

**REPORT**

# **SEXUAL AND REPRODUCTIVE HEALTH COMMODITIES:** AVAILABILITY, AFFORDABILITY AND STOCKOUTS

Kenya 2019



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Kenya 2019

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# CONTENTS

<b>GLOSSARY</b>	<b>4</b>
<b>BACKGROUND</b>	<b>5</b>
<b>DATA COLLECTION</b>	<b>6</b>
<b>RESULTS</b>	<b>7</b>
1. Overall Availability of SRH Commodities	<b>7</b>
2. Availability of SRH Commodities by Service	<b>7</b>
3. Stock-outs	<b>11</b>
4. Affordability of SRHC	<b>14</b>
5. Stakeholder Interviews	<b>15</b>
<b>DISCUSSION</b>	<b>21</b>
<b>RECOMMENDATIONS</b>	<b>23</b>
<b>APPENDICES</b>	<b>26</b>

# GLOSSARY

HAI	Health Action International
HSAP	Health Systems Advocacy Partnership
KEMSA	Kenya Medical Supplies Authority
MeTA	Medicines Transparency Alliance
NHIF	National Hospital Insurance Fund
SRH	Sexual and Reproductive Health
SRHC	Sexual and Reproductive Health Commodities
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UHC	Universal Health Coverage
WHO	World Health Organization

# BACKGROUND

**Sexual and reproductive health and rights or SRHR is the concept of human rights applied to sexuality and reproduction. According to United Nations Population Fund (UNFPA), good sexual and reproductive health (SRH) is a state of complete physical, mental and social well-being in all matters relating to reproduction for both men and women, including adolescents.<sup>1</sup>**

Maintaining good SRH means people need access to accurate information and safe, effective, affordable and acceptable contraception methods of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections and, when necessary, receive timely and affordable treatment. When they decide to have children, women must have access to services that ensure they have a fit pregnancy, safe delivery and healthy baby. Every individual has the right to make their own choices about their SRH and family planning.

The constitution of Kenya, under Article 43 (1) (a), provides that every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare. Although there has been progress in the realisation of the right to health, significant gaps still exist. For this reason, we collected data in ten counties for the third year to generate reliable information on the price, availability and affordability of select SRH commodities (SRHC) in Kenya's public, private and mission health sectors.

The basket of commodities assessed was developed by combining the World Health Organization's (WHO) Essential Medicines for Reproductive Health, the Interagency List of Essential Medicines for Reproductive Health, the

Interagency List of Medical Devices for Essential Interventions for Reproductive, Maternal, New-born and Child Health, and the United Nations Commission on Life Saving Commodities.

The commodities cover male and female contraceptives, medicines for the prevention and management of postpartum haemorrhage, management of pre-eclampsia and eclampsia, treatment for pregnancy-induced hypertension, treatment for maternal syphilis, antibiotics for maternal and neonatal sepsis and pneumonia, anti-anaemia medicines, medicines for diarrhoea and candidiasis, cord care antiseptic, and a range of equipment for anaesthesia, surgery and safe delivery.

The methodology uses a cross-sectional design with quantitative methods and a semi-structured questionnaire adapted from the standardised HAI-WHO methodology, measuring medicine prices, availability, affordability and price components. It allows for data collection on availability and out-of-pocket patient prices of SRHC in the public, private and mission sectors. It also assesses health provider perspectives on access to SRHC beyond the medicines supply chain. The methodology facilitates reliable data collection and enables price and availability indicators to be compared within and between individual countries.

1. United Nations Population Fund. Sexual & Reproductive Health. <https://www.unfpa.org/sexual-reproductive-health>

This report is the third in a series of surveys undertaken from 2017 to 2019 in select counties by Health Action International (HAI) and Medicines Transparency Alliance (MeTA) Kenya. The data collection for the survey for 2019 was undertaken in July 2019, and provides findings and recommendations to the following research questions:

- What price do people pay for SRH commodities and services?
- Do the prices and availability of the SRHC vary across the public, private and mission sectors?
- How affordable are the SRHC for individuals?
- What do healthcare providers see as the main barriers to accessing SRHC?
- What recommendations are the health providers giving to improve access to these commodities?

## DATA COLLECTION

This report presents data from the 2019 roll-out of the HAI research methodology, Sexual Reproductive Health Commodities (SRHC): Measuring prices, stock outs, availability and affordability, in Kenya. The methodology used for data collection follows HAI's SRHC data collection manual, produced in 2017. Please refer to this manual for all details on the methodology followed for data collection. Data collectors were trained in July 2019.

Data collectors visited facilities from the health post level and above in the public, private and mission sectors, both in urban and rural areas. The counties selected for data collection were: Isiolo, Kakamega, Kisumu, Kwale, Makueni, Meru, Mombasa, Nairobi, Nakuru, and Narok. A total of 221 facilities were surveyed across the three sectors. The distribution of these facilities is as outlined below in Table 1.

**Table 1.** Distribution of surveyed facilities, per county and sector.

County	Public	Private	Mission	Total
Isiolo	7	8	7	22
Kakamega	8	6	8	22
Kisumu	8	9	7	24
Kwale	10	8	1	19
Makueni	8	16	0	24
Meru	8	8	8	24
Mombasa	8	8	6	22
Nairobi	8	8	9	25
Nakuru	7	11	6	24
Narok	7	6	2	15
Total	79	88	54	221

# RESULTS

This section contains analysis of the quantitative data measuring availability, stock-outs and affordability of SRH commodities at facility level across the public, private and mission sectors. For a full list of surveyed commodities please refer to Annex 1.

## 1. Overall Availability of SRH Commodities

This research showed that mean availability of SRHC in Kenya was 43% in 2019, which is an improvement from 2018, and more along the lines with the availability in 2017 (see Table 2). Availability of SRH commodities was higher in the public (48%) and mission sectors (46%), while the private sector had a lower availability (36%). For a full breakdown of availability of SRHC per sector and area, please refer to Annex 2.

**Table 2: Mean availability of SRHC by sector and location.**

	2017	2018	2019
<b>Public</b>	51	45	47
<b>Private</b>	44	27	37
<b>Mission</b>	42	35	46
<b>Total</b>	46	36	43

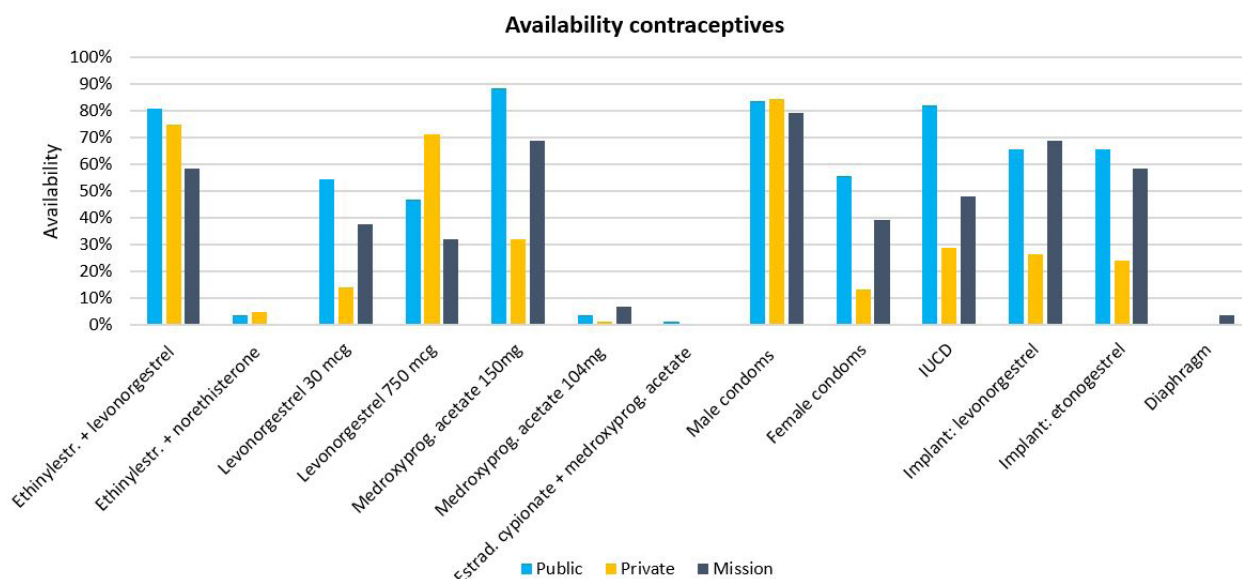
## 2. Availability of SRH Commodities by Service

### Availability of Contraceptives

There is a general improvement in the availability of contraceptives over the years, except for ethinylestradiol + norethisterone, which tended to remain around the 5% availability each year. The contraceptives with highest availability in the public sector were male condoms and

medroxyprogesterone acetate 150mg in 1ml vial (Depo-Provera), with an availability of 84% and 89%, respectively (see figure 1). In 2018, the availability of male condoms was higher (98%), indicating a drop in availability. Availability of male condoms was also high in the private and mission sectors: 85% and 79%, respectively. This availability is comparable to 2018, even though it slightly decreased. The private sector seemed to have a lower availability of most contraceptives. For instance, medroxyprogesterone acetate 150mg was available in only 32% of private facilities (compared to the 89% availability in the public sector), and implants were available in about 25% of facilities in the private sector, compared to 65% of facilities in the public sector. Interestingly, levonorgestrel 750mcg, the emergency contraceptive pill, was the exception to this trend: availability in the public sector was 47%, compared to 71% in the private sector.

Availability of female condoms increased compared to 2018: in 2019 they were available in 56% of public facilities, 13% private facilities and 39% of mission facilities, while in 2018 availability was 31% in public facilities, 9% in mission facilities, and they were unavailable in all private facilities. There were also a few contraceptives with an availability of less than 10%. However, for three of them (ethinylestradiol + norethisterone, medroxyprogesterone acetate 104mg and estradiol cypionate + medroxyprogesterone acetate), there were similar commodities with different formulations (e.g., medroxyprogesterone acetate 150mg) or commodities with the same effect (e.g., ethinylestradiol + levonorgestrel) that did have a high availability. Only the diaphragm was very rarely available: it was unavailable in all public and private facilities, and only in 4% of mission facilities.

**Figure 1.** Availability of contraceptives, per sector.

At county level, Kakamega, Kisumu, Kwale and Meru had the highest mean contraceptive availability (43%), while Isiolo had the lowest mean contraceptive availability (31%). Overall, male condoms had the highest availability across all counties, with Meru leading at 94%. For an overview of contraceptive availability per county, please refer to Annex 3.

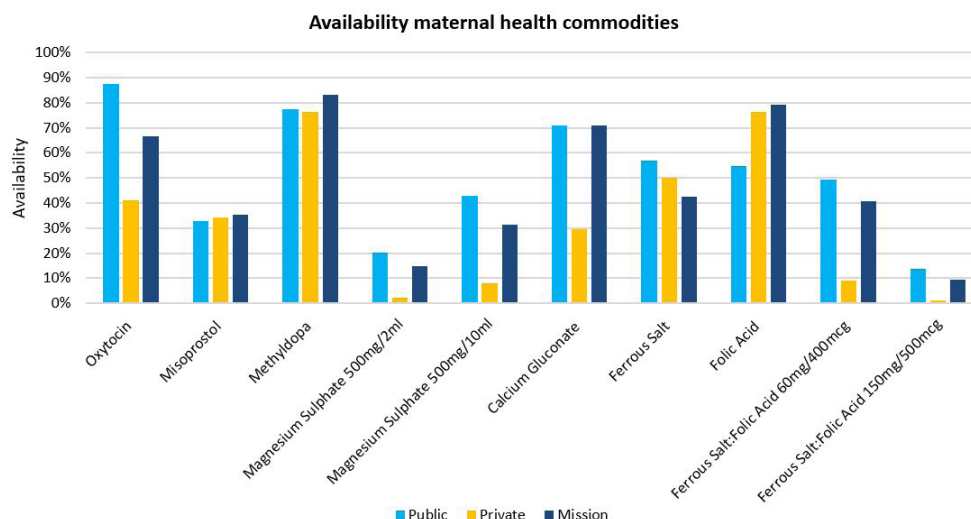
#### Availability of Maternal Health Commodities

Oxytocin, used to induce labour and for the prevention and treatment of post-partum haemorrhage, had a high availability in the public sector (87%), a 67% availability in the mission sector, and only a 41% availability in the private sector (see Figure 2). These numbers were comparable to 2018. Misoprostol, also used to stop bleeding (post-partum haemorrhage), had a similar availability across the sectors: 33% availability in the public sector, 34% availability in the private sector and a 35% availability in the mission sector. Availability in the public sector dropped from 42% in 2018 to 33% in 2019, while in the private sector a slight increase was seen (from 29% in 2018 to 34% in 2019).

It is further discouraging to note that availability of some of the other maternal health commodities has also been decreasing over the years. An example is the availability of magnesium sulphate 500mg in 10ml, which dropped from a 73% availability in the public sector in 2017 to 43% availability in 2019, dropped in the private sector from 40% availability to 8% availability, and in the mission sector availability dropped from 65% to 32%.

Supplements, such as folic acid, ferrous salt and the combination of folic acid-ferrous salt that are given to pregnant women were available at around 60% of public facilities in 2017 and 2018, which is comparable to the findings of 2019, when availability of these supplements ranged from 50% to 57%. However, availability is still not optimal, and more needs to be done in terms of provision of commodities that ensure healthy pregnancies and babies.



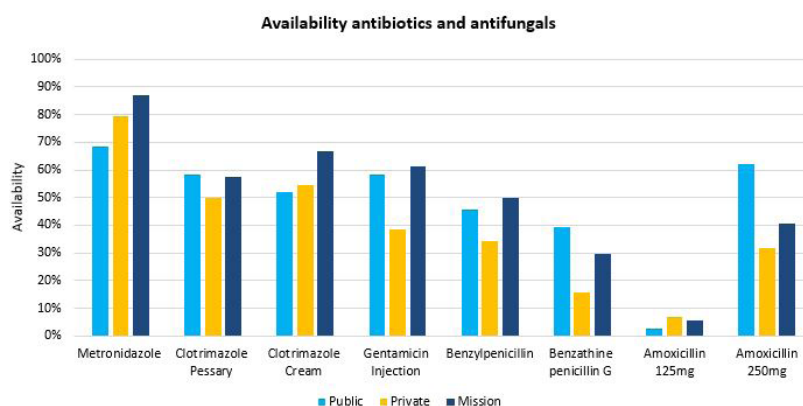
**Figure 2.** Availability of maternal health commodities, per sector

Kakamega county had the highest availability of maternal health commodities in the surveyed counties at 58%, while Isiolo and Makueni had the lowest availability at 30%. Generally, folic acid had the highest availability, while ferrous salt: folic acid (tablet, 150mg Iron + 500mcg folic acid) had the lowest availability across the counties. Please refer to Annex 3 for a full breakdown of availability per county.

### Availability of Antibiotics and Antifungals

The general availability of antibiotics used to treat Sexually Transmitted Infections (STIs) and other infections has not improved over the years. While some availability increased, availability of other commodities decreased. For instance, metronidazole, used for the treatment of vaginal infections, remained about the same in the public sector (68% availability in 2019, compared to 71%

in 2018), while in the mission sector it increased from 79% to 87% (see Figure 3). In the private sector, availability in 2019 was 80%, an increase of 5% compared to 2018. Availability of procaine benzylpenicillin also increased from 7% in 2018 to 46% in 2019 in the public sector, from 30% to 34% in the private sector and from 24% to 50% in the mission sector. However, availability of benzathine benzylpenicillin G decreased in 2019 compared to 2018. In the public sector it decreased from 73% to 39%, in the private sector from 48% to 16%, and in the mission sector from 71% to 30%. Availability of gentamicin, used to treat pneumonia and maternal and neonatal sepsis, and for antenatal and post-natal care, also continues to decrease each year; in the public sector availability in 2017 was 80%, 75% in 2018, and 58% in 2019. In the private sector it decreased from 79% in 2017 to 46% in 2018 and 39% in 2019.

**Figure 3:** Availability of antibiotics and antifungals, per sector.

The overall availability of antibiotics and antifungals in Isiolo was the highest at 64%, while Nairobi had the lowest availability at 26%. Isiolo county and Meru county had the highest availability of metronidazole at 96%, while Nairobi had the lowest at 52%. Availability of the antibiotics and antifungals across the counties is shown in Annex 3.

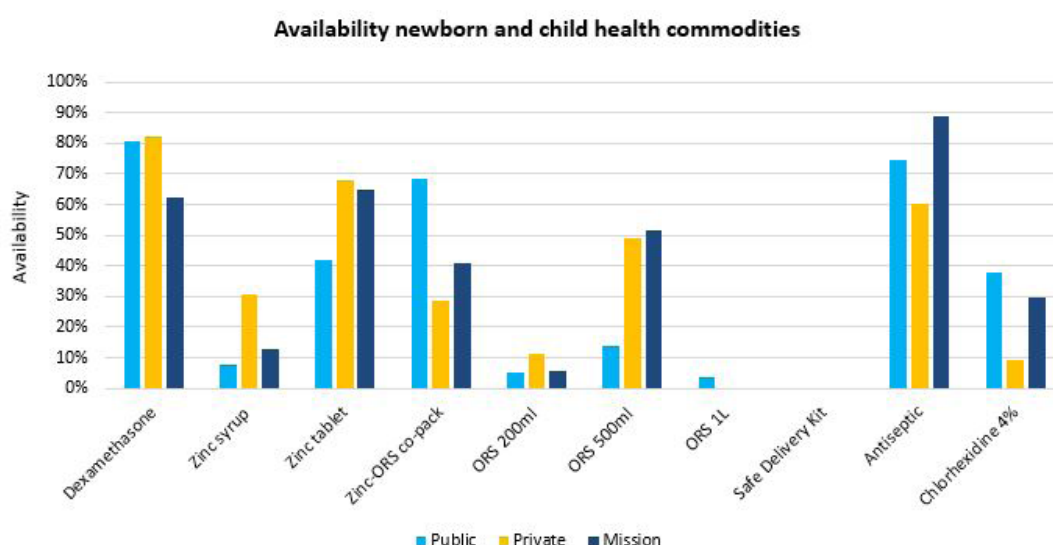
### Availability of Newborn and Child Health Commodities

All three strengths of oral rehydration salts (ORS) surveyed had a low availability in the public sector, with highest availability found for ORS 500ml, which was 14% (see figure 4). This is a decrease compared to 2018 and 2017, when ORS 500ml was available in 29% and 36% of public facilities, respectively. Availability in the private and mission sectors, while slightly higher, also registered a drop compared to 2018 (49% and 52%, respectively, versus 63% and 62%, respectively). However, ORS sachets might not be the preferred formulation used in the public sector, as the Zinc-ORS co-pack had a higher availability than the ORS sachets; here, availability of the co-pack was 68%, which was a slight increase compared to 2018, when it was available at 60% of facilities.

Zinc syrup had a low availability across the sectors, while zinc tablets were doing slightly better, even though availability was still not high. Dexamethasone had in general the highest availability of the new-born and child health commodities across the sectors, with 81% availability in the public sector, 82% in the private sector and 63% in the mission sector. Only antiseptic had a higher availability in the mission sector (89%). Availability of chlorhexidine 4%, used for cord-care, increased from 11% in the public sector in 2018, to 38% in 2019.

Kisumu county had the highest overall availability of newborn and child health commodities at 45%. Nairobi county and Narok county had the lowest overall availability (24%). Highest availability of a newborn and child commodity was found in Isiolo for dexamethasone (100%). Mombasa county was the only county that had ORS sachets of 1 litre available. Please refer to Annex 3 for a full breakdown of availability per county.

**Figure 4.** Availability of new-born and child health commodities, per sector.

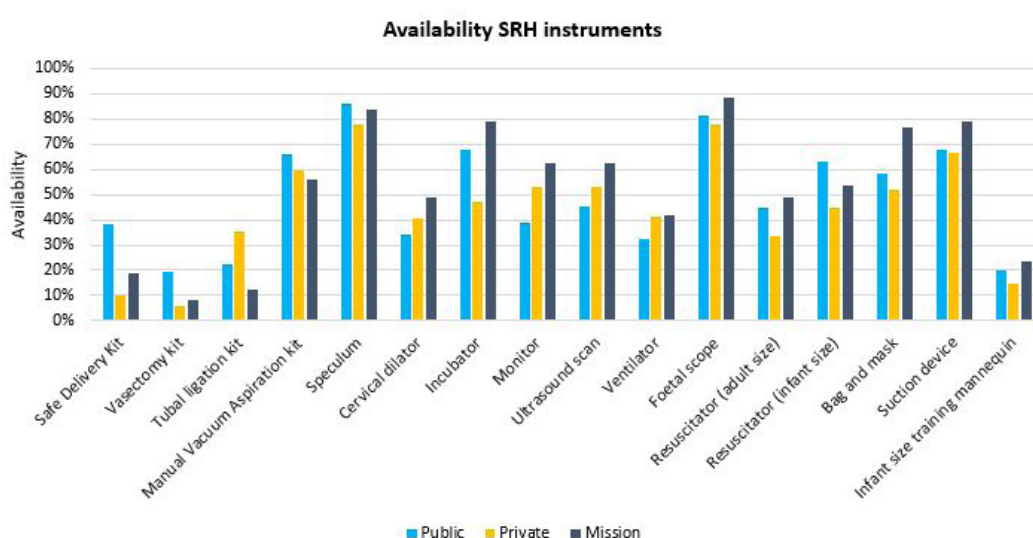


### Availability of SRH Instruments

A range of essential SRH devices and instruments were also included in the survey. In the public sector, highest availability was found for the speculum (86%) and the foetal scope (82%) (see Figure 5). Lowest availability was found for vasectomy kits (19%), tubal ligation kits (23%) and infant-size training mannequins (20%). In the private and mission sectors availability of the speculum and foetal scope were also highest, and availability of vasectomy kits, tubal ligation kits and infant-size training mannequins were lowest.

Meru county had the highest general availability of SRH instruments at 77%, while Makueni county had the lowest at 25%. Tubal ligation kits and vasectomy kits had the highest availabilities in Meru county at 47% and 40%, respectively. The rest of the counties studied show very low availability of these two instruments. Please refer to Annex 3 for a full breakdown of availability per county.

**Figure 5.** Availability of SRH instruments, per sector.



### 3. Stock-outs

Stock-out information was recorded by data collectors when it could be seen via stock cards or stock-taking databases. As a result, in cases where stock information was not recorded by the facility, the stock-out days were also not recorded. Stock-outs were measured for a period of six months. The respondents were asked how many days they had experienced stock-outs within a period of six months preceding the day of data collection.

On average, stock-outs were experienced in 23% of public facilities, an increase from 7.4% in

2018. In the private sector, 17% of the facilities reported stock-outs, as did 12% of facilities in the mission sector. The highest percentage of stock-outs in the public sector was observed for ethinylestradiol + norethisterone (70%), in the private sector for ORS 1L (100%), and for ferrous salt: folic acid 150mg/500mcg in the mission sector (50%). Multiple facilities experienced stock-outs for some commodities that lasted the entire six month period. For a full breakdown of number of stock-out days per month per commodity, please refer to Annex 4.

**Table 3.** Percentage of facilities reporting a stock-out in the previous six months and average duration of stock-outs per month, per sector.

	% of facilities reporting stock-outs	Number of stock-out days per month
Public	23	6.5
Private	17	3.5
Mission	12	3.3

### Stock-outs of Contraceptives

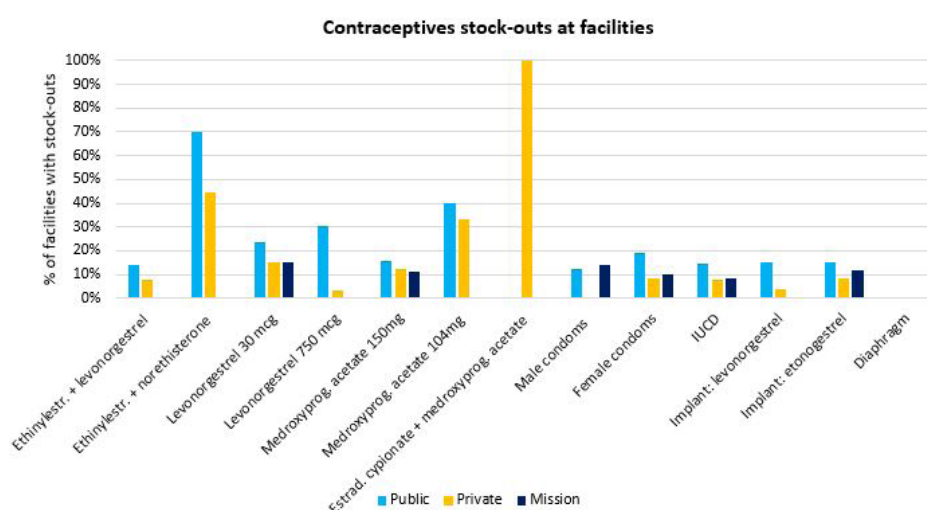
In the public sector, ethinylestradiol + norethisterone was stocked-out most often (70% of facilities) (see Figure 6). In the private sector, estradiol cypionate + medroxyprogesterone acetate experienced a stock-out at all facilities at which it was available, while in the mission sector the most commonly stocked-out contraceptive was levonorgestrel 30mcg (15% of facilities). The number of stock-out days per month ranged from one day (medroxyprogesterone acetate 104mg)

to 11 days (levonorgestrel 30mcg) in the public sector, from one day (medroxyprogesterone acetate 104mg, male condoms and levonorgestrel 30mcg) to nine days (ethinylestradiol + norethisterone) in the private sector, and from two days (IUCD and levonorgestrel 30mcg) to 13 days (male condoms) in the mission sector.

### Stock-outs of Maternal Health Commodities

Maternal health commodities stock-outs are illustrated in Figure 7 below. Ferrous salt: folic acid 150mg/500mcg and misoprostol were the most commonly stocked-out commodity in the public sector (35% and 33%, respectively). Ferrous salt: folic acid 150mg/500mcg was also the most common stock-out in the private and mission sectors. When stock-outs occurred in the public sector, they lasted 3 days (oxytocin and ferrous salt: folic acid 60mg/400mcg) to 7 days (calcium gluconate and folic acid) per month. In the private sector methyldopa and folic acid were stocked out on average 10 days per month, while in the mission sector calcium gluconate was out-of-stock on average five days per month.

**Figure 6.** Stock-outs of contraceptives, per sector





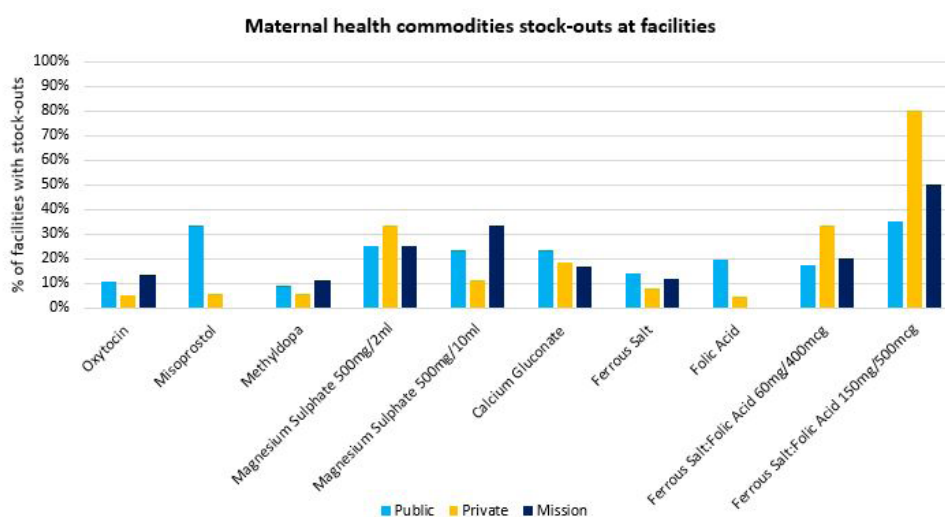
### Stock-outs of Antibiotics and Antifungals Commodities

Amoxicillin 125mg was the commodity most often out-of-stock across the three sectors, with highest stock-out in the public sector (64%), followed by the mission sector (29%) and the private sector (25%) (see Figure 8). Public facilities experienced stock-outs most often for all antibiotics and antifungals. In the public sector benzathine penicillin G was the commodity with the least frequent stock-outs (14%). When looking at average number of days, in the public sector, both formulations of amoxicillin had the longest duration of stock-outs per month (10 days). In the private sector gentamicin was the longest out-of-stock commodity on average (seven days per month), while in the mission sector this was the case for metronidazole (six days).

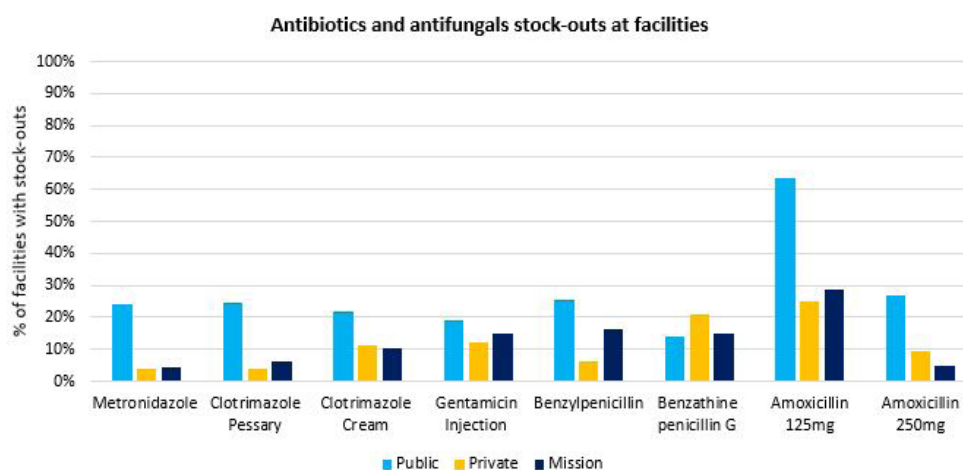
### Stock-outs of Newborn and Child Health Commodities

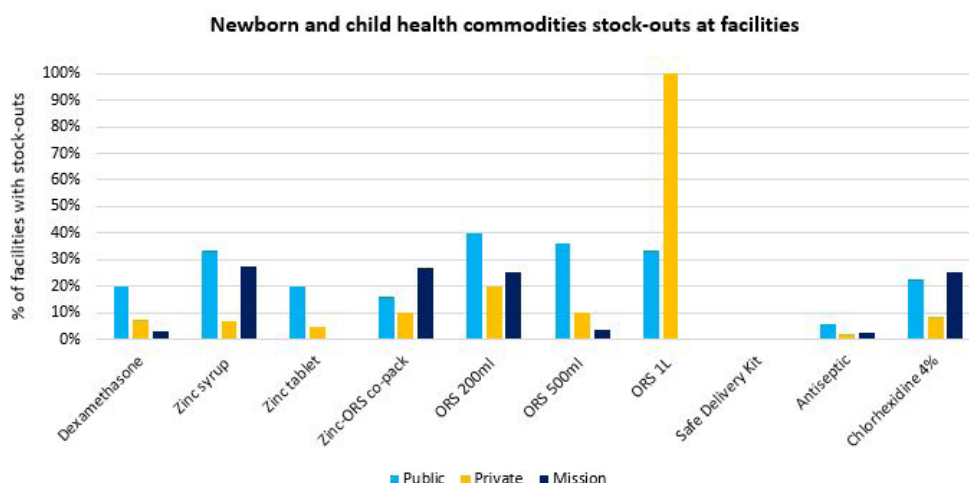
Stock-outs of newborn and child health commodities were again more frequent in the public sector. Here, ORS 200ml was the most out-of-stock commodity at the facilities (40%) (see Figure 9). In the private sector ORS 1L had the highest stock-out level, as it had been out-of-stock at least once in all the facilities that should have it in-stock in the previous six months. In the public sector, zinc syrup was out-of-stock for an average of 14 days per month, and ORS 200ml for 11 days on average. ORS 1L, when out-of-stock, remained so for 10 days per month. In the mission sector the longest stock-out occurred for antiseptic and lasted five days per month on average.

**Figure 7.** Stock outs of maternal health commodities, per sector.



**Figure 8.** Stock-outs of antibiotics and antifungals, per sector.



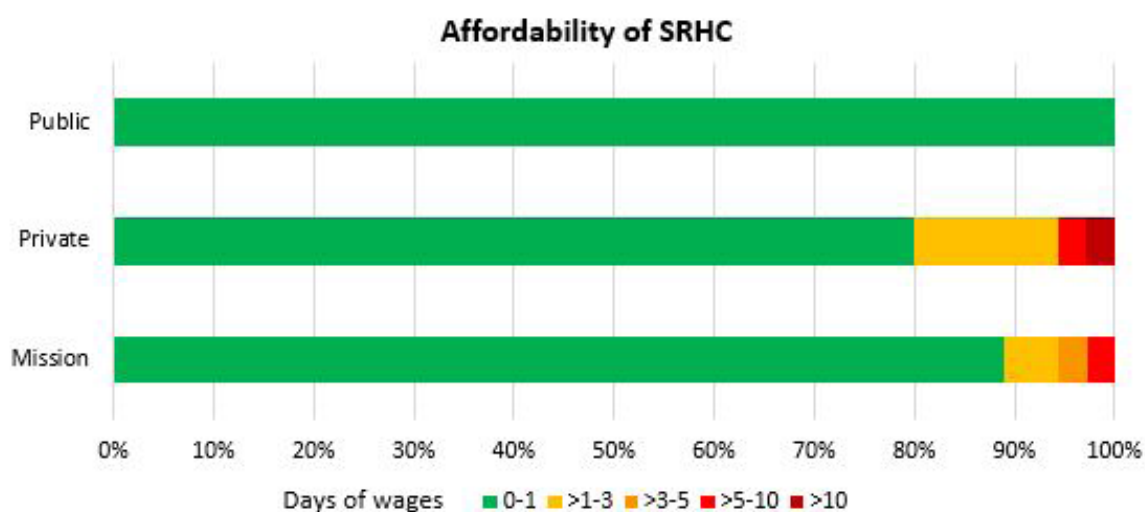
**Figure 9.** Stock-outs of newborn and child health commodities, per sector.

#### 4. Affordability of SRHC

Affordability was measured using the prices of SRHC (Annex 5), treatment regimens (Annex 6) and the daily salary of a lowest-paid government worker (LPGW), which was 448.7 KSH at the time of the study. The public sector had the highest affordability rates, with all 38 surveyed commodities costing less than a day's wage for an LPGW. In the private sector 28 commodities ranged between zero and one days of wage and seven cost more than a day's wage, while in the mission sector 32 commodities cost less than a day's wage and four cost more than a day's wage.

Magnesium sulphate (500mg in 10ml vial) is the most unaffordable SRHC in both the private and mission sectors, costing 12.33 and 7.94 days of wages, respectively.

In both the private and mission sectors, magnesium sulphate (500mg in 2ml) was also very expensive, costing 8.83 days in the private sector and 3.64 days in the mission sector. For a full breakdown of affordability per commodity, please refer to Annex 7.

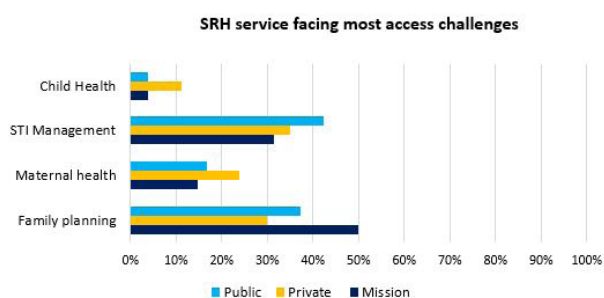
**Figure 10.** Affordability of SRH Commodities in public, private and mission sectors.

## 5. Stakeholder Interviews

### SRHC and Services Facing Access Challenges

The following section contains data based on stakeholder interviews with healthcare providers to identify the challenges and factors that hinder access to SRHC. One of the key findings of the survey was that, according to the healthcare providers, family planning commodities faced the most challenges overall (38%) while they believed child health services faced the least challenges overall (7%) (see Figure 11). Healthcare providers in the mission sector believed most challenges were faced for clients when trying to access family planning commodities (50%). In the public and private sectors, access to STI management was believed to be the most challenging (42% and 35%, respectively). For a breakdown of the data per county, please refer to Annex 8.

**Figure 11.** Services facing the most challenges related to access in public, private, mission sectors.



When looking at the responses per county:

- In Kwale county, 68% of healthcare providers believed clients faced the most challenges accessing family planning services.
- In Nakuru county, 52% of healthcare providers believed the most challenges were faced by clients when trying to access STI management services.
- In Narok county, 33% of healthcare providers believed accessing maternal health services was a challenge for clients.
- In Mombasa county, 23% healthcare providers believed that clients faced the most problems when trying to access newborn and child health services (see Table 4).

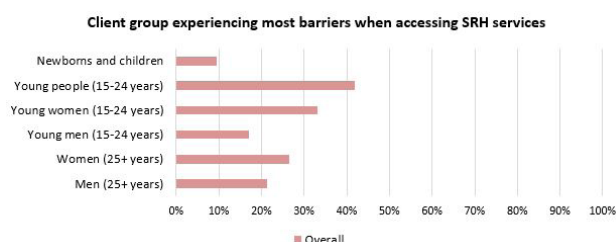
**Table 4.** Services facing the most challenges related to access, per county.

County	Family Planning	Maternal Health	STI Mngmt	Child Health
Isiolo	50	14	36	0
Kakamega	45	23	27	5
Kisumu	41	23	27	9
Kwale	68	11	11	11
Makueni	21	21	50	8
Meru	46	8	42	4
Mombasa	27	14	36	23
Nairobi	32	16	52	0
Nakuru	18	26	52	4
Narok	47	33	20	0

### Client Groups Facing Challenges Accessing SRHC

The healthcare providers were also asked which people they believed experienced the most barriers to accessing these services. They believed that young people—both men and women—from the age of 15-24 years face the most barriers (42% of healthcare providers), while they believed newborns and children didn't face much difficulty in accessing services and commodities (see Figure 12). Many healthcare providers also believed that young women aged 15-24 years and women aged 25 years or older faced significant barriers when accessing SRH services (33% and 26%, respectively).

**Figure 12.** Clients experiencing the most barriers when accessing SRH services in public, private and mission sectors.



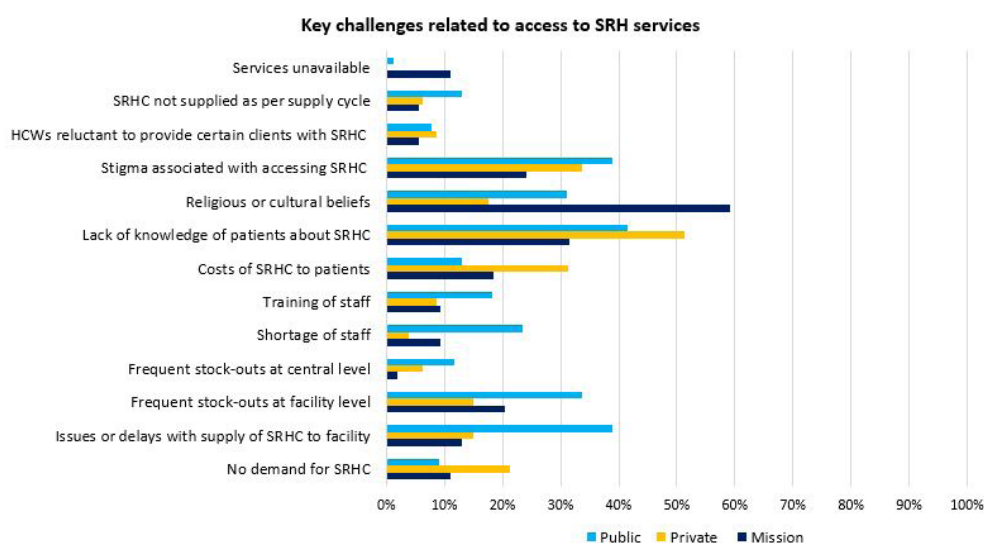
### Key Challenges for Accessing SRHC

When asked about the key challenges related to accessing SRHC, healthcare providers felt that the lack of knowledge of patients about the commodities and services was one of the main challenges in the public and private sectors, with 51% of private sector and 42% of public sector healthcare providers believing this (see Figure 13). In the mission sector, it was the second most commonly named challenge, with 31% of healthcare providers mentioning it. The most commonly mentioned challenge in the mission sector was religious and cultural beliefs, which was especially challenging for access to family planning services. In the public sector, religious and cultural beliefs and the stigma associated with accessing SRHC were also commonly mentioned (31% and 39%, respectively).

Annex 8 gives a comprehensive look at the challenges experienced at county level. In the counties, it is not surprising that many of the healthcare providers mentioned lack of client knowledge as one of the major challenges. Religious and cultural beliefs were also commonly mentioned. In Mombasa, the major challenge was the lack of demand for SRHC (mentioned by 41% of healthcare providers), and according to 32% of the healthcare providers access was further complicated due to SRHC not being supplied according to the supply cycle.

In Narok and Kwale county, healthcare providers believed that an interplay of multiple barriers influenced access to SRHC. For example, in Kwale healthcare providers believed that issues and delays with the supply of SRHC facility (61%), lack of knowledge of clients (56%), frequent stock-outs at facility and central level (56% and 44%, respectively), religious and cultural beliefs (44%), and lack of staff and staff training (33%) all led to accessibility issues. In Narok county, 53% of healthcare providers believed that the major barriers were due to societal barriers: lack of client knowledge and cultural and religious beliefs. Stigma was seen as a major challenge in Kakamega, Meru and Nakuru. In Kisumu and Nakuru county, costs of SRHC to patients were also seen as a major challenge by healthcare providers (41% and 39%, respectively).

**Figure 13.** Key challenges related to access to SRH services, per sector.





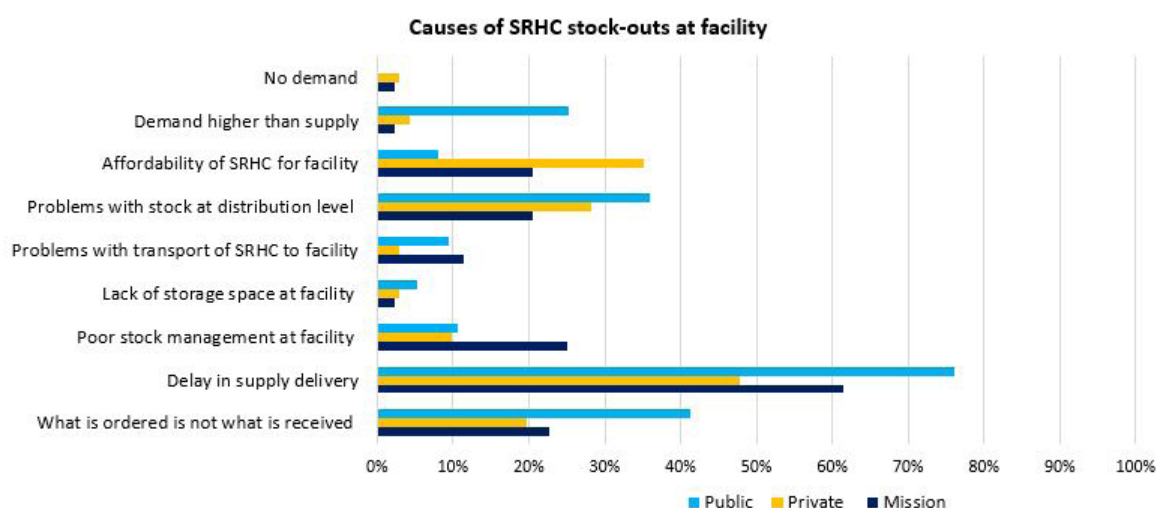
### Reasons for SRHC Stock-outs at Facilities

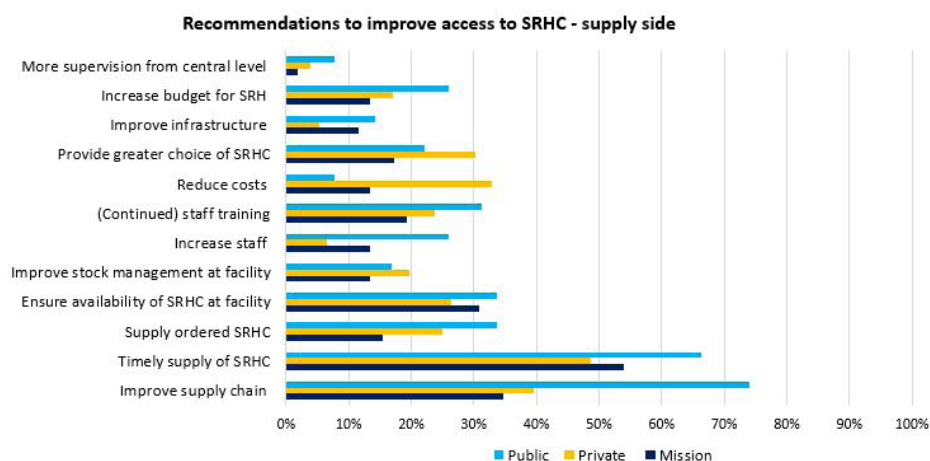
Respondents were also asked what they believed were the causes of stock-outs at their facilities. In all three sectors, the major issue was the delay in delivery of SRHC. In the public sector 76% of healthcare providers mentioned delays, followed by 61% of providers in the mission sector and 48% of providers in the private sector (see Figure 14). Other commonly mentioned causes of stock-outs in the public sector were what is ordered by the facility is not what is received (41% of respondents) and that there were problems with the stock at the distribution level (36%). Further, 25% of the public sector healthcare providers believed that the demand for the SRHC was higher than the supply. In the private sector, 35% of healthcare providers mentioned the problem of affordability of SRHC for the facility, while 28% also mentioned the problems with stock at the distribution level. Mission sector healthcare providers believed poor stock management at the facility was a major reason for stock-outs (25%), followed by what is ordered is not what was received (23%). Lack of storage space and no demand for the SRHC were not believed to be significant causes of stock-outs. For a breakdown per county, please refer to Annex 8.

### Healthcare Providers' Recommendations for Improving Access to SRHC—Supply Side

Respondents were also asked about what they believe can be done to improve access to SRHC on the supply side. In the public sector, the main recommendations were to improve the supply chain in general (74%), and more specifically to ensure the timely supply of commodities (66%), to supply the commodities that were ordered (34%) and to make sure that essential SRHC are always available at the facilities (34%). In the private sector, timely supply of SRHC (66%), a general improved supply chain (39%), reduction in costs the facility needs to pay for SRHC (33%) and an expansion in the choice of SRHC offered at the facility (30%) were the most commonly mentioned recommendations. In the mission sector, timely supply of SRHC, general improvement of the supply chain and ensuring the availability of essential SRHC were also a few of the most mentioned recommendations. For a breakdown per county, please refer to Annex 8.

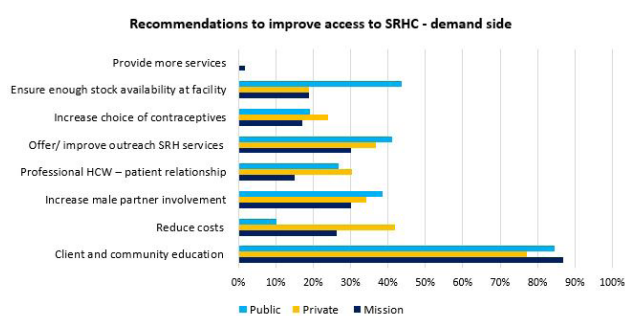
**Figure 14.** Causes of SRHC stock-outs, per sector.



**Figure 15.** Recommendations to improve access to SRHC on the supply side, per sector.

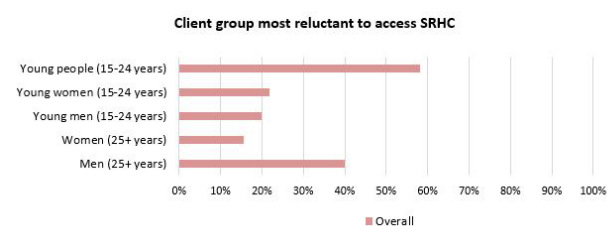
### Healthcare Providers' Recommendations for Improving Access to SRHC—Demand Side

When asked what needed to be done to improve access to the commodities from the demand side, the majority of healthcare providers argued for client education. In the public sector this recommendation was made by 85%, in the private sector by 77% and in the mission sector by 87% of healthcare providers (see Figure 16). In the public sector, ensuring the availability of SRHC at the facility (44%) and improving or offering outreach services (41%) were also recommendations often made by healthcare providers. In the private sector, reducing the costs for patients was an important recommendation made by 42% of healthcare providers. In all three sectors, healthcare providers also raised the point that male partner involvement should be increased. For a breakdown per county, please refer to Annex 8.

**Figure 16.** Recommendations to improve access to SRHC on the demand side, per sector.

### Clients' Reluctance to Access SRHC

Healthcare providers were also asked whether or not clients were reluctant to access SRH commodities and services: 54% of the healthcare providers believed they were. When asked which client group was most reluctant to access SRH commodities and services, it is not surprising that the majority of healthcare providers (58%) chose young people aged 15-24 years (see Figure 17). Interestingly, 40% of healthcare providers also believed men aged 25 years or older were reluctant to access SRH commodities and services.

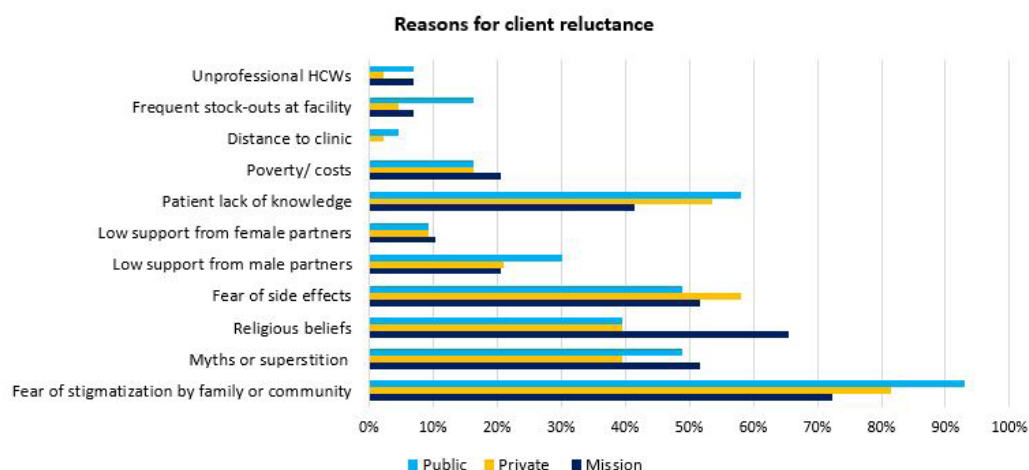
**Figure 17.** Client groups most reluctant to access SRHC.

Reasons given for clients' reluctance were more or less similar across the sectors: fear of stigmatisation by family or the community was the most commonly mentioned reason, while fear of side effects, lack of knowledge, myths and superstition, and religious beliefs were also commonly raised reasons why clients might be reluctant (see Figure 18).

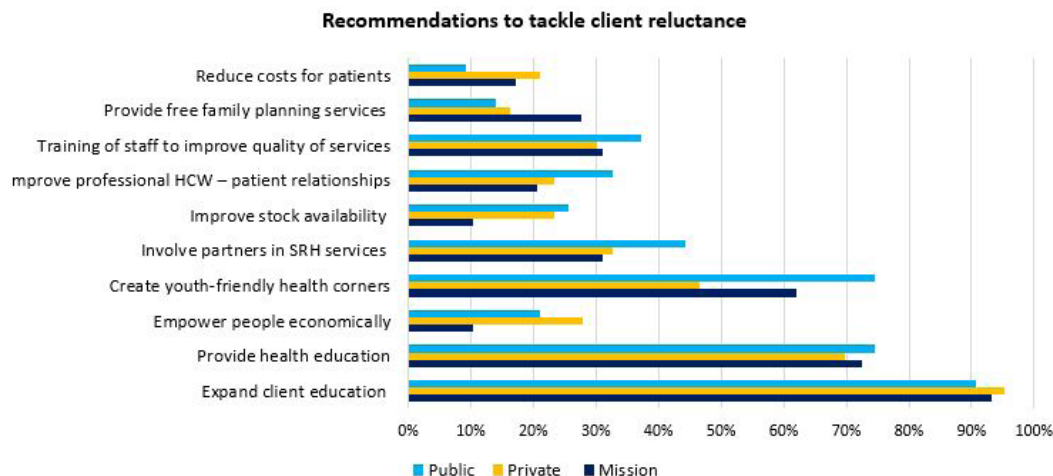
To tackle client reluctance, healthcare providers believed—again—that expanding client education is key. Over 90% of all healthcare providers across the sectors argued for this. In line with this, they also believe that providing health education at schools, in churches and in communities is also

critical in decreasing the reluctance of clients to access SRH services. Further, they also believed that creating youth-friendly health corners would take away some of the reluctance amongst the younger clients (see Figure 19).

**Figure 18.** Reasons for clients' reluctance, per sector.



**Figure 19.** Recommendations to tackle clients' reluctance, per sector.

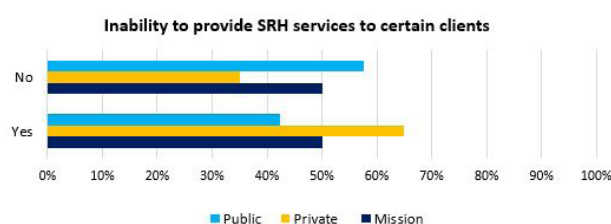


### Inability of Healthcare Providers to Make SRH Services Available for all Clients

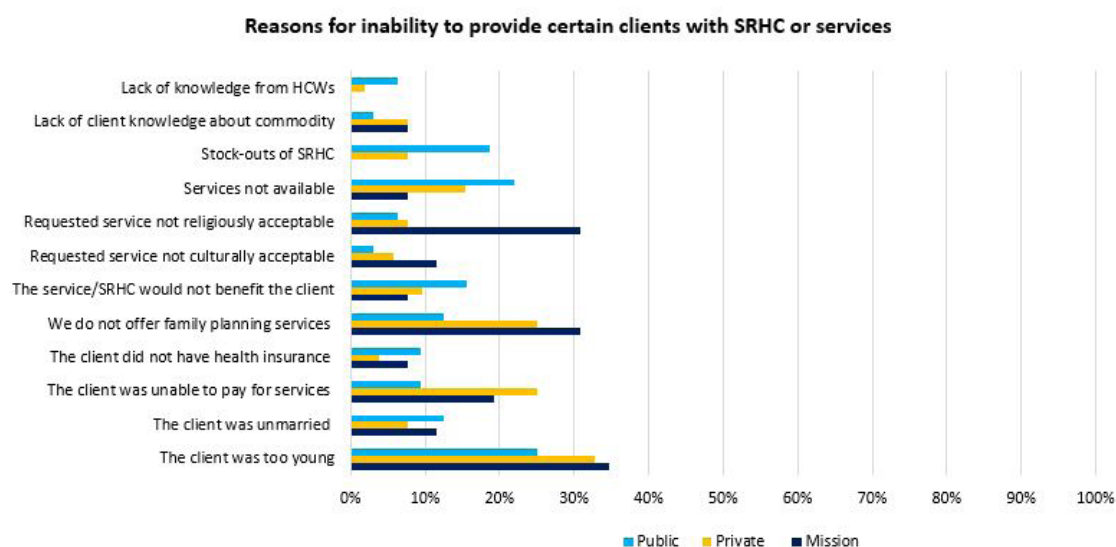
Healthcare providers were also asked if they are unable to provide some clients with SRH services and commodities. In the public sector, 42% were unable to provide services to everyone, compared with 65% of providers in the private sector and 50% of providers in the mission sector (see Figure 20). When asked why they were unable to do so, a common answer given was that the clients were too young: 25% of healthcare providers in the public sector, 33% in the private sector, and 35% in the mission sector gave this as a reason (see Figure 21). In the mission sector, other reasons given were that they did not offer family planning services and were therefore unable to provide it (31%), and in line with that, that the service was

religiously unacceptable (31%). Interestingly, 25% of private sector healthcare providers also stated they were unable to provide clients with family planning services because the facility does not offer family planning. Costs to the patients was another reason why not all clients were provided with services in the private sector according to 25% of healthcare providers.

**Figure 20.** Inability of healthcare providers to provide SRH services to certain clients, per sector.



**Figure 21.** Reasons for inability to provide certain clients with SRHC or services, per sector.





# DISCUSSION

This is the third in a series of four surveys (2017–2020) that investigate the levels of access to SRHC in the public, private and mission sectors of select counties in Kenya. In 2017, data was collected from 120 facilities in seven counties, in 2018 data was collected in from 169 facilities in nine counties, and in 2019 we collected data across 10 counties in a total of 221 facilities. This survey is part of Health Action International's SRHC research under the Health Systems Advocacy Partnership (HSAP). It is used firstly to track access to SRHC within countries and, secondly, to compare access between countries (Kenya, Tanzania, Uganda and Zambia) to create a clearer picture of the situation. The surveyed commodities include contraceptives, antibiotics and antifungals, and commodities for maternal, newborn and child health.

This survey also sought the views on issues affecting access to SRHC from healthcare providers working in the surveyed facilities. Due to their expertise and experience of working on the ground, their insights into the topic allow for recommendations that are in line with the situation at facility level.

## Availability

While comparing the data collected from 2017–2019, which showed that overall availability in 2019 was 43%, in 2018 36% and in 2017 46%, it becomes clear that there was only a marginal improvement in 2019 compared to 2018. Further, availability was still lower in 2019 than in 2017, and is still certainly below average. When comparing availability of contraceptives, you can see a marginal decline in the availability of condoms, from 98% in the public sector in 2018 to 84% in the public sector in 2019. The availability of Microgynon (ethinylestradiol + levonorgestrel) continues to increase; in 2017 availability in the public sector was 59%, increasing to 71% in 2018, with a further increase to 81% in 2019.

A similar trend, albeit less strong, was seen in the private sector, with availability increasing from 67% in 2017 to 75% in 2019. Availability of the injectable Depo-Provera (medroxyprogesterone acetate), the most commonly used type of contraceptive in Kenya<sup>2</sup>, also increased slightly from 2018 to 2019 in the public sector (84% versus 89%, respectively), while availability remained low in the private sector (32%). In the mission sector, availability seems high at 69%, but this was measured only in mission facilities that offered family planning services. Interestingly, in 2019 the availability of the female condom in the public sector increased to 56%, compared to the 31% availability observed in 2018. Comparable to the data from 2017 and 2018, the diaphragm was still rarely available across the sectors. When looking at the average availability of contraceptives per county, the counties with highest average contraceptive availability (43%) were Kakamega, Kisumu, Kwale and Meru. The counties with the lowest average contraceptive availability were Makueni (30%) and Isiolo (31%).

Availability of oxytocin, used to induce labour and in the prevention and management of post-partum haemorrhage, remained similar in 2019 compared to 2018, with only a 2% increase in the public sector to 87%, and a 1% increase in the mission sector to 67%. Only in the private sector was there a bigger increase, from 27% to 41%. However, availability remained low. Misoprostol, similar in use as oxytocin, decreased in availability in the public sector, going from 42% in 2018 to 33% in 2019. Gentamicin, used in the treatment of pneumonia and maternal and neonatal sepsis, further decreased to 59% in 2019 (availability was 85% in 2017 and 75% in 2018); this is a worrying trend that needs to be further investigated. Magnesium sulphate, critical in the management of pre-eclampsia, also dropped compared to the previous year, from 71% in 2018 to 59% in 2019.<sup>3</sup>

2. United Nations, Department of Economic and Social Affairs, Population Division, Trends in Contraceptive Use Worldwide 2015. (Geneva: United Nations, 2015), p. 1-63.

3. For both years, this is the combined availability of either the magnesium sulphate 500mg/2ml or magnesium sulphate 500mg/10ml at the surveyed facilities.

When comparing the counties, highest average availability of maternal health commodities was found for Kakamega (58%) and Kisumu (53%). The counties with the lowest average availability of maternal health commodities were Isiolo (30%) and Makueni (30%).

For antibiotics and antifungals, the biggest increase in availability can be seen for procaine benzylpenicillin in the public sector. This had an availability of 39% in 2017, dropping to a very low point of 7% in 2018 and increasing again to 46% in 2019. Amoxicillin 125mg had a very low availability across the sectors (less than 10%), but availability of the 250mg formulation was better, especially in the public sector (62%). Comparing the counties, Isiolo and Kakamega county had the highest availability of antibiotics at 63% and 64%, respectively, while Nairobi had the lowest at 26%.

ORS and zinc are important for newborns and children in the management of diarrhoea and to prevent dehydration. In Kenya, it seems like a combination of ORS and zinc formulation is the preferred treatment in the public sector, as availability of such a co-pack was higher than that of zinc or ORS separately. For instance, the co-pack was available in 68% of public facilities, while zinc tablets were available in 42% of the facilities, and ORS 500ml in only 14% of facilities. Interestingly, in the private and mission sectors, this seemed to be the other way around, with ORS sachets and zinc tablets having a higher availability than the co-pack. Another interesting observation is that the preference for the co-pack in the public sector seems to be a trend of recent years, as in 2017 availability was 55% and in 2018 60%, while availability of ORS 500ml was 34% in 2017 and 29% in 2018, with availability of zinc tablets also decreasing in this time period. Further, there was an improvement in availability of chlorhexidine 4%, used for cord care, in the public and mission sectors, with availability increasing from 11% and 3%, respectively, in 2018, to 38% and 30%, respectively in 2019. Highest average availability of newborn and child health commodities was found in Kisumu county (45%).

Lowest availability was found in Nairobi and Narok county (24% both).

This research also surveyed a range of 16 SRH instruments across the 221 facilities in the 10 counties. Lowest availability was found for vasectomy and tubal ligation kits, and infant-sized training mannequins. The county with the highest availability of SRH instruments was Meru county at 77%, followed by Isiolo at 72%. The lowest availability was found in Makueni county at 17%, Nakuru at 20%, Mombasa at 25% and Narok at 27%.

### Stock-outs

The research showed that stock-outs are still problematic in Kenya with, on average, stock-outs experienced in 23% of public facilities, 17% of private facilities and 12% in of mission facilities. To prevent this, changes are needed in the supply chain and management of commodities at the health facility and central level.

### Affordability

Affordability of SRHC was measured based on the salary of a lowest-paid government worker, which was 448.7 KSH at the time of the study. The public sector had the highest affordability rates, with all 38 SRHC surveyed costing between zero and one days of the wage. In the private sector 28 commodities ranged between zero and one days of wage and seven cost more than a day's wage, while in the mission sector 32 commodities cost less than a day's wage and four cost more than a day's wage. However, the wage of the lowest-paid government worker is higher than what a significant proportion of the population earns: a lowest-paid government worker earns an equivalent to 4.40 USD, while a third of the populations lives below the poverty line of 1.90 USD per day. As was illustrated in last year's research, if you use the household final consumption expenditure to calculate affordability, then affordability in the private and mission sectors becomes problematic for 60% of the population.<sup>4</sup>

4. Health Action International. Sexual and Reproductive Health Commodities: availability, affordability and stockouts. Kenya 2018. (Amsterdam: Health Action International, 2018). p. 1-38.

# RECOMMENDATIONS

Many of the recommendations made in the previous reports remain relevant when looking at the findings of this year's research. One of the main findings this year is that the availability of maternal health commodities decreased in 2019 compared to the previous years. This highlights an urgent need for more focus on ensuring access to these commodities as their importance in preventing pregnancy- and childbirth related deaths is critical. Below, recommendations to improve access to SRHC will be given and elaborated further.

## Supply Side

It is evident that even with the decentralisation of ordering commodities from the Kenya Medical Supplies Authority (KEMSA) directly by the counties, many challenges remain. A few of the issues are related to delayed payments to KEMSA, with some counties citing late disbursement of funds from central government as the main cause for this. Counties should strive to ensure that they are able to order commodities for their populations to guarantee communities can access these medicines when they need them without undue inconvenience. With the country-wide roll-out of Universal Health Coverage (UHC) expected in 2020, counties have an opportunity to tailor a package that works for their context specifically, while remembering that the health of the child and mother is the cornerstone of sustained economic development in any country. Access to comprehensive SRH services and commodities should be part and parcel of the Essential Package List that will be developed by each county as part of what is offered within their UHC package.

When looking specifically at the supply side, the most relevant recommendation remains that the supply chain needs to be improved. There continue to be delays in delivery of commodities, which, like in 2018, was again identified as one of the causes of both low availability and stock-outs of SRHC at the facility. Healthcare providers also stressed the importance of supplying commodities that have been ordered to ensure

availability of these commodities at facility level. Often this is not the case, and facilities do not receive all the commodities ordered. One of the reasons for this is problems with the stock at the distribution level.

There are also problems with the supply chain at the health facility level. Three years after the first study, the need for improved stock management remains relevant; counties must prioritise training on both stock management and quantification to ensure seamless supply and availability of commodities. Healthcare providers should be able to adequately forecast when a commodity is likely to run out and ensure that they have ordered a new supply and, anticipating any delays of the supply, that it has been delivered before they have run out.

Next to the need for more training of healthcare providers on quantification and stock management, there is also a need to provide follow-up training on SRH care amongst the health workforce. A quarter of the surveyed healthcare providers mentioned the need for more staff training, while the research also showed that clients are still at times not provided with SRH services. This was because healthcare providers thought the client was too young, because the client was unmarried, or because the service was culturally or religiously unacceptable. The training of healthcare providers should therefore include elements of customer care to ensure that patients are not only getting the treatment they need but are treated with respect and without discrimination or stigmatisation. This is especially important in the case of adolescents seeking family planning services. Sensitising healthcare providers about the fact that everyone should have access to SRH services, irrespective of their age, marital status or the healthcare providers' own views, can help make SRH services more accessible for adolescents, and prevent unwanted pregnancies. While having dedicated youth friendly health corners has remained a rallying call to improve access to SRH Services to the youth, it is also important to recognise that in

limited resource settings, such as most counties in Kenya, having dedicated health corners might not be feasible. However, having friendly staff that can maintain confidentiality and offer unbiased and comprehensive information and services will go a long way in ensuring youth are able to access the much needed SRH services at any health facility.

Related to the training of healthcare providers, the health workforce in Kenya remains inadequate, even though the government has allocated a larger proportion of the health budget to pay the health workforce. More healthcare providers are needed to be able to treat all those who want to access the healthcare system.<sup>5</sup>

The general infrastructure needs to be improved to ensure access to SRH and other health services, especially in emergency situations. This is particularly the case for access to health facilities in counties like Isiolo, Narok and Kakamega, where some facilities are located in very remote and inaccessible areas. This challenge was noted by the data collectors during field visits to facilities. In Isiolo for instance, some sub-counties could only be accessed by hiring a four-wheel drive vehicle because of the terrain and distances involved. In Narok there was no reliable public transport—in some areas public transport operated only once per day and missing it would mean being stranded in that location. Hiring of vehicles was costly and required that data collectors approach individual car owners to negotiate the rates. The situation was the same for some sub-counties in Kakamega that were also only accessible by four-wheel drive vehicle—a cost that is very prohibitive for the local communities seeking to access basic health services. These three counties have one of the highest maternal death rates in Kenya and improving infrastructure might be an extra tool to be used to improve these negative indicators.<sup>6</sup>

Along with health services, budget functions were also devolved to county level. While looking at the budgetary allocations for health, very little is allocated to SRH, covering the spectrum of family planning, STI management, and maternal, newborn and child health.<sup>7</sup> Some counties, such as Kakamega and Makueni, have flagship health programmes that cover maternal health. However, while noble, these efforts are inadequate in addressing the reproductive health challenges faced by the counties. There is therefore a need not only to provide adequate budgets for SRH, but also to ring-fence these funds to guarantee they are actually spent on ensuring the optimal health of newborns, children, adolescents and mothers. There is also need for a wider variety of available SRHC to choose from, and greater supervision from the central level in delivering these services is essential.

### Demand side

Even if all supply side challenges are addressed, there is still a need to educate the population on access and use of SRH services and commodities. Eighty-two percent of healthcare providers at the facilities we visited in the 10 counties echoed these sentiments, an indication that the supply and demand side go hand in hand.

One area of sensitisation and community education that must be undertaken is on challenging myths and superstitions around the use of contraceptives, such as allaying the fears about perceived side effects of their use. One way to do this is ensuring service providers are well trained and give all the information on the full range of method mix to allow clients the opportunity to make informed choices based on what is available.

Fear of stigmatisation in the access to and use of SRHC is yet another issue that needs to be addressed.

5. [https://taskforce.org/wp-content/uploads/2019/09/KHWF\\_2017Report\\_Fullreport\\_042317-MR-comments.pdf](https://taskforce.org/wp-content/uploads/2019/09/KHWF_2017Report_Fullreport_042317-MR-comments.pdf)

6. [https://kenya.unfpa.org/sites/default/files/pub-pdf/RMNCAH%20JP%20Prodoc\\_0.pdf](https://kenya.unfpa.org/sites/default/files/pub-pdf/RMNCAH%20JP%20Prodoc_0.pdf) page 83

<http://erepository.uonbi.ac.ke/handle/11295/97814>

7. <https://www.unicef.org/esaro/UNICEF-Kenya-2018-Health-Budget-Brief.pdf> pgs 6,7,11

<https://sokodirectory.com/2019/02/health-sector-budget-leaves-kenyans-spending-too-much/>

This is particularly true for seeking treatment for STI infections, use of condoms and even SRHC in general for youth and teenagers, given the fact that these services are all centrally offered, and public perception on why teenagers should be accessing these commodities is hinders access. This has formed part of our standing recommendation to either set aside youth friendly centres or designate youth friendly corners within the existing public health facility infrastructure, thereby eliminating the barriers to accessing SRH services and commodities for all that need them, when they need them.

The Ministry of Health at national level has developed and reviewed a number of Information, Education and Communication (IEC) materials for patient education and demand creation. There is need for these IEC materials to be disseminated to the counties and enable wider use. This is to make sure all public health officers are part of the patient education campaign. If these campaigns are to be successful, county governments need to ensure demand is matched by supply, and access is assured.

Involvement of male partners in access, provision and education around use of contraceptives, and testing and adhering to STI treatment is critical. Given that in many of the counties, and I Kenyan society, men still have most of the decision-making power about family matters, it is important that any programmes on community sensitisation and client education involve men as well. These programmes can educate both men and women about the choice women have in accessing SRH services, about the different contraceptives that can be used and the advantages of their use, as well as teach them about the importance of adequately treating STIs in both partners. This can help facilitate the uptake of contraceptive use if the woman wants it and, when required, both get STI treatment to prevent reinfection.

To improve access to SRHC at the primary level, there is need to expand outreach services provided by community health workers to include provision of SRH information, services and commodities that do not require specialised knowledge. This can contribute to the reduction in newborn and child deaths associated with diarrhoea, reduction in teenage pregnancies, and support the increased uptake of contraceptives and provision of family planning information, including knowledge of the full method range.

In the private sector, the cost of SRH services and commodities also remain problematic for clients. The issue of affordability is a critical factor influencing access to SRH services and commodities in situations where access to the public sector is difficult. A way to tackle this barrier is to reduce or subsidise costs, especially in hard to reach and marginalised areas, where the poorest often live. There is a need to integrate SRH services under UHC to ensure that those who cannot afford the services are given priority under this programme.

Lastly, a review of the different newborn, child and maternal health programmes, both at national and county levels, may be beneficial. These programmes include, among others, Linda Mama, Oparanya Care, Beyond Zero Campaign, Makueni Care Scheme, the National Health Insurance Fund, and UHC. Such a review can create a clearer picture of the effectiveness and impact of each of these programmes and inform the programmes on what can be included in a comprehensive care package for SRH services and commodities at all levels.



# ANNEX 1: SRHC SURVEYED

**Table 1.** List of surveyed Commodities

<b>Commodity (strength)</b>
Ethinylestradiol + levonorgestrel (tablet, 30mcg + 150 mcg)
Ethinylestradiol + norethisterone (tablet, 35mcg + 1.0 mg)
Levonorgestrel (tablet, 30 mcg)
Levonorgestrel (tablet, 750 mcg)
Medroxyprogesterone acetate (150 mg in 1 ml)
Medroxyprogesterone acetate (104 mg in 1 ml)
Estradiol cypionate + medroxyprogesterone acetate (5mg + 25mg)
Male condoms
Female condoms
Intrauterine Contraceptive Device (IUCD)
Implant: levonorgestrel
Implant: etonogestrel
Diaphragm
Oxytocin injection (10IU, 1ml)
Misoprostol (tablet, 200mcg)
Methyldopa (tablet, 250mg)
Magnesium Sulphate (500mg in 2ml)
Magnesium Sulphate (500mg in 10ml vial)
Calcium Gluconate (100mg/ml in 10ml ampoule)B
Ferrous Sulphate (tablet, 200mg)
Folic Acid (tablet, 5mg)
Ferrous Sulphate: Folic Acid (tablet, 60mg iron + 400mcg folic acid)

<b>Ferrous Sulphate: Folic Acid (tablet, 150mg iron + 500mcg folic acid)</b>
<b>Metronidazole (tablet, 200mg)</b>
<b>Clotrimazole Pessary (500mg)</b>
<b>Clotrimazole Cream (1%, 15g tube)</b>
<b>Gentamicin Injection (40mg/ml in 1ml)</b>
<b>Benzylpenicillin (sodium or potassium) (powder for injection 600mg (1MU))</b>
<b>Benzathine penicillin G 900mg (1.2MU)</b>
<b>Amoxicillin (tablet, 125mg, dispersible)</b>
<b>Amoxicillin (tablet, 250mg, dispersible)</b>
<b>Dexamethasone (4mg/ml)</b>
<b>Zinc (10mg in 5ml syrup)</b>
<b>Zinc (tablet, 20mg)</b>
<b>Zinc-ORS co-pack (10mg tablet/1L)</b>
<b>Oral Rehydration Salts (ORS) sachets of 200ml</b>
<b>Oral Rehydration Salts (ORS) sachets of 500ml</b>
<b>ORS/ReSoMal sachets of 1L</b>
<b>Safe Delivery Kit/ Mama Kit</b>
<b>Antiseptic</b>
<b>Chlorhexidine 4%</b>
<b>Vasectomy kit</b>
<b>Tubal ligation kit</b>
<b>Manual Vacuum Aspiration (MVA) kit</b>
<b>Speculum</b>

<b>Cervical dilator</b>
<b>Incubator</b>
<b>Monitor</b>
<b>Ultrasound scan</b>
<b>Ventilator</b>
<b>Foetal scope</b>
<b>Resuscitator (adult size)</b>
<b>Resuscitator (infant size)</b>
<b>Bag and mask (size 0)</b>
<b>Suction device</b>
<b>Training mannequin for infant resuscitation</b>

## ANNEX 2: SRHC MEAN AVAILABILITY

**Table 2.** Availability of SRH commodities in the public, private and mission sectors per area.

Availability						
	PUBLIC SECTOR		PRIVATE SECTOR		MISSION SECTOR	
Commodity	Urban	Rural	Urban	Rural	Urban	Rural
Ethinyl/levonorgestrel	85	78	73	79	79	40
Ethinyl/norethisterone	0	7	3	8	0	0
Levonorgestrel 30mcg	52	57	17	8	57	20
Levonorgestrel 750mcg	36	54	72	71	43	21
Medroxyprogesterone acetate 150mg/1ml	85	91	33	29	79	60
Medroxyprogesterone acetate 104mg/1ml	6	2	0	4	14	0
Estradiol cypionate + medroxyprogesterone acetate	0	2	0	0	0	0
Male condoms	82	85	83	88	86	73
Female condoms	64	50	15	8	43	36
Intrauterine contraceptive device	79	85	32	21	29	67
Levonorgestrel implant	73	61	25	29	57	80
Etonogestrel implant	58	72	24	25	71	47
Diaphragm	0	0	0	0	7	0
Oxytocin injection	79	93	44	32	63	70
Misoprostol	27	37	40	20	33	37

Methyldopa	76	79	80	50	73	92
Magnesium sulphate 500mg/ 2ml	24	17	3	0	13	17
Magnesium sulphate 500mg/10ml	36	48	11	0	25	37
Calcium gluconate	71	71	33	0	73	69
Ferrous salt tablet	64	52	49	52	50	37
Folic acid tablet	59	50	80	50	73	85
Ferrous salt: Folic tablet 60/400	48	50	8	12	38	43
Ferrous salt: Folic tablet 150/500	15	13	2	0	4	13
Metronidazole	79	61	81	76	88	87
Clotrimazole pessary	67	52	56	36	58	57
Clotrimazole cream	61	46	54	56	50	80
Gentamicin injection	61	57	40	36	58	63
Benzylpenicillin	45	46	35	32	46	53
Benzathine penicillin G	42	37	17	12	29	30
Amoxicillin 125mg	6	0	10	0	8	3
Amoxicillin 250mg	76	52	32	32	50	33
Dexamethasone	82	79	80	100	55	69
Zinc 10mg/5ml syrup	9	7	33	24	13	13
Zinc 20mg tablet	39	43	73	56	71	60
Zinc: ORS co-pack	70	67	25	36	29	50
ORS 200ml	6	4	14	4	4	7
ORS 500ml	18	11	49	48	50	53



ORS 1L	6	2	0	0	0	0
Safe Delivery Kit/ Mama Kit	0	0	0	0	0	0
Antiseptic	70	78	62	56	88	90
Chlorhexidine 4%	52	28	11	4	29	30
Vasectomy kit	24	14	7	0	18	0
Tubal ligation kit	24	21	40	0	18	8
Manual Vacuum Aspiration (MVA) kit	63	68	60	57	50	59
Speculum	78	92	80	71	81	85
Cervical dilator	48	24	55	0	50	48
Incubator	59	79	47	50	73	85
Monitor	41	36	53	50	45	77
Ultrasound scan	47	43	53	50	64	62
Ventilator	35	29	47	0	27	54
Foetal scope	78	84	75	86	94	85
Resuscitator (adult size)	37	50	35	29	31	59
Resuscitator (infant size)	41	79	45	43	38	63
Bag and mask (size 0)	44	68	55	43	69	81
Suction device	52	79	70	57	69	85
Training mannequin for infant resuscitation	26	16	15	14	31	19

## ANNEX 3: AVAILABILITY OF SRHC PER COUNTY

**Table 3.** Availability of contraceptives per county.

	Ethinylestr. + levonor- gestrel	Ethinylestr. + nor- ethisterone	Levonor- gestrel 30mcg	Levonor- gestrel 750mcg	Medroxy- prog. acetate 150mg	Medroxy- prog. acetate 104mg	Estradiol cypionate + medroxy- prog. acetate	Male condoms	Female condoms	IUCD	Levonor- gestrel implant	Etono- gestrel implant	Diaph- ragm	Total average availability
Isiolo	83%	0%	11%	67%	44%	0%	0%	78%	24%	0%	41%	53%	0%	31%
Kakamega	70%	0%	25%	70%	80%	0%	0%	75%	50%	70%	65%	50%	0%	43%
Kisumu	79%	0%	33%	44%	56%	11%	0%	89%	39%	67%	72%	67%	6%	43%
Kwale	81%	13%	38%	31%	69%	0%	0%	81%	31%	75%	63%	81%	0%	43%
Makueni	64%	0%	0%	56%	52%	8%	0%	80%	0%	52%	36%	40%	0%	30%
Meru	94%	0%	18%	82%	53%	0%	0%	88%	53%	71%	65%	35%	0%	43%
Mombasa	90%	0%	50%	47%	55%	0%	0%	95%	52.6%	45%	35%	30%	0%	38%
Nairobi	55%	15%	40%	50%	60%	0%	5%	70%	35%	60%	40%	30%	0%	35%
Nakuru	83%	9%	61%	48%	65%	9%	0%	91%	30%	48%	52%	39%	0%	41%
Narok	54%	0%	77%	62%	77%	0%	0%	85%	46%	54%	23%	62%	0%	41%

**Table 4.** Availability of maternal health commodities per county.

	Oxytocin	Misoprostol	Methyl-dopa	Magnesium sulphate 500mg/2ml	Magnesium sulphate 500mg/10ml	Calcium gluconate	Ferrous salt	Folic acid	Ferrous salt: folic acid (60mg + 400mcg)	Ferrous salt: folic acid (150mg + 500mcg)	Total average availability
Isiolo	50%	18%	0%	14%	9%	0%	55%	100%	50%	5%	30%
Kakamega	68%	36%	100%	36%	27%	100%	64%	100%	18%	27%	58%
Kisumu	82%	68%	75%	18%	36%	56%	59%	94%	32%	9%	53%
Kwale	74%	37%	100%	11%	26%	40%	53%	100%	47%	11%	50%
Makueni	60%	20%	44%	4%	16%	44%	56%	44%	12%	0%	30%
Meru	88%	29%	100%	13%	54%	87%	38%	20%	67%	4%	50%
Mombasa	36%	23%	60%	9%	23%	60%	59%	80%	27%	5%	38%
Nairobi	68%	48%	89%	4%	32%	56%	32%	67%	16%	4%	42%
Nakuru	52%	35%	100%	4%	4%	80%	52%	100%	22%	0%	45%
Narok	60%	20%	33%	7%	40%	33%	33%	67%	20%	20%	33%

**Table 5.** Availability of antibiotics and antifungals per county and sector.

	Metroni- dazole	Clotrimazole pessary	Clotrimazole cream	Gentamicin injection	Benzyl- penicillin	Benzathine penicillin G	Amoxicillin 125mg	Amoxicillin 250mg	Total average availability
Isiolo	96%	91%	82%	86%	46%	59%	0%	55%	64%
Kakamega	73%	96%	82%	77%	64%	64%	14%	32%	63%
Kisumu	91%	68%	77%	64%	23%	14%	9%	50%	49%
Kwale	90%	47%	53%	53%	42%	16%	16%	79%	49%
Makueni	68%	28%	24%	36%	32%	8%	8%	32%	30%
Meru	96%	46%	96%	46%	71%	33%	0%	17%	51%
Mombasa	55%	64%	55%	41%	23%	14%	0%	36%	36%
Nairobi	52%	16%	36%	32%	28%	16%	0%	24%	26%
Nakuru	91%	48%	30%	48%	39%	26%	4%	91%	47%
Narok	60%	47%	20%	27%	53%	27%	0%	40%	34%

**Table 6.** Availability of newborn and child health commodities per county and sector.

	Dexametha- sone	Zinc syrup	Zinc tablet	Zinc-ORS co-pack	ORS 200ml	ORS 500ml	ORS 1L	Clorhexidine 4%	Total average availability
Isiolo	100%	36%	86%	32%	5%	27%	0%	18%	38%
Kakamega	67%	0%	64%	46%	9%	36%	0%	5%	28%
Kisumu	75%	36%	77%	32%	9%	68%	0%	59%	45%
Kwale	100%	5%	63%	53%	21%	11%	0%	37%	36%
Makueni	89%	4%	44%	40%	4%	32%	0%	8%	28%
Meru	80%	8%	42%	75%	4%	33%	0%	50%	37%
Mombasa	80%	36%	73%	36%	14%	32%	14%	0%	38%
Nairobi	33%	4%	52%	44%	8%	44%	0%	8%	24%
Nakuru	80%	35%	52%	57%	0%	61%	0%	22%	38%
Narok	67%	13%	27%	47%	7%	13%	0%	0%	24%



**Table 7.** Availability of SRH instruments per county.

	Safe delivery kit	Vasectomy kit	Tubal ligation kit	MVA kit	Speculum	Cervical dilator	Incurbator	Monitor	Ultra-sound scan	Ventilator	Foetal scope	Resuscitator (adult)	Resuscitator (infant)	Bag and mask	Suction device	Infant size mannequin	Total average availability
Isiolo	9%	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	0%	72%
Kakamega	27%	0%	0%	71%	88%	29%	67%	67%	67%	0%	71%	71%	53%	77%	775	24%	49%
Kisumu	27%	19%	31%	71%	94%	71%	81%	38%	56%	38%	88%	47%	65%	77%	88%	12%	56%
Kwale	63%	0%	0%	64%	91%	9%	60%	20%	0%	20%	73%	55%	55%	73%	91%	27%	44%
Makueni	20%	0%	0%	39%	69%	15%	22%	22%	22%	0%	54%	23%	62%	8%	39%	0%	25%
Meru	25%	40%	47%	85%	95%	95%	80%	80%	73%	73%	100%	95%	95%	100%	100%	50%	77%
Mombasa	23%	0%	0%	50%	75%	33%	80%	60%	60%	0%	83%	25%	25%	42%	50%	0%	38%
Nairobi	16%	0%	22%	67%	78%	17%	89%	67%	67%	56%	89%	22%	72%	72%	89%	44%	54%
Nakuru	9%	0%	40%	33%	92%	33%	20%	40%	40%	40%	92%	17%	17%	33%	33%	0%	34%
Narok	20%	0%	0%	42%	58%	17%	33%	0%	33%	33%	83%	8%	25%	42%	33%	0%	27%

## ANNEX 4: STOCK-OUT DAYS PER MONTH IN THE PUBLIC, PRIVATE AND MISSION SECTORS.

**Table 8.** Number of stock-out days per month, per sector.

Commodity	Affordability (days)		
	Public Sector	Private Sector	Mission Sector
Ethinyl/levonorgestrel	6	3	NA
Ethinyl/norethisterone	9	9	NA
Levonorgestrel 30mcg	11	1	2
Levonorgestrel 750mcg	9	2	NA
Medroxyprogesterone acetate 150mg/1ml	6	7	5
Medroxyprogesterone acetate 104mg/1ml	1	1	NA
Estradiol cypionate + medroxyprogesterone acetate	NA	5	NA
Male condoms	10	NA	13
Female condoms	8	0	7
Intrauterine contraceptive device	8	3	2
Levonorgestrel implant	10	5	NA
Etonogestrel implant	7	8	7
Diaphragm	NA	NA	NA
Oxytocin injection	3	4	1
Misoprostol	5	1	NA
Methyldopa	6	10	3
Magnesium sulphate 500mg/ 2ml	5	1	3

Magnesium sulphate 500mg/10ml	5	1	3
Calcium gluconate	7	3	5
Ferrous salt tablet	4	2	1
Folic acid tablet	7	10	NA
Ferrous salt: Folic tablet 60/400	3	5	1
Ferrous salt: Folic tablet 150/500	6	5	3
Metronidazole	8	1	6
Clotrimazole pessary	6	1	2
Clotrimazole cream	3	2	2
Gentamicin injection	2	7	1
Benzylpenicillin	7	2	3
Benzathine penicillin G	3	1	1
Amoxicillin 125mg	10	6	2
Amoxicillin 250mg	10	2	4
Dexamethasone	8	1	2
Zinc 10mg/5ml syrup	14	2	2
Zinc 20mg tablet	4	3	NA
Zinc: ORS co-pack	5	4	2
ORS 200ml	11	1	2
ORS 500ml	9	2	3
ORS 1L	6	10	NA
Safe delivery kit	NA	NA	NA
Antiseptic	0	1	5
Chlorhexidine 4%	5	1	3

## ANNEX 5: SRHC PRICES

**Table 9.** SRHC prices in the public, private and mission sectors.

Prices in Kenyan Shilling (KES)									
Commodity	Public Sector			Private Sector			Mission Sector		
	Mean Unit Price	Min Unit Price	Max Unit Price	Mean Unit Price	Min Unit Price	Max Unit Price	Mean Unit Price	Min Unit Price	Max Unit Price
Ethinyl/levonorgestrel	0	0	0	84	0	480	30	0	150
Ethinyl/norethisterone	0	0	0	50	0	120	NA	NA	NA
Levonorgestrel 30mcg	2	0	50	49	0	150	45	0	167
Levonorgestrel 750mcg	3	0	50	112	0	200	37	0	150
Medroxyprogesterone acetate 150mg/1ml	1	0	60	107	0	250	44	0	130
Medroxyprogesterone acetate 104mg/1ml	33	0	100	100	100	100	25	0	50
Estradiol cypionate + medroxyprogesterone acetate	0	0	0	NA	NA	NA	NA	NA	NA
Male condoms	0	0	30	55	0	300	2	0	50
Female condoms	0	0	0	27	0	200	0	0	0
Intrauterine contraceptive device	0	0	250	789	0	3500	605	0	3000
Levonorgestrel implant	1	0	150	544	0	3400	325	0	2500
Etonogestrel implant	0	0	0	631	0	3400	407	0	2000
Diaphragm	NA	NA	NA	NA	NA	NA	0	0	0
Oxytocin injection	4	0	100	95	0	300	88	0	400
Misoprostol	21	0	200	119	0	500	77	0	250
Methyldopa	1	0	10	8	0	50	5	0	23

Magnesium sulphate 500mg/ 2ml	0	0	0	220	20	420	91	0	500
Magnesium sulphate 500mg/10ml	6	0	200	307	0	500	198	0	500
Calcium gluconate	8	0	120	151	0	500	163	0	500
Ferrous salt tablet	0	0	2	2	0	15	1	0	5
Folic acid tablet	0	0	2	2	0	10	2	0	5
Ferrous salt: Folic tablet 60/400	0	0	3	9	2	17	4	0	50
Ferrous salt: Folic tablet 150/500	0	0	3	NA	0	0	1	0	5
Metronidazole	0	0	5	2	0	12	3	0	12
Clotrimazole pessary	41	0	300	150	0	550	136	0	700
Clotrimazole cream	14	0	150	72	0	400	71	0	315
Gentamicin injection	11	0	150	41	0	150	43	0	100
Benzylpenicillin	178	0	178	50	0	250	59	0	250
Benzathine penicillin G	21	0	100	53	0	150	71	0	260
Amoxicillin 125mg	0	0	0	74	8	200	6	1	12
Amoxicillin 250mg	0	0	10	11	0	100	13	0	150
Dexamethasone	16	0	150	60	0	300	60	0	180
Zinc 10mg/5ml syrup	60	0	150	118	0	250	143	0	493
Zinc 20mg tablet	0	0	2	7	0	15	7	0	50
Zinc: ORS co-pack	9	0	280	125	13	500	72	0	280
ORS 200ml	0	0	0	31	0	100	3	0	8
ORS 500ml	3	0	10	13	5	20	8	0	30
ORS 1L	0	0	0	NA	NA	NA	NA	NA	NA



## ANNEX 6: TREATMENT UNITS

**Table 10.** Treatment regimens per SRHC.

Treatment Regimen		
Commodity	Treatment Unit	Treatment Days
Ethinyl/levonorgestrel	1 strip	NA
Ethinyl/norethisterone	1 strip	NA
Levonorgestrel 30mcg	1 strip	NA
Levonorgestrel 750mcg	1 pill	NA
Medroxyprogesterone acetate 150mg/1ml	1 vial	NA
Medroxyprogesterone acetate 104mg/1ml	1 vial	NA
Estradiol cypionate + medroxyprogesterone acetate	1 vial	NA
Male condoms	1 pack	NA
Female condoms	1 pack	NA
Intrauterine contraceptive device	1 device	NA
Levonorgestrel implant	1 device	NA
Etonogestrel implant	1 device	NA
Diaphragm	1 device	NA
Oxytocin injection	1 vial	NA
Misoprostol	1 tablet	NA
Methyldopa	3 tablets	30
Magnesium sulphate 500mg/ 2ml	18 vials	NA
Magnesium sulphate 500mg/10ml	18 vials	NA
Calcium gluconate	1 ampoule	NA

Ferrous salt tablet	1 tablet	30
Folic acid tablet	1 tablet	30
Ferrous salt: Folic tablet 60/400	1 tablet	30
Ferrous salt: Folic tablet 150/500	1 tablet	30
Metronidazole	6 tablets	5
Clotrimazole pessary	1 tablet	1
Clotrimazole cream	1 tube	NA
Gentamicin injection	1 ampoule	10
Benzylpenicillin	1 vial	10
Benzathine penicillin G	1 vial	1
Amoxicillin 125mg	3 tablets	5
Amoxicillin 250mg	3 tablets	5
Dexamethasone	1 vial	1
Zinc 10mg/5ml syrup	1 vial	1
Zinc 20mg tablet	1 tablet	10
Zinc: ORS co-pack	1 kit	NA
ORS 200ml	1 sachet	NA
ORS 500ml	1 sachet	NA
ORS 1L	1 sachet	NA

## ANNEX 7: AFFORDABILITY OF SRHC

**Table 11.** Affordability of SRHC, per sector.

Affordability (days)			
Commodity	Public Sector	Private Sector	Mission Sector
Ethinyl/levonorgestrel	0	0.19	0.07
Ethinyl/norethisterone	0	0.11	NA
Levonorgestrel 30mcg	0	0.11	0.10
Levonorgestrel 750mcg	0.01	0.25	0.08
Medroxyprogesterone acetate 150mg/1ml	0	0.24	0.10
Medroxyprogesterone acetate 104mg/1ml	0.07	0.22	0.06
Estradiol cypionate + medroxyprogesterone acetate	0	NA	NA
Male condoms	0	0.12	0
Female condoms	0	0.06	0
Intrauterine contraceptive device	0	1.76	1.35
Levonorgestrel implant	0	1.21	0.72
Etonogestrel implant	0	1.41	0.91
Diaphragm	NA	NA	0
Oxytocin injection	0.01	0.21	0.20
Misoprostol	0.05	0.26	0.17
Methyldopa	0.18	1.66	1.03
Magnesium sulphate 500mg/ 2ml	0	8.83	3.64

Magnesium sulphate 500mg/10ml	0.24	12.33	7.94
Calcium gluconate	0.02	0.34	0.36
Ferrous salt tablet	0.02	0.14	0.08
Folic acid tablet	0.01	0.15	0.12
Ferrous salt: Folic tablet 60/400	0.01	0.62	0.24
Ferrous salt: Folic tablet 150/500	0.02	NA	0.07
Metronidazole	0.03	0.13	0.18
Clotrimazole pessary	0.09	0.33	0.30
Clotrimazole cream	0.03	0.16	0.16
Gentamicin injection	0.25	0.92	0.96
Benzylpenicillin	0.40	0.11	0.13
Benzathine penicillin G	0.05	0.12	0.16
Amoxicillin 125mg	0	2.46	0.20
Amoxicillin 250mg	0.01	0.35	0.43
Dexamethasone	0.04	0.13	0.13
Zinc 10mg/5ml syrup	0.13	0.26	0.32
Zinc 20mg tablet	0	0.16	0.15
Zinc: ORS co-pack	0.02	0.28	0.16
ORS 200ml	0	0.07	0.01
ORS 500ml	0.01	0.03	0.02
ORS 1L	0	NA	NA

## ANNEX 8: SRHC QUALITATIVE DATA

**Table 12.** Key challenges related to access to SRH services, per county.

	Isiolo	Kakamega	Kisumu	Kwale	Makueni	Meru	Mombasa	Nairobi	Nakuru	Narok
No demand for SRHC	7%	18%	0%	28%	8%	17%	41%	12%	4%	7%
Issues or delays with supply of SRHC to facility	29%	14%	18%	61%	25%	8%	23%	20%	13%	33%
Frequent stock-outs at facility level	7%	18%	23%	56%	33%	13%	23%	8%	13%	47%
Frequent stock-outs at central level	0%	14%	5%	44%	0%	0%	5%	0%	4%	7%
Shortage of staff	29%	5%	18%	33%	13%	0%	14%	0%	9%	13%
Training of staff	21%	0%	27%	33%	4%	4%	5%	0%	4%	40%
Costs of SRHC to patients	0%	23%	41%	11%	21%	21%	23%	8%	39%	20%
Lack of knowledge of patients about SRHC	7%	41%	45%	56%	50%	42%	23%	44%	52%	53%
Religious or cultural beliefs	36%	45%	27%	44%	21%	42%	23%	20%	30%	53%
Stigma associated with accessing SRHC	14%	59%	23%	28%	25%	50%	27%	16%	48%	33%
HCWs reluctant to provide certain clients with SRHC	0%	0%	18%	17%	0%	8%	5%	12%	9%	7%
SRHC not supplied as per supply cycle	0%	0%	18%	6%	13%	4%	32%	4%	4%	0%
Services unavailable	14%	14%	5%	0%	0%	0%	5%	0%	0%	0%

**Table 13.** Causes of SRH Commodities stock-outs according to healthcare providers, per county.

	Isiolo	Kakamega	Kisumu	Kwale	Makueni	Meru	Mombasa	Nairobi	Nakuru	Narok
What is ordered is not what is received	0%	39%	29%	65%	32%	30%	14%	27%	13%	40%
Delay in supply delivery	89%	78%	43%	76%	63%	70%	62%	55%	39%	80%
Poor stock management at facility	0%	22%	33%	35%	0%	26%	0%	0%	4%	7%
Lack of storage space at facility	0%	0%	0%	24%	0%	9%	5%	0%	0%	0%
Problems with transport of SRHC to facility	0%	0%	14%	41%	0%	0%	0%	0%	13%	7%
Problems with stock at distribution level	0%	22%	29%	53%	21%	13%	43%	23%	22%	60%
Affordability of SRHC for facility	0%	11%	29%	12%	21%	4%	33%	32%	35%	13%
Demand higher than supply	0%	33%	10%	47%	11%	0%	10%	0%	4%	13%
No demand	11%	0%	0%	0%	0%	0%	0%	9%	0%	0%



**Table 14.** Recommendations to improve access to SRHC on the supply side, per county.

	Isiolo	Kakamega	Kisumu	Kwale	Makueni	Meru	Mombasa	Nairobi	Nakuru	Narok
Improve supply chain	7%	62%	71%	79%	38%	33%	59%	38%	39%	93%
Timely supply of SRHC	79%	67%	24%	79%	62%	54%	55%	50%	35%	93%
Supply ordered SRHC	0%	19%	19%	63%	29%	42%	18%	13%	26%	29%
Ensure availability of SRHC at facility	14%	5%	48%	63%	14%	29%	36%	29%	17%	43%
Improve stock management at facility	0%	14%	24%	47%	14%	25%	5%	4%	9%	21%
Increase staff	21%	5%	24%	32%	19%	13%	9%	0%	17%	21%
(Continued) staff training	36%	0%	52%	42%	14%	17%	14%	4%	35%	57%
Reduce costs	0%	19%	29%	26%	19%	17%	9%	13%	26%	29%
Provide greater choice of SRHC	0%	5%	43%	47%	19%	42%	18%	0%	39%	7%
Improve infrastructure	7%	5%	0%	32%	5%	8%	0%	0%	35%	14%
Increase budget for SRH	0%	19%	24%	53%	24%	13%	23%	0%	22%	21%
More supervision from central level	14%	5%	0%	11%	0%	4%	5%	0%	4%	14%

**Table 15.** Recommendations to improve access to SRHC on the demand side, per county.

	Isiolo	Kakamega	Kisumu	Kwale	Makueni	Meru	Mombasa	Nairobi	Nakuru	Narok
Client and community education	93%	81%	82%	84%	91%	83%	82%	92%	57%	80%
Reduce costs	7%	38%	45%	32%	13%	33%	32%	4%	35%	20%
Increase male partner involvement	29%	29%	23%	53%	35%	50%	23%	32%	26%	53%
Professional HCW-patient relationship	0%	29%	50%	47%	13%	25%	36%	0%	22%	20%
Offer/improve outreach SRH services	7%	43%	50%	68%	35%	38%	36%	0%	48%	33%
Increase choice of contraceptives	14%	19%	27%	58%	17%	29%	14%	0%	22%	7%
Ensure enough stock availability at facility	0%	14%	32%	84%	17%	21%	36%	12%	26%	40%
Provide more services	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%

**Table 16.** Reasons for clients' reluctance, per county.

	Isiolo	Kakamega	Kisumu	Kwale	Makueni	Meru	Mombasa	Nairobi	Nakuru	Narok
Fear of stigmatisation by family or community	100%	92%	94%	69%	91%	64%	100%	75%	80%	89%
Myths or superstitions	100%	69%	29%	69%	9%	73%	50%	0%	50%	89%
Religious beliefs	100%	62%	24%	62%	9%	73%	67%	25%	60%	44%
Fear of side effects	0%	62%	47%	62%	27%	36%	50%	70%	70%	44%
Low support from male partners	33%	8%	24%	54%	18%	27%	0%	10%	40%	44%
Low support from female partners	0%	0%	12%	38%	0%	27%	0%	0%	0%	0%
Patient lack of knowledge	0%	15%	71%	77%	64%	45%	33%	20%	80%	89%
Poverty/costs	0%	0%	24%	31%	9%	27%	0%	0%	60%	11%
Distance to clinic	33%	0%	0%	15%	0%	0%	0%	0%	0%	0%
Frequent stock-outs at facility	0%	8%	18%	23%	9%	0%	17%	5%	0%	0%
Unprofessional HCWs	0%	0%	0%	15%	0%	0%	0%	0%	10%	33%

**Table 17.** Recommendations to tackle clients' reluctance, per county.

	Isiolo	Kakamega	Kisumu	Kwale	Makueni	Meru	Mombasa	Nairobi	Nakuru	Narok
Expand client education	100%	100%	76%	92%	91%	100%	100%	95%	100%	89%
Give health education	100%	85%	82%	85%	55%	73%	50%	40%	80%	100%
Empower people economically	0%	8%	47%	38%	18%	45%	0%	5%	0%	11%
Create youth-friendly corners	67%	77%	59%	77%	27%	45%	33%	60%	80%	78%
Involve partners in SRH services	67%	8%	47%	62%	45%	36%	83%	5%	60%	22%
Improve stock availability	0%	8%	41%	62%	0%	18%	50%	5%	0%	11%
Improve professional HCW-patient relationships	0%	15%	53%	54%	9%	0%	50%	0%	20%	44%
Training of staff to improve quality of services	67%	15%	65%	54%	9%	9%	0%	0%	60%	67%
Provide free family planning services	0%	8%	47%	15%	0%	18%	0%	0%	70%	11%
Reduce costs for patients	0%	15%	29%	8%	9%	9%	17%	0%	60%	11%

ADVANCING ACCESS  
TO MEDICINES.  
FOR EVERYONE.  
EVERYWHERE.