

REPORT

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

Zambia 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.



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Prepared by Gaby Ooms and Choolwe Jacobs.

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GLOSSARY

HAI	Health Action International
HHFCE	Household final consumption expenditure
LPGW	Lowest-paid government worker
MeTA	Medicines Transparency Alliance
SRH	Sexual and reproductive health
SRHC	Sexual and reproductive health commodities
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. Additionally, when they decide to have children, women must have access to services that ensure they have a fit pregnancy, safe delivery and a 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 affordable and available. While policies are also greatly needed to improve health infrastructure, health education and financing are further required to ensure the rational use of medicines. 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 budgets 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)^{1,2}.

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 Prices, 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/other 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 partners (Medicines Transparency Alliance [MeTA]) between July and August 2018 in Zambia.

¹ 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.

² For a full list of the commodities surveyed, see Annex 1.

The report provides data relating to the following questions:

- What price do people pay for SRH commodities?
- Do the prices and availability of the same commodities vary across the public, private and mission sectors?
- How affordable are commodities 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 the country of study.

DATA COLLECTION

This report presents data from the 2018 roll-out of the HAI research methodology, SRHC: *Measuring Prices, Availability and Affordability, in Zambia*. 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 August 2018.

Table 1: Provinces and districts surveyed.

Province	District
Central	Chimombo, Kabwe, Kapiri Mposhi, Mumbwa, Kabarole, Hoima
Copperbelt	Ndola, Kitwe, Masaiti, Luanshya, Mufulira, Mpongwe
Eastern	Chipata, Petauke, Nsinda, Nymba, Katete
Luapula	Mansa, Samfya, Nchelenge, Lubwe
Lusaka	Lusaka, Luangwa, Chongwe, Kafue
Northern	Kasama, Mbala, Mporokoso, Mpulungu, Nsenga
North-Western	Solwezi, Kasempa
Southern	Choma, Kalomo, Monze, Livingstone
Western	Mongu, Kaoma

Data collectors visited facilities at 'health post' levels and above belonging to public, private and mission sectors in both urban and rural areas. All the 10 provinces in Zambia were included in the study to provide a representative picture for the country. See Table 1 for an overview of the districts per province included in the research. A total of 237 facilities were surveyed across public, private and mission sectors. The distribution of these facilities is outlined in Table 2.

Table 2: Distribution of surveyed facilities.

	Urban	Rural	Total (N)
Public	63	85	148
Private	45	11	56
Mission	6	27	33
Total	114	123	237

RESULTS

The results from this research showed that overall the mean availability of SHRC in Zambia was 34%, with the average availability in the mission sector being highest at 39%.

1. Overall Availability of SRHC

Differences between public and private sector availability were noticeable, as the commodities were on average available in only 27% of private sector facilities, compared with the 37% availability in the public sector. Table 3 shows the mean availability of SHRC across sectors and locations.

Differences in availability of SHRC for urban and rural areas across the sectors were not considerable, except for in the public sector where SHRC were more likely to be available in urban facilities than rural facilities (43% versus 33%, respectively). As shown in Table 3, for the mission and private sector, no considerable differences existed in availability of SHRC between urban and rural areas.

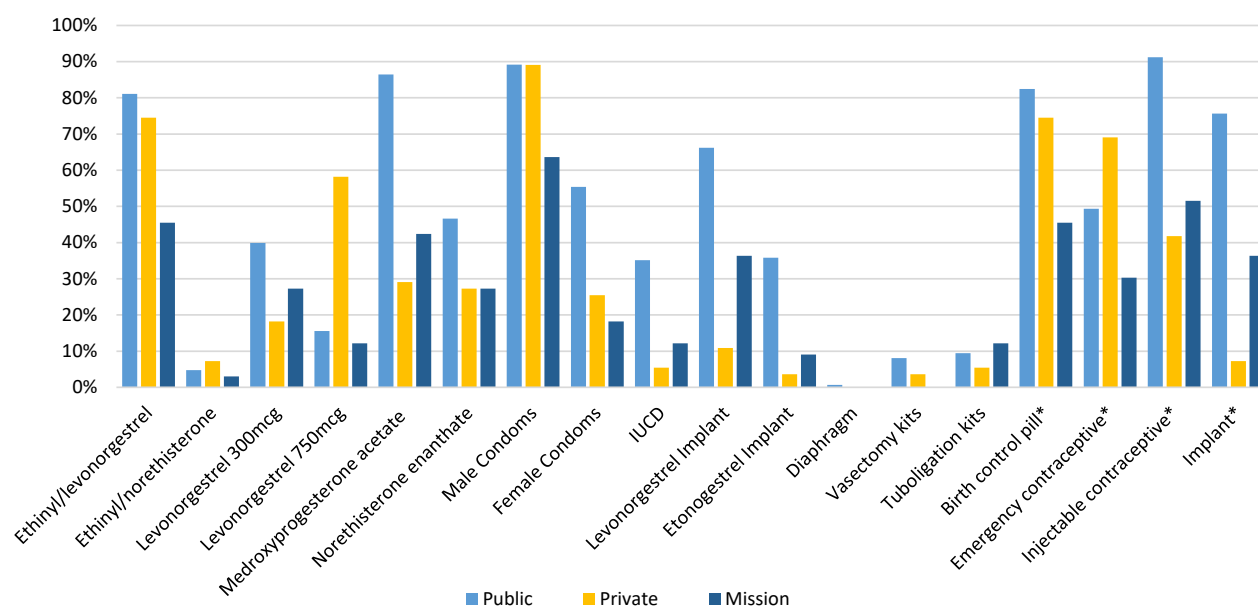
Table 3: Mean availability of SRH commodities by sector and location.

	Overall (%)	Urban (%)	Rural (%)
Public	37	43	33
Private	27	27	24
Mission	39	44	38
Total	34	38	32

2. Availability of SRHC by Service

2.1. Availability of Contraceptive Commodities

Differences in availability of contraceptives across the sectors were noticeable. Overall, most contraceptives had a higher availability in the public sector than the private and mission sectors. Figure 1 provides an overview of contraceptive availability across sectors. Please refer to Annex 2 for a full breakdown of the availability data across sectors.

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

*Birth control pill combines availability of ethinyl/levonorgestrel and/or ethinyl/norethisterone at the facility. *Morning after pill 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 levonorgestrel implant and etonogestrel implant at the facility.

As shown in Figure 1, availability of ethinylestradiol + levonorgestrel tablets, known as the birth control pill, was highest in the public sector (81%), followed by the private sector (75%), and with lowest availability in the mission sector (45%). Urban public facilities had a slightly higher (87%) availability for ethinylestradiol + levonorgestrel tablets than rural public facilities (87% versus 76%, respectively), while in the private sector availability was slightly higher in rural facilities (82%) than in urban facilities (73%).

Availability of different formulations of levonorgestrel tablets, used as emergency contraceptive after birth control failure or unprotected intercourse, varied across the sectors. Levonorgestrel 750mcg tablets had a higher availability in the private sector (58%) than the public (16%) and mission (12%) sectors. In the public sector, the 300 mcg formulation was available at 40% of facilities. Since both formulations are used as emergency contraceptive, it is interesting to know the availability of either of these tablets at the facilities. As can be seen in Figure 1, either

formulation of levonorgestrel tablets (labelled as 'emergency contraceptive*') was available in 49% of public facilities, 69% of private facilities, and in 30% of mission facilities.

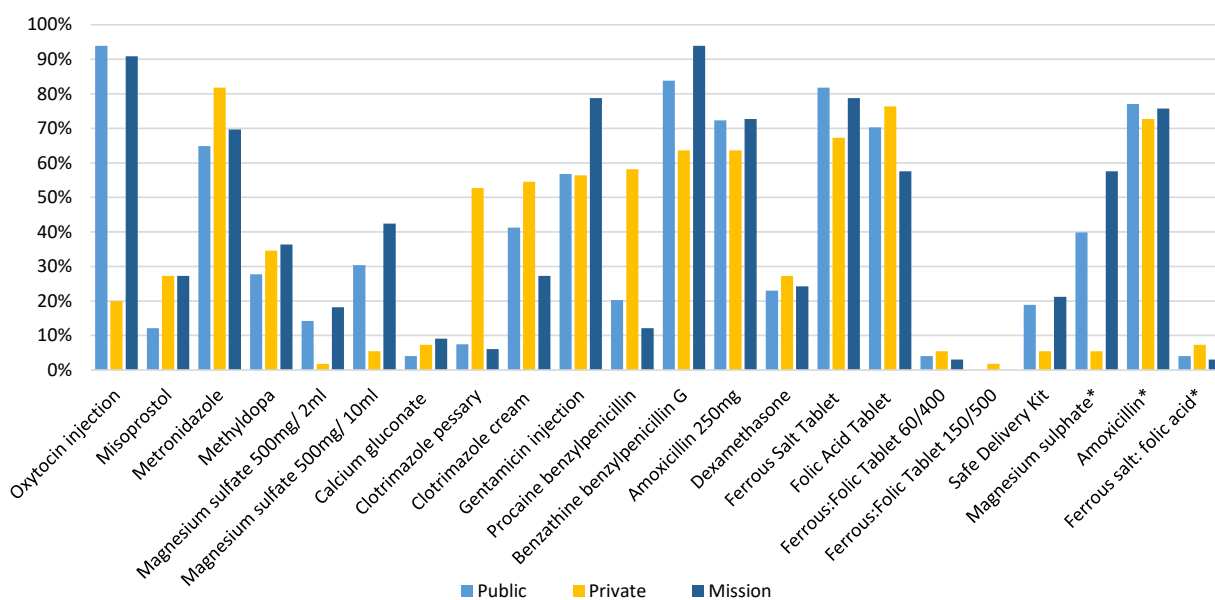
Availability of male condoms was high in the public and private sectors; in both sectors availability was 89%. Availability in the mission sector was lower (64%). Female condoms were on average less available than male condoms, ranging from 0% in urban mission facilities to 60% in urban public facilities (see Annex 2). Interestingly, implants, either the levonorgestrel or etonogestrel implant, had a high availability in the public sector (79%), but lower availability in the private and mission sectors (7% and 36%, respectively). Availability of the intra-uterine contraceptive device (IUCD) varied across sectors, ranging from 5% in the private sector to 35% in the public sector. Comparisons between the urban and rural areas show that IUCDs are more commonly available in urban public facilities (57%) compared to rural public facilities (19%). Vasectomy and tubal ligation kits were not commonly found at facilities in any sector. For instance, vasectomy kits could not be found in any mission facilities, and was only found in 8% of public facilities.

2.2. Availability of Maternal Health Commodities

Availability of maternal health commodities was inconsistent in all sectors (see Figure 2). For instance, oxytocin injection, used to induce labour and for the prevention and treatment of post-partum haemorrhage, was available in the public and mission sector at 94% and 91% of facilities, respectively. In the private sector it was less commonly available with only one fifth (20%) of facilities having it in stock. Conversely, misoprostol, also used to induce labour, had a much lower availability in all sectors: availability in the public sector was 12%, while in the private and mission sectors it was 27%.

Magnesium sulphate, used for treating pre-term labour and pre-eclampsia, was surveyed for two different strengths: 500mg in 2ml and 500mg in 10ml. When analysed separately, highest availability was found for the 500mg/10ml in the mission sector, and lowest availability for the 500mg/2ml in the private sector. However, when looking at the availability of either formulation of magnesium sulphate, availability increased in the public (40%) and mission (58%) sectors. Availability of dexamethasone, also used in the management of pre-term labour for improving foetal lung maturity, had a relatively equal availability across the public (23%), private (27%), and mission (24%) sectors.

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, 500mg/5ml, and 500mg/10ml. 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. Ferrous salt:folic acid* is a combination of availability of Ferrous salt:folic acid 60/400mg and Ferrous salt:folic acid 150/500mg*

Ferrous salt and folic acid, used as supplements to prevent iron and folic acid deficiency during pregnancy, had a relative high availability. For instance, ferrous salt had an 82% availability in the public sector and a 79% in the mission sector, while folic acid had a 70% availability in the public sector and a 76% availability in the private sector. Notably, availability of ferrous salt tablets was higher in rural areas than in urban areas across the sectors. See Annex B for more detail. Availability of delivery kits, special packs used to assist in childbirth, had a very low availability

across the sectors, with a lower availability in the private sector (5%) than in the public and mission sectors (19% and 21%, respectively).

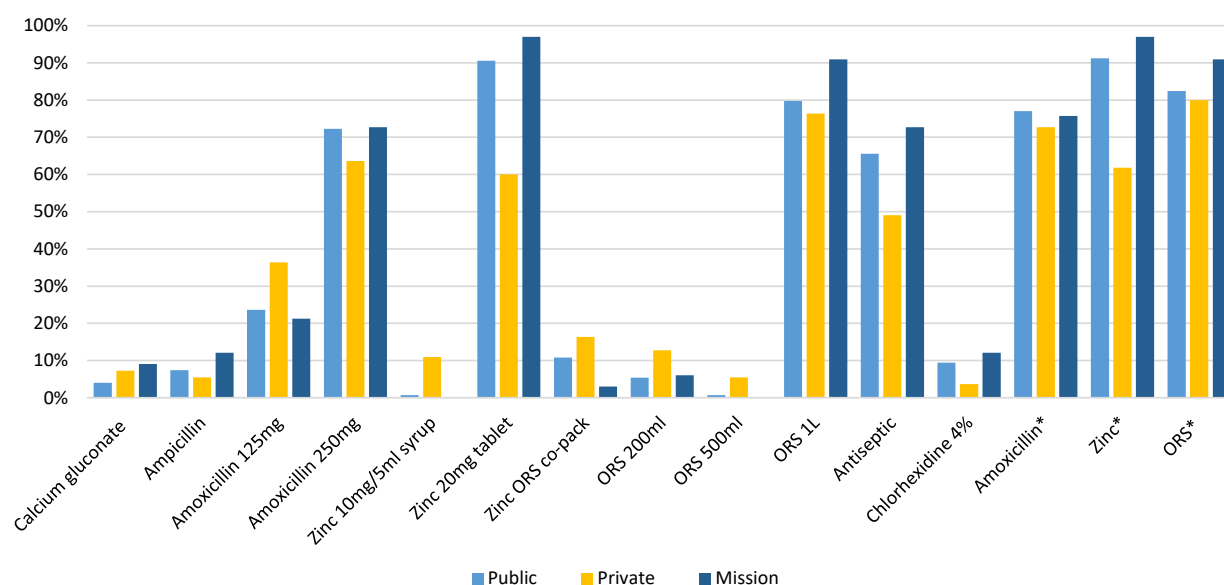
Overall, antibiotics, used for treatment of sexually transmitted diseases and other bacterial infections, were commonly available. Benzathine benzylpenicillin, used in the treatment of syphilis, was available in 84% of public facilities and 94% of mission facilities, and to a lesser extent in private facilities (64%). In the private sector, gentamicin injection, used to treat a range of infections

including meningitis, pneumonia and urinary tract infections, was commonly available at more than 70% of facilities. Availability of metronidazole, also used to treat a range of bacterial infections, was around 70% across the sectors, with highest availability in the private sector (85%), and lowest availability in the public sector (65%). Availability of clotrimazole pessary and cream, used to treat yeast infections, differed considerably. For instance, clotrimazole pessary had a very low availability in the public (7%) and mission (6%) sectors, while availability in the private sector was 53%. Clotrimazole cream also had the highest availability in the private sector (55%), but availability in the public and mission sectors was higher than for the pessary (41% and 27%, respectively).

2.3. Availability of Newborn and Child Health Commodities

Availability of newborn and child health commodities was also inconsistent, with some commodities being relatively more available than others. For instance, as shown in Figure 3, availability of zinc, either in syrup or tablet form, was high in the public (91%) and mission (97%) sectors, and lower in the private sector (62%). ORS sachets of any size had a high availability across the sectors, ranging from 80% (private sector) to 91% (mission sector). On the contrary, calcium gluconate, used for management of neonatal hypocalcaemia had very low availability across the sectors: it was available in 4% of public, 7% of private, and 9% of mission facilities.

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

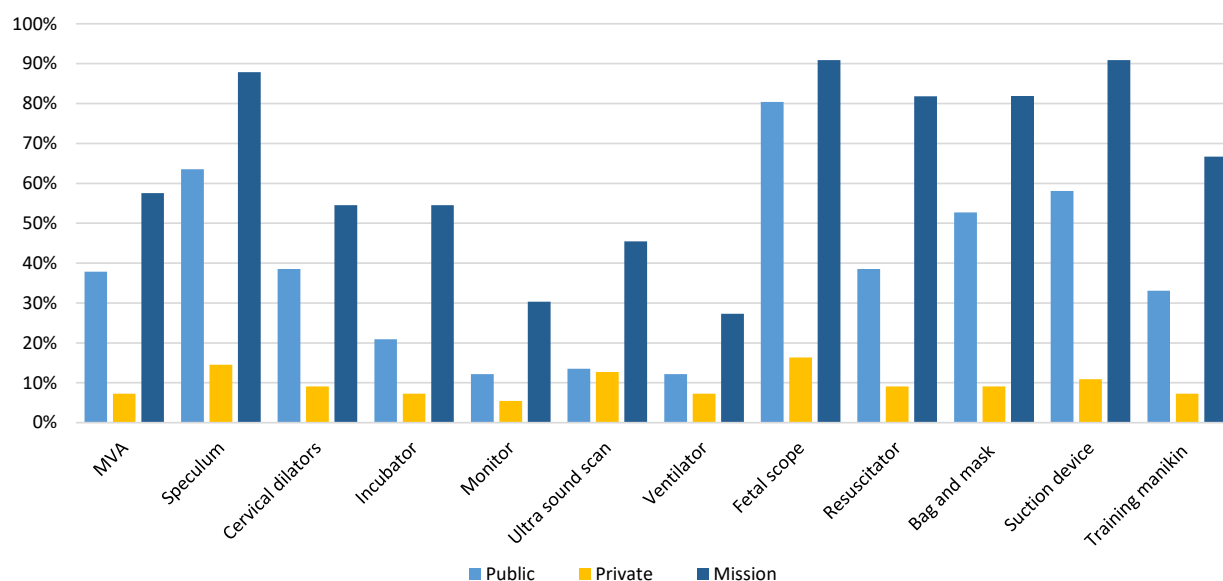


Amoxicillin is a combination of availability of 125- and 250mg dispersible tablet. The National Medical Stores currently supplies only 250mg dispersible tablets to public facilities. Zinc is a combination of availability of Zinc 10mg/5ml syrup and zinc 20mg tablet. ORS is a combination of availability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

2.4. Availability of SRH Instruments

Overall, the mission sector had higher availability for most of the SRH instruments than the other sectors. For instance, speculums, foetal scopes, resuscitators, bag and masks, antiseptics and suction devices were commonly available in the

mission sector (80%). In the public sector only the foetal scope was available at 80% of facilities, while availability in the private sector was extremely low for all commodities (less than 20%). See Figure 4.

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

3. Stock-out Days

Stock-out information was only recorded by data collectors when stock information could be seen via a stock card or stock-taking database. As a result, in cases where stock information was not recorded, or anecdotal evidence was presented, the stock-out days could not be recorded. Stock cards were available in half of the facilities researched (120 facilities; 72 public, 15 private, 33 mission). Please refer to Annex 3 for a full

breakdown of the stock-out data across sectors. Stock-outs occurred in 21% of public sector facilities, 14% of private sector facilities, and 22% of mission sector facilities (see Table 4). As shown in Table 4, all sectors were relatively similar in the average number of days SRHC were stocked-out per month: in the public and mission sectors the average number of stock-out days was 9, and in the mission sector 10 days.

Table 4: Percentage of facilities reporting stock-outs in the six months prior to the survey and the average stock-out days per month.

	Facilities reporting stock-outs (%)	Average number of stock-out days per month
Public	21	9
Private	14	9
Mission	22	10

In the public sector, two commodities were not stocked out at any of the facilities (zinc syrup and ORS 200ml). When commodities were stocked out, stock-outs ranged from 2% to 100%, of which ORS 500ml (100%) amoxicillin 125 and 250mg (64% and 31%, respectively), calcium gluconate (44%), clotrimazole cream (40%), ampicillin (34%), and levonorgestrel 750mcg (34%) were stocked out most often (see Figures 5-7).

Private sector stock-outs ranged from 0% to 50% of facilities, with levonorgestrel 750mcg (50%), and clotrimazole pessary (50%) experiencing stock-outs at most facilities, followed by clotrimazole cream (42%), levonorgestrel implants (40%), and amoxicillin 125mg (34%). Fourteen

SRHC were not stocked-out at any facility, including medroxyprogesterone acetate, etonogestrel implants, oxytocin and amoxicillin 250mg. However, it is important to note that only 15 private sector facilities had stock cards available.

In the mission sector, stock-outs ranged from 0% to 75%, of which 75% of facilities experienced a stock-out for ampicillin, 62% and 50% of facilities for clotrimazole cream and pessary, respectively, and 60% of facilities for amoxicillin 125mg. Moreover, 50% of facilities were stocked out of dexamethasone and 46% were out of misoprostol, while another eleven SHRC were stocked out at more than 20% of facilities.

Figure 5: Facilities reporting contraceptive stock-outs in the public, private and mission sectors.

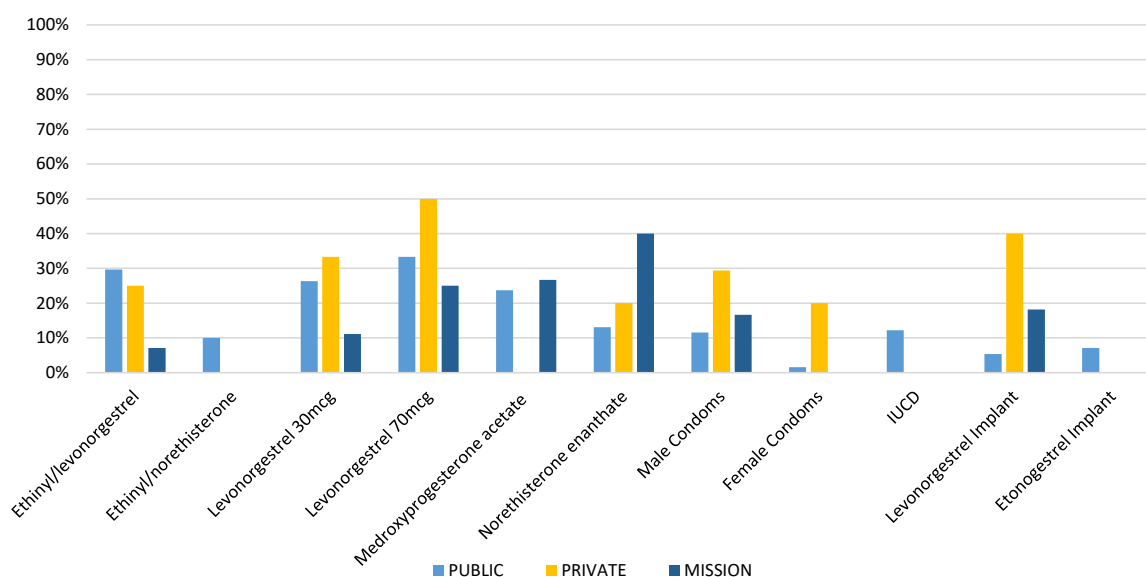


Figure 6: Facilities reporting maternal health commodity stock-outs in the public, private and mission sectors.

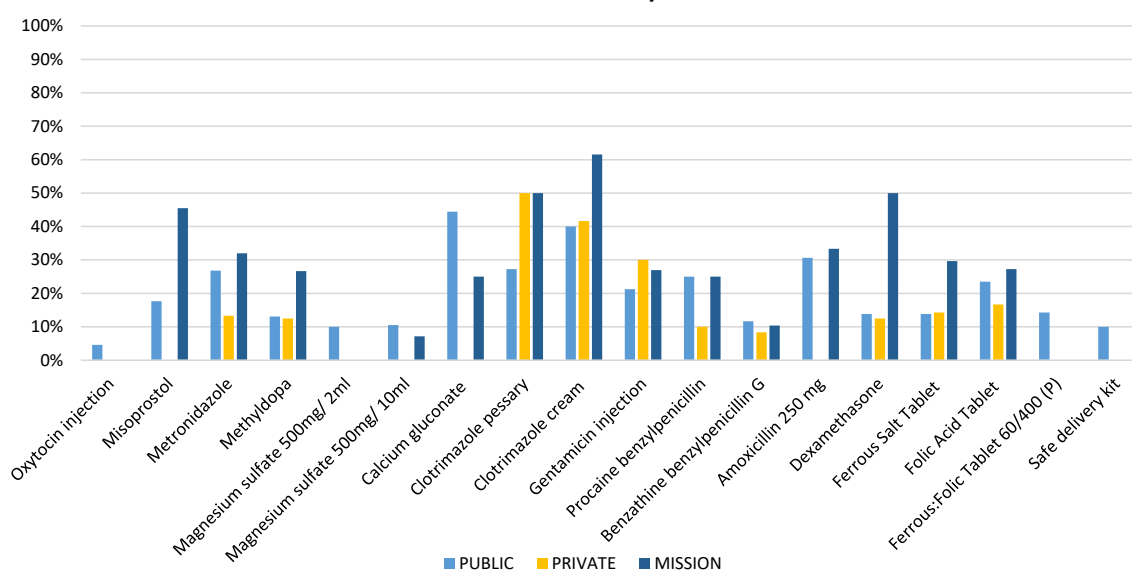
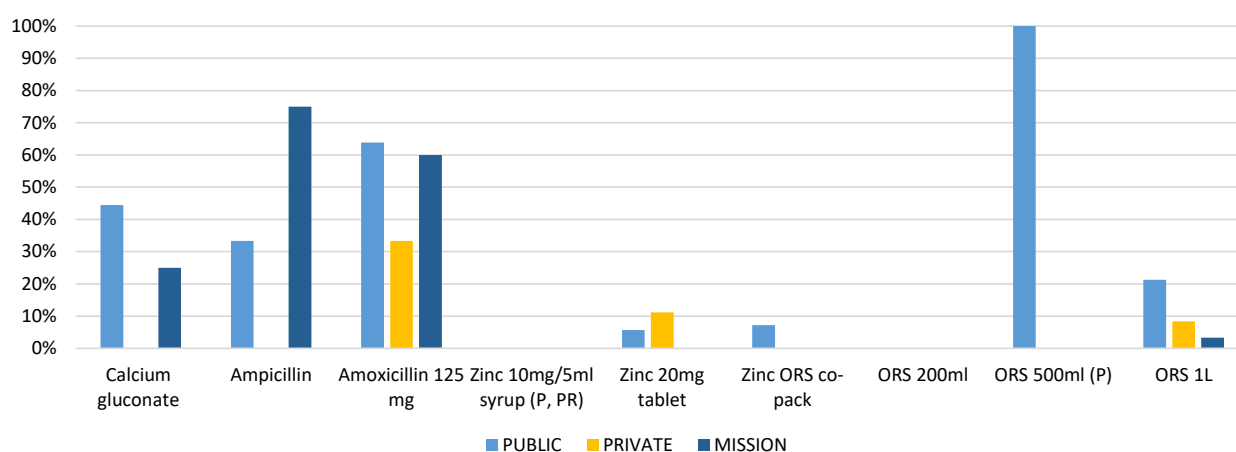


Figure 7: Facilities reporting newborn and child health commodities stock-outs in the public, private and mission sectors.



In the public sector, 6 of the 37 SRHC for which stock-out data was collected were on average stocked out for 15 days or more per month, including levonorgestrel 750mcg, levonorgestrel implants, procaine benzylpenicillin and amoxicillin 125mg. In the private sector, two commodities (methyldopa and benzathine benzylpenicillin G) were stocked out the entire month, while norethisterone enanthate, levonorgestrel implants, and folic acid tablets

were out of stock for more than 15 days on average. Levonorgestrel implants and magnesium sulphate 500mg/ 10ml were stocked out the entire month in the mission sector, while ethinylestradiol + levonorgestrel and clotrimazole pessary were out of stock for more than 15 days per month on average. Figures 8-10 are an overview of the number of stock-out days per sector and commodity.

Figure 8: Number of days per month that contraceptives were stocked out in the public, private and mission sectors.

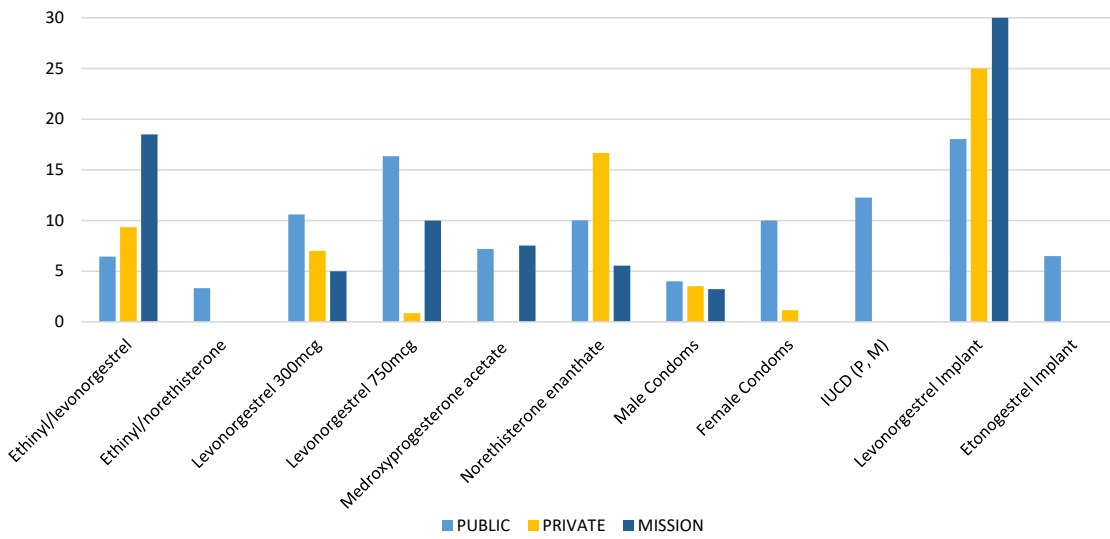


Figure 9: Number of days per month that maternal health commodities were stocked out in the public, private and mission sectors.

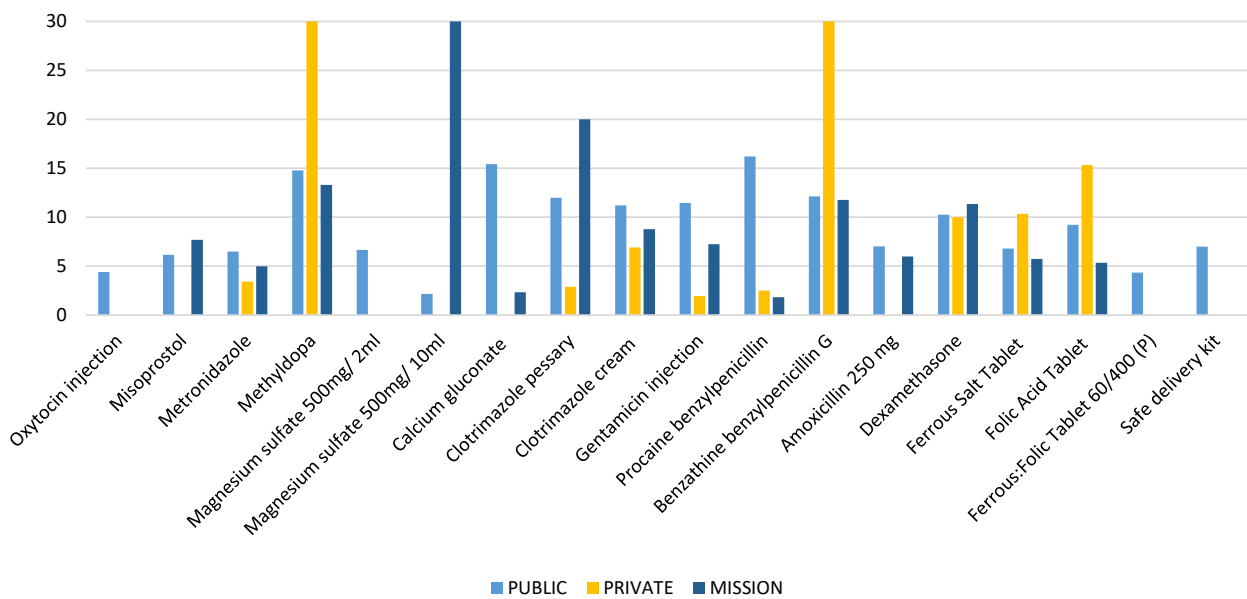
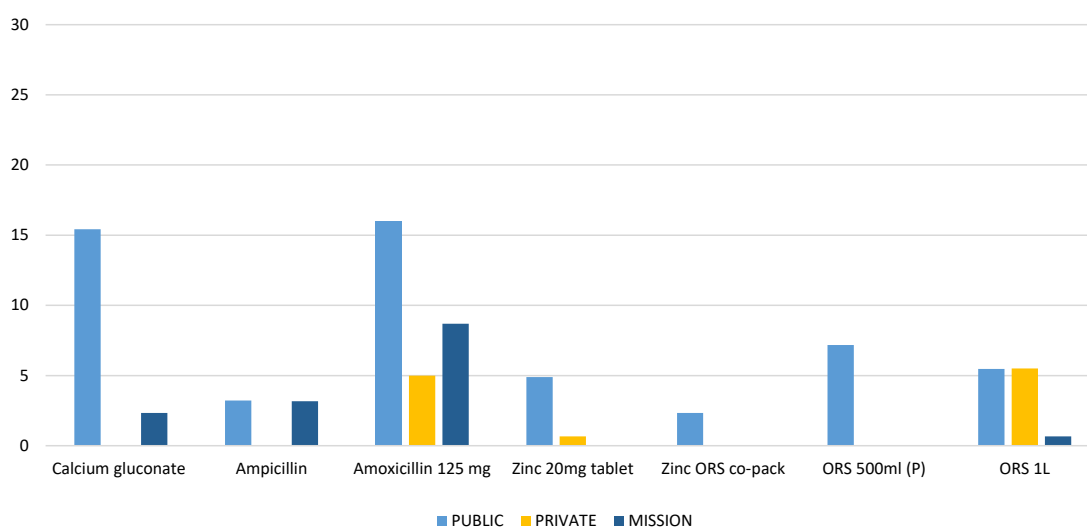


Figure 10: Number of days per month that newborn and child health commodities were stocked out in the public, private and mission sectors.



4. SRHC Prices in Public, Private and Mission Sectors

This section measures the pricing of commodities at facilities. 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). In the public sector, all SRHC were free to the patient. Even in the mission sector, almost all SRHC were free to the patients.

In the private sector, most of the SRHC were being sold, with a mean price ranging from 0-100 ZMW (etonogestrel implant) for the patient. Table 5 shows the SRHC commodity prices.

Notably, this research showed that in the private sector, the mean price for some commodities differed per area (see Figure 11 and Annex 4). The mean prices of SRHC were often higher in private urban facilities than in private rural facilities.

Figure 11: Mean prices in the private sector, by area

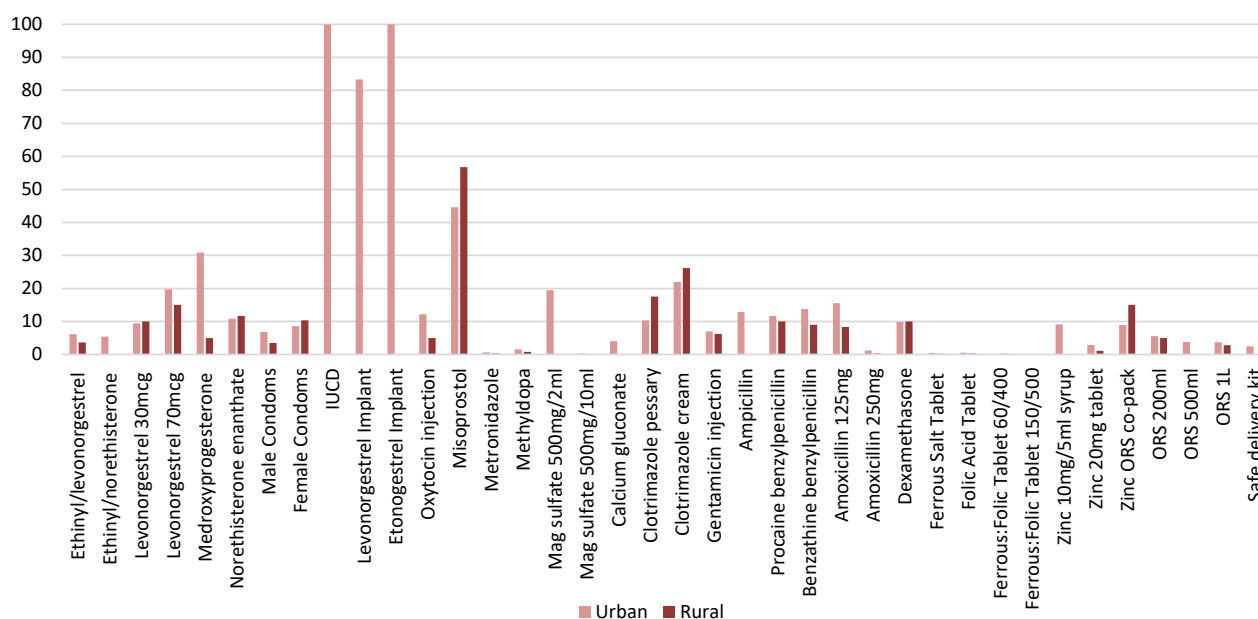


Table 5: Mean, minimum and maximum prices of SRHC in the public, private and mission sectors.

	Prices in Zambian Kwacha (ZMW)								
	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	6	0	15	0	0	0
Ethinyl/norