-profit health facilities, registered and unregistered pharmacies and drug shops. Regulations for provision of contraceptive commodities and services are shown on page 13.

HOW ARE THE OUTLETS IDENTIFIED?

The FPwatch outlet survey included all outlets in selected localities with the potential to sell modern contraceptive commodities or offer contraceptive services. As many of these outlets are unregistered, mobile or recently opened, official listings of these outlets and their locations were not available. A census approach was therefore implemented, supported by local informants, maps and lists of registered outlets where available.

WHAT IS AN OUTLET CENSUS?

This involves a team of data collectors moving systematically through a defined area to identify all outlets that have the potential to sell or distribute contraceptive methods.

WHAT HAPPENS AFTER AN OUTLET IS IDENTIFIED?

The outlet is screened for availability of modern contraceptive methods or services. Outlets were eligible for the full survey if they had modern contraceptive commodities including oral contraceptives, emergency contraceptives, injectables, implants or IUDs in stock at the time of survey or in the previous three months, or offered contraceptive services including contraceptive injections, implant or IUD insertions, or male or female sterilizations. Some information on brands, prices and distribution of condoms was collected from all outlets screened if condoms were available. Other commodities including vaginal foaming tablets, diaphragms, and birth control rings were considered but not found in outlets surveyed. Permission to conduct the interview was obtained from the main provider.

HOW IS INFORMATION ON CONTRACEPTIVE COMMODITIES AND SERVICES CAPTURED?

Full contraceptive audits were conducted among outlets with eligible contraceptive commodities in stock. Information was recorded for each unique contraceptive identified in the outlet. Among outlets offering eligible contraceptive services, providers were interviewed on each type of service.

WHAT INFORMATION IS RECORDED ON THE AUDITS AND PROVIDER INTERVIEWS?

An audit sheet is completed for each unique modern contraceptive commodity in stock. The audit sheet captures product information from the product package, including the brand name, manufacturer, country of manufacturer and formulation/strength (if applicable). The audit sheet also captures information from the provider including the amount sold in the last month, retail price and stock-outs in the previous three months. The provider interview captures the number of services performed, price, provider credentials and the availability of a minimum set of essential equipment.

Comprehensive product information and provider reports on amount distributed and retail price allow for calculating estimates of contraceptive method availability, price and relative market share. Comprehensive service and provider information allows for calculating estimates of readiness for contraceptive services.



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Photo credit: Kate Thanel, PSI

Sample

Outlet types providing modern contraceptive methods

HOW MANY OUTLETS WERE INCLUDED IN THE SAMPLE AND SCREENED?

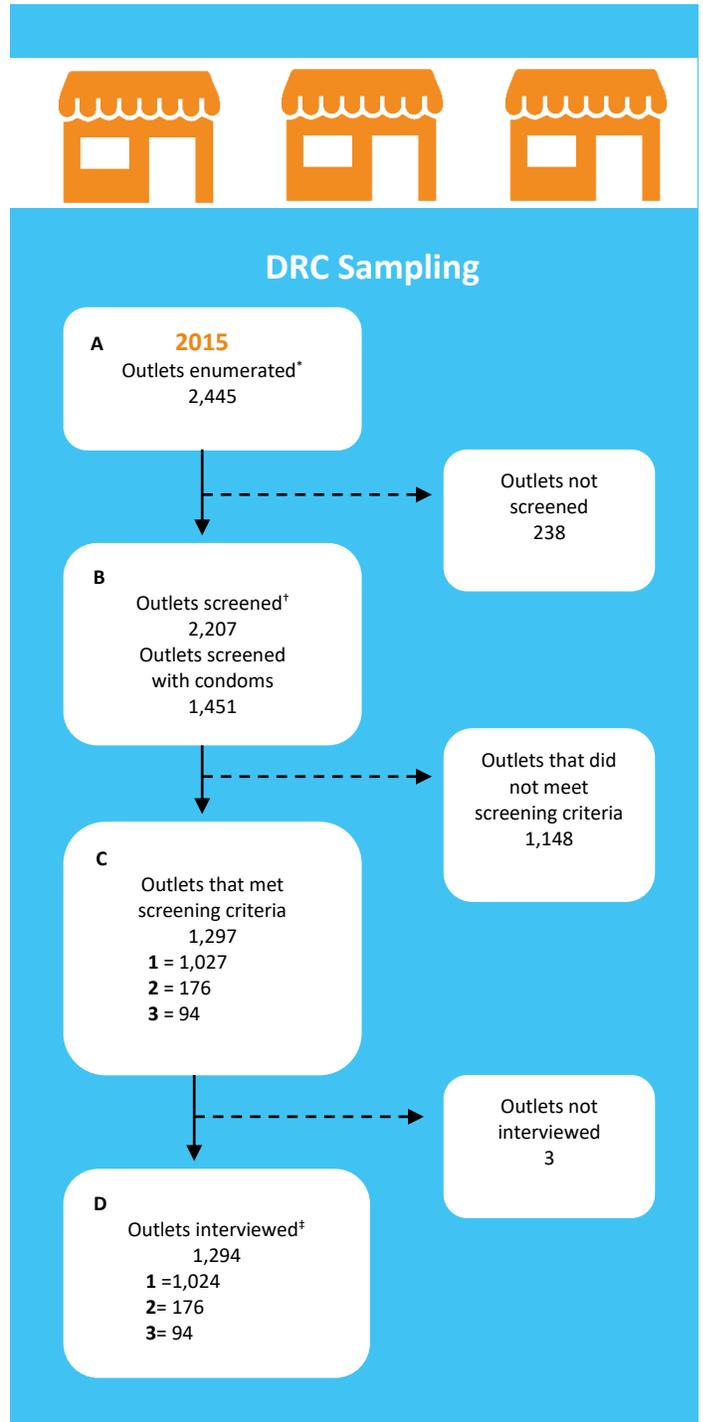
A total of 2,066 outlets were enumerated across 113 *health areas* (i.e. identified as outlets with potential to sell or provide modern contraceptive commodities and services) from the main sample. An additional 379 public health facilities and registered pharmacies were enumerated from corresponding health zones for the booster sample. Among those that were screened, just over half (53%) met at least one of the three eligibility criteria in that they had at least one type of modern contraceptive commodity other than condoms currently in stock, in stock in the previous three months or that they provided contraceptive services.

1 in 2

Number of outlets screened that met eligibility for a full interview

Key:

- 1: Modern contraceptive commodities (includes oral contraceptives, emergency contraceptives, injectables, implants or IUDs) in stock on day of visit
- 2: Modern contraceptive commodities reportedly in stock during the previous three months but not on the day of the visit
- 3: Contraceptive services (including contraceptive injections, implant insertions, IUD insertions, male sterilizations or female sterilizations) available but no modern contraceptive commodities in stock (commodities purchased elsewhere and brought for service)
- * Outlets enumerated: Identified as outlets with potential to sell or distribute modern contraceptive commodities (oral contraceptives, emergency contraceptives, injectables, implants, IUDs) and/or provide contraceptive services (injections, implants, IUDs, male/female sterilizations) during the census; this includes 379 outlets enumerated in the booster sample
- † Outlets screened: Administered questions to assess current or recent (previous three months) availability of modern contraceptive commodities or services; this includes 362 outlets screened in the booster sample
- ‡ Outlets interviewed: A partial or complete interview was conducted with an outlet representative, which includes the senior-most available outlet staff member; this includes 279 outlets interviewed in the booster sample



HOW WAS GEOGRAPHIC SAMPLING CONDUCTED?

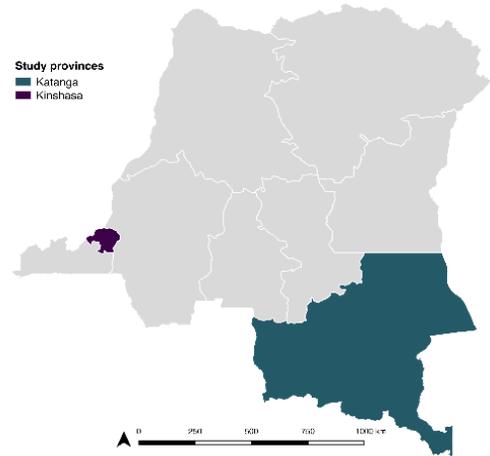
FP market monitoring in the DRC was conducted to provide generalizable estimates for all of Kinshasa and Katanga provinces as well as for urban and rural areas within each of the two provinces.

Health areas were selected through a multi-stage cluster design using PPS sampling. Thirty-four (17 urban and 17 rural) health areas were selected in Kinshasa. Eighty health areas (20 urban and 60 rural) were selected in Katanga across 80 health zones.

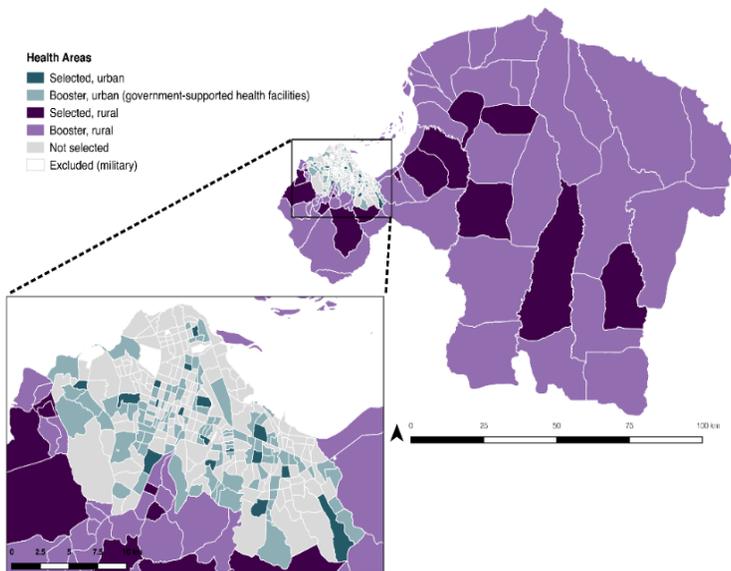
All public health facilities and registered pharmacies in health zones selected for the booster sample were eligible for selection.

Four health zones in rural Katanga were excluded in sampling due to military restrictions and insecurity. Lastly, one selected health area in rural Katanga was dropped due to inaccessibility.

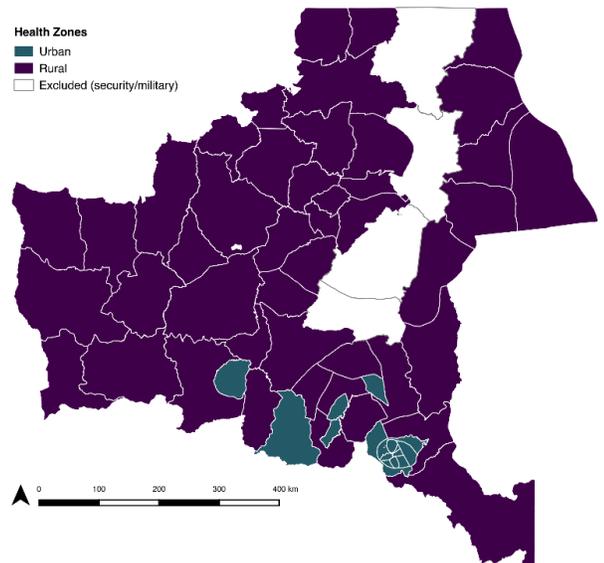
Study Regions



Kinshasa Sample by Health Area



Katanga Sample by Health Zone



Strata	# Selected Health Areas	Total # Outlets Enumerated (# in booster sample)	Total # Outlets that Interviewed (# in booster sample)
Kinshasa Urban	17	877 (167)	497 (120)
Kinshasa Rural	17	480 (54)	247 (48)
Katanga Urban	20	568 (71)	358 (53)
Katanga Rural	59	520 (87)	192 (58)
Total	114	2,445	1,294

Market composition

WHAT IS CONTRACEPTIVE MARKET COMPOSITION?

Contraceptive market composition illustrates the distribution of all outlets that were found to have at least one modern contraceptive commodity in stock on the day of survey or in the past three months or provide at least one contraceptive service. The pie charts below illustrate the distribution of these outlet types according to the public and private sector and by each outlet category. Outlets in the booster sample were not considered for market composition graphs.

WHAT IS THE 2015 MODERN CONTRACEPTIVE MARKET COMPOSITION?

The private sector accounted for 86 percent of outlets stocking contraceptives or providing services in Kinshasa and 71 percent of outlets in Katanga. Drug shops alone accounted for 79 and 59 percent of market composition in each respective province, while registered pharmacies represented only 1% in both. Public health facilities made up 9 percent of eligible outlets in Kinshasa and 25 percent in Katanga, while private not-for-profit facilities comprised only 3 percent in both provinces.

DRC OUTLET GUIDELINES**

Public facilities consist of public hospitals and health centers. According to National FP Guidelines, public facilities can stock all contraceptive commodities. **Public hospitals** can provide all contraceptive services. **Health centers** can provide all contraceptive services, except male and female sterilization. **CHWs** can stock condoms, oral contraceptives and cycle beads. CHWs are not trained to provide contraceptive insertion services. **Private health facilities** consist of private hospitals and clinics. **Private hospitals** can stock all contraceptive commodities and provide all contraceptive services if trained staff is available. **Clinics** can stock all short-acting methods and provide contraceptive injection and LARC insertion services. **Pharmacies** and **drug shops** can stock all short- and long-acting contraceptive commodities but are not allowed to provide any contraceptive services.

**In health zones where there are no public facilities, a private or not-for-profit facility is selected to assume the role of state facility. Since these facilities function more like public facilities and are responsible for implementing state initiatives, they have been categorized in this report as public health facilities. The public health facility category in the following graphs and tables includes 70 private not-for-profit and 115 private for profit facilities.¹⁰

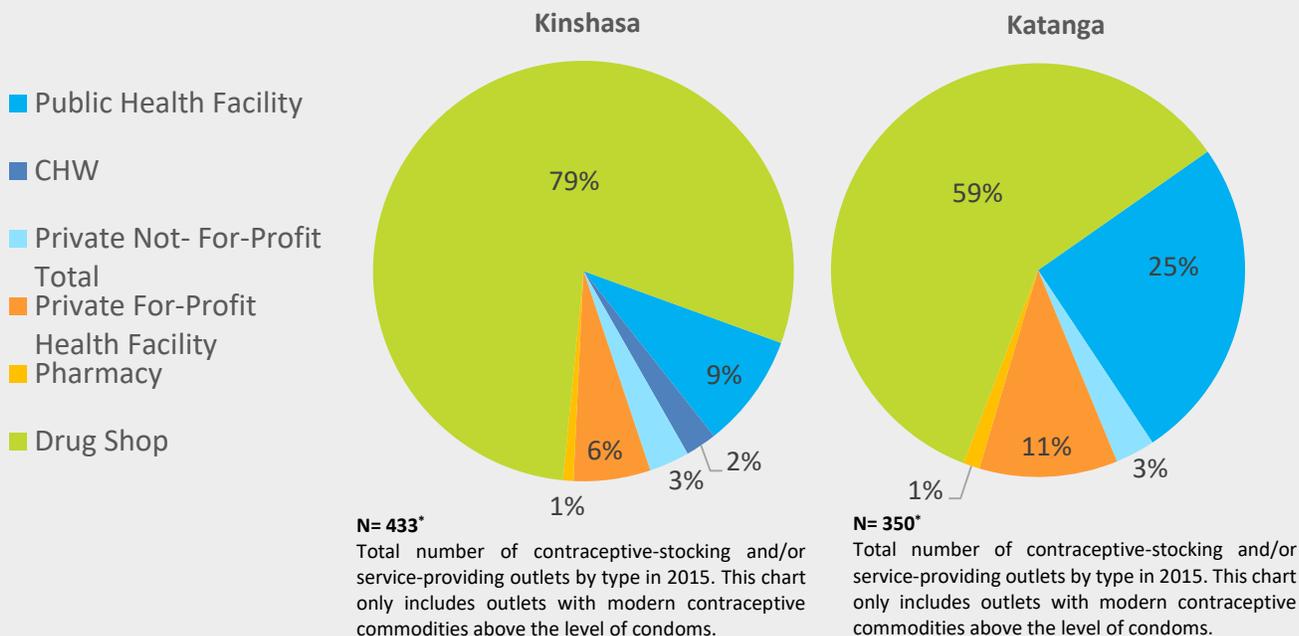
86%

The modern FP market composition accounted for by the private sector in 2015 in Kinshasa

71%

The modern FP market composition accounted for by the private sector in 2015 in Katanga

CONTRACEPTIVE MARKET COMPOSITION FOR PROVINCES, BY OUTLET



* Outlets in the booster sample were not considered for market composition.

