

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

Tanzania 2018



This work is part of  
Health Action International's contribution to the  
Health Systems Advocacy Partnership,  
financed by the Dutch Ministry of Foreign Affairs.



## REPORT

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

Tanzania 2018

Prepared by Gaby Ooms, Maximilian Msuya and Radhia Mambole.

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# GLOSSARY

EML	Essential medicine list
HAI	Health Action International
HHFCE	Household final consumption expenditure
HSA	Health Systems Advocacy
ICPD	International Conference on Population and Development
ILS	Integrated logistics system
LPGW	Lowest-paid government worker
MeTA	Medicines Transparency Alliance
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHC	Sexual and reproductive health commodities
STI	Sexually transmitted infection
WHO	World Health Organization

# BACKGROUND

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. 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. And when they decide to have children, women must have access to services that ensure they have a healthy pregnancy, safe delivery and healthy baby. Every individual has the right to make their own choices about their SRH and family planning.

National policies on medicine pricing and procurement strategies are needed to ensure medicines are available and affordable. Policies to improve health infrastructure, health education and financing are further required to ensure the rational use of medicine. Even in the face of weak infrastructure and gross inequality that underpins poverty prevalence, improvements in access can be achieved. However, without reliable information on medicine prices and availability, governments are working in an evidence vacuum. This restricts their ability to construct meaningful policy and properly evaluate the impact of any policy interventions. Reliable information is also a useful means of comparison between countries with similar health budget for knowledge transfer and learning. Thus, in order to develop evidence-based policies, robust data is required. The Health Action International (HAI)- World Health Organization (WHO) methodology to assess the price, availability and affordability components of medicines provides valuable data. To date, the methodology has not specifically targeted commodities for SRH. HAI

has now adapted the methodology to focus on a specific set of sexual and reproductive health commodities (SRHC)<sup>1,2</sup>.

The objective of the survey is to generate reliable information on the price, availability and affordability of selected important commodities in the SRH supply chain, with the ultimate goal of improving access to affordable medicines for all. The methodology uses a cross sectional design with quantitative methods and a semi-structured questionnaire adapted from the standardised HAI-WHO methodology, *Measuring Medicine Availability, Affordability And Price Components (2nd Edition)*. It allows data on the availability and out-of-pocket patient prices of SRHC in the public, private and mission sectors to be collected. It also assesses health provider perspectives on access to SRHC beyond the medicines supply chain. The method facilitates rapid and reliable data collection and enables price and availability indicators to be compared within and between individual countries.

The following report presents the results of the survey carried out by HAI and in-country partner UMATI in July 2018 in Tanzania. The report provided data relating to the following questions:

- What price do people pay for SRH medicines?
- Do the prices and availability of the same medicines vary across the public, private and mission sectors?
- How affordable are medicines for ordinary people?
- What do health providers see as the main barriers to accessing SRH commodities?

The following report should be used to highlight potential areas for intervention to improve access to SRHC and monitor changes to access over time in Tanzania.

<sup>1</sup> Please refer to the *Sexual and Reproductive Health Commodities: Measuring Prices, Availability and Affordability methodology and data entry manual (1st editions)* for a full description of the methodology used for data collection.

<sup>2</sup> For a full list of the commodities surveyed, see Annex 1.

# DATA COLLECTION

This report presents data from the initial roll-out of the HAI research methodology, SRHC: *Measuring Prices, Availability and Affordability in Tanzania*. The methodology used for the data collection follows the first version of 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 Tanzania in June 2018.

Data collectors visited facilities at dispensary level and above belonging to public, private and mission sectors in both urban and rural areas. Random selection of regions to survey ensured a representative picture for the country. The districts selected for data collection with their regions were: Temeke (Dar es salaam), Ifakara (Morogoro), Bahi (Dodoma), Lushoto (Tanga), Mtwara MC (Mtwara) and Iringa DC (Iringa). A total of 126 facilities were surveyed across public, private and mission sectors. In Tanzania 73.7% of the health facilities are public, 14.4% are private and 11.9% are mission health facilities<sup>3</sup>. The distribution of the facilities visited is outlined in table 1 below.

**Table 1:** Distribution of surveyed facilities.

	Urban	Rural	Total (N)
Public	33	40	73
Private	29	9	38
Mission	10	5	15
Total	<b>72</b>	<b>55</b>	<b>126</b>

<sup>3</sup> Ministry of Health, Community Development, Gender, Elderly and Children, *Health Facility Registry*, 2018 <[www.moh.go.tz/hfrportal](http://www.moh.go.tz/hfrportal)> [accessed 20 December 2018].

# RESULTS

## 1. Overall Availability of SRHC

This research showed that overall availability of SRHC in Tanzania was 29% (see Table 2). Availability in the public sector was highest at 37%, while availability of SRHC in the private sector was 26% and in the mission sector 24%. The mean availability for all three sectors did not differ greatly between urban and rural areas.

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

Percentage Availability			
	Overall	Urban	Rural
Public	37	37	36
Private	26	25	27
Mission	24	24	23
Total	<b>29</b>	<b>29</b>	<b>29</b>

## 2. Availability of SRHC by Sector

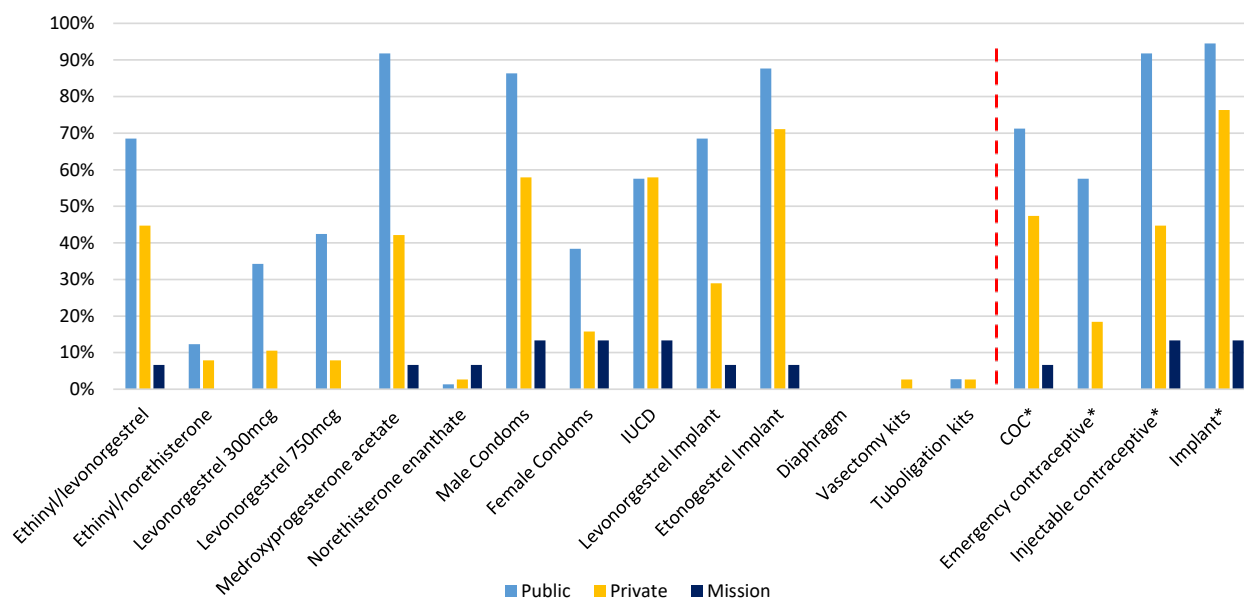
A closer examination of the availability of selected SRHC across the public, private and mission sectors, and urban and rural locations is shown below. Figures 1-4 provide an overview of the availability of SRHC across the sectors, separated per service. Please refer to Annexes 3-6 for a full breakdown of the availability of SRH commodities in urban and rural areas in the public, private and mission sectors.

### 2.1. Contraceptives

Ethinylestradiol + levonorgestrel tablets, commonly known as the birth control pill, were available in 73% of urban public facilities and 65% of rural public facilities (see Figure 1). In urban

private facilities, the birth control pill's availability was 48%, and it had a 33% availability in rural private facilities. The research also showed that in the mission sector availability was 0% for urban facilities and only 20% for rural facilities. Availability of levonorgestrel tablets (300 mcg), used as an emergency contraceptive after birth control failure or unprotected intercourse, was inconsistent in public and private facilities, and unavailable in all mission facilities. For instance, in the public sector, levonorgestrel 300 mcg tablets were available in 34% of facilities, and the 750 mcg tablets were found in 42% of public facilities. As can be seen in Figure 1, either formulation of levonorgestrel tablets (labelled as 'emergency contraceptive\*'), was available in 58% of public facilities.

Medroxyprogesterone acetate, an injectable birth control method, had a high availability in the public sector (92%), but a lower availability in the private (42%) and mission (7%) sectors. Male condoms had a similar pattern as medroxyprogesterone acetate with regards to availability; high availability in the public sector (86%), and low availability in the private (58%) and mission (13%) sectors. Female condoms had a low overall availability, and were available in only 38% of public, 16% of private, and 13% of mission facilities. Either form of contraceptive implant (either the levonorgestrel or etonogestrel) had high availability in the public sector (95%), moderate availability in the private sector (76%), and again a low availability in the mission sector (13%). Tuboligation kits and vasectomy kits, if at all available, had very low availability across the sectors.

**Figure 1:** Availability of contraceptives in the public, private and mission sectors.

Combined Oral Contraceptives (COC)\*, known as the birth control pill, combines availability of ethinyl/levonorgestrel and/or ethinyl/norethisterone at the facility. Emergency contraceptive\* combines availability of levonorgestrel 300mcg and/or 750mcg at the facility. Injectable contraceptive\* combines availability of medroxyprogesterone acetate and/or norethisterone enanthate at the facility. Implant\* combines availability of the levonorgestrel implant and the etonogestrel implant.

## 2.2. Maternal Health

Pregnancy supplements had a relatively low availability across the sectors. Highest availability of a supplement was found for folic acid tablets, which were found in 34% of all public facilities visited (see Figure 2). In the remaining sectors, availability was 24% in private facilities and 27% in mission facilities. Ferrous salt tablets were available in 11% of public facilities, none of the private facilities, and 7% in mission facilities. Ferrous salt: folic acid combination tablets also had a very low availability across the sectors (less than 12%).

Availability of gentamicin, used to treat pneumonia and maternal and neonatal sepsis, ranged from 20% in mission sector facilities to 26% in private sector facilities, with a 22% availability in the public sector. Oxytocin, used to induce labour and for prevention and

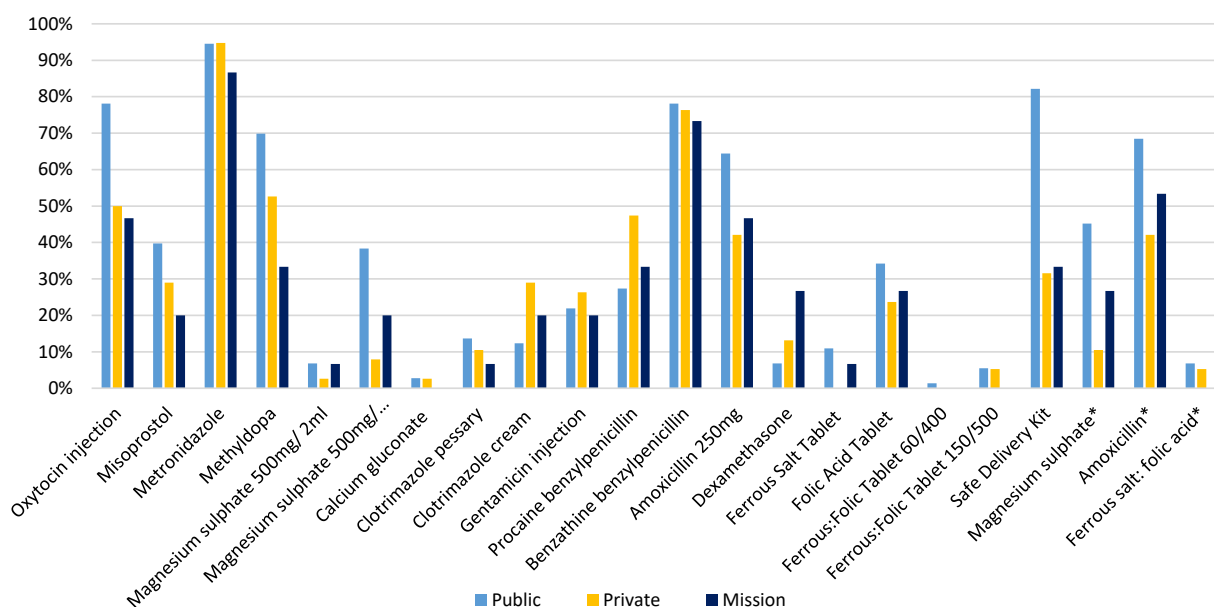
treatment of post-partum haemorrhage, had a slightly higher availability. It was available in 78% of public facilities, but still only in 50% of mission sector facilities and 47% of private sector facilities. Misoprostol, another medicine used to induce labour, was available in 40% of public facilities, and in 29% and 20% of private and mission sector facilities, respectively. Magnesium sulphate, either the 500mg in 2ml or 500mg in 10ml formulation, which is used in the treatment of pre-term labour and pre-eclampsia, was available in 45% of public sector facilities and 27% of mission sector facilities. In the private sector, it was only available in 11% of the facilities. Availability of dexamethasone, used in the management of pre-term labour for improving foetal lung maturity, had a very low availability in public and private facilities (7% and 13%, respectively), while in the mission facility it was slightly higher, but still low (27%).



Benzathine benzylpenicillin, used in the treatment of syphilis, had a relatively high availability across the sectors: 78% availability in the public sector, 76% availability in the private sector and 73% availability in the mission sector. Clotrimazole pessary, used to treat yeast infections, was available in only 14% of the public

facilities, 11% of private facilities and 7% of the mission facilities. Availability of metronidazole, used for treating vaginal infections, was found to be highly available in all facilities, ranging from 95% in the public and private sectors to 87% in the mission sector.

**Figure 2:** Availability of maternal health commodities in the public, private and mission sectors.

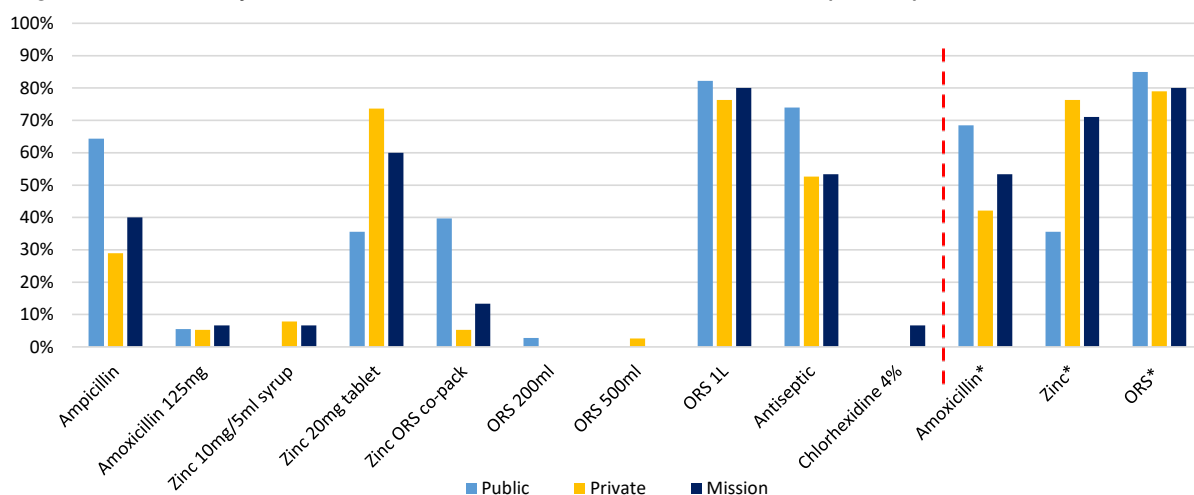


*Magnesium sulphate\* is a combination of availability of Magnesium sulphate 500mg/2ml and 500mg/10ml. Amoxicillin\* is a combination of availability of 125mg and 250mg dispersible tablet. Ferrous salt: folic acid\* is a combination of availability of ferrous salt:folic acid 60/400mg and ferrous salt:folic acid 150/500mg.*

### 2.3. Newborn and Child Health

Ampicillin, used to treat pneumonia and sepsis, had a higher availability in the public sector compared to the private and mission sectors (64% versus 29% and 40%, respectively) (see figure 3). Availability of zinc, either in tablet form or syrup form, was low in the public sector (36%), but higher in the private (76%) and

mission (71%) sectors. Any form of oral rehydration sachets (ORS) (200ml, 500ml or 1L) were available at 85% of public facilities, 79% of private facilities, and 80% of mission facilities. Paediatric amoxicillin (125mg) had a very low availability: it was available in only 5% of public and private facilities, and 7% of mission facilities. Chlorhexidine 4%, used for cord care, was only available in the mission sector, and only in 7% of facilities.

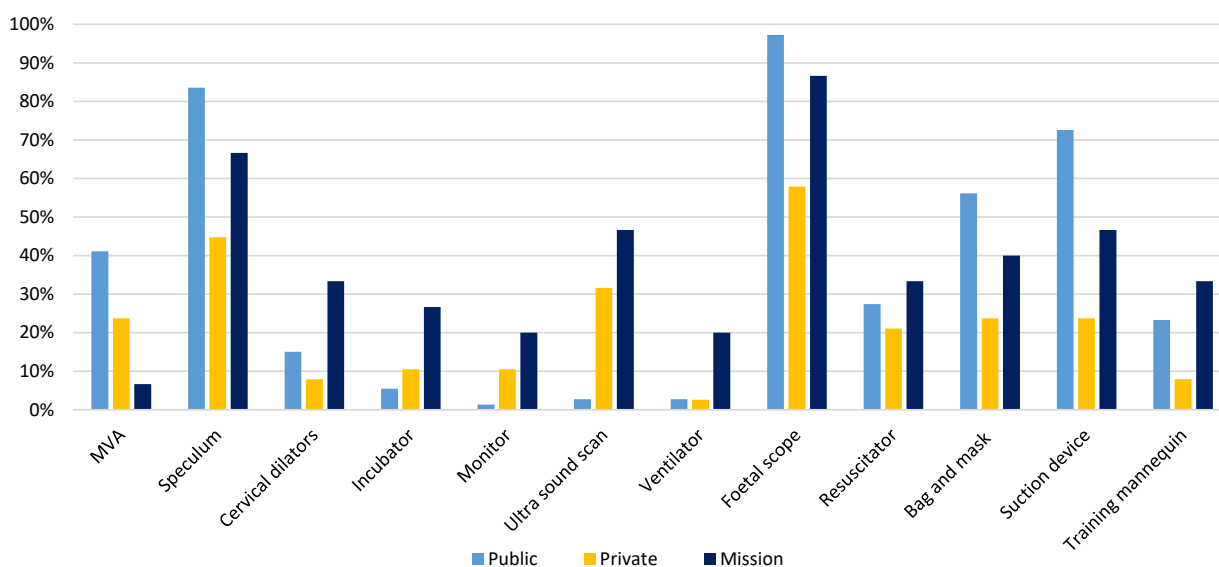
**Figure 3:** Availability of newborn and child health commodities in the public, private and mission sectors.

*Amoxicillin is a combination of availability of 125- and 250mg dispersible tablet. The National Medical Stores currently supplies only 250mg dispersible tablets to public facilities. Zinc is a combination of availability of Zinc 10mg/5ml syrup and zinc 20mg tablet. ORS is a combination of availability of ORS 200ml, 500ml and 1000ml*

## 2.4. SRH Instruments

Speculums had high availability in the public sector (84%), moderate availability in the mission sector (67%), and lower availability in the private sector (45%) (see Figure 4). The suction device had a similar availability as the speculum; it was available in 73% of public facilities, 47% of

mission facilities and in 24% of private facilities. The ultrasound scan had a higher availability in private and mission facilities (32% and 47%, respectively) than in public facilities (3%). Incubators also had a low availability; they were available in 5% of public facilities, 11% of private facilities, and 27% of mission facilities.

**Figure 4:** Availability of SRH instruments in the public, private and mission sector.

### 3. Stock-out Days

Stock-out information was only recorded by data collectors when stock information was observed on the stock card or in a stock-taking database. As a result, in cases where stock information was not recorded, or anecdotal evidence was presented, stock-out information could not be collected. In general, stock cards were available for only 37 of the 126 (29%) facilities under study (19 public facilities, 9 private facilities and 9 mission facilities). Please refer to Annex 7 for a full breakdown of the stock-out data across sectors.

Based on the stock card information, stock-outs occurred in 17.2 % of public facilities, 11.9% of mission facilities and 2.7% of private facilities (see Table 3). The number of stock-out days differed per sector, averaging 15 days in the mission sector, 13 in the public sector and 8 days in the private sector.

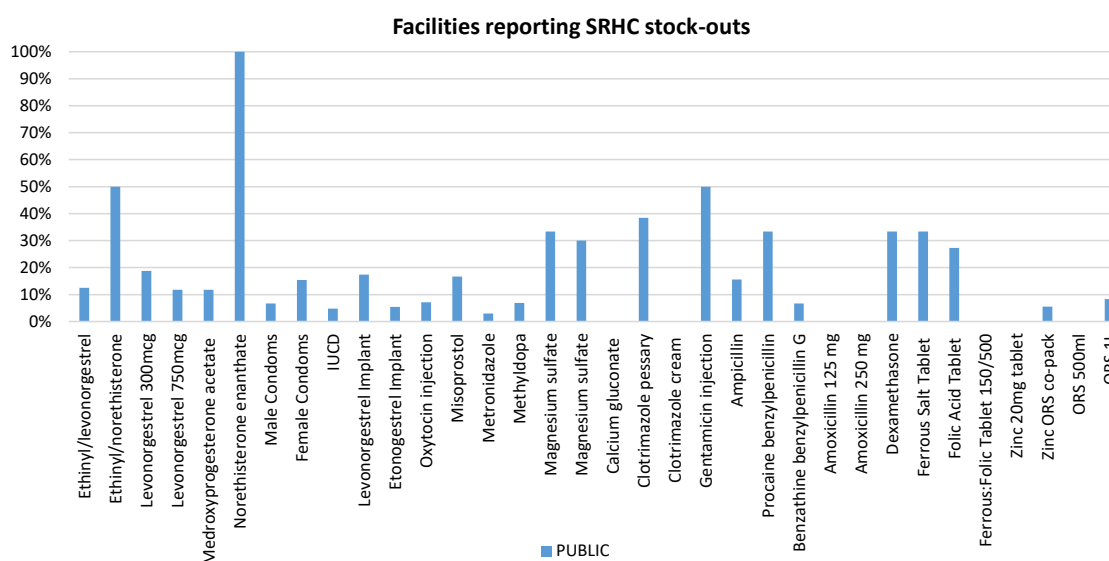
**Table 3:** Percentage of facilities reporting stock-outs in the six months prior to survey and the average number of sock-out days per month recorded per facility.

	Facilities reporting stock-outs (%)	Average number of stock-out days per month
<b>Public</b>	17.2	13
<b>Private</b>	2.7	8
<b>Mission</b>	11.9	15

Since there were only a few private and mission facilities that had a stock card available, the results of the analysis for these sectors will not be shown here. See Annex 7 for a full break-down of the stock-out data for these sectors.

Stock-outs for specific SRHC in the public sector ranged from 0% (7 commodities) to 100% (norethisterone enanthate). Commodities that did not experience a stock-out included calcium gluconate, clotrimazole cream, amoxicillin 125mg and 250mg, ferrous salt:folic acid tablets (60/400), zinc tablets, and ORS 500ml (see Figure 5).

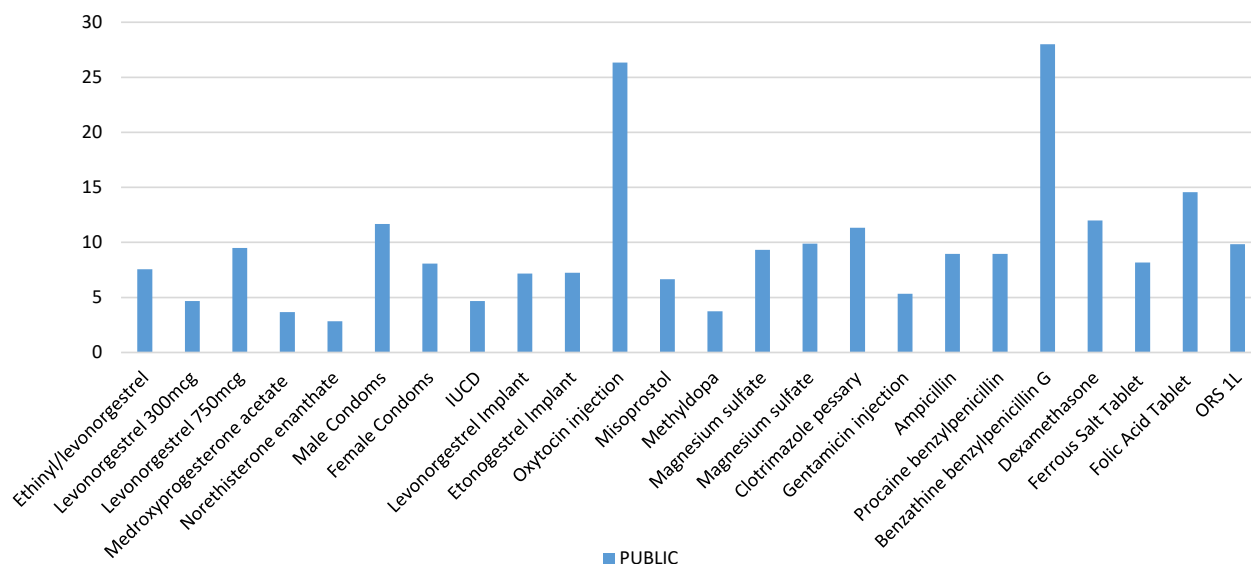
**Figure 5:** Percentage of public facilities reporting stock-outs for SRHC in the six months prior to survey.



In the public sector, two SRHCs (oxytocin and benzathine benzylpenicillin G) for which stock-out data was collected was stocked-out for almost the entire month if a stock-out occurred (see Figure 6). Norethisterone enanthate, which experienced a stock-out at each facility it was

available, had on average 3 days of stock-outs per month. Levonorgestrel 750mcg, male condoms, and folic acid tablets were on average stocked out for half a month or longer when a stock-out occurred, while another four commodities experienced stock-outs of 10 days or more.

**Figure 6:** Average number of reported stock-out days per month for SRHC in the public sector.



#### 4. SRHC Prices in Public, Private and Mission Sectors

The following section measures the pricing of commodities at facilities. SRHC not included in the analysis below are those which are not typically sold in facilities, such as equipment and

devices (e.g., incubators and monitors). Prices displayed are for individual units of a commodity: a unit is the single most effective amount of a commodity that can be used (e.g., one tablet, a strip of 28 contraceptive tablets, 1ml or 1 vial). Table 4 gives an overview of SHRC prices.

**Table 4:** SRHC mean, minimum and maximum unit prices in public, private and mission sector facilities.

	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	206	0	1500	0	0	0
Ethinyl/norethisterone	0	0	0	500	0	1500	NA	NA	NA
Levonorgestrel 30mcg	0	0	0	250	0	1000	NA	NA	NA
Levonorgestrel 70mcg	0	0	0	500	0	1500	NA	NA	NA
Medroxyprogesterone acetate	0	0	0	563	0	3000	0	0	0
Norethisterone enanthate	NA	NA	NA	0	0	0	1800	1800	1800
Male Condoms	0	0	0	136	0	1500	0	0	0
Female Condoms	0	0	0	250	0	1500	0	0	0
IUCD	0	0	0	386	0	5500	0	0	0
Levonorgestrel Implant	0	0	0	0	0	0	0	0	0
Etonogestrel Implant	0	0	0	574	0	10000	0	0	0
Diaphragm	NA	NA	NA	NA	NA	NA	NA	NA	NA
Oxytocin injection	0	0	0	1184	0	4000	743	0	2500
Misoprostol	0	0	0	973	0	5000	1233	0	2000
Metronidazole	475	0	6000	175	0	2500	95	0	500
Methyl dopa	79	0	2500	294	0	3000	216	0	500
Magnesium sulphate 500mg/ 2ml	0	0	0	0	0	0	2000	2000	2000
Magnesium sulphate 500mg/ 10ml	0	0	0	0	0	0	1667	0	5000
Calcium gluconate	0	0	0	5000	5000	5000	NA	NA	NA
Clotrimazole pessary	1690	0	7000	3563	750	9000	400	400	400
Clotrimazole cream	842	0	3000	1864	0	3000	1367	600	2000
Gentamicin injection	0	0	0	1220	0	3000	1333	1000	2000
Ampicillin	1026	0	6000	2364	1000	5000	1417	0	3000
Procaine benzylpenicillin	350	0	2000	2433	0	5000	2500	2000	4000
Benzathine benzylpenicillin G	830	0	6000	2679	0	6000	2364	0	5000
Amoxicillin 125mg	0	0	0	1550	100	3000	200	200	200
Amoxicillin 250mg	109	0	3000	559	0	6000	134	31	300
Dexamethasone	200	0	1000	2660	2000	3000	1625	500	2500
Ferrous Salt Tablet	0	0	0	NA	NA	NA	30	30	30
Folic Acid Tablet	1	0	33	84	50	120	125	50	250
Ferrous:Folic Tablet 60/400	0	0	NA	NA	NA	NA	NA	NA	NA
Ferrous:Folic Tablet 150/500	0	0	NA	300	300	300	NA	NA	NA
Zinc 10mg/5ml syrup	NA	NA	NA	3000	3000	3000	3000	3000	3000
Zinc 20mg tablet	0	0	0	315	0	2000	272	100	1000
Zinc ORS co-pack	69	0	2000	0	0	0	500	0	1000
ORS 200ml	0	0	0	NA	NA	NA	NA	NA	NA
ORS 500ml	NA	NA	NA	500	500	500	NA	NA	NA
ORS 1L	67	0	500	621	0	1000	479	100	1000

Note: NA denotes the SRHC was unavailable and, therefore, no price information can be calculated.

## 5. SRHC Affordability in Public, Private and Mission Sectors

Affordability of the commodities was measured by collecting the pricing information of commodities at the facilities, and then comparing this with the household final consumption expenditure (HHFCE) of different quintiles of the population, and with the daily salary of the lowest-paid government worker (LPGW) in 2018 (10,227.3 Tanzanian Shillings [TSH])<sup>4</sup>. HHFCE and income share per population quintile data were retrieved from the World Bank's 2016 World Development Indicators, which were used to calculate per

capita HHFCE. Affordability has been calculated for one treatment regimen (e.g. one strip of pills, one treatment regimen of antibiotics, one vial of injectable contraceptive, etc.). Please refer to Annex 8 for the treatment regimens used. Per WHO guidelines, a commodity is considered affordable if it costs no more than a day's income.

In the public sector, affordability of SRHC ranged from optimal (0 days of income) to 19.9 days of income needed by the 10% of the population with the lowest income to pay for a treatment with ampicillin (see Table 5). All contraceptives were for free in the public sector, while another

<sup>4</sup> National Bureau of Statistics, Ministry of Finance, 2012 Population and Housing Census: Population Distribution by Administrative Areas (Dar es Salaam: 2012).

thirteen commodities were also for free, including oxytocin, misoprostol, magnesium sulphate, gentamicin, amoxicillin 125mg, and ferrous salt and folic acid. Six commodities were

unaffordable for the 10% of the population with the lowest income compared to one commodity (ampicillin) that was considered unaffordable to the 10% of the population with the highest income.

**Table 5:** Affordability of SRHC in the public sector.

	Number of days income needed for treatment in the public sector							LPG worker
	Lowest 10%	11-20%	21-40%	41-60%	61-80%	81-90%	Highest 10%	
Ethinyl/levonorgestrel	0	0	0	0	0	0	0	0
Ethinyl/norethisterone	0	0	0	0	0	0	0	0
Levonorgestrel 300mcg	0	0	0	0	0	0	0	0
Levonorgestrel 750mcg	0	0	0	0	0	0	0	0
Medroxyprogesterone acetate	0	0	0	0	0	0	0	0
Norethisterone enanthate	0	0	0	0	0	0	0	0
Male Condoms	0	0	0	0	0	0	0	0
Female Condoms	0	0	0	0	0	0	0	0
IUCD	0	0	0	0	0	0	0	0
Levonorgestrel Implant	0	0	0	0	0	0	0	0
Etonogestrel Implant	0	0	0	0	0	0	0	0
Diaphragm	NA	NA	NA	NA	NA	NA	NA	NA
Oxytocin injection	0	0	0	0	0	0	0	0
Misoprostol	0	0	0	0	0	0	0	0
Metronidazole	1.3	0.9	0.7	0.5	0.4	0.3	0.1	0.1
Methyldopa	6.9	5.0	3.8	2.9	2.1	1.4	0.7	0.7
Magnesium sulphate 500mg/2ml	0	0	0	0	0	0	0	0
Magnesium sulphate 500mg/10ml	0	0	0	0	0	0	0	0
Calcium gluconate	0	0	0	0	0	0	0	0
Clotrimazole pessary	9.9	7.1	5.5	4.1	3.0	2.1	1.0	1.0
Clotrimazole cream	0.8	0.6	0.5	0.3	0.2	0.2	0.1	0.1
Gentamicin injection	0	0	0	0	0	0	0	0
Ampicillin	19.9	14.5	11.1	8.3	6.0	4.2	2.0	2.0
Procaine benzylpenicillin	3.4	2.5	1.9	1.4	1.0	0.7	0.3	0.3
Benzathine benzylpenicillin G	0.8	0.6	0.4	0.3	0.2	0.2	0.1	0.1
Amoxicillin 125mg	0	0	0	0	0	0	0	0
Amoxicillin 250mg	1.6	1.2	0.9	0.7	0.5	0.3	0.2	0.2
Dexamethasone	0.2	0.1	0.1	0.1	0.1	0	0	0
Ferrous Salt	0	0	0	0	0	0	0	0
Folic Acid	0	0	0	0	0	0	0	0
Ferrous salt: Folic Acid 60/400	0	0	0	0	0	0	0	0
Ferrous salt: Folic Acid 150/500	0	0	0	0	0	0	0	0
Zinc 10mg/5ml syrup	NA	NA	NA	NA	NA	NA	NA	NA
Zinc 20mg	0	0	0	0	0	0	0	0
Zinc ORS co-pack	0.1	0	0	0	0	0	0	0
ORS 200ml	0	0	0	0	0	0	0	0
ORS 500ml	NA	NA	NA	NA	NA	NA	NA	NA
ORS 1L	0.1	0	0	0	0	0	0	0

In the private sector, SRHCs were more expensive and affordability therefore differed. All contraceptives were affordable across the quintiles and for the LPGW; the most expensive contraceptive was the etonogestrel implant, which cost the 10% of the population earning the least 0.6 days of income (see Table 6).

Affordability in the private sector was a major problem for 60% of the population: they were unable to afford more than 40% of the commodities. The most expensive commodity was ampicillin, which cost 45.9 days of income (10% of the population with the least income) to 4.6 days of income (10% of the population with the highest income).

**Table 6:** Affordability of SRHC in the private sector.

	HHFCE per quintile							LPG worker
	Lowest 10%	11-20%	21-40%	41-60%	61-80%	81-90%	Highest 10%	
Ethinyl/levonorgestrel	0.2	0.1	0.1	0.1	0.1	0	0	0
Ethinyl/norethisterone	0.5	0.4	0.3	0.2	0.1	0.1	0	0
Levonorgestrel 300mcg	0.2	0.2	0.1	0.1	0.1	0.1	0	0
Levonorgestrel 750mcg	0.5	0.4	0.3	0.2	0.1	0.1	0	0
Medroxyprogesterone acetate	0.5	0.4	0.3	0.2	0.2	0.1	0.1	0.1
Norethisterone enanthate	0	0	0	0	0	0	0	0
Male Condoms	0.1	0.1	0.1	0.1	0	0	0	0
Female Condoms	0.2	0.2	0.1	0.1	0.1	0.1	0	0
IUCD	0.4	0.3	0.2	0.2	0.1	0.1	0	0
Levonorgestrel Implant	0	0	0	0	0	0	0	0
Etonogestrel Implant	0.6	0.4	0.3	0.2	0.2	0.1	0.1	0.1
Diaphragm	NA	NA	NA	NA	NA	NA	NA	NA
Oxytocin injection	1.2	0.8	0.6	0.5	0.3	0.2	0.1	0.1
Misoprostol	0.9	0.7	0.5	0.4	0.3	0.2	0.1	0.1
Metronidazole	5.1	3.7	2.8	2.1	1.5	1.1	0.5	0.5
Methyldopa	25.7	18.6	14.3	10.7	7.7	5.4	2.6	2.6
Magnesium sulphate 500mg/2ml	0	0	0	0	0	0	0	0
Magnesium sulphate 500mg/10ml	0	0	0	0	0	0	0	0
Calcium gluconate	4.9	3.5	2.7	2.0	1.5	1.0	0.5	0.5
Clotrimazole pessary	20.8	15.1	11.5	8.7	6.2	4.3	2.1	2.1
Clotrimazole cream	1.8	1.3	1.0	0.8	0.5	0.4	0.2	0.2
Gentamicin injection	11.9	8.6	6.6	4.9	3.6	2.5	1.2	1.2
Ampicillin	45.9	33.3	25.5	19.1	13.8	9.6	4.6	4.6
Procaine benzylpenicillin	23.6	17.2	13.1	9.9	7.1	4.9	2.4	2.4
Benzathine benzylpenicillin G	2.6	1.9	1.4	1.1	0.8	0.5	0.3	0.3
Amoxicillin 125mg	22.6	16.4	12.5	9.4	6.8	4.7	2.3	2.3
Amoxicillin 250mg	8.2	5.9	4.5	3.4	2.4	1.7	0.8	0.8
Dexamethasone	2.6	1.9	1.4	1.1	0.8	0.5	0.3	0.3
Ferrous Salt	NA	NA	NA	NA	NA	NA	NA	NA
Folic Acid	2.5	1.8	1.4	1.0	0.7	0.5	0.2	0.2
Ferrous salt: Folic Acid 60/400	NA	NA	NA	NA	NA	NA	NA	NA
Ferrous salt: Folic Acid 150/500	8.7	6.3	4.9	3.6	2.6	1.8	0.9	0.9
Zinc 10mg/5ml syrup	2.9	2.1	1.6	1.2	0.9	0.6	0.3	0.3
Zinc 20mg	3.1	2.2	1.7	1.3	0.9	0.6	0.3	0.3
Zinc ORS co-pack	0	0	0	0	0	0	0	0
ORS 200ml	NA	NA	NA	NA	NA	NA	NA	NA
ORS 500ml	0.5	0.4	0.3	0.2	0.1	0.1	0	0
ORS 1L	0.6	0.4	0.3	0.3	0.2	0.1	0.1	0.1

In the mission sector, affordability ranged from optimal (0 days of wages) to 35 days of wages (magnesium sulphate 500mg/10ml for 10% of the population with lowest income) (see Table 7). Norethisterone enanthate was the only contraceptive unaffordable, and was unaffordable to the 20% of the population with the lowest income. For the 10% of the population

with the lowest income, 18 of 28 commodities were unaffordable, while this was the case for 6 commodities for the 10% of the population with the highest income; methyl dopa, magnesium sulphate (both strengths), gentamicin, ampicillin and procaine benzylpenicillin were the most expensive commodities, and were unaffordable even to the highest income decile.

**Table 7:** Affordability of SRHC in the mission sector.

Number of days income needed for treatment in the mission sector								
	HHFCE per quintile							LPG worker
	Lowest 10%	11-20%	21-40%	41-60%	61-80%	81-90%	Highest 10%	
Ethinyl/levonorgestrel	0	0	0	0	0	0	0	0
Ethinyl/norethisterone	NA	NA	NA	NA	NA	NA	NA	NA
Levonorgestrel 300mcg	NA	NA	NA	NA	NA	NA	NA	NA
Levonorgestrel 750mcg	NA	NA	NA	NA	NA	NA	NA	NA
Medroxyprogesterone acetate	0	0	0	0	0	0	0	0
Norethisterone enanthate	1.7	1.3	1.0	0.7	0.5	0.4	0.2	0.2
Male Condoms	0	0	0	0	0	0	0	0
Female Condoms	0	0	0	0	0	0	0	0
IUCD	0	0	0	0	0	0	0	0
Levonorgestrel Implant	0	0	0	0	0	0	0	0
Etonogestrel Implant	0	0	0	0	0	0	0	0
Diaphragm	NA	NA	NA	NA	NA	NA	NA	NA
Oxytocin injection	0.7	0.5	0.4	0.3	0.2	0.2	0.1	0.1
Misoprostol	1.2	0.9	0.7	0.5	0.4	0.3	0.1	0.1
Metronidazole	2.8	2.0	1.5	1.2	0.8	0.6	0.3	0.3
Methyl dopa	18.9	13.7	10.5	7.9	5.7	4.0	1.9	1.9
Magnesium sulphate 500mg/2ml	35.0	25.4	19.4	14.6	10.5	7.3	3.5	3.5
Magnesium sulphate 500mg/10ml	29.1	21.2	16.2	12.1	8.7	6.1	2.9	2.9
Calcium gluconate	NA	NA	NA	NA	NA	NA	NA	NA
Clotrimazole pessary	2.3	1.7	1.3	1.0	0.7	0.5	0.2	0.2
Clotrimazole cream	1.3	1.0	0.7	0.6	0.4	0.3	0.1	0.1
Gentamicin injection	13.0	9.4	7.2	5.4	3.9	2.7	1.3	1.3
Ampicillin	27.5	20.0	15.3	11.5	8.3	5.8	2.8	2.8
Procaine benzylpenicillin	24.3	17.6	13.5	10.1	7.3	5.1	2.4	2.4
Benzathine benzylpenicillin G	2.3	1.7	1.3	1.0	0.7	0.5	0.2	0.2
Amoxicillin 125mg	2.9	2.1	1.6	1.2	0.9	0.6	0.3	0.3
Amoxicillin 250mg	2.0	1.4	1.1	0.8	0.6	0.4	0.2	0.2
Dexamethasone	1.6	1.1	0.9	0.7	0.5	0.3	0.2	0.2
Ferrous Salt	0.9	0.6	0.5	0.4	0.3	0.2	0.1	0.1
Folic Acid	3.6	2.6	2.0	1.5	1.1	0.8	0.4	0.4
Ferrous salt: Folic Acid 60/400	NA	NA	NA	NA	NA	NA	NA	NA
Ferrous salt: Folic Acid 150/500	NA	NA	NA	NA	NA	NA	NA	NA
Zinc 10mg/5ml syrup	2.9	2.1	1.6	1.2	0.9	0.6	0.3	0.3
Zinc 20mg	2.6	1.9	1.5	1.1	0.8	0.6	0.3	0.3
Zinc ORS co-pack	0.5	0.4	0.3	0.2	0.1	0.1	0	0
ORS 200ml	NA	NA	NA	NA	NA	NA	NA	NA
ORS 500ml	NA	NA	NA	NA	NA	NA	NA	NA
ORS 1L	0.5	0.3	0.3	0.2	0.1	0.1	0	0



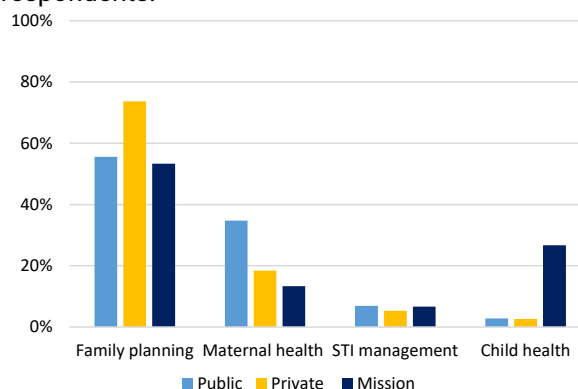
## 6. Stakeholder Interviews

The following sections contain data analysed from section B of the methodology, SRHC: *Measuring Prices, Availability and Affordability*, which investigated access to SRHC at facilities from the perspective of the interviewed health provider. The respondents remained the same as those providing assistance in part A of the survey, and the response rate was 100%. Please refer to Annex 9 for additional graphs.

### 6.1 Key Challenges to SRHC Access

Respondents were asked what they believed to be the SRH service that experienced most challenges with regards to access. In all three sectors, family planning was thought to be the service facing the most challenges (see Figure 7). In the private sector 74% of respondents mentioned family planning, while 56% and 53% of public and mission sector healthcare workers, respectively, did. In the mission sector, accessing child health services was also thought to be a challenge by 27% of respondents, and maternal health was a challenge according to 35% of public sector respondents.

**Figure 7:** SRH service facing the most challenges related to access to commodities according to respondents.

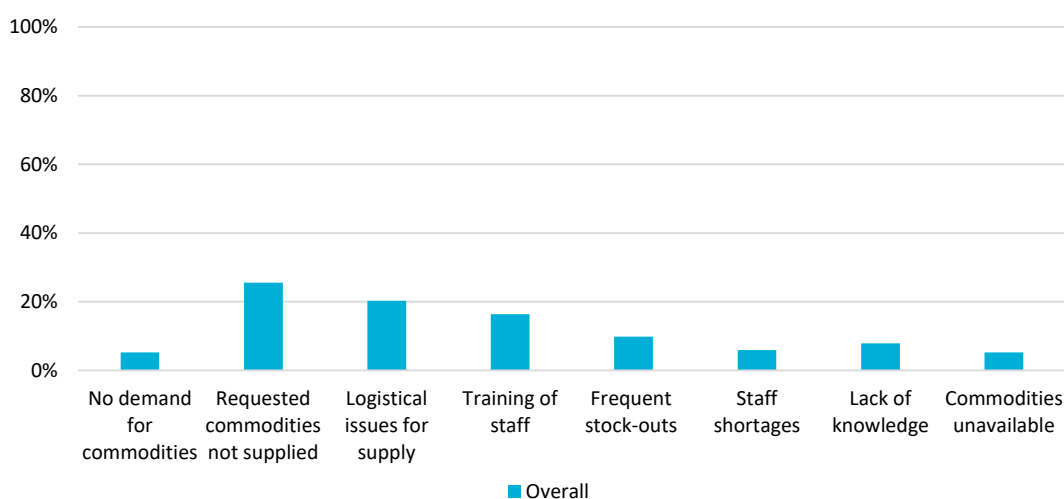


When asked about what they thought were the key challenges to SRHC access, respondents mentioned:

- Lack of supply of medicines and commodities (25%);
- Logistical supply issues (20%);
- Training of staff (16%).

Figure 8 shows an overview of the key challenges to accessing SRH commodities.

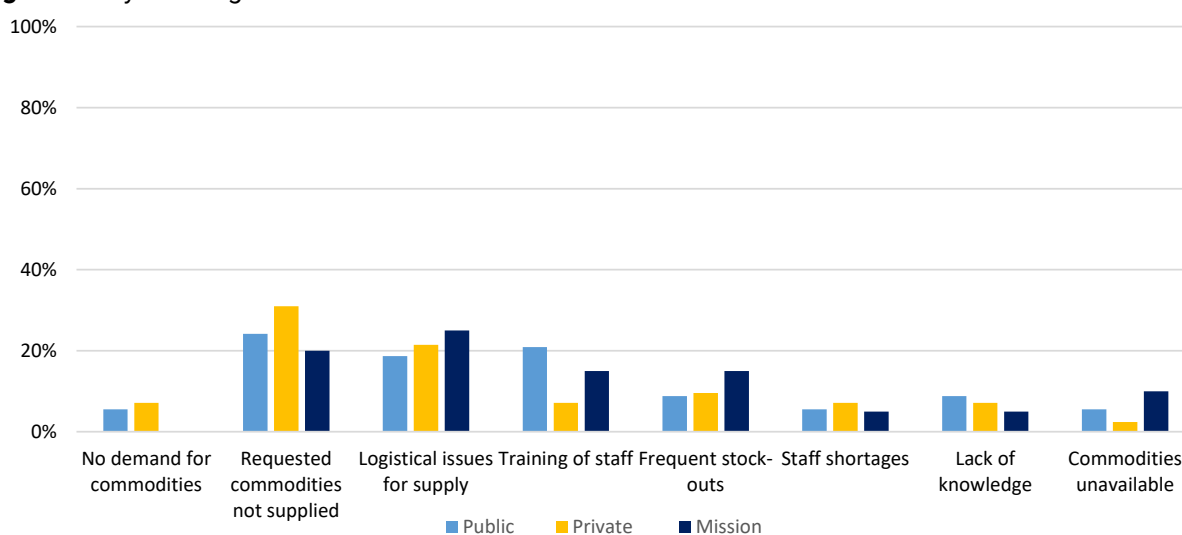
**Figure 8:** Key challenges to SRHC access.



When the key challenges were ordered according to sector, some slight differences emerged, even though the three main challenges remained the same. In the public sector, the biggest challenge to SRHC access, mentioned by 24% of respondents, was that requested commodities are not supplied, which was closely followed by the lack of training for staff (21%) (see Figure 9). In the

private and mission sectors, most respondents also believed that the main challenge was that requested commodities are not supplied or not supplied on time (31% and 20%, respectively). Another challenge that was mentioned was logistical issues for supply of the commodities (21% and 25%, respectively). Frequent stock-outs was mentioned by 15% of mission sector health workers.

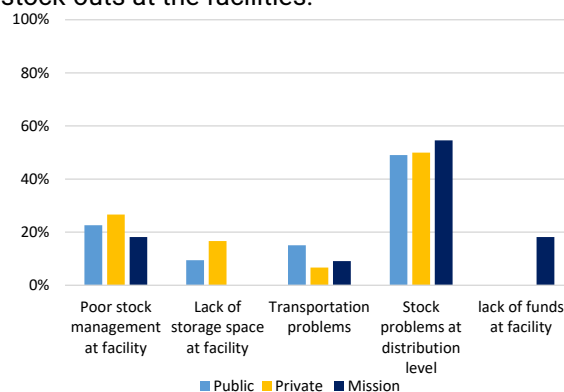
**Figure 9:** Key challenges to SRHC access.



## 6.2. Reasons for stock-outs of SRHCs at facilities

Respondents were also asked about their opinion on the causes of stock-outs at facilities. Across the three sectors, stock problems at the distribution level were thought to be the main cause of stock-outs (see Figure 10). For instance, in the public and private sector, 49% and 50% of respondents, respectively, argued this to be the cause, and 55% of respondents in the mission sector believed it to be the main cause. Interestingly, respondents also believed poor stock management at the facility contributed to stock-outs, as 23% of public sector respondents, and 27% of private sector respondents mentioned this as a cause of the stock-outs. In the mission sector, lack of funds was also a leading cause (mentioned by 18% of respondents).

**Figure 10:** Reasons given by respondents for SRHC stock-outs at the facilities.

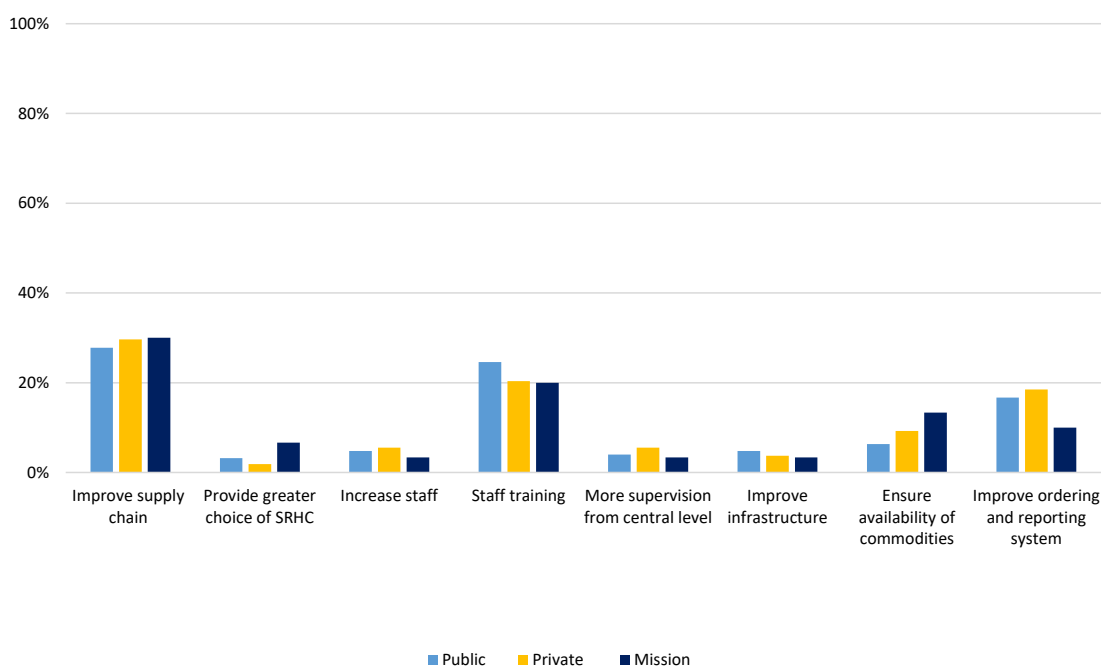


### 6.3. Improving Access to SRHC

Respondents were then asked what they thought could be done on the supply side to improve access to SRHC in Tanzania. Where possible, they were asked to list their top three priorities. Responses were similar across the sectors (see Figure 11). For instance, in the public sector 28% of respondents believed that improving the supply chain could improve access to SRHC, and 30% of private and mission sector respondents

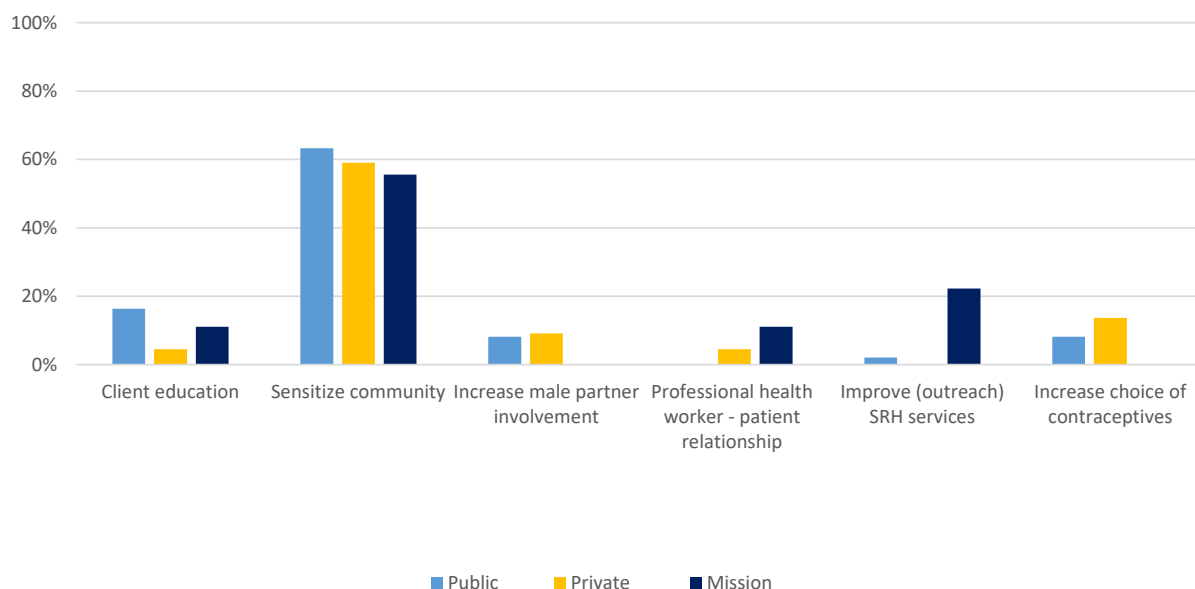
believed this as well. Continuing education or training for health workers was also often mentioned by respondents in all sectors: 25% of public sector respondents, and 20% of private and mission sector respondents believed this to be a way to improve SRHC access. In the public and private sectors, improving the ordering and reporting system was also commonly thought to be a way to improve access to SRHC from the supply side.

**Figure 11:** Recommendations to improve access to SRHCs on the supply side.



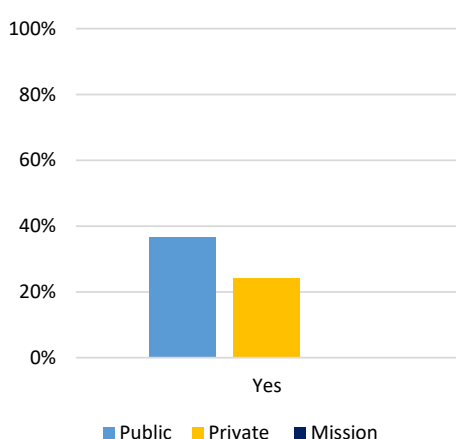
Respondents were also asked what could be done to ensure access to SRHC from the demand side. Sensitisation of the community was believed by most respondents to do this (see Figure 12). For instance, 63% of public sector respondents

mentioned community sensitisation, and 59% and 56% of private and mission sectors, respectively, did as well. In the mission sector, improving SRH services, specifically outreach services, was also mentioned by 22% of respondents.

**Figure 12:** Recommendations to improve access to SRHCs on the demand side.

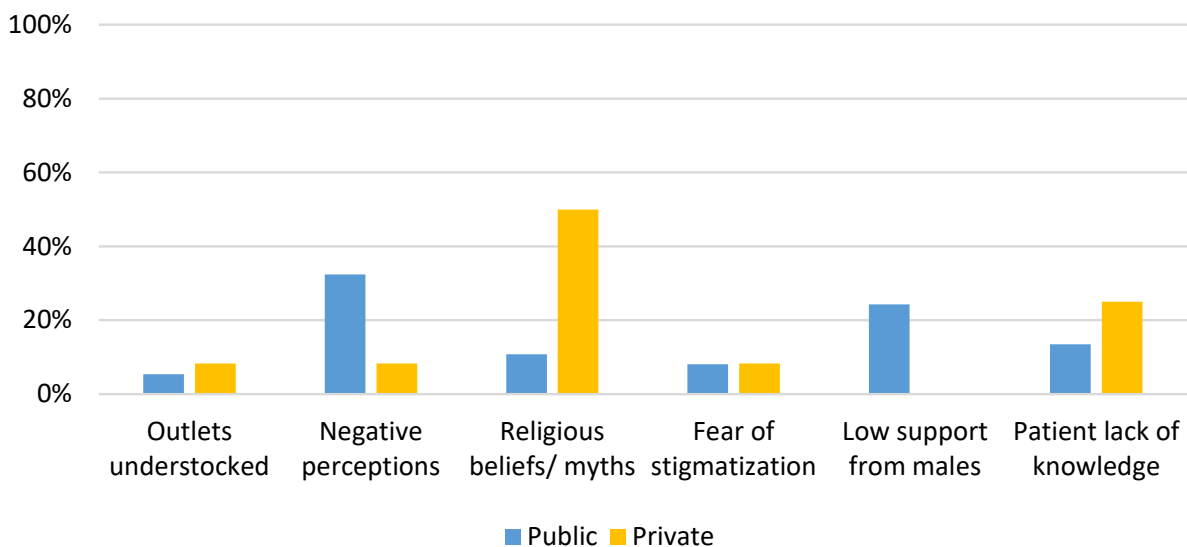
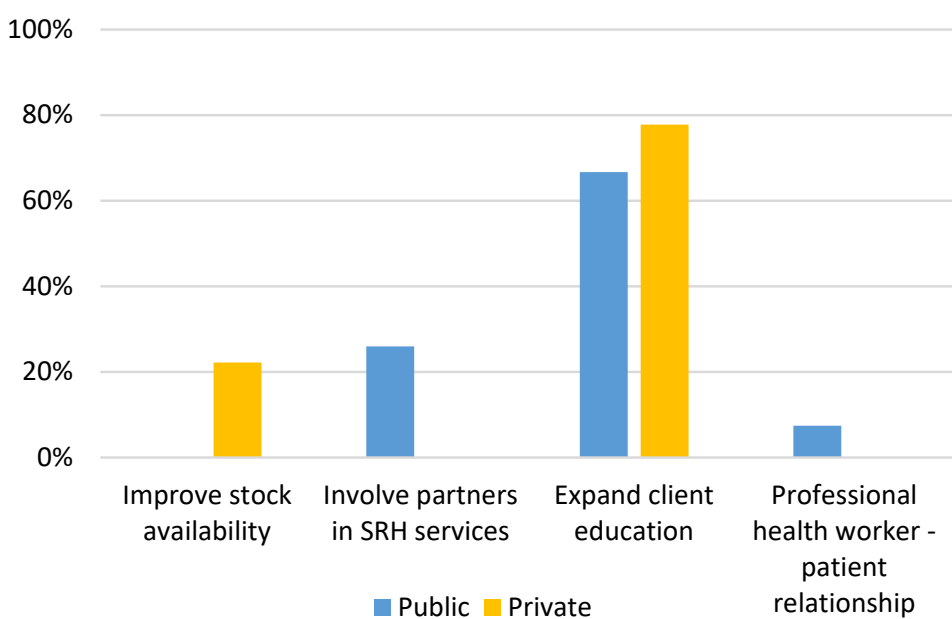
#### 6.4. Reluctance for Clients to Access SRHC

Respondents were also asked if they thought clients that visited their facility were reluctant to access SRHC and SRH services. If respondents replied 'yes', they were then asked to provide their thoughts on what the reasons were for this reluctance, and what they believe can be done to tackle this issue. Of the respondents, 37% of public sector health workers, and 24% of private

**Figure 13:** Reluctance of clients to access SRH services

sector health workers believed clients were at times reluctant to access SRHC or SRH services (see Figure 13). Interestingly, none of the mission sector respondents believed clients were reluctant.

When respondents were asked why clients were reluctant to access SRH services, respondents in the public sector believed negative perceptions, resulting in fear of side effects, was the main reason for the reluctance (32%), which was followed by the belief that women often experience low support from their male partners (24%). In the private sector respondents thought religious beliefs and myths about SRH services, including family planning, were the major reasons for client reluctance (50%), while 25% of private sector respondents also thought the lack of knowledge of patients played a role.

**Figure 14:** Reasons for client reluctance in accessing SRHC in public, private and mission sectors.**Figure 15:** Recommendations to overcome clients' reluctance to access SRHC at facilities.

# DISCUSSION AND RECOMMENDATIONS

**This study in Tanzania is the first roll-out of a planned yearly survey as part of Health Action International's SRHC research under the Health Systems Advocacy (HSA) Partnership, and aims to inform stakeholders of the country situation regarding access to SRHC.**

The International Conference on Population and Development (ICPD) Programme of Action and the Sustainable Development Goals (SDGs) both include universal access to SRH as a key target for achieving its goals<sup>5</sup>. For SRH to be realised, universal access to services and commodities is necessary. This is achieved when individuals are able to obtain and use sexual and reproductive health commodities of their choice whenever they need them.

The research was conducted in 126 health facilities in public, private and mission sectors, and showed that general availability of SRH commodities was low in both urban and rural facilities and across the sectors; highest availability was found in the public sector, where availability was still only 37%. Commodity-specific availability ranged from 0% availability for some commodities, to over 90% for other commodities.

Although contraceptive availability was generally low, availability was typically higher in the public sector than in the other sectors. Still, only three contraceptives, medroxyprogesterone acetate, male condoms and etonogestrel implants, were

available in more than 80% of the public facilities. Availability of contraceptives was evidently lower in private facilities, with only the etonogestrel implant found in more than 70% of the private facilities. In mission facilities, availability was critically low; highest availability was found for the intrauterine contraceptive device (13%). Interestingly, vasectomy and tuboligation kits were found in none of the mission sector facilities, and in only 3% of private sector facilities. In public sector facilities, no vasectomy kits were found, and tuboligation kits were only found in 3% of facilities. Access to family planning services is still problematic for a significant number of women in Tanzania: 22.7% of married women aged 15-24 have unmet family planning needs, while unmarried women aged 15-24 experience an even greater unmet need (33.1%). Interestingly, unmet need is higher for married women aged 25-49 (26.2%) than for those aged 15-24<sup>6</sup>. The sub-optimal availability of contraceptives contributes to the quarter of women experiencing unmet needs for family planning in Tanzania, likely also contributing to the high rate of teenage pregnancies; 44% of women aged 19 are pregnant or have already given birth to their first child<sup>7</sup>.

<sup>5</sup> United Nations, *Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014* (Geneva: United Nations, 2014), pp. 1-276.

<sup>6</sup> United States Agency for International Development, *Unmet need for family planning among young women: levels and trends. DHS Comparative Reports No. 34* (Rockville, Maryland, USA: ICF International, 2014), pp. 1-209.

<sup>7</sup> Ministry of Health, Community Development, Gender, Elderly and Children, *The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016-2020)* (Dar es Salaam: MoHCDGEC, 2016), pp. 1-132.

Availability of maternal health commodities, including those used for antenatal and postnatal care to induce labour, treat postpartum haemorrhage and pre-eclampsia, generally had a lower availability in private and mission facilities than in the public sector. Only the safe delivery kit in the public sector had an availability of 80% or higher. Apart from oxytocin injection, metronidazole, benzathine benzylpenicillin, amoxicillin 250mg, which were found in more than 40% of the facilities across the sectors, other commodities, including magnesium sulphate, dexamethasone, ferrous salt and folic acid, were inaccessible in many facilities due to the crucially low availability. Availability of maternal health commodities is essential for saving the lives of mothers and babies, ensuring healthy pregnancies and reducing maternal morbidity and mortality. Since maternal mortality is still dangerously high in Tanzania– 556 deaths per 100,000 live births– ensuring the availability of commodities necessary for quality care is imperative.<sup>8</sup>

Ampicillin had a 64% availability in the public sector, but a low availability in the private (29%) and mission (40%) sectors, even though it is crucial in the treatment of pneumonia and neo-natal sepsis. Commodities for the management of acute diarrhoea in children, such as zinc and ORS had a 70% to 80% availability across the sectors, although interestingly zinc availability in the public sector was substantially lower (36%). Availability of paediatric amoxicillin (125mg) was also low (less than 7%), while chlorhexidine 4% was unavailable in the public and private sectors, and in only 7% of mission sector facilities.

Antibiotics used to treat STIs and other bacterial infections with highest availability were metronidazole and benzathine benzylpenicillin. Metronidazole had more than 90% availability in

the public and private sector, and an 87% availability in the mission sector. Availability of benzathine benzylpenicillin was also relatively high (73%-78%), while clotrimazole (pessary or cream) had lower availability (less than 30%). Considering the fact that there is a high burden of curable STIs in Tanzania– it was estimated that between 10-20% of the sexually active population of Tanzania contracts an STI each year. Given that these illnesses pose risks on reproductive health, (e.g., risks of infertility and still births) access to commodities to treat STIs is highly important to ensure a healthy population.<sup>9,10</sup>

The study also observed low availability of SRH instruments in the surveyed facilities. Instruments play an important part in ensuring the provision of quality SRH services. Inadequate availability of instruments necessary for various procedures contribute to poor service provision and reduce the ability of clients to access quality SRH services.

Even though availability of SRHC is shown to be low, it is also important to note that some of the assessed commodities are not included on the Standard Treatment Guidelines & National Essential Medicines List Tanzania Mainland (EML), and therefore their availability in health facilities cannot be guaranteed. For instance, the emergency contraceptive formulations included in this research differ from the formulations that are included on the Tanzanian EML, which might explain the lower availability in the facilities. Also, ethinylestradiol + norethisterone, a type of birth control pill which had a very low availability across the sectors, is also not included on the EML; a different formulation is used instead. The exclusion of these commodities from the Tanzania EML might contribute to the low availability of some of these commodities. It is thus recommended that next year the counterparts included on the EML are studied to

<sup>8</sup> Ministry of Health, Community Development, Gender, Elderly and Children, *Demographic and Health Survey and Malaria Indicator Survey*. (Rockville, Maryland, USA: MoHCDGEC, 2016)

<sup>9</sup> Newman et al., *Global Estimates of the Prevalence and Incidence of Four Curable Sexually Transmitted Infections in 2012 Based on Systematic Review and Global Reporting* (PLoS ONE, 2015)

<sup>10</sup> Ministry of Health and Social Welfare, *National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections* (Dar es Salaam: Ministry of Health and Social Welfare, 2007), pp. 1-151.

compare if the availability of those formulations is higher. Please refer to Annex 10 for a list of SRHC included in this research that are not included on the EML.

The low availability of some SRHC in the mission sector can be explained by the fact that some mission facilities, often those owned by churches, experience limitations in providing some of these SRH services, especially family planning, due to religious beliefs.

The study further observed inadequate stock management of SRH commodities in many facilities. As recommended in the Integrated Logistics System (ILS) National Guidelines, health commodities ought to be managed through stock cards or a computerised system so quantification and forecasting is possible to ensure commodities are available at all times.<sup>11</sup> It was noted however, that only 27% of the facilities surveyed used stock cards in the six months prior to the survey to quantify their stocks and needs. Also, when facilities did have stock cards, it became clear that stock-outs were a problem, as 17% of public facilities reported stock-outs, with these stock-outs lasting on average 11 days per month. Not surprisingly, many respondents recommended that better stock management at the facility, and improving the supply at the distribution level are necessary to improve access to SRHC.

In the private and mission sectors, affordability of SRHC was an issue, especially for maternal and child health commodities. Interestingly, contraceptives were affordable in all sectors, with the exception of norethisterone acetate in the mission sector, where it was considered unaffordable for the 20% of the population with the least income. The price of other commodities in the private and mission sectors far exceeded the one day of income that is used as a measure to determine the affordability of a commodity. Importantly, even in the public sector, some commodities, specifically antibiotics, were unaffordable. Given that Tanzania's LPGW earns the equivalent of USD 4.48,<sup>12</sup> while in 2011, 49.1% of the population was living below the international poverty line of USD 1.90,<sup>13</sup> in this survey we have also used the household final consumption expenditure (HHFCE) per share of the population to calculate affordability. This measure was used because we are interested in knowing what people actually have available to spend, and it is believed that HHFCE is a better reflection of a household's resources than for example gross domestic product.<sup>14</sup> There is a significant discrepancy between the HHFCE of the population and the wage of a LPGW. One explanation for this is that the HHFCE has been calculated per capita, so even a baby will have a HHFCE, while the wage of a LPGW might be used to provide for an entire family. Note that the average family size in Uganda is 4.9 persons.<sup>15</sup>

<sup>11</sup> Ministry of Health and Social Welfare, *National Guidelines for Integrated Logistic Management System* (Dar es Salaam: 2012).

<sup>12</sup> Oanda, *Currency Converter*, <<https://www.oanda.com/currency/converter/>> [accessed 18 July 2018].

<sup>13</sup> The World Bank, *Poverty and Equity Data Portal: Tanzania*, <<http://povertydata.worldbank.org/poverty/country/TZA>> [accessed 13 December, 2018].

<sup>14</sup> Niens et. al., 'Practical Measurement of Affordability: an Application to medicines', 2012, *Bulletin of the World Health Organization* (Geneva: WHO, 2012), pp. 219-227.

<sup>15</sup> United Nations, Department of Economic and Social Affairs, Population Division, *Household Size and Composition Around the World 2017* (Geneva: United Nations, 2017), pp. 1-31.



Apart from stock-outs, inadequate stock management and supply chain issues, another major challenge affecting access to SRHC mentioned by health workers was the lack of training. On the client side, issues with accessing SRH services and commodities were thought to be the negative perceptions surrounding SRH, religious beliefs, fear of side effects and poor male participation.

Inadequate availability of SRH commodities, frequent stock-outs, poor logistic management, and limited community knowledge are major factors contributing to the problems people are experiencing with accessing SRH commodities in Tanzania. To achieve the country targets and the SDGs of universal access to SRH services, there is

a high need to improve access to SRHC. In order to improve access to SRHC, the following steps are recommended:

- Ensure an adequate supply of SRH commodities by:
  - Improving the supply chain from the central level down;
  - Improving logistics management at the facility.
- Increase capacity building of healthcare providers through regular trainings on SRH.
- Sensitise communities about SRH services and commodities.
- Ensure all family planning commodities on international EMLs are also included on the Tanzania EML.

## Annex 1: SRHC Surveyed

**Table 8:** Full list of SRHCs surveyed.

Commodity (strength)
Ethinylestradiol + levonorgestrel (tablet, 30 mcg + 150 mcg)
Ethinylestradiol + norethisterone (tablet, 35 mcg + 1.0 mg)
Levonorgestrel (tablet, 300 mcg)
Levonorgestrel (tablet, 750 mcg)
Medroxyprogesterone acetate (150mg in 1 ml)
Norethisterone enanthate (200mg/ml in 1 ml)
Male Condoms
Female Condoms
Intrauterine contraceptive devices (IUCD)
Implant: Levonorgestrel
Implant: Etonogestrel
Diaphragm
Oxytocin injection (10IU, 1ml)
Misoprostol (200 mcg tablet)
Metronidazole (200 mg tablet)
Methyldopa (250mg tablet)
Magnesium sulfate (500mg in 2ml)
Magnesium sulfate (500mg in 10ml)
Calcium gluconate (100mg in 10ml)
Clotrimazole pessary (500mg)
Clotrimazole cream (1% in 15g tube)
Gentamicin injection (40mg/ml in 2ml)
Ampicillin (500mg powder for injection)
Procaine benzylpenicillin (fort) powder for injection (4MU)
Benzathine benzylpenicillin G (2.4MU in 10ml)
Amoxicillin (125mg, dispersible)
Amoxicillin (250mg, dispersible)
Dexamethasone (4mg/ml)
Ferrous Salt (200mg tablet)
Folic Acid (5mg tablet)
Ferrous Salt and Folic Acid Tablet (60mg iron + 400mcg Folic Acid)
Ferrous Salt and Folic Acid Tablet (150mg iron + 500mcg Folic Acid)
Zinc (10mg in 5ml syrup)
Zinc (20mg tablet)
Zinc ORS co-pack (10mg/1L)
ORS sachets (200ml)
ORS sachets (500ml)
ORS sachets (1L)
Safe delivery kit
Vasectomy kits
Tuboligation kits
Antiseptic
Chlorhexidine 4%
Manual vacuum aspiration kits (MVA)
Speculum
Cervical dilators
Incubator
Monitor
Ultra sound scan
Ventilator
Fetal scope
Resuscitator
Bag and mask size 0
Suction device
Training manikin for infant resuscitation

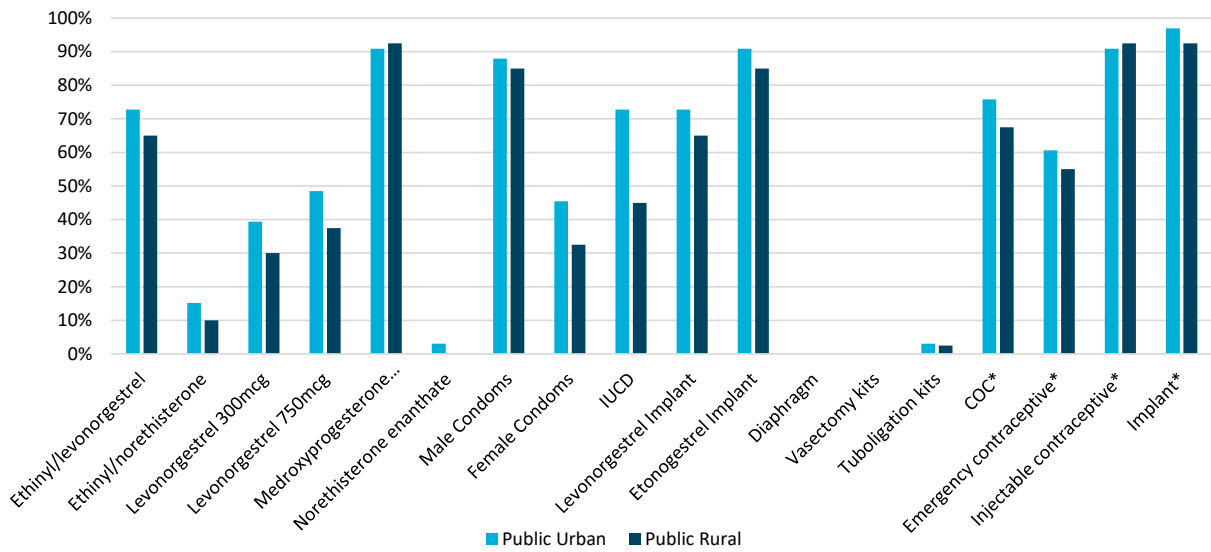
## Annex 2: SRHC Availability

**Table 9:** Availability of SRHC in the public, private and mission sectors, per area.

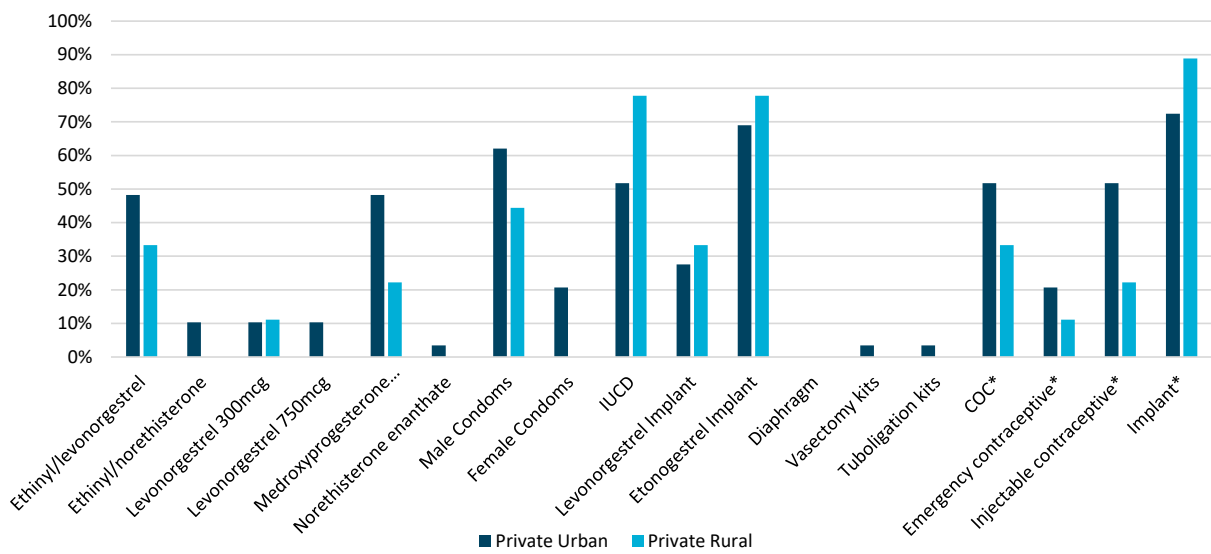
	Percentage Mean Availability					
	Public		Private		Mission	
	Urban	Rural	Urban	Rural	Urban	Rural
Ethinyl/levonorgestrel	73	65	48	33	0	20
Ethinyl/norethisterone	15	10	10	0	0	0
Levonorgestrel 30mcg	39	30	10	11	0	0
Levonorgestrel 70mcg	48	38	10	0	0	0
Medroxyprogesterone acetate	91	93	48	22	10	0
Norethisterone enanthate	3	0	3	0	10	0
Male Condoms	88	85	62	44	20	0
Female Condoms	45	33	21	0	10	20
IUCD	73	45	52	78	20	0
Levonorgestrel Implant	73	65	28	33	10	0
Etonogestrel Implant	91	85	69	78	10	0
Diaphragm	0	0	0	0	0	0
Oxytocin injection	70	85	48	56	50	40
Misoprostol	33	45	28	33	30	0
Metronidazole	94	95	97	89	90	80
Methyl dopa	79	63	45	78	40	20
Magnesium sulphate 500mg in 2ml	6	8	0	11	10	0
Magnesium sulphate 500mg in 10ml	55	25	10	0	20	20
Calcium gluconate	3	3	3	0	0	0
Clotrimazole pessary	9	18	7	22	10	0
Clotrimazole cream	15	10	31	22	20	20
Gentamicin injection	12	30	34	0	20	20
Ampicillin	45	80	21	56	40	40
Procaine benzylpenicillin	39	18	38	78	40	20
Benzathine benzylpenicillin G	85	73	76	78	70	80
Amoxicillin 125mg	3	8	7	0	0	20
Amoxicillin 250mg	67	63	55	0	50	40
Dexamethasone	9	5	10	22	40	0
Ferrous Salt Tablet	15	8	0	0	10	0
Folic Acid Tablet	45	25	17	44	20	40
Ferrous:Folic Tablet 60/400	0	3	0	0	0	0
Ferrous:Folic Tablet 150/500	12	0	7	0	0	0
Zinc 10mg/5ml syrup	0	0	3	22	10	0
Zinc 20mg tablet	33	38	72	78	60	60
Zinc ORS co-pack	21	55	7	0	20	0
ORS 200ml	0	5	0	0	0	0
ORS 500ml	0	0	3	0	0	0
ORS 1L	76	88	79	67	80	80
Safe Delivery Kit	79	85	31	33	30	40
Vasectomy kits	0	0	3	0	0	0
Tuboligation kits	3	3	3	0	0	0
Antiseptic	73	75	55	44	40	80
Chlorhexidine 4%	0	0	0	0	10	0
MVA	36	45	21	33	0	20
Speculum	79	88	41	56	60	80
Cervical dilators	15	15	7	11	20	60
Incubator	9	3	10	11	30	20
Monitor	0	3	10	11	20	20
Ultra sound scan	0	5	31	33	50	40
Ventilator	0	5	3	0	30	0
Fetal scope	94	100	48	89	80	100
Resuscitator	39	18	21	22	40	20
Bag and mask	42	68	21	33	30	60
Suction device	61	83	21	33	40	60
Training mannequin	27	20	7	11	20	60

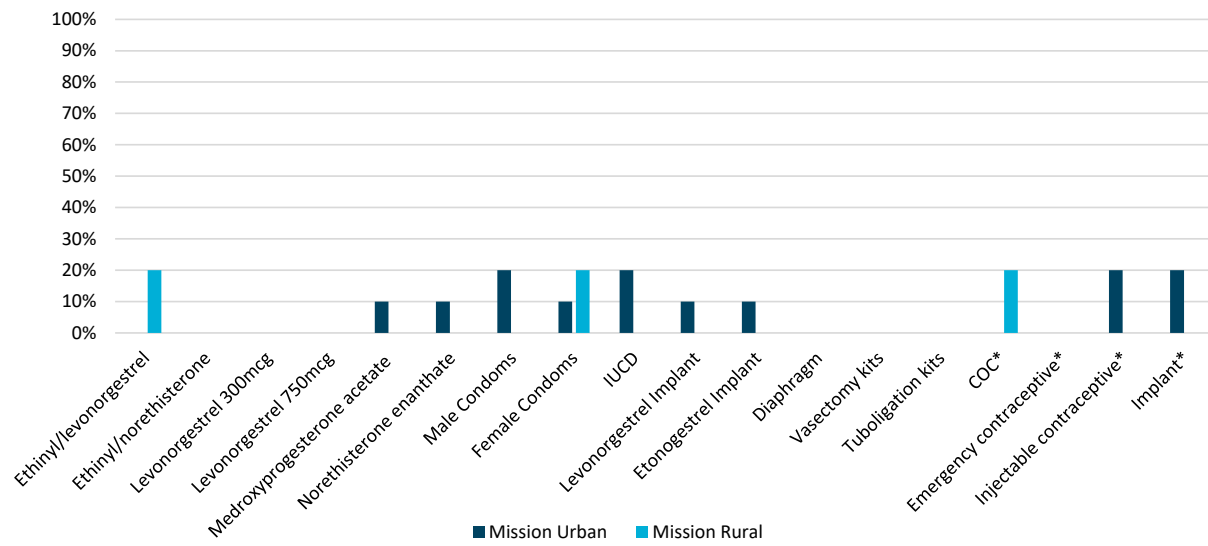
### Annex 3: Availability of Contraceptives per Sector, by Urban and Rural Areas

**Figure 16:** Availability of contraceptives in the public sector.



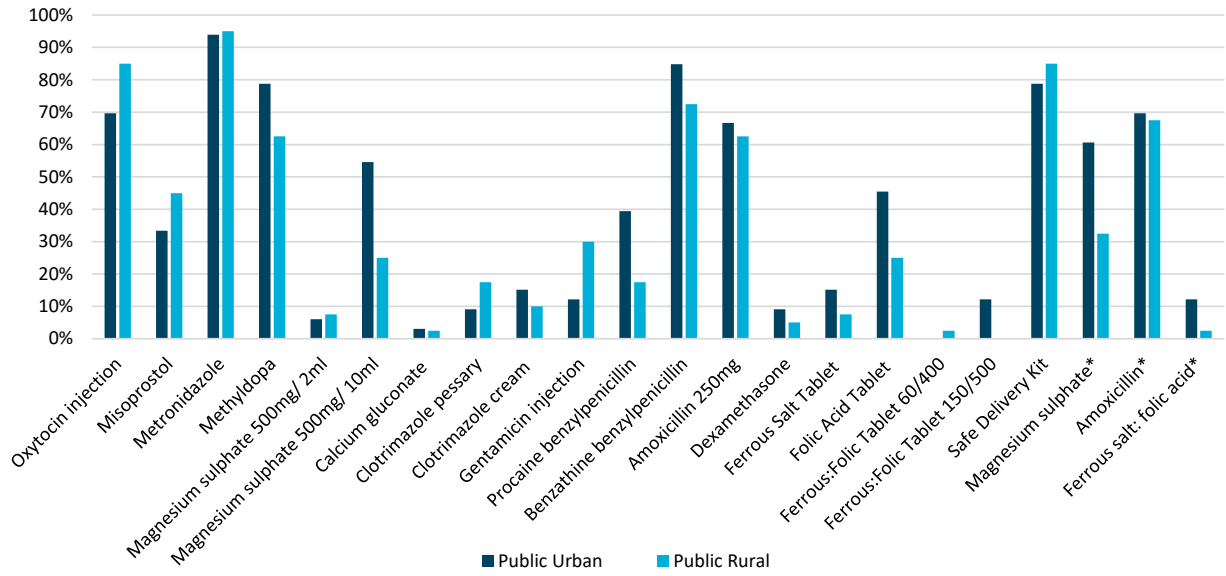
**Figure 17:** Availability of contraceptives in the private sector.



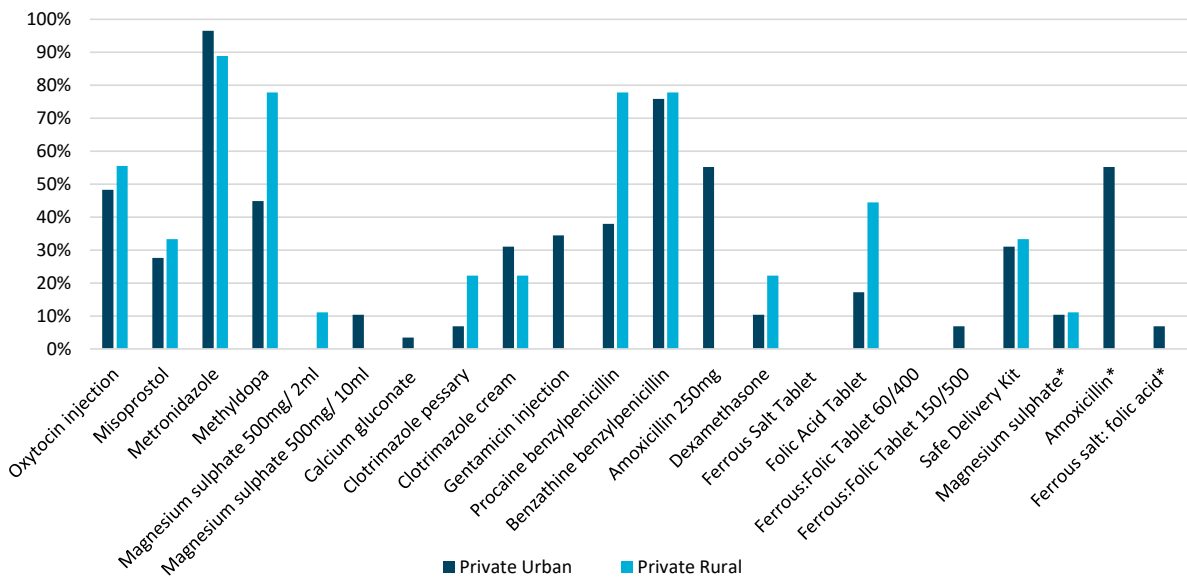
**Figure 18:** Availability of contraceptives in the mission sector.

### Annex 4: Availability of Maternal Health Commodities per Sector, by Urban and Rural Areas

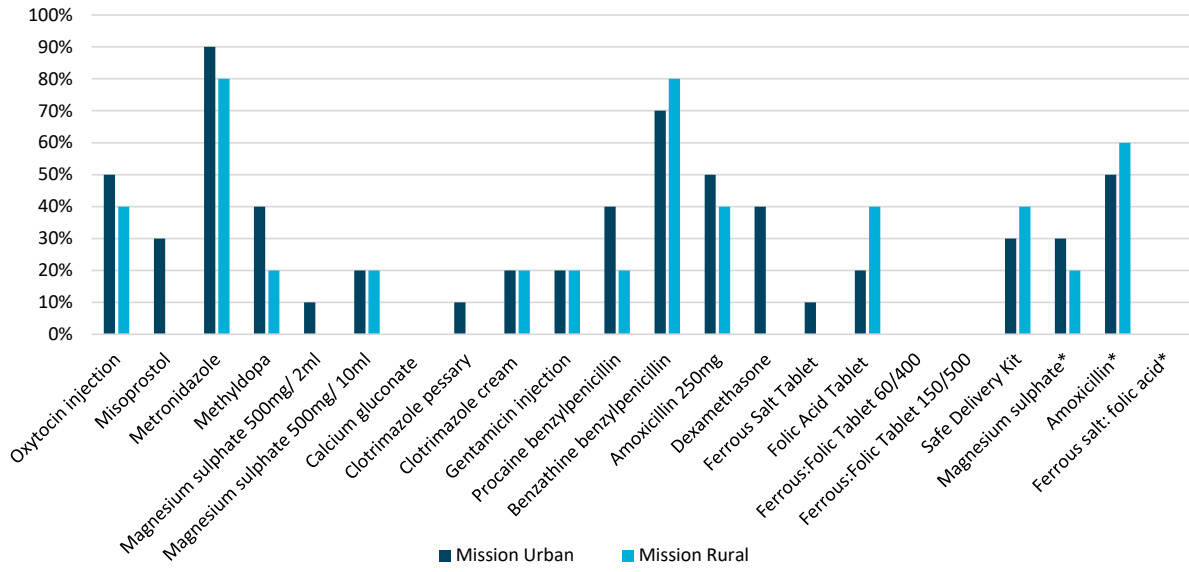
**Figure 19:** Availability of maternal health commodities in the public sector.



**Figure 20:** Availability of maternal health commodities in the private sector.

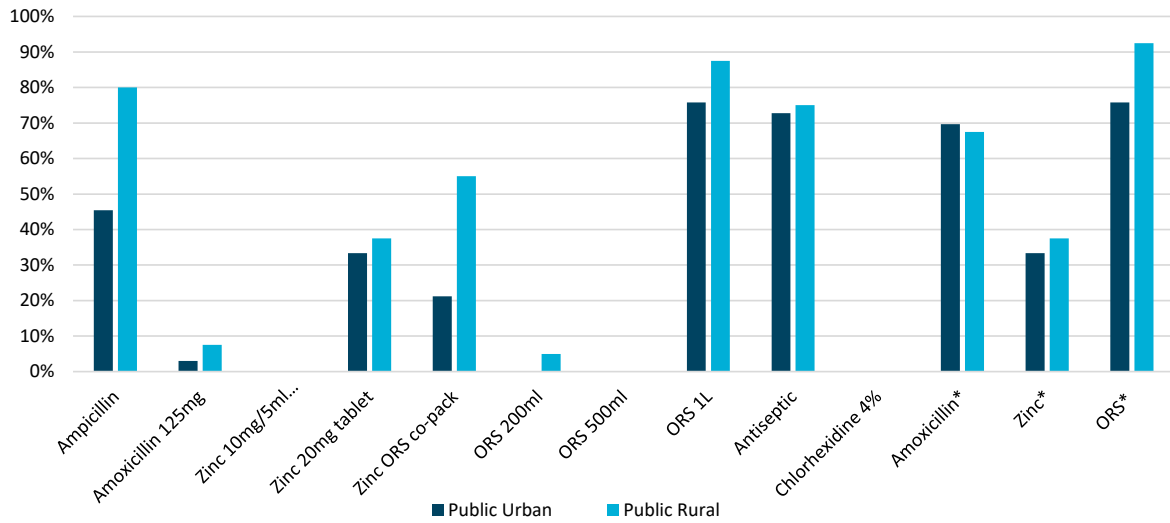


**Figure 21:** Availability of maternal health commodities in the mission sector.

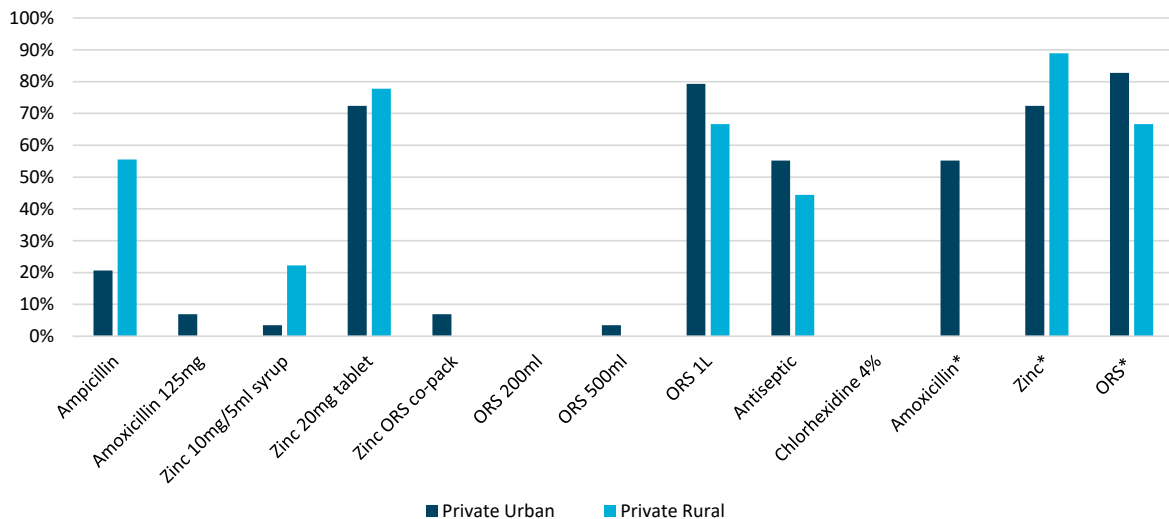


## Annex 5: Availability of Newborn and Child Health Commodities per Sector, by Urban and Rural Areas

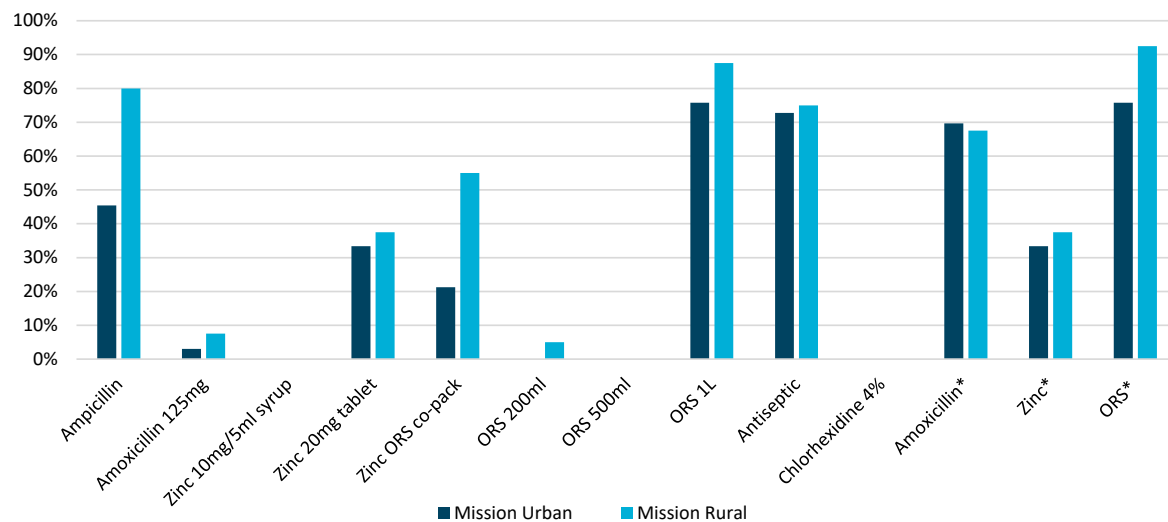
**Figure 22:** Availability of newborn and child health commodities in the public sector.



**Figure 23:** Availability of newborn and child health commodities in the private sector.

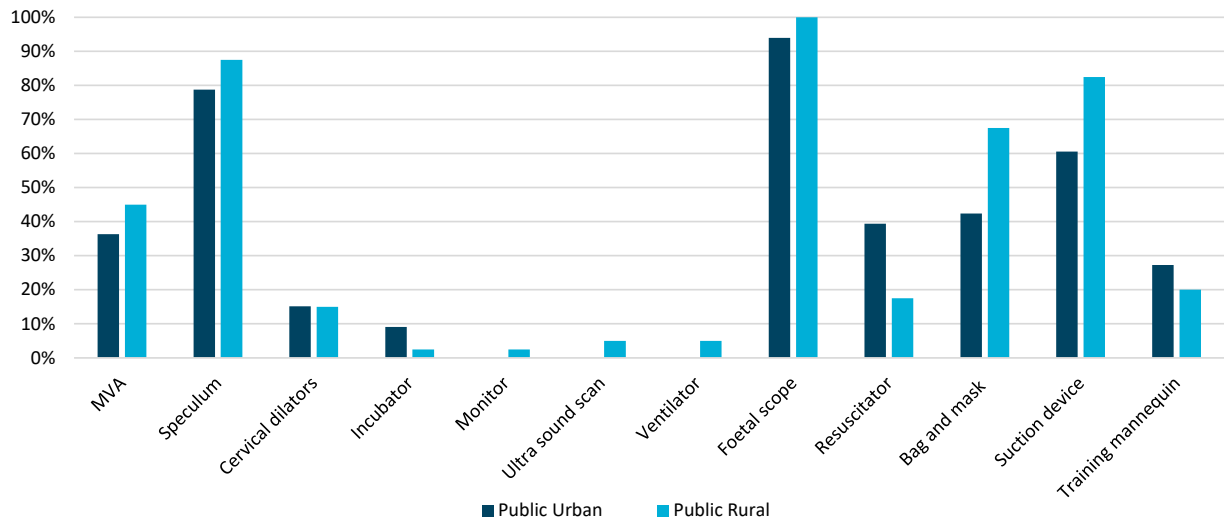




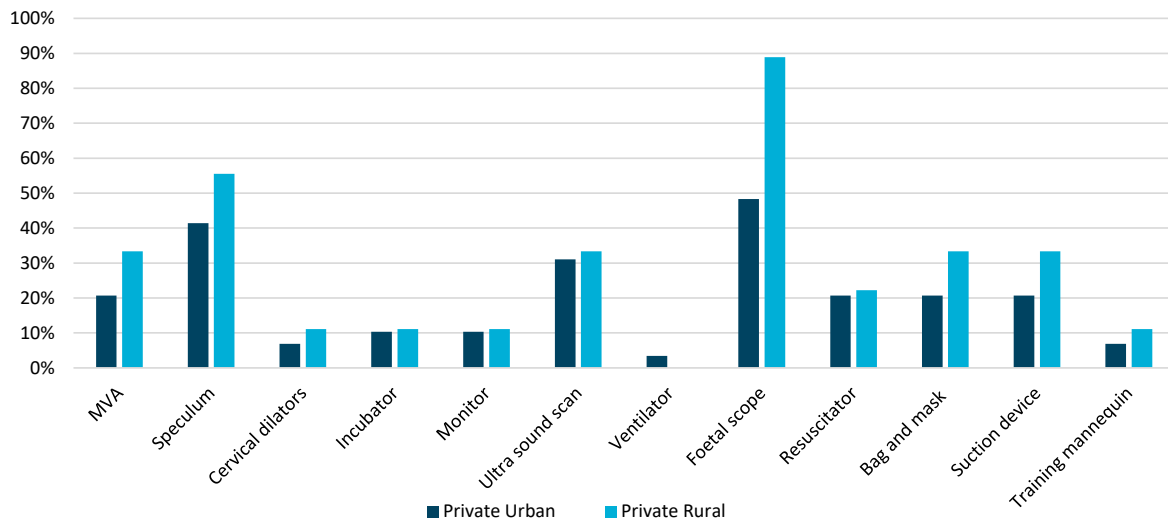
**Figure 24:** Availability of newborn and child health commodities in the mission sector.

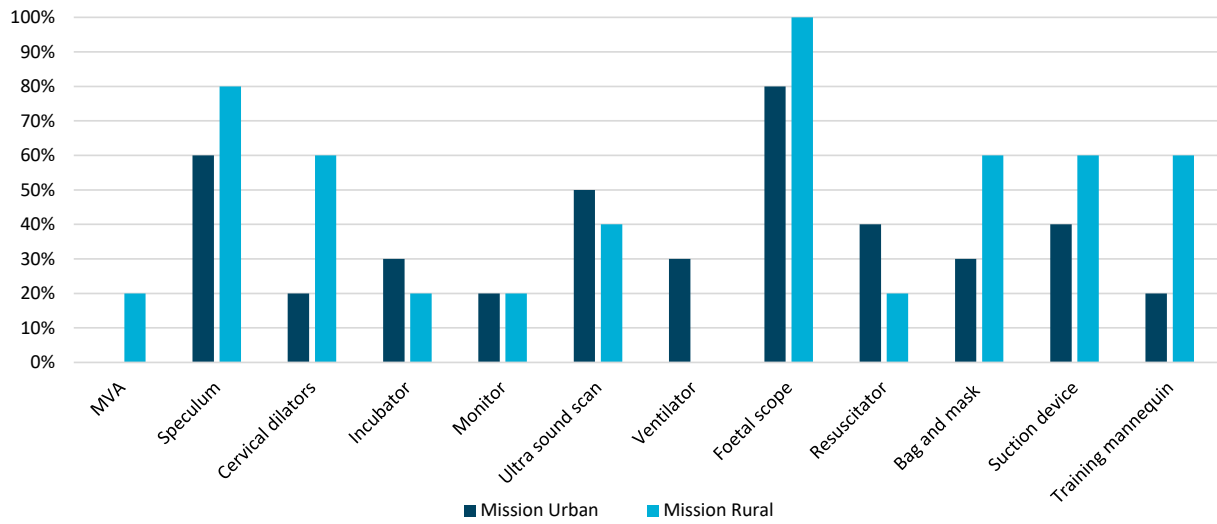
## Annex 6: Availability of SRH Instruments per Sector, by Urban and Rural Areas

**Figure 25:** Availability of SRH instruments in the public sector.



**Figure 26:** Availability of SRH instruments in the private sector.



**Figure 27:** Availability of SRH instruments in the mission sector.

## Annex 7: SRHC Stock-out Data

**Table 10:** Facilities reporting SRHC stock-outs in the six months prior to the survey, and the average number of stock-out days per month.

	% of facilities reporting a stock-out in a 6 month period			Average number of stock-out days/month		
	Public	Private	Mission	Public	Private	Mission
Ethinyl/levonorgestrel	12.5	33.3	NA	8	7	NA
Levonorgestrel 30mcg	50.0	0	NA	1	NA	NA
Levonorgestrel 70mcg	18.8	0	NA	5	NA	NA
Medroxyprogesterone acetate	11.8	0	NA	10	NA	NA
Norethisterone enanthate	11.8	0	NA	4	NA	NA
Male Condoms	100	NA	0	3	NA	NA
Female Condoms	6.7	0	NA	12	NA	NA
IUCD	15.4	0	NA	8	NA	NA
Levonorgestrel Implant	4.8	0	NA	5	NA	NA
Etonogestrel Implant	17.4	0	NA	7	NA	NA
Oxytocin injection	5.4	0	0	7	NA	NA
Misoprostol	NA	NA	NA	NA	NA	NA
Metronidazole	7.1	16.7	0	26	12	NA
Methyldopa	16.7	0	0	7	NA	NA
Magnesium sulfate	2.9	0	0	21	NA	NA
Magnesium sulfate	6.9	0	0	4	NA	NA
Calcium gluconate	33.3	0	NA	9	NA	NA
Clotrimazole pessary	30.0	NA	33.3	10	NA	2
Clotrimazole cream	0	0	100	NA	NA	15
Gentamicin injection	38.5	0	0	11	NA	NA
Ampicillin	0.0	0	0	NA	NA	NA
Procaine benzylpenicillin	50.0	0	25.0	5	NA	20
Benzathine benzylpenicillin G	15.6	0	0	9	NA	NA
Amoxicillin 125 mg	33.3	0	25.0	9	NA	20
Amoxicillin 250 mg	6.7	0	0	28	NA	NA
Dexamethasone	0	NA	0	NA	NA	NA
Ferrous Salt Tablet	0	0	16.7	NA	NA	6
Folic Acid Tablet	33.3	0	33.3	12	NA	7
Ferrous:Folic Tablet 150/500	33.3	0	0	8	NA	NA
Zinc 10mg/5ml syrup	27.3	33.3	25.0	15	4	30
Zinc 20mg tablet	0	NA	NA	NA	NA	NA
Zinc ORS co-pack	NA	0	NA	NA	NA	NA
ORS 500ml	NA	0	0	NA	NA	NA
ORS 1L	0	0	14.3	NA	NA	20
<b>Average</b>	<b>17.2</b>	<b>2.7</b>	<b>11.9</b>	<b>11</b>	<b>8</b>	<b>15</b>

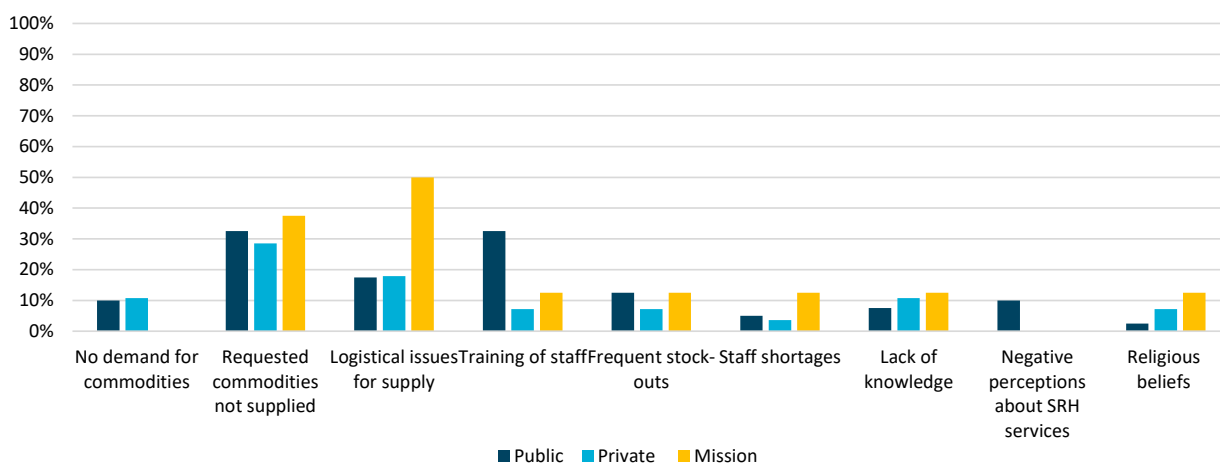
## Annex 8: Treatment Regimens

**Table 11:** SRHC treatment regimens.

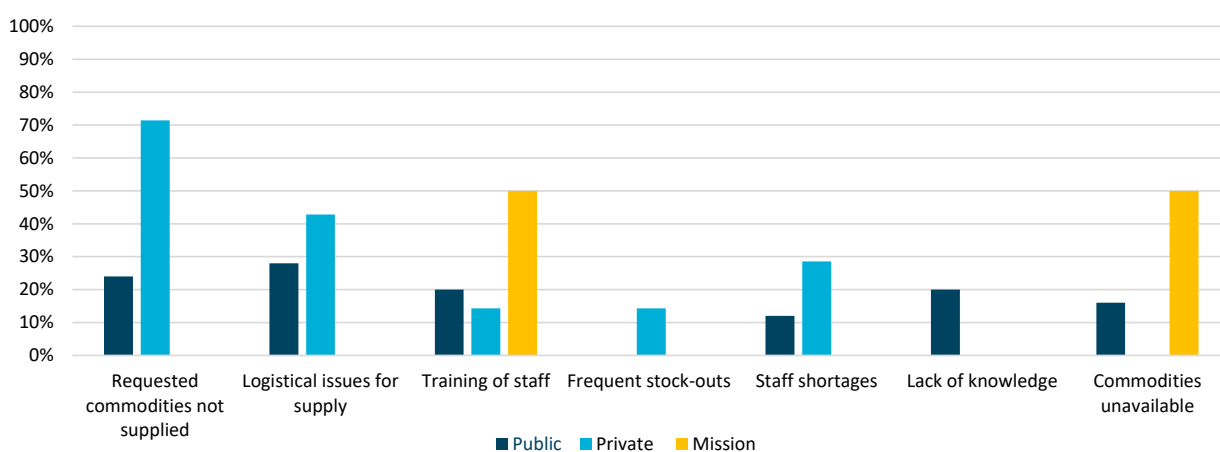
	Treatment Unit	Treatment Days
Ethinyl/levonorgestrel	1 strip	NA
Ethinyl/norethisterone	1 strip	NA
Levonorgestrel 300mcg	1 pill	NA
Levonorgestrel 750mcg	1 pill	NA
Medroxyprogesterone acetate	1 vial	NA
Norethisterone enanthate	1 vial	NA
Male condoms	1 pack	NA
Female condoms	1 pack	NA
Intrauterine contraceptive 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
Metronidazole	6 tablets	5
Methyldopa	3 tablets	30
Magnesium sulfate 500mg/ 2ml	18 vials*	NA
Magnesium sulfate 500mg/10ml	18 vials*	NA
Calcium gluconate	1 ampoule	1
Clotrimazole pessary	1 tablet	6
Clotrimazole cream	1 tube	NA
Gentamicin injection	1 ampoule	10
Ampicillin	4 vials	5
Procaine benzylpenicillin	1 vial	10
Benzathine benzylpenicillin G	1 vial	1
Amoxicillin 125mg	3 tablets	5
Amoxicillin 250mg	3 tablets	5
Dexamethasone	1 vial	1
Ferrous salt tablet	1 tablet	30
Folic acid tablet	1 tablet	30
Ferrous:Folic tablet 60/400	1 tablet	30
Ferrous:Folic tablet 150/500	1 tablet	30
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

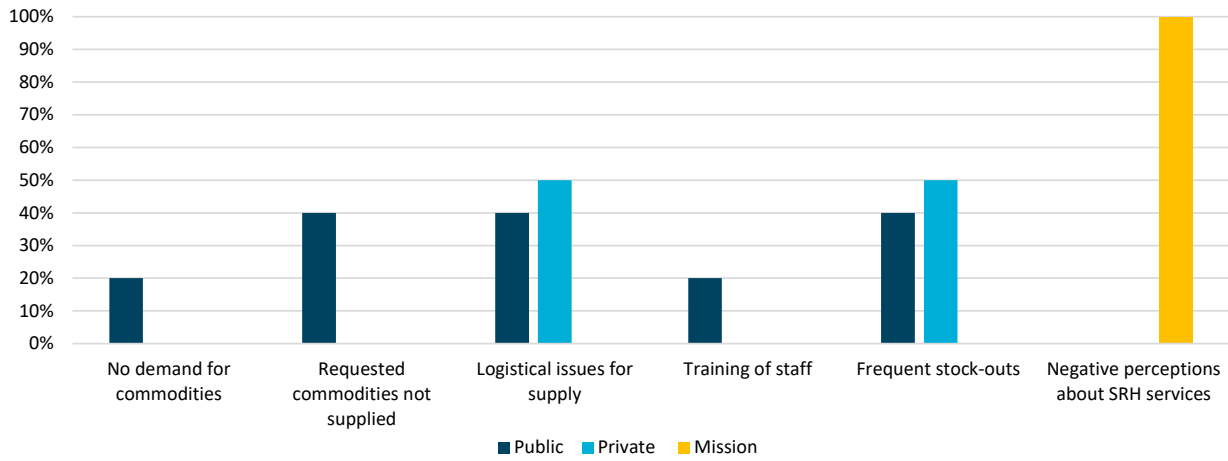
## Annex 9: SRHC Access: Qualitative Data

**Figure 28:** Key challenges related to accessing family planning services.



**Figure 29:** Key challenges related to accessing maternal health services.



**Figure 30:** Key challenges related to accessing STI management services.

## Annex 10: List of SRHC Included in SRHC Research vs Inclusion on Tanzania EML

**Table 12:** Differences between formulations included in the SRHC research compared with as listed on the EML.

<b>Formulation included in SRHC research</b>	<b>Formulation included on Tanzania EML</b>
Ethinylestradiol + norethisterone (35mcg + 1.0mg)	Ethinylestradiol + norgestrel (0.03mg + 0.03mg) Ethinylestradiol + desogestrel (0.03mg + 0.15mg)
Norethisterone enanthate (200mg/ml in 1ml)	Not included
Intrauterine Contraceptive Device (IUCD)	Not included
Diaphragm	Not included