¹⁰ Normes De La Zone De Sante Relatives Aux Interventions Integrees De Sante De La Mere, Du Nouveau-Ne Et De L'enfant En Republique Democratique Du Congo. Volume 6: Les Interventions De Planification Familiale. Secretariat General de La Ministere De La Sante Publique Edition 2012.

HOW DOES CONTRACEPTIVE MARKET COMPOSITION DIFFER AMONG URBAN AND RURAL STRATA?

It is important to consider the contraceptive market composition according to variations in geography and population density. For example, the public sector share of outlets with at least one modern contraceptive commodity was only 10 percent for urban Kinshasa and 17 percent for rural Kinshasa. The difference is more marked in Katanga, with 8 percent of the market being public sector outlets in urban and 39 percent in rural areas.

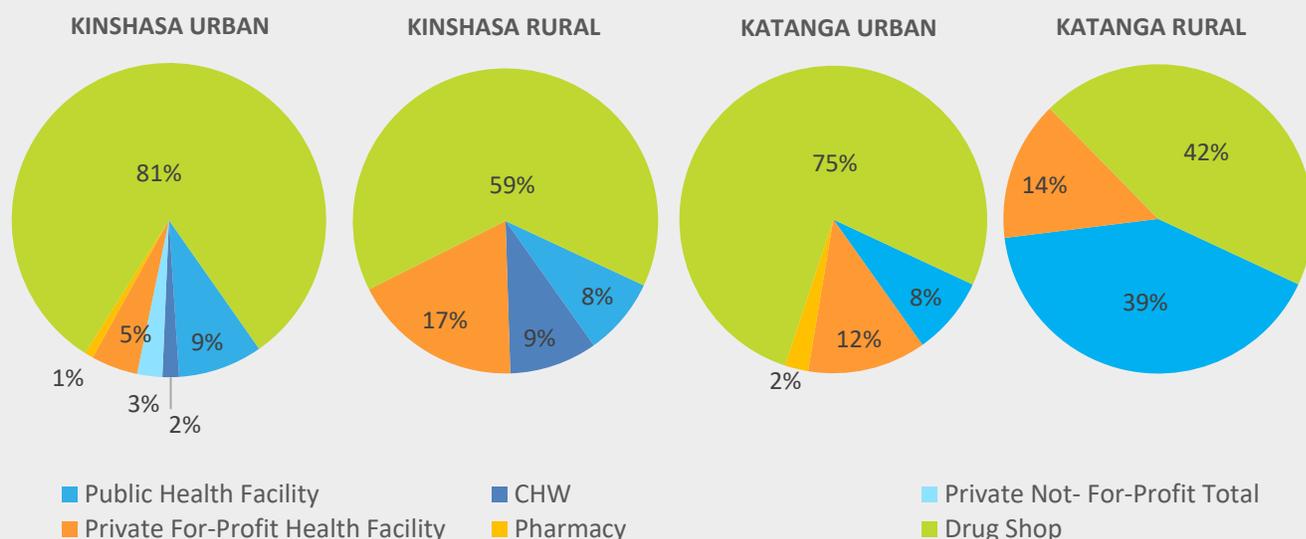
Drug shops were the most commonly represented outlet type with at least one modern contraceptive available in all strata, but tended to comprise more of the FP market in urban areas as compared to rural areas. Community health workers comprised an appreciable proportion of the FP market composition in rural Kinshasa (9 percent) and not-for-profit outlets were only found in small numbers across all strata.

These findings show diversity in the market landscape composition according to location and especially as they relate to the rural/urban make-up of these dissimilar provinces. The findings are indicative of the types of outlets that may be ready to provide access to modern contraceptive methods in different regions of the DRC.

The regional and urban/rural market landscapes vary. While public health facility composition was low across strata, it made up nearly 40% of the market in rural Katanga, nearly equivalent to that represented by drug shops.

Drug shops dominated the private sector in all strata, but especially in urban areas of both provinces.

CONTRACEPTIVE MARKET COMPOSITION FOR URBAN/RURAL STRATA, BY REGION AND OUTLET TYPE



N= 793: Kinshasa Urban N=299; Kinshasa Rural N=144; Katanga Urban N=254; Katanga Rural N=96.*

These charts only include outlets with modern contraceptive methods above the level of condoms.

Outlets from booster areas are not represented in these figures.

Public health facilities primarily consist of public health centers with smaller numbers of public hospitals and public health posts.

Private health facilities primarily consist of private health centers with smaller numbers of private hospitals and private health posts.



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CENTRE MEDICAL
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Availability of diversity of methods

WHAT IS THE AVAILABILITY OF AT LEAST ONE AND SELECTED RANGES OF CONTRACEPTIVE METHODS AMONG SCREENED OUTLETS?

Access and choice of contraceptive methods are integral components of the FP2020 Initiative and the DRC's national FP2020 commitments. This section reports on the availability of any modern contraceptive method, three or more methods, three or more methods with at least one LARC/PM and five or more methods. Graphs are shown on this and the following page.

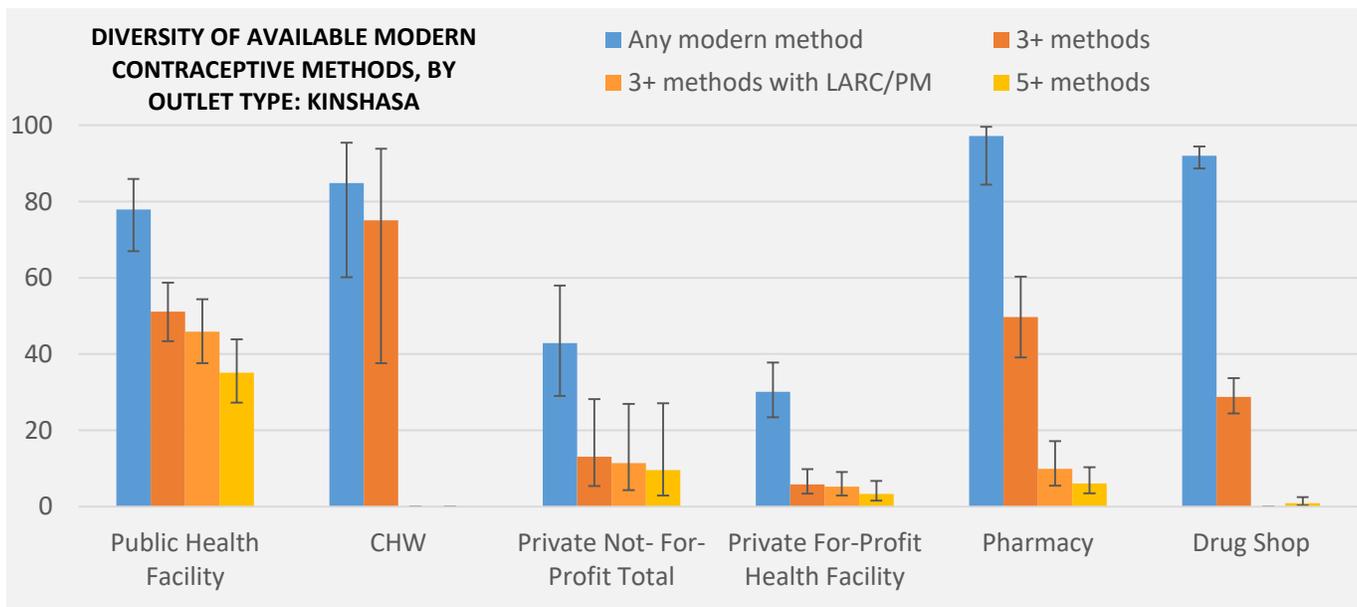
In Kinshasa, three-quarters or more of public health facilities, CHWs, pharmacies and drug shops were stocking at least one modern contraceptive method at the time of the survey. More than half of public health facilities, CHWs and pharmacies stocked three or more methods and one-third of public facilities stocked five or more methods. Only one-third of drug shops, the most common outlet stocking contraceptives in Kinshasa, had three or more methods. Less than half of not-for-profit facilities and private health facilities were stocking at least one modern contraceptive commodity and only about 10 percent or less of each of these outlet types offered three or more methods.

In Katanga, nearly two-thirds of public health facilities, not-for-profit outlets, pharmacies and drug shops had at least one

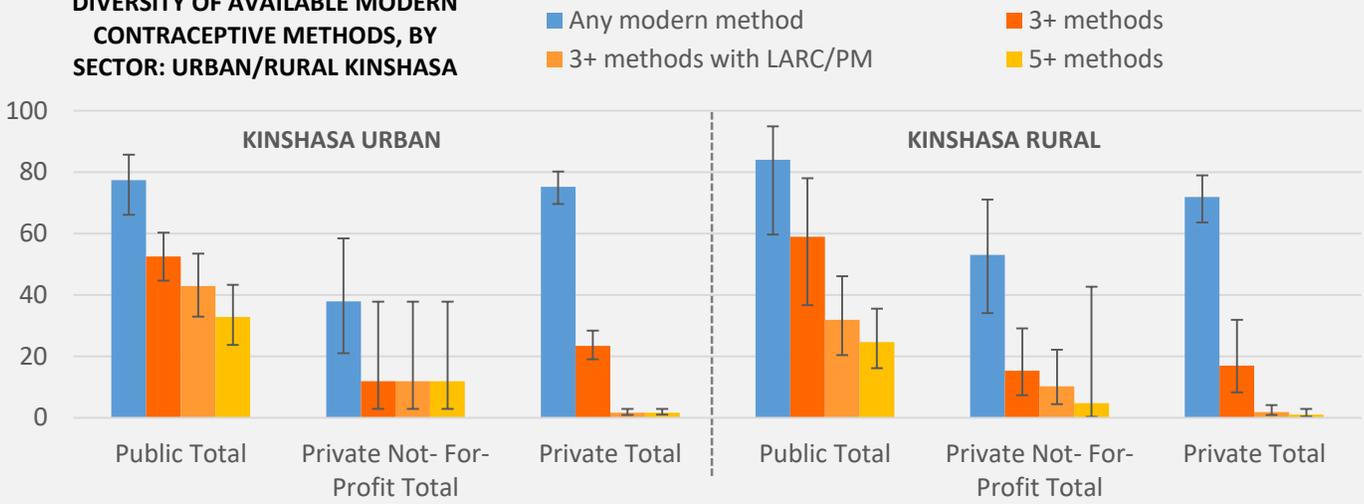
modern method available. Compared to Kinshasa, fewer of these outlet types had three or more methods available. However, not-for-profit outlets in Katanga were about twice as likely to offer three or more methods. Less than 40 percent of private health facilities offered at least one modern method and about one-tenth offered three or more methods. Only about 10 percent of drug shops, the most common outlet type carrying contraceptive methods in Katanga, had three or more methods available.

ARE THERE DIFFERENCES IN AVAILABILITY OF AT LEAST ONE SELECTED RANGES OF METHODS BY RURAL/URBAN STATUS?

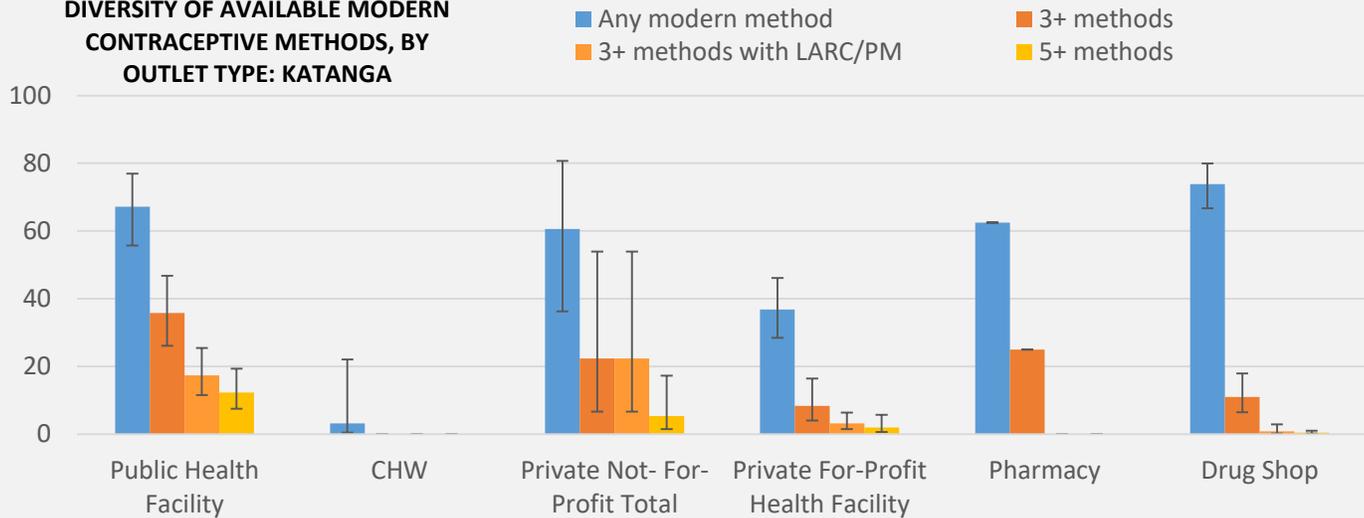
In Kinshasa, there were few differences in availability of at least one or selected ranges of methods by sector. In Katanga, about 80 percent of urban public and private sector outlets, compared to only about half of rural public and private sector outlets, provided at least one method. Similarly, almost 60 percent of urban public sector outlets offered three or more methods, compared to about 20 percent of rural public sector outlets. For private sector outlets, 20 percent of urban outlets offered three or more methods, compared to less than 5 percent of rural outlets.



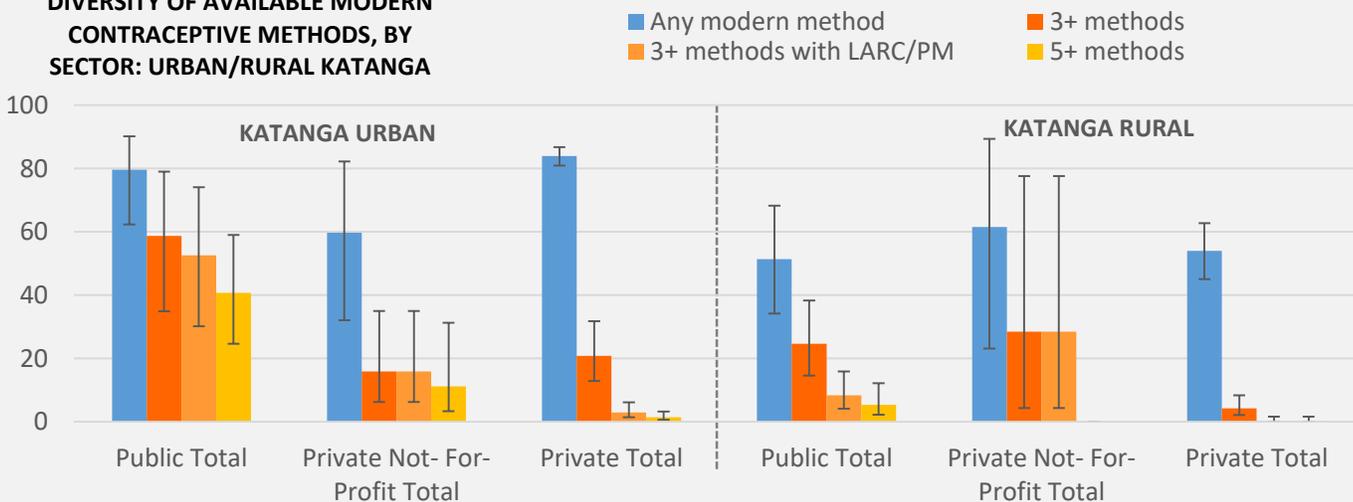
DIVERSITY OF AVAILABLE MODERN CONTRACEPTIVE METHODS, BY SECTOR: URBAN/RURAL KINSHASA



DIVERSITY OF AVAILABLE MODERN CONTRACEPTIVE METHODS, BY OUTLET TYPE: KATANGA



DIVERSITY OF AVAILABLE MODERN CONTRACEPTIVE METHODS, BY SECTOR: URBAN/RURAL KATANGA





Contraceptive commodity availability

WHAT IS THE AVAILABILITY OF SELECTED SHORT-ACTING CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS?

Kinshasa Province

In the Kinshasa public sector (graphs on page 20), three-quarters of public outlets had at least one brand of short-acting contraceptive commodity available. About 70 percent of public health facilities had male condoms available and about 40 percent had female condoms or CycleBeads available. Roughly 40 percent of public health facilities in Kinshasa had oral contraceptives available but only 13 percent had progestin-only pills available. Nearly half had contraceptive injectables available (primarily Depo-provera). Emergency contraceptives were not widely available in public health facilities (<10 percent). Over three-quarters of CHWs in Kinshasa stocked male condoms, CycleBeads or oral contraceptives. Nearly half of CHWs had progestin-only pills available. CHWs did not stock any other modern contraceptive methods. Only one-quarter of not-for-profit facilities provided male condoms or emergency contraceptives and 10 - 20 percent stocked female condoms, CycleBeads, oral contraceptives or contraceptive injectables.

In the Kinshasa private sector (graphs on page 20), three-quarters of private outlets had at least one brand of short-acting contraceptive commodity available. One-quarter of private health facilities stocked male condoms and less than 10 percent stocked all other short-acting methods. Nearly all pharmacies stocked male condoms, about two-thirds stocked oral contraceptives (primarily combined oral contraceptives) and half stocked emergency contraceptives. Less than 15 percent of Kinshasa pharmacies stocked female condoms, progestin-only pills or contraceptive injectables. Nearly 90 percent of drug shops, the most common outlet carrying modern contraceptive methods in Kinshasa, had male condoms available, over one-third had oral contraceptives available and one-quarter stocked emergency contraceptives and contraceptive injectables.

Katanga Province

In the Katanga public sector (graphs on page 23), two-thirds of public outlets had at least one brand of short-acting contraceptive commodity available. About half of public health facilities had male condoms available and about 20 percent had CycleBeads available. Roughly 40

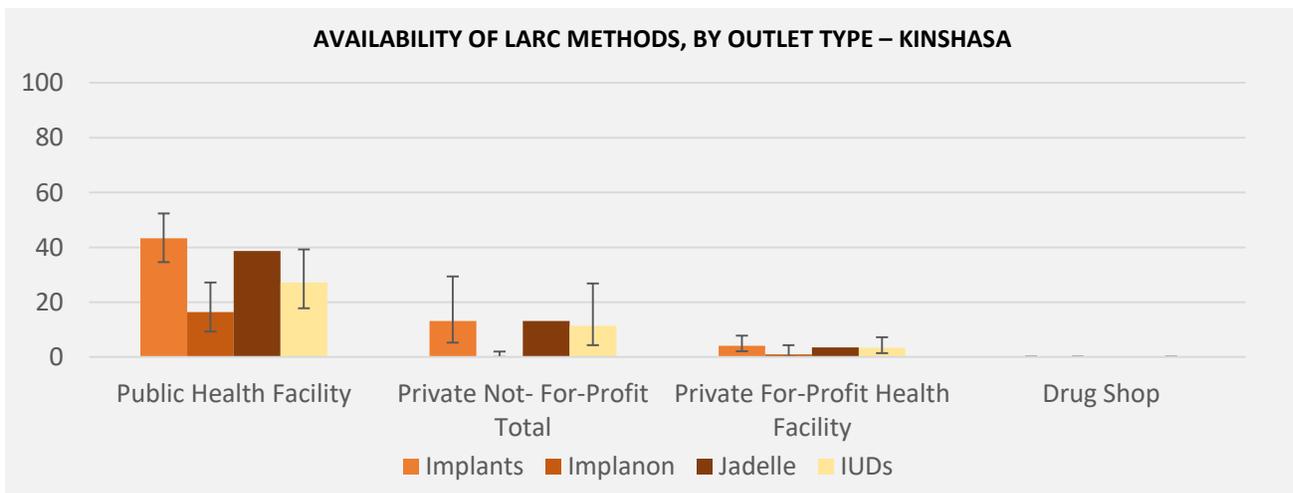
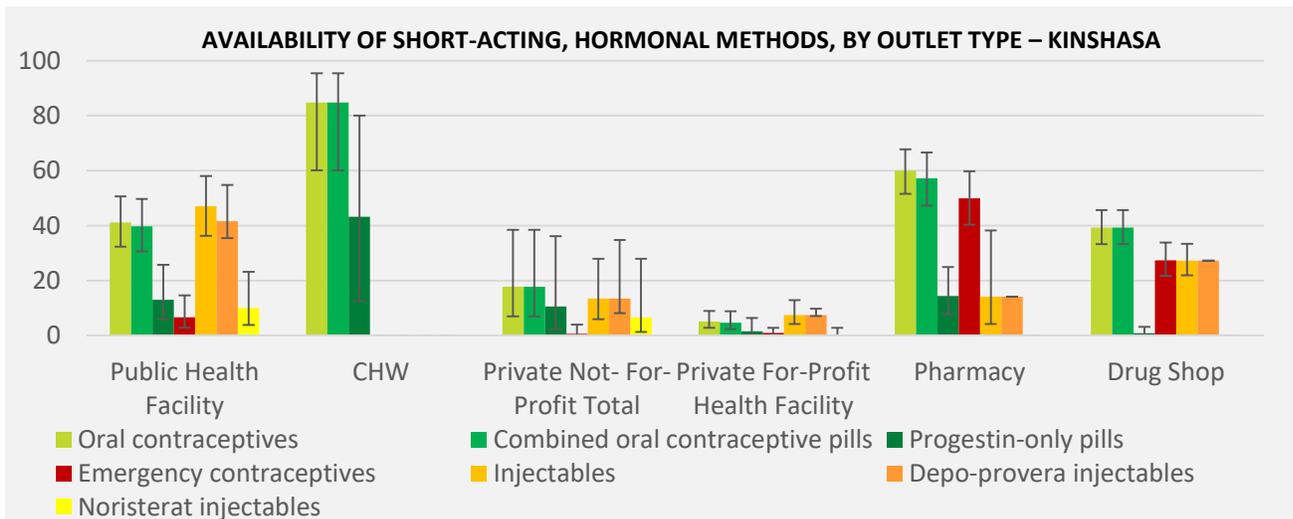
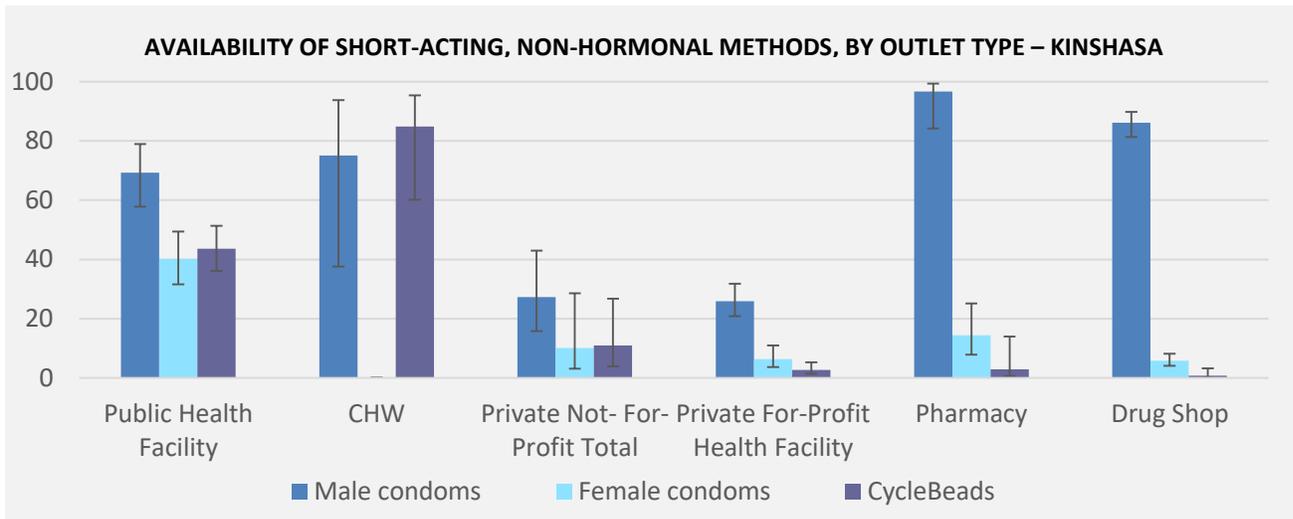
percent of public health facilities in Katanga had oral contraceptives available but only 10 percent had progestin-only pills available. Over one-third had contraceptive injectables available (primarily Depo-provera). Emergency contraceptives were not widely available in public facilities (<5 percent). The few CHWs in Katanga stocked only male condoms (3 percent) and no other modern contraceptive methods. Over one-third of not-for-profit facilities provided male condoms, oral contraceptives or contraceptive injectables and 5 - 10 percent stocked female condoms or CycleBeads.

In the Katanga private sector (graphs on page 23), two-thirds of private outlets had at least one brand of short-acting contraceptive commodity available. One-quarter of private health facilities stocked male condoms, slightly more than 10 percent stocked oral contraceptives and injectable contraceptives and less than 10 percent stocked all other short-acting methods. There were only a handful of pharmacies screened in Katanga. Nearly 70 percent of drug shops, the most common outlet carrying modern contraceptive methods in Kinshasa, had male condoms available, over one-quarter had oral contraceptives available and 12 percent had contraceptive injectables. Less than 10 percent of Katanga drug shops had all other short-acting contraceptive methods available.

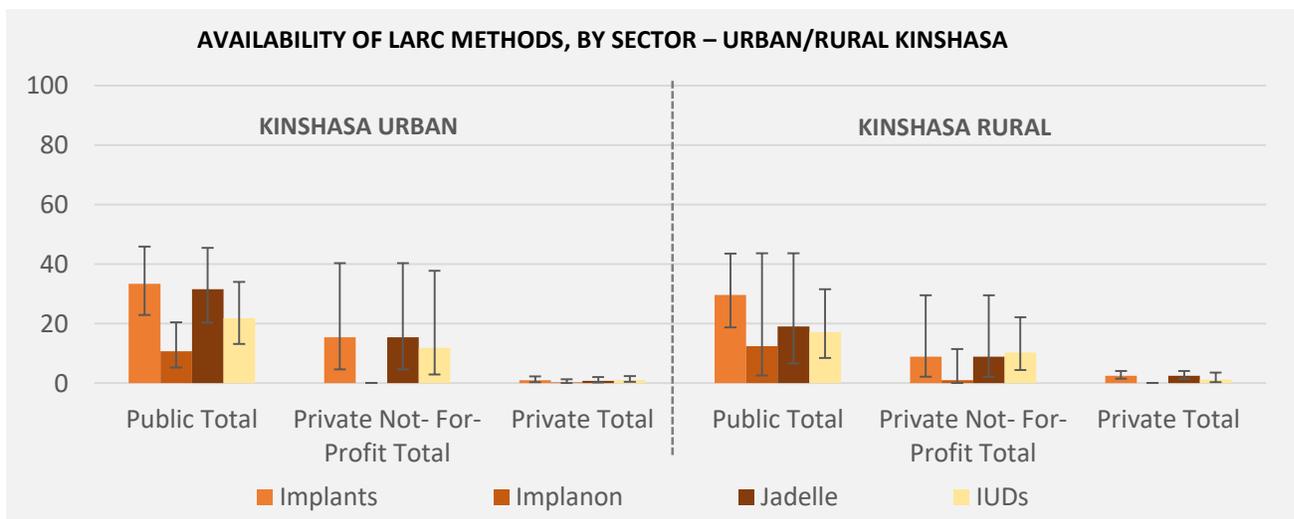
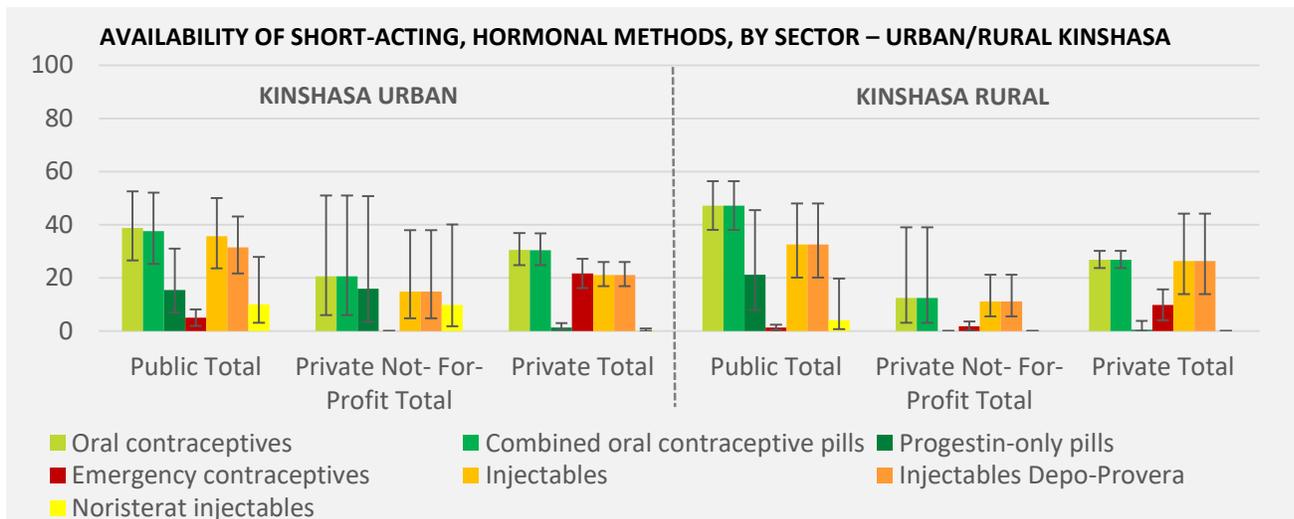
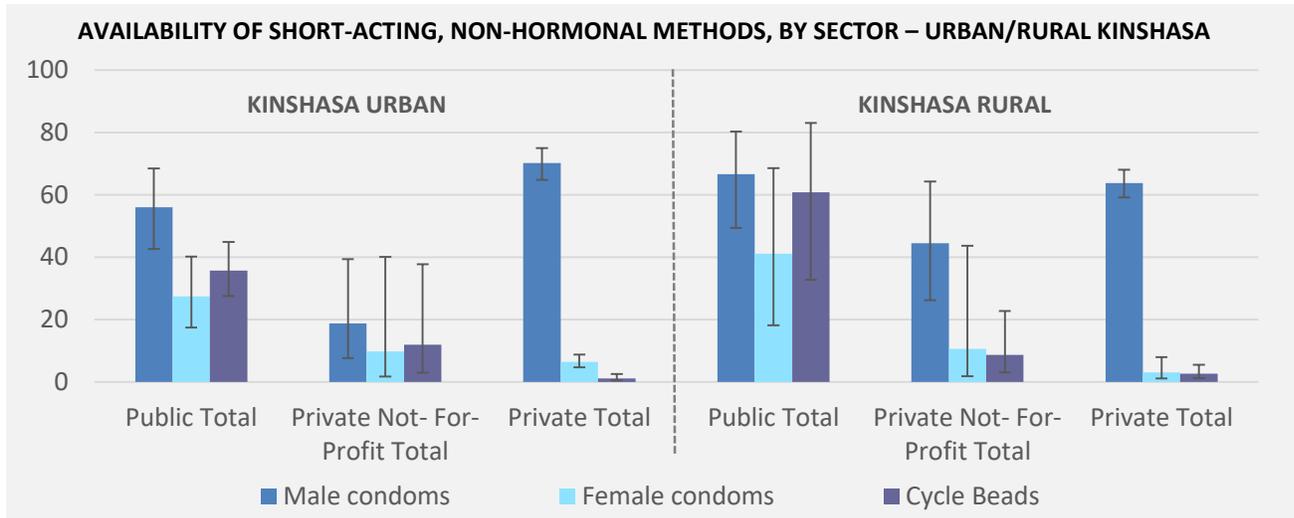
WHAT IS THE AVAILABILITY OF QA (QUALITY-ASSURED) SHORT-ACTING CONTRACEPTIVE BRANDS AMONG ELGIBLE OUTLETS?

International quality-assured (IQA) contraceptives are defined as those brands listed on the World Health Organization Prequalification List or a Stringent Regulatory Authority list. All injectable, implant and IUD brands found during the survey were quality-assured according to this definition. All oral contraceptives found in Kinshasa and over 90 percent of those found in Katanga were quality assured with the private sector responsible for the majority of the non-quality-assured products. The majority of emergency contraceptives found in both provinces did not meet these quality-assurance criteria. Accordingly, only half of the emergency contraceptive brands found in Kinshasa pharmacies and fewer than 10 percent of those found in drug shops were quality assured. In Katanga, one-third of the emergency contraceptive brands found in pharmacies and 41 percent found in drug shops were quality assured. Public facilities, although less well-stocked, carried mostly quality-assured brands of emergency contraceptives.

KINSHASA PROVINCE



KINSHASA URBAN/RURAL



39%

of Kinshasa public sector outlets stock at least one brand of LARC

1%

of Kinshasa private sector outlets stock at least one brand of LARC

13%

of Katanga public sector outlets stock at least one brand of LARC

2%

of Kinshasa private sector outlets stock at least one brand of LARC

WHAT IS THE AVAILABILITY OF SELECTED LONG-ACTING REVERSIBLE CONTRACEPTION AND PERMANENT METHODS AMONG ELIGIBLE OUTLETS?

Kinshasa Province

For LARC commodities in the Kinshasa public sector (graphs on page 20), more than 40 percent of Kinshasa public health facilities had implants, with Jadelle® being more common than Implanon®. About one-quarter had IUDs available. CHWs were not found to be stocking LARCs. A little over 10 percent of not-for-profit outlets stocked both implants and IUDs in Kinshasa.

In the private sector in Kinshasa (graphs on page 20), low availability of both implants and IUDs was reported. Only about 4 percent of private health facilities had implants or IUDs available. LARC commodities were not found in private drug shops, the most common outlet type carrying contraceptive methods. A small number of pharmacies had IUDs available, but none had implants available.

Katanga Province

In Katanga (graphs on page 23), LARCs were less commonly available in the public and private sector compared to Kinshasa. Only about 15 percent of public health facilities had implants available (primarily Jadelle®) and about 10 percent had IUDs available. As in Kinshasa, CHWs in Katanga did not stock a LARC method. About 20 percent of not-for-profit outlets stocked implants and 5 percent stocked IUDs.

In Katanga's private sector (graphs on page 23), only about 4 percent and 2 percent of private health facilities had implants or IUDs, respectively, available. Pharmacies were not found to be stocking LARC commodities in Katanga, but about 1 percent of drug shops had at least one brand of implant or IUD available.

There is significantly higher availability of nearly all methods in urban Katanga compared to rural Katanga in both public and private sector facilities.

HOW DOES AVAILABILITY OF SELECTED SHORT-ACTING CONTRACEPTIVES AND LARCS AMONG ELIGIBLE OUTLETS DIFFER AMONG GEOGRAPHIC STRATA?

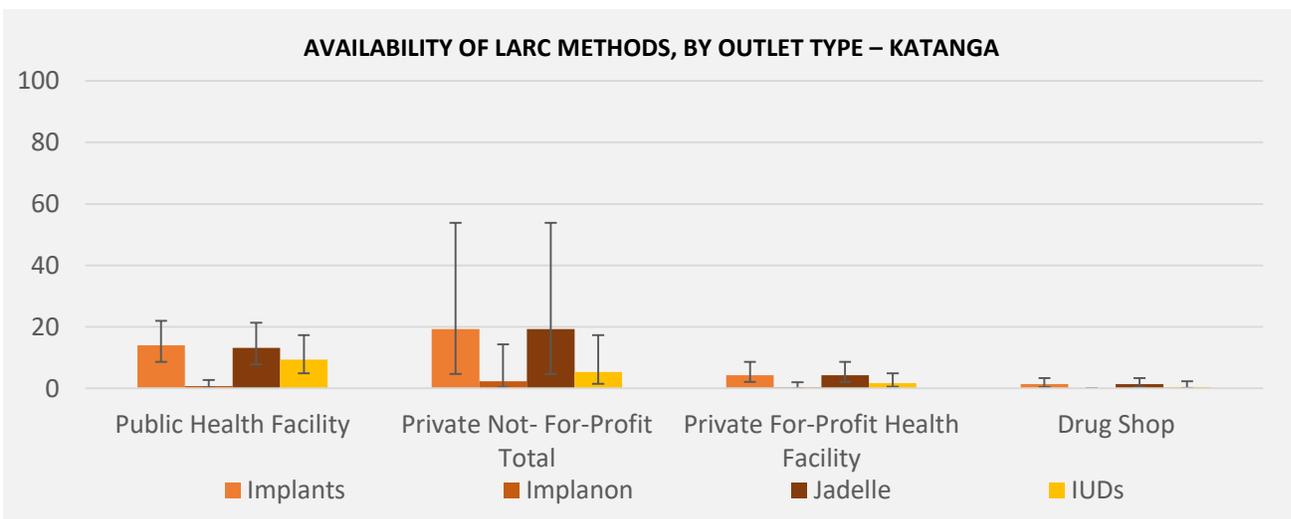
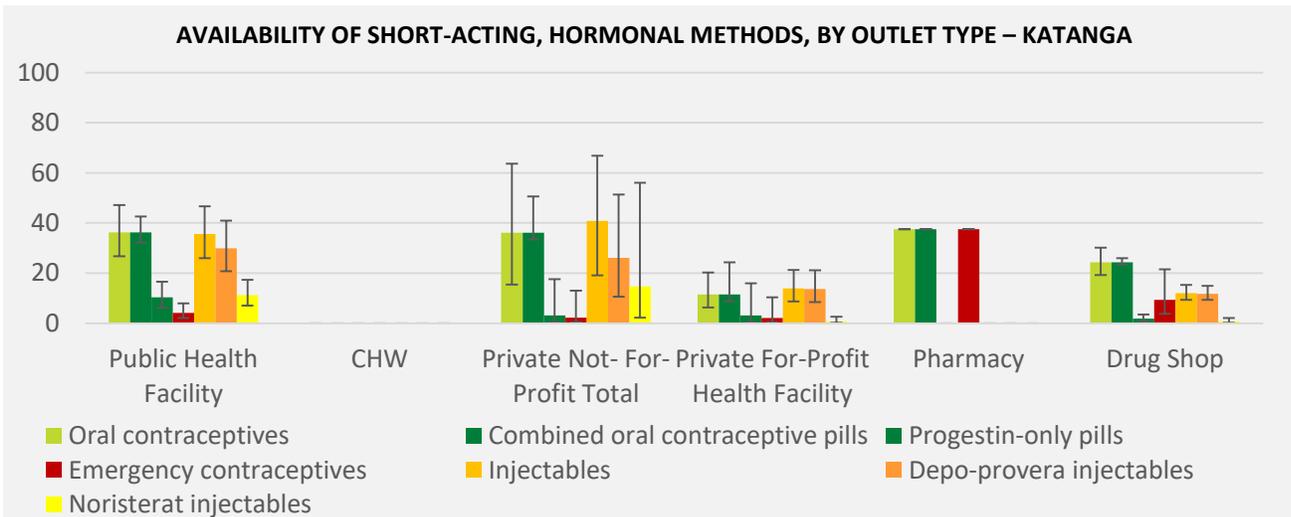
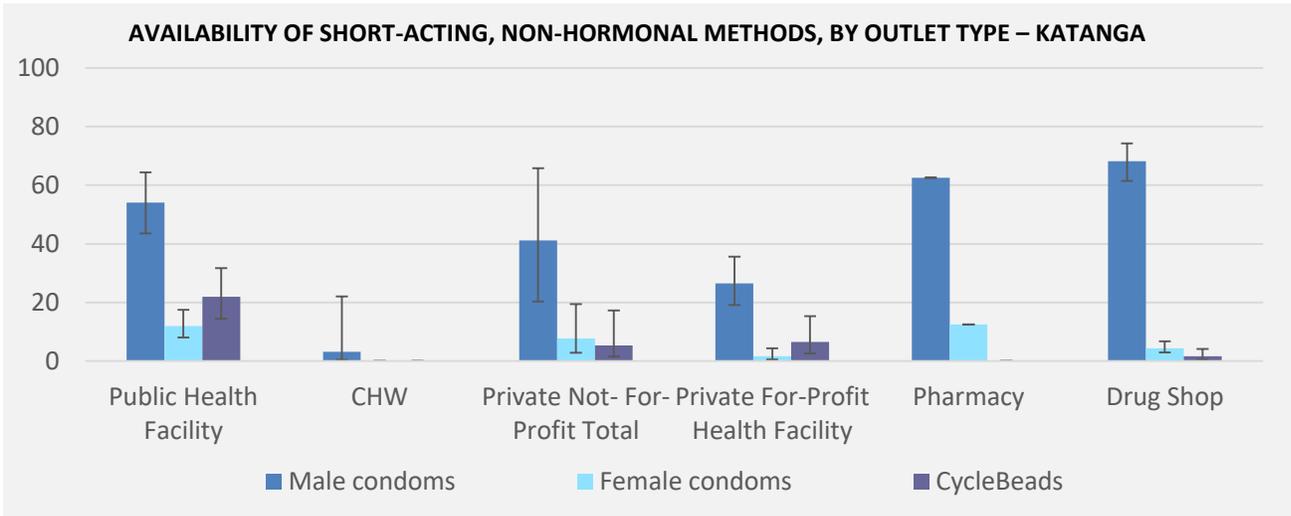
Kinshasa Province

In regional graphs for Kinshasa (page 21), few major differences were seen in the availability of products between urban and rural areas of Kinshasa in the private sector, except for higher availability of emergency contraceptives in urban outlets. In the public sector, there tended to be slightly higher availability of short-acting methods in the rural outlets whereas urban outlets had slightly higher availability of LARCs.

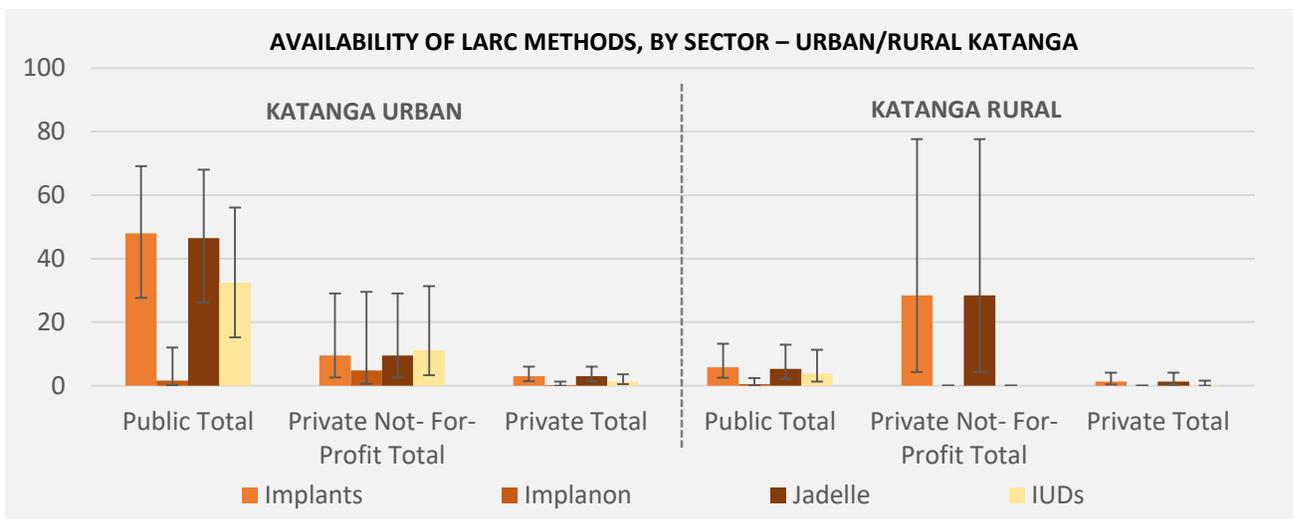
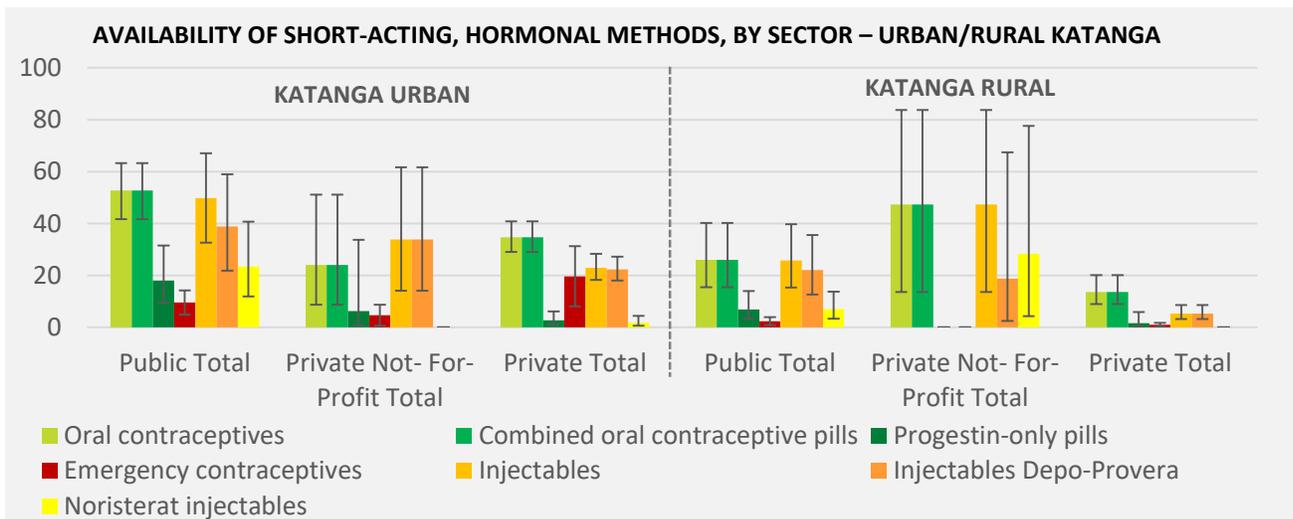
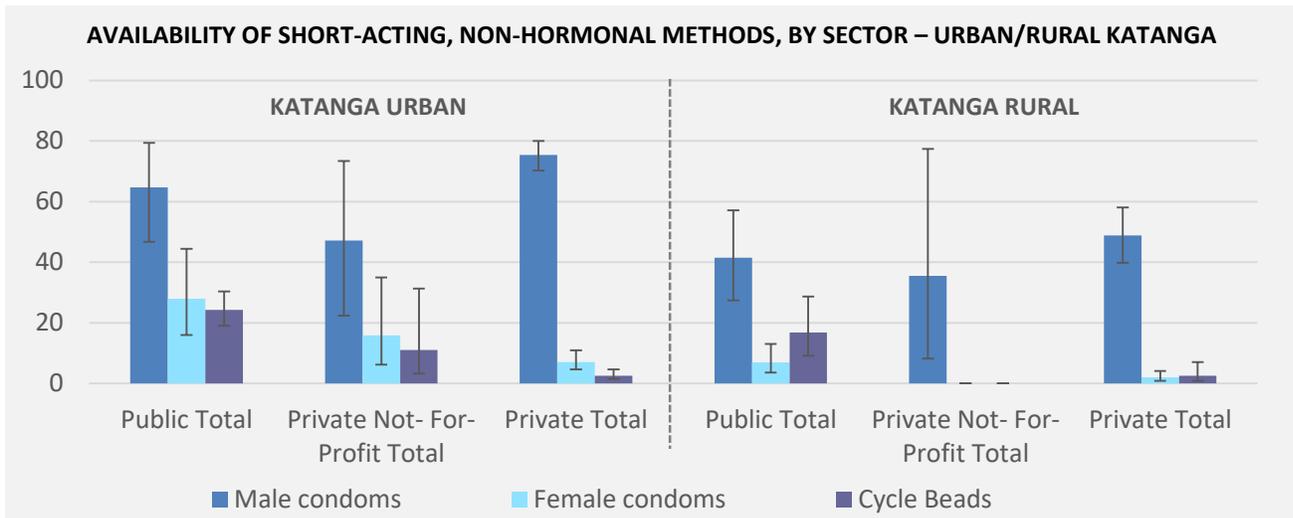
Katanga Province

In regional graphs for Katanga (page 24), public, not-for-profit and private outlets in urban areas tended to have higher availability of all short-acting methods compared to rural areas. There was considerably higher availability of oral contraceptives in urban public outlets (over half) compared to rural public outlets (about one-quarter) and higher availability in urban private outlets (about one-third) compared to rural private outlets (about 15 percent). Similarly, there was higher availability of emergency contraceptives in urban private (20 percent) outlets compared to rural private outlets (less than 2 percent) and higher availability of injectables in urban public outlets (about half) compared to rural public outlets (about one-quarter). Urban private outlets (about 20 percent) had higher injectable availability than rural private outlets (less than 5 percent). Katanga had considerably higher availability of LARC commodities in urban areas compared to rural areas. In urban Katanga public sector outlets, approximately half of public outlets had at least one brand of implant available compared with less than 5 percent of rural public outlets. Lastly, about one-third of public sector outlets in urban Katanga stocked IUDs compared to less than 5 percent in rural Katanga.

KATANGA PROVINCE



KATANGA URBAN/RURAL



Stock-outs

WHAT ARE STOCK-OUTS?

The graph below presents data for point-in-time stock-outs or the percentage of outlets stocked out on the day of the survey of all brands of a method, among outlets reportedly stocking at least one brand of the method in the previous three months and among those that have not stocked at least one brand of the method in the previous three months.

WHAT CONTRACEPTIVE METHODS ARE OUT OF STOCK AMONG OUTLETS TYPICALLY STOCKING THE METHOD?

In Kinshasa’s public sector, over half of public sector outlets did not stock oral contraceptives on the day of the survey, with 7 percent having stocked at least one brand in the previous three months. Over 9 in 10 public sector outlets did not carry emergency contraceptives when surveyed. Almost 60 percent of public sector outlets did not carry injectables, with 9 percent of those having stocked an injectable in the past three months. For LARC methods, over three-fifths of public sector outlets did not carry implants and over three-fourths did not carry IUDs, with about 6 percent having stocked either method in the previous three months.

In Kinshasa’s private sector, more than 70 percent of outlets did not stock oral contraceptives, emergency contraceptives or injectables, with 10 percent or less of these outlets having stocked the methods in the previous three months. Looking

at LARCs, just one percent of private sector outlets stocked an implant or an IUD on the day of the survey. Less than 1 percent of these had stocked the method in the previous three months.

In Katanga’s public sector, over 70 percent of outlets did not stock oral contraceptives or injectables on the day of the survey, with 5 percent of outlets having stocked oral contraceptives and 16 percent having stocked injectables in the previous three months. More than 95 percent of public outlets did not stock emergency contraceptives on the day of the survey. For LARCs, over 85 percent of public outlets did not stock implants or IUDs on the day of the survey. For both methods, about 6 percent of public outlets had stocked the product in the past three months.

In Katanga’s private sector, more than three-quarters of all outlets did not stock oral contraceptives when surveyed, with 6 percent having stocked the method in the previous three months. Stock outs at the time of the survey reached 90 percent for emergency contraceptives and over 87 percent for injectables. Greater than 98 percent of private sector outlets were stocked out of implants and IUDs on the day of the survey, with less than one percent having stocked either method in the previous three months.

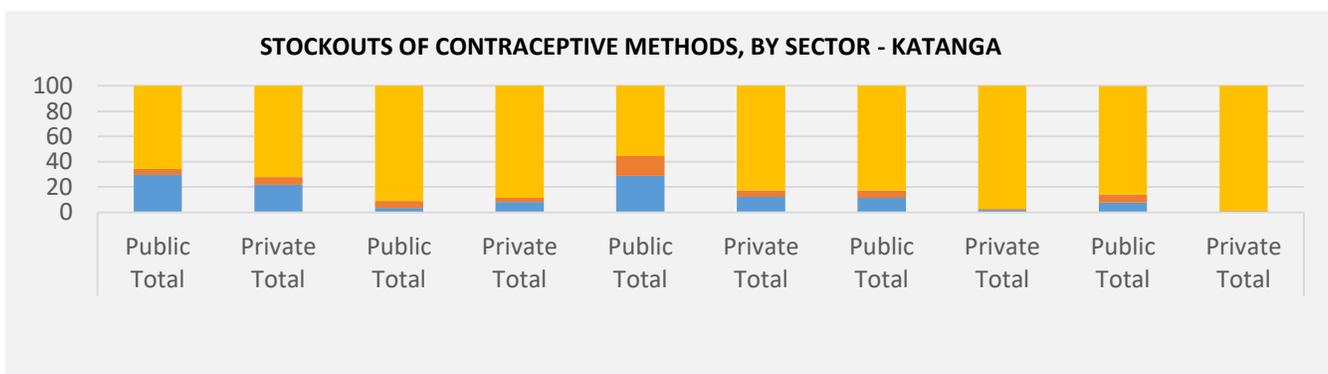
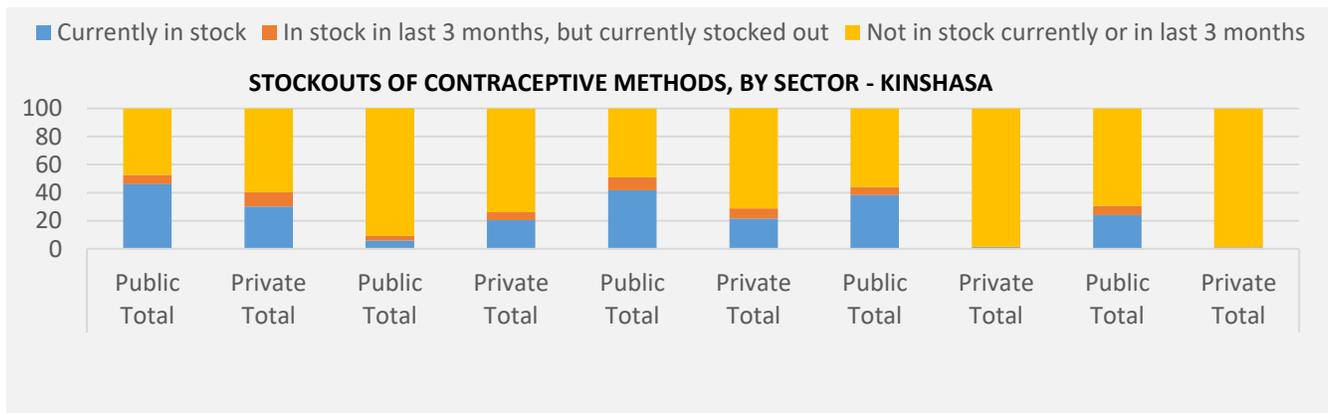




Photo credit: Benjamin Schilling

Contraceptive market share

Role of the public and the private sectors

WHAT IS CONTRACEPTIVE MARKET SHARE?

Market share of modern contraceptive methods, or the relative public and private sector distribution for all modern contraceptive commodities, is estimated using information about reported distribution of each commodity sold during the one-month period preceding the survey. Market share is reported in couple years of protection (CYP). **CYP is the estimated protection provided by contraceptive methods during a one-year period.** Volume distributed for each method type is converted to CYP by a conversion factor specific to each method.¹¹ The graphs on pages 27 and 29 show contraceptive market share as a proportion of the total CYPs by outlet and method types for Kinshasa and Katanga, respectively. The first graphs on pages 28 and 30 compare this for urban vs. rural areas. The second graphs on page 28 and 30 present market share as a proportion of the total CYPs within outlet types by method for Kinshasa and Katanga, respectively.

50%*

Private sector contribution to total contraceptive market share in CYP in Kinshasa

28%

Percent of CYPs, across outlets, accounted for by LARCs in Kinshasa

The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor.

For example, 1 sterilization service equals:

139.5 Oral contraceptives

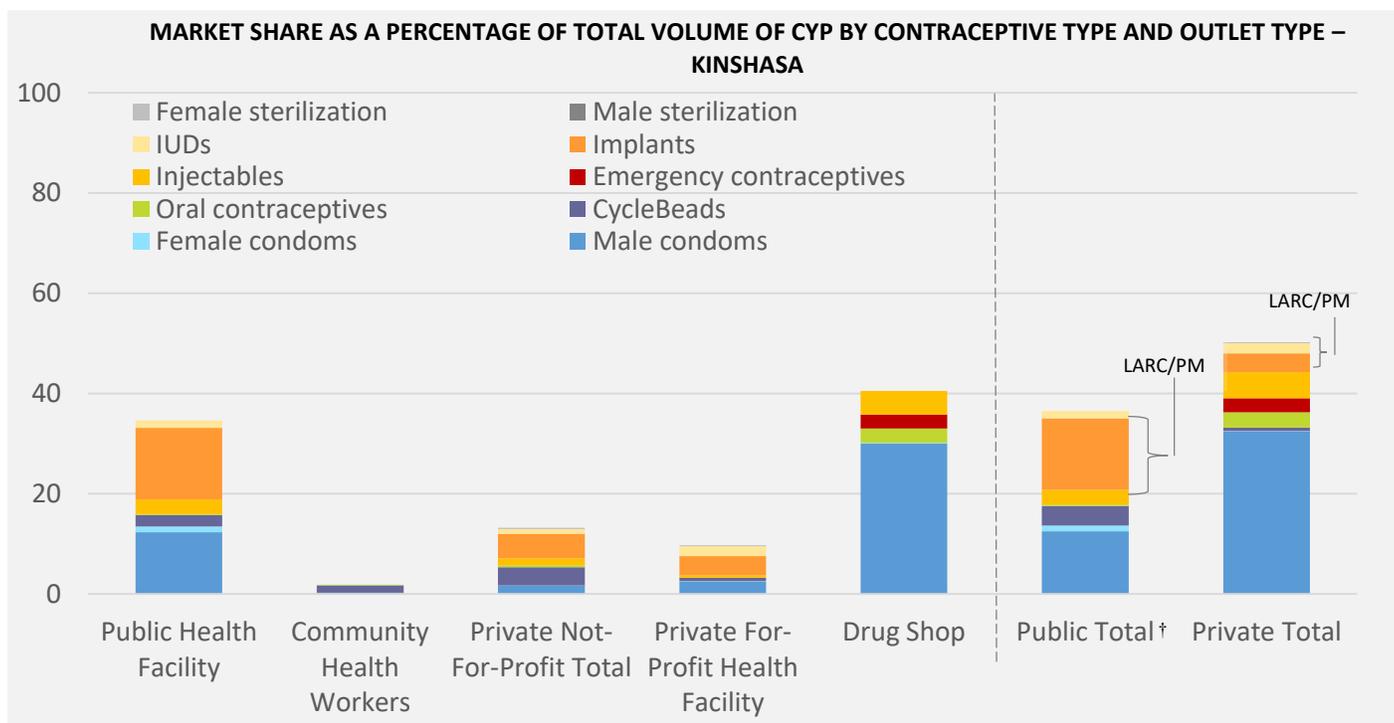
37.2 Injectables

~2.0 IUDs

UNPACKING THE PUBLIC SECTOR CONTRACEPTIVE MARKET SHARE

Kinshasa Province

As a proportion of the total volume of CYP for all methods, the public sector in Kinshasa accounts for more than one-third of total volume of CYP, almost entirely from public health facilities. Implants (14 percent), followed by male condoms (13 percent) and CycleBeads (4 percent) are the primary contributors in the public sector of total CYP. Within outlet types, LARCs (implants, 39 percent; and IUDs, 4 percent) account for slightly less than half of public sector outlet CYP. Comparing urban to rural Kinshasa, the public sector accounts for considerably more of the total market share in rural Kinshasa (51 percent) compared to urban Kinshasa (35%), with over 40 percent of the total rural Kinshasa CYP coming from implants.



¹¹The RESPOND Project technical meeting. (2011). *New Developments in the Calculation and Use of CYP and Their Implications for Evaluation of Family Planning Programs*. September 8, 2011.

Available from: http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/tp/cyp/.

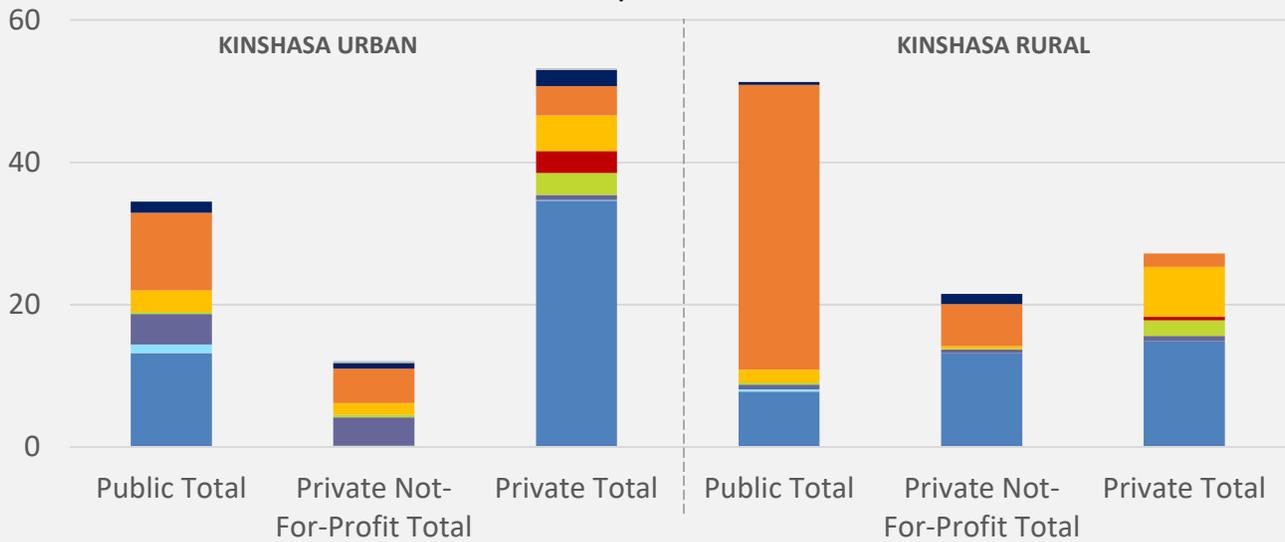
*This reflects distribution by private sector outlets directly to the consumer.

†In health zones where a private or not-for-profit facility is selected to assume the role of state facility, distribution by these facilities is categorized as public sector distribution.

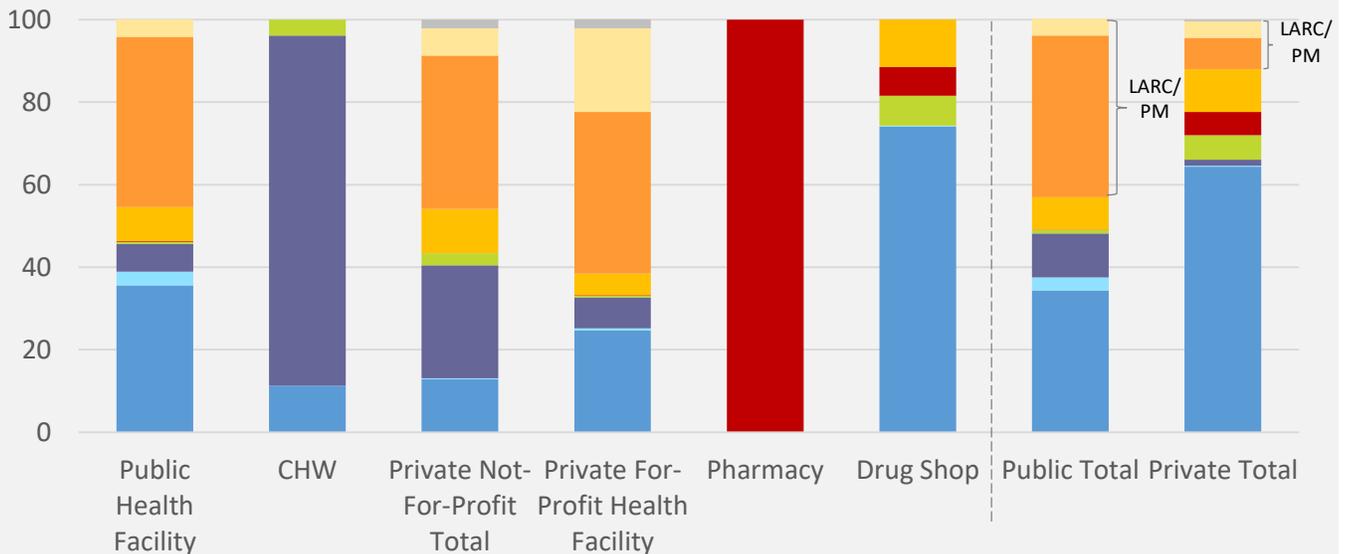
- Female sterilization
- Male sterilization
- IUDs
- Implants
- Injectables
- Emergency contraceptives
- Oral contraceptives
- CycleBeads
- Female condoms
- Male condoms



MARKET SHARE AS A PERCENTAGE OF TOTAL VOLUME OF CYP BY CONTRACEPTIVE TYPE AND SECTOR – URBAN/RURAL KINSHASA



MARKET SHARE AS A PERCENTAGE OF TOTAL WITHIN OUTLET TYPE VOLUME OF CYP BY CONTRACEPTIVE TYPE AND SECTOR – KINSHASA



In Kinshasa, not-for-profit outlets account for 13 percent of the total volume for all methods distributed. This comes primarily from implants (5 percent) and CycleBeads (4 percent).

Katanga Province

As a proportion of the total volume of CYP for all methods, the public sector in Katanga accounts for over 65 percent of total volume of CYP, almost entirely from public health facilities. Implants (22 percent), followed by male condoms (19 percent), CycleBeads (12 percent) and injectables (6 percent) are the primary contributors in the public sector, of total CYPs. Within outlet types, LARCs (implants, 34 percent; and IUDs, 2 percent) account for slightly more than one-third of public sector outlet CYP. Comparing urban to rural Katanga, the public sector account for considerably more of the total market share in rural Katanga (65 percent) compared to urban Kinshasa (53%). In Katanga, not-for-profit outlets account for only 2 percent of the total volume of CYP distributed in Katanga, primarily from CycleBeads and injectables.

UNPACKING THE PRIVATE SECTOR CONTRACEPTIVE MARKET SHARE

Kinshasa Province

In Kinshasa, private sector outlets account for just over half of the total volume of CYP for all methods, primarily from drug shops (41 percent) followed by private health facilities (10 percent). Condoms distributed in drug shops accounted for nearly one-third of the total CYP volume distributed in Kinshasa and injectables another 5 percent. LARCs distributed in the private sector accounted for about 6 percent of the total volume of CYP. Looking at within sector market share, nearly two-thirds of private sector CYPs come from condoms, 10 percent from injectables and 12 percent from LARCs. In urban Kinshasa, the private sector accounted for over half of the total volume of CYP compared to only about one-quarter in rural Kinshasa.

Katanga Province

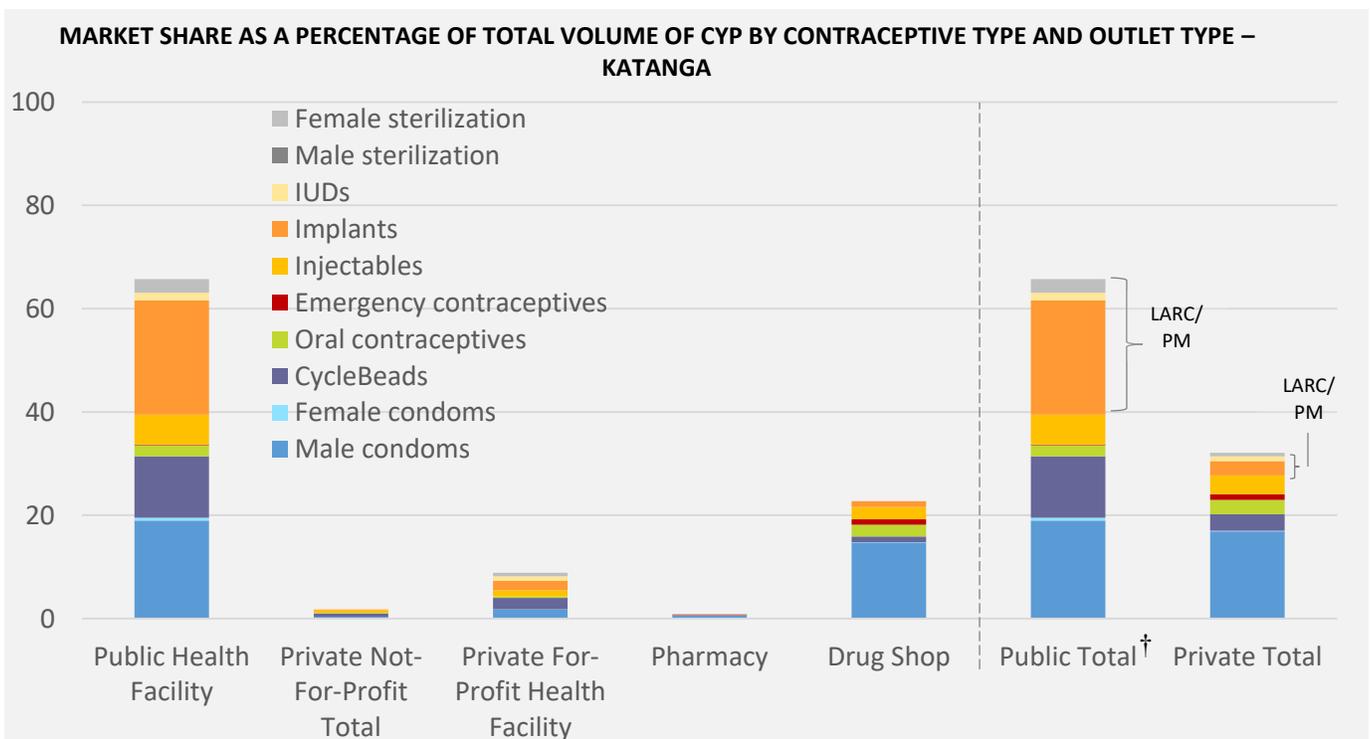
In Katanga, private sector outlets account for 32 percent of the total volume of CYP, primarily from drug shops (23 percent) followed by private health facilities (9 percent). Condoms distributed by drug shops account for 15% of the total CYP volume in Katanga and oral contraceptives, injectables, CycleBeads and implants an additional 6 percent total. LARCs distributed in the private sector account for about 4 percent of the total volume of CYP. Within private sector market share, male condoms account for just over half of private sector CYP, followed by 11 percent for injectables and 10 percent for CycleBeads.

32%*

Private sector contribution to total contraceptive market share in CYP in Katanga

31%

Percent of CYPs, across outlets, accounted for by LARCs in Katanga



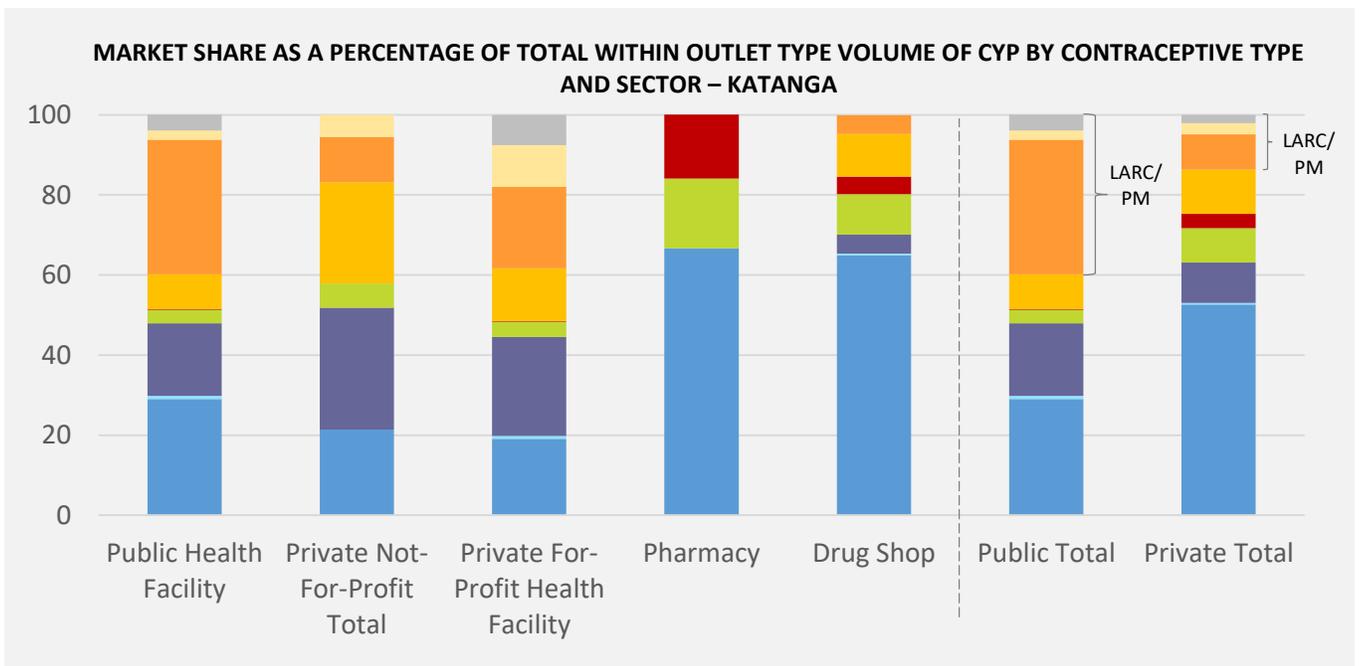
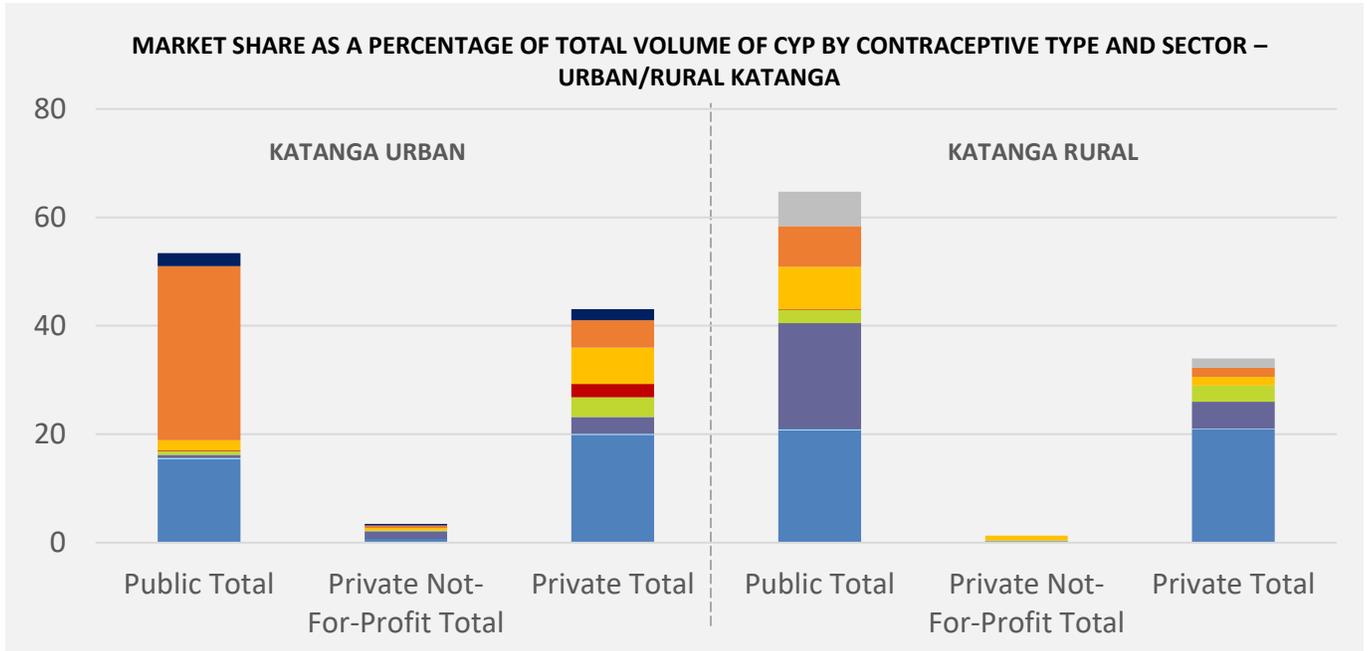
*This reflects distribution by private sector outlets directly to the consumer.

†In health zones where a private or not-for-profit facility is selected to assume the role of state facility, distribution by these facilities is categorized as public sector distribution.

- Female sterilization
- Male sterilization
- IUDs
- Implants
- Injectables
- Emergency contraceptives
- Oral contraceptives
- CycleBeads
- Female condoms
- Male condoms



In Urban Katanga, the private sector accounted for 43 percent of the total volume of CYP compared to about one-third in rural Katanga.





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Readiness to provide contraceptive services

This section addresses the public and private sector readiness to offer provider-dependent contraceptive services (or procedures) according to DRC National FP Guidelines. It addresses availability and service readiness to provide contraceptive services.

Outlets that offer contraceptive services

WHERE ARE PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES OFFERED?

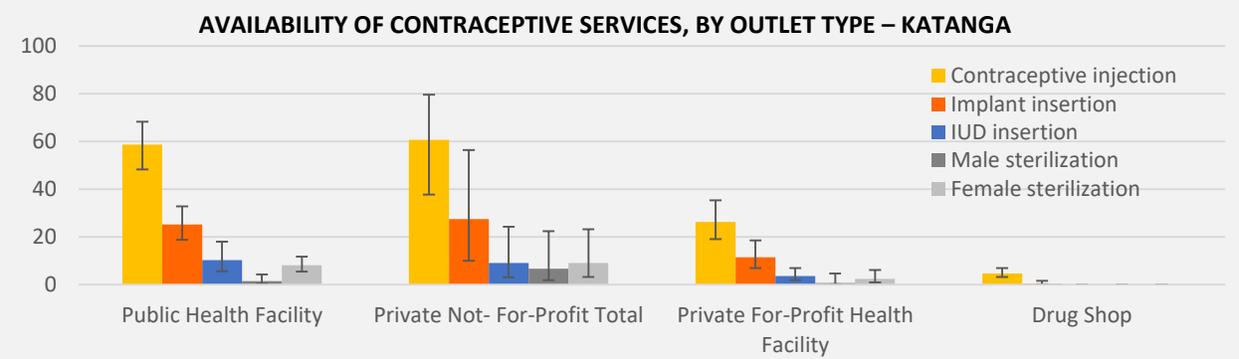
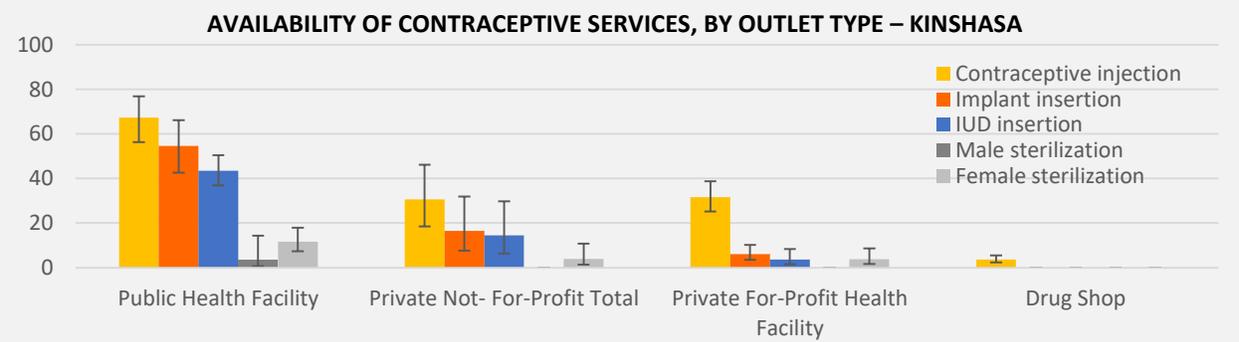
This graph shows the percentage of outlets with selected provider-dependent procedures available among all screened outlets of the outlet type. No available services were reported by CHWs and a handful were reported by pharmacies and drug shops.

Kinshasa

In the public sector, nearly two-thirds of facilities offered an injection, about half of screened facilities provided implant insertion services, and 40 percent offered IUD insertion services. Female sterilization was offered in about 10 percent of facilities and male sterilization in less than 5 percent of facilities. In not-for-profit outlets, injection services were offered in about one-third of facilities and implant and IUD insertions in about 20 percent. Services were not commonly offered in private facilities, except for contraceptive injections (about one-third).

Katanga

Among both public facilities and not-for-profit outlets, about 60 percent had contraceptive injection services available, 20 percent had implant insertions, 10 percent had IUD insertions and 10 percent had female sterilizations. In the private sector, about one-quarter of public facilities offered contraceptive injections, 10 percent implant insertions and less than five percent IUD insertions. In Katanga, there were considerable differences in availability of services comparing urban to rural areas (graph not shown), particularly for services for LARC commodities. While in urban areas, 60 percent and 40 percent of public facilities offered implant and IUD insertion services, respectively, only about 10 percent of rural public facilities offered implant insertion services and less than 5 percent offered IUD insertion services. It was not common for private facilities in rural Katanga to offer contraceptive services.



ARE OUTLETS MEETING QUALITY STANDARDS TO DELIVER PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES?

In the service readiness graphs on the following page, overall service readiness is given for contraceptive injection, implant insertion, IUD insertion and male and female sterilization procedures. Estimates are given only for public health facilities, not-for-profit outlets and private facilities reportedly offering the service. Although a small number of drug stores reported providing contraceptive injections, this number was very small and drug stores were not included in the graphs. Readiness to provide contraceptive services is a composite indicator combining: 1. Availability of the contraceptive on-site on the day of the survey; 2. Availability of a credentialed and trained provider, on current staff; and 3. Availability of a sentinel set of equipment needed for the service.*

Kinshasa

For injection services, nearly two-thirds of public health facilities, about 40 percent of not-for-profit outlets and only about 15 percent of private health facilities reportedly offering contraceptive injection services were found to meet service readiness requirements. For public health facilities, only about two-thirds of those reportedly offering injections had the injectable commodity available on the day of the survey. For not-for-profit outlets, less than half of outlets reportedly offering the service had the injectable commodity available or had equipment available. For private health facilities, less than half of private outlets reportedly offering the service had trained/credentialed providers or the equipment available.

Service readiness for implant insertion services was relatively high for all outlet types noted, with approximately half of those providing services meeting conditions. About two-thirds of these outlet types either had the implant commodity available on the day of the survey or had the necessary equipment. Looking at IUD insertion services, only one-quarter of all public health facilities and not-for-profit outlets and over half of private health facilities met conditions for service readiness. Only about two-thirds of public health facilities and about half of all facility types had equipment available.

Male sterilizations were rarely reported as available, except in public health facilities. About three-quarters of public and private health facilities were service ready for female sterilizations, with about one-quarter lacking either trained/credentialed staff or equipment.

Katanga

For injection services in Katanga, about half of public health facilities and not-for-profit outlets reportedly

Readiness to provide contraceptive services is a composite indicator combining:

- 1. Availability of contraceptive on-site (not applicable to sterilizations);*
- 2. Availability of a trained/credentialed providers; and*
- 3. A sentinel, minimum set of equipment needed for the service.*

If an outlet meets all 3 conditions, it is classified as service-ready.



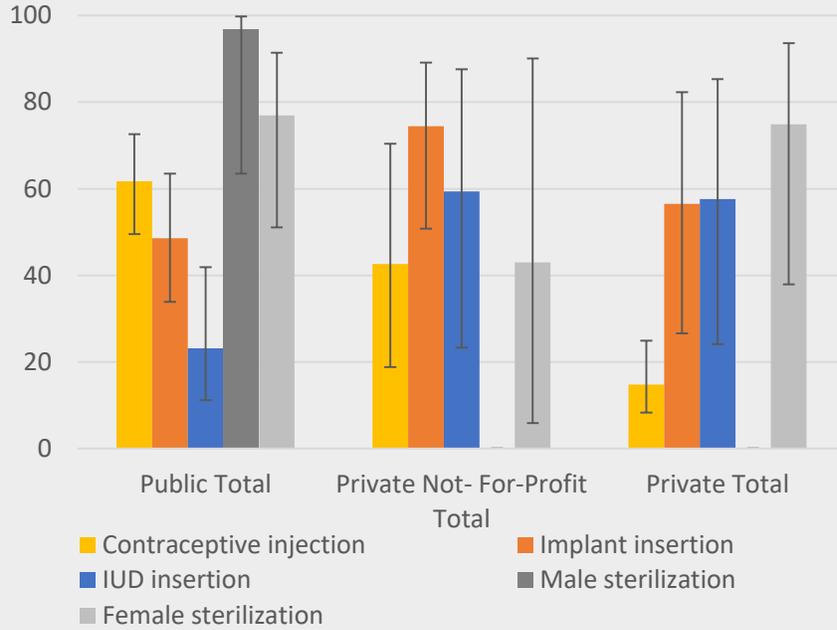
Photo credit: Kate Thanel, PSI

offering contraceptive injection services were found to be service ready while over one-third of private health facilities were service ready. A little over half of these facilities stocked an injectable commodity and only about three-quarters had equipment available.

Only about one-third of public and private health facilities in Katanga offering implant insertion services were found to be service ready. Slightly more than half of public health facilities and one-third of private health facilities stocked an implant commodity on the day of the survey and roughly 60 percent had equipment available. For IUD insertion services, only about 20 percent of public health facilities offering IUD insertion services were service ready, primarily due to only one-third having equipment available. Only small numbers of private health facilities offered IUD insertions and none were found to be service ready, with less than half having the commodity or equipment available.

Similar to Kinshasa, very few outlets offered male sterilization services and very few private health facilities offered female sterilizations. Among public health facilities, only about one-quarter were service ready, primarily due to lack of equipment.

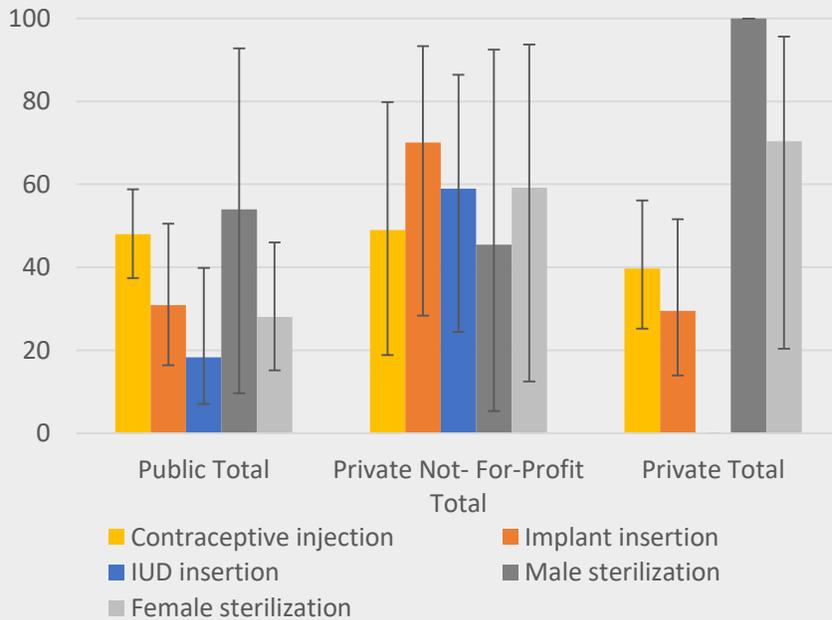
**SERVICE READINESS AMONG OUTLETS REPORTEDLY OFFERING THE SERVICE
– KINSHASA**



>40%

Percent of all public, not-for-profit and private facilities in **Kinshasa** reportedly offering implant insertion services meeting service readiness requirements

**SERVICE READINESS AMONG OUTLETS REPORTEDLY OFFERING THE SERVICE
– KATANGA**



>25%

Percent of all public, not-for-profit and private facilities in **Katanga** reportedly offering implant insertion services meeting service readiness requirements



Modern contraceptive market prices

WHAT IS THE COST PER CYP IN USD, FOR CONTRACEPTIVE METHODS IN THE PRIVATE SECTOR?

Prices for contraceptive methods were standardized across methods by converting into price per CYP. The following graphs report median USD price and price per CYP with interquartile ranges for all brands of a method in the private sector in Kinshasa and Katanga. In the public sector, nearly all contraceptive commodities are distributed for free. The prices listed are those incurred by the end-user and do not necessarily reflect any subsidy that may be provided.

Kinshasa

Comparing methods, the median price per CYP ranged from \$0.73 per CYP for CycleBeads and \$1.10 per CYP for IUDs to \$1.30 per CYP for implants and \$2.20 per CYP for injectables to \$3.96 per CYP for male condoms (the largest market contributor) and \$4.95 per CYP for oral contraceptives for those commonly distributed methods in Kinshasa. With some variation, prices tended to be higher for a given method in pharmacies compared to private facilities and lowest in drug shops. Prices were roughly equivalent comparing urban to rural Kinshasa (not shown).

Katanga

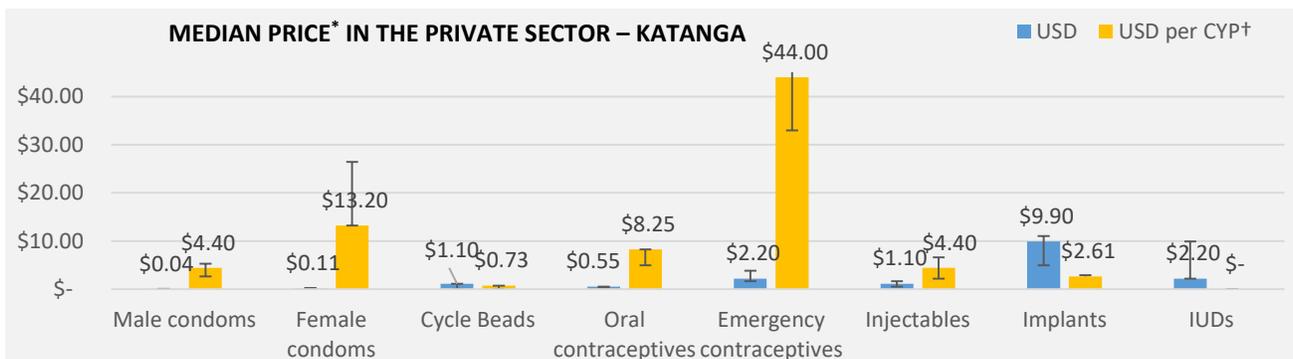
In Katanga, the median price per CYP ranged from \$0.73 per CYP for CycleBeads and \$2.61 per CYP for implants to \$4.40 per CYP for male condoms and injectables to \$8.25 per CYP for oral contraceptives. Most private sector outlets in Katanga were drug shops and there was little variation in price by outlet type. Similarly, there was little variation comparing price of methods between urban and rural Katanga (not shown).

3x

The increase in price of one CYP for male condoms (largest market share) vs. implants in the Kinshasa private sector

2x

The increase in price of one CYP for male condoms (largest market share) vs. implants in the Katanga private sector



* For those outlets selling both the commodity and providing the service, prices were often not distinguished into separate prices for both the commodity and service and, instead the combination was reported. In these cases, the combined price was used.

† Price conversion was done from DRC Francs to USD based on the average conversion rates during the period of data collection, October 9, 2015 – December 2, 2015 of 912.270 DRC Francs per 1 USD.



Photo credit: Catharine Hurley, PSI

Summary

While the DRC is making strides toward reaching its ambitious FP2020 goals to increase CPR and reach an additional 1.2 million women with modern contraceptive methods, FPwatch findings on the family planning markets in Kinshasa and Katanga suggest that there is potential to expedite progress toward FP2020 commitments, providing increased access and choice to women in the DRC.

This 2015 study in Kinshasa and Katanga, conducted among 1,294 public and private outlets with modern contraceptives and/or services within fully-censused health areas, provides total market data for the contraceptive environment in Kinshasa and Katanga. The data is relevant for monitoring and informing the DRC's FP2020 commitments and as part of a market development approach. This process aims to better understand health markets and consumer needs to improve market performance with a vision towards universal health coverage. FP2020 targets require an understanding of the current market for modern contraceptive methods. This includes the need for market information on distribution volume of each method, types of methods available at country and service delivery levels, choice within those methods as well as price points for consumers. Market information on the size and scale of the market is critical to guide investment decisions and provide information symmetry across all market players. FPwatch was designed to provide high-quality and timely information to understand and shape markets at country and regional levels.

What types of outlets in the public and private sectors are carrying modern contraceptive methods?

Of the 783 outlets from the non-booster sample, private sector outlets in the contraceptive market comprise 86 percent of all outlets with at least one modern method available in Kinshasa and 71 percent in Katanga, not including outlets with condoms only. Private health facilities (predominantly drug stores) comprise 79 percent of all facilities with at least one modern method available in Kinshasa and 59 percent in Katanga. In Kinshasa and Katanga, drug stores comprised a larger share of urban markets. In Kinshasa, rural markets comprised a higher share of CHWs and private facilities and in Katanga, rural markets comprised a higher share of public health facilities. In both provinces, nearly three-quarters of public health facilities had at least one modern contraceptive available. CHWs were not commonly encountered in Katanga and rarely stocked modern contraceptives. Over three-quarters of drug shops stocked a modern



Photo credit: Kate Thanel, PSI

contraceptive in both provinces, while only one-third of private health facilities in both provinces stocked a modern contraceptive commodity.

What proportion of public and private sector outlets are stocking selected modern contraceptive commodities and providing a range of methods?

About three-quarters of both public and private sector outlets in Kinshasa stocked at least one brand of a short-acting method, most commonly male condoms. About one-third of public sector outlets in Kinshasa stocked female condoms or CycleBeads. About one-half stocked oral contraceptives. Private sector outlets were much less likely to stock female condoms or CycleBeads and about one-third stocked oral contraceptives. Progestin-only pills were not commonly stocked by public or private outlets in Kinshasa. Emergency contraceptives were more commonly found in private sector outlets, with about 20 percent stocking at least one brand. However, most brands of emergency contraceptives found in the private sector did not meet international quality assurance standards. About half of public sector outlets stocked an injectable (primarily Depo-provera), while only about 20 percent of private sector outlets stocked an injectable.

Looking at the availability of LARC methods in Kinshasa, over 40 percent of public health facilities had at least one brand of a LARC method available, including



Photo credit: Damien Schumann, PSI

implants (38 percent; most commonly Jadelle®) or IUDs (27 percent) on the survey. LARC methods were not commonly available in private sector outlets, not-for-profit outlets or CHWs in Kinshasa, potentially due to regulations around provision of services

Over half of public health facilities, three-quarters of CHWs, 13 percent of not-for-profit outlets and one-quarter of private sector outlets had three or more methods available. Except for public health facilities (one-third), other outlet types did not commonly have more than five methods available.

More than half of Kinshasa's public sector outlets did not stock oral contraceptives on the day of the survey, with 7 percent having stocked the method in the previous three months. Over 9 in 10 public sector outlets did not stock emergency contraceptives, while about sixty percent did not carry injectables or implants and three-quarters did not stock IUDs on the day of the survey. In the private sector, more than 70 percent of outlets did not stock oral contraceptives, emergency contraceptive pills or injectables, with 10 percent or less of these outlets having stocked the methods in the previous three months. For LARCs, just one percent of private sector outlets stocked an implant or an IUD on the day of the survey, with a negligible amount having stocked the method in the previous three months.

There were few major differences between urban and rural Kinshasa in terms of methods or method mixes available. In Katanga, about two-thirds of both

public and private sector outlets stocked at least one brand of a short-acting method, most commonly male condoms. Less than 20 percent of public sector outlets in Katanga stocked female condoms or CycleBeads and about one-third stocked oral contraceptives. Private sector outlets were much less likely to stock female condoms or CycleBeads and about one-quarter stocked oral contraceptives. Progestin-only pills were not commonly stocked by public or private outlets. Emergency contraceptives were more commonly found in private sector outlets, with about 8 percent stocking at least one brand. However, most brands of emergency contraceptives found in the private sector did not meet international quality assurance standards. About one-third of public sector outlets stocked an injectable (primarily Depo-provera), while slightly more than 10 percent of private sector outlets stocked an injectable.

Looking at the availability of LARC methods in Katanga, 14 percent of public health facilities had implants and 9 percent had at least one brand of IUD available. Nearly one-quarter of not-for-profit outlets had at least one brand of a LARC method available, while LARC methods were not commonly available in private sector outlets or among CHWs in Katanga.

Over one-third of public health facilities, one-quarter of not-for-profit outlets and 11 percent of private sector outlets had three or more methods available. Except for public health facilities (12 percent), other outlet types did not commonly have more than five methods available.

In urban Katanga, there was considerably higher availability of nearly all methods, especially injectables and LARCs compared to rural Katanga. Similarly, the proportion of



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outlet types with three or more methods was considerably higher in urban public (59 percent) compared to rural public (31 percent) as well as for urban private (21 percent) compared to rural private (4 percent) outlets.

In Katanga, greater than 70 percent of public sector outlets did not carry oral contraceptives or injectables on the day of the survey and over 95 percent of public sector outlets did not stock emergency contraceptives. In terms of LARCs, more than 85 percent of public facilities did not stock IUDs or implants when surveyed, with about 6 percent of outlets having stocked either method in the past three months. In the private sector, more than three-quarters of outlets did not stock oral contraceptives and more than 85 percent did not stock emergency contraceptives or injectables. Almost all (>98 percent) private sector outlets were stocked out of implants and IUDs on the day of the survey, with less than one percent having stocked either method in the previous three months.

What is the relative market share for each contraceptive method and for each outlet type?

Despite accounting for 86 percent of all outlets censused with at least one modern contraceptive method available in Kinshasa and 71 percent in Katanga, private sector outlets directly distributed only 50 percent of the total volume of CYP in Kinshasa and 32 percent in Katanga. The smaller market share is due to the higher volume of short-acting methods distributed in private outlets relative to higher volumes of LARC methods in public outlets.

Of the 50 percent of total volume of CYP accounted for by private sector outlets in Kinshasa, drug shops contribute the large majority of total CYP volume, mostly from distribution of male condoms. Private

health facilities account for only about 9 percent of the total CYP volume in all Kinshasa, primarily from implants and male condoms. Private sector distribution in the contraceptive market was considerably higher in urban Kinshasa, where private outlets accounted for over half of the total CYP volume distributed, compared to rural Kinshasa, where it accounted for only about one-quarter.

Of the 32 percent of total volume of CYP volume accounted for by private sector outlets in Katanga, drug shops contribute a majority of the total CYP volume, primarily from male condoms. Private health facilities account for 9 percent of the total CYP volume in Katanga, primarily from CycleBeads, implants and male condoms. Private sector distribution in the contraceptive market was slightly higher in urban Katanga (43 percent) compared to rural Katanga (34 percent).

While public sector outlets accounted for only 14 percent of the FP market composition in Kinshasa and 29 percent of the market composition in Katanga, they distributed over one-third of the total CYP volume in Kinshasa and over 65 percent in Katanga. In both, public health outlets were the primary contributor with CHWs contributing only 2 percent of the total CYP volume in Kinshasa (almost all from CycleBeads) and none in Katanga. Public health facilities generally distributed high volumes of contraceptives and in particular, higher-CYP implants. However, a large share of public health facility CYP volumes in both Kinshasa and Katanga came from male condoms and CycleBeads.

IUDs accounted for only about 4 percent of the total volume of CYP in Kinshasa and 2.5 percent of the total CYP in Katanga, with most coming from distribution at private health facilities. Not-for-profit outlets accounted for 13 percent of the total volume of CYP for Kinshasa, mostly from implant distribution, but only 2 percent for Katanga. Permanent methods accounted for less than 1 percent of the market share in Kinshasa and less than 4 percent in Katanga.

What is the consumer price of modern contraceptive methods among private sector outlets?

For the most commonly used method in the DRC, male condoms, the median price for one male condom is about \$0.03 and \$0.04 in Kinshasa and Katanga, respectively. However, in cost per CYP, male condoms tend to be more expensive at \$3.96 per CYP in Kinshasa

and \$4.40 per CYP in Katanga compared to other commonly used methods such as injectables (\$2.20 and \$4.40 per CYP), implants (\$1.20 and \$2.61) and CycleBeads (\$0.73 in both provinces). There was little variability between private outlet types or by urban/rural status in cost of methods. Prices for contraceptive commodities and services were typically free to women in public sector outlets.

What is the availability of provider dependent procedures and readiness of selected outlet types for performing procedures?

In Kinshasa and Katanga, nearly two-thirds of public health facilities and about 30 percent of private health facilities offered contraceptive injection services. Of those that reportedly offered injection services, about half of public health facilities and one-quarter of private health facilities met service readiness criteria, having the commodity, trained/credential staff and a minimum set of sentinel equipment available. Typically, lack of service readiness was mostly due to lack of availability of a contraceptive injectable commodity on the day of the survey. Implant insertions were more likely to be offered by Kinshasa public health facilities (about half) compared to Katanga public health facilities

compared to Kinshasa private health facilities (about 5 percent). Both Kinshasa public health facilities (one-half) and private health facilities (60 percent) were more likely to meet service readiness characteristics compared to Katanga public health facilities (one-third) and private health facilities (one-third). A larger share of outlets did not possess the necessary equipment and did not meet service readiness requirements for implant insertion compared to contraceptive injection procedures.

Only about 40 percent of public health facilities in Kinshasa and 10 percent in Katanga offered IUD insertion services. Of these, only about one-fifth met service readiness requirements for IUD insertion procedures in both provinces. In Kinshasa, IUD insertions procedures were available in less than 5 percent of private health facilities, but of those, about 60 percent were service ready in contrast to none being service ready in Katanga.

Contraceptive injection or other procedures were not typically offered to an appreciable degree by drug shops, pharmacies or CHWs. Male and female sterilizations were typically rarely offered across all outlet types.



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Assessing progress toward FP2020 goals and national DRC policies

The contraceptive market findings in both Kinshasa and Katanga demonstrate a mixed market with contributions from the public, not-for-profit and private sectors. However, unlike other FPwatch countries, such as Ethiopia, the DRC does not have an active role in distributing family planning commodities and providing services through the CHW cadre.

Most of the outlets considered had at least one contraceptive method available. However, considerably fewer had a diversity of methods available. Moreover, LARCs and provider-dependent services are often not available at the more numerous and accessible private outlets. There are often disparities in availability of methods and method mixes when comparing urban and rural areas of Kinshasa and Katanga. The FPwatch survey showed that there were a number of oral contraceptive brands and emergency contraceptive brands that were not quality assured. In the case of emergency contraceptives, these brands accounted for a majority of the emergency contraceptives distributed. Finally, of those outlets offering provider-dependent procedures, a significant number did not meet service readiness criteria. Overall, the FPwatch survey in Kinshasa and Katanga provide key data to inform and supplement FP market monitoring and highlight key action points toward the DRC FP2020 goals to achieve a contraceptive prevalence rate (CPR) of 19% by 2020 and to reach an additional 2.1 million women with modern methods by 2020.

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The project will inform FP market strategies and priorities for national Ministries of Health and their partners. Additional resources are available on the website (www.FPwatch.info).

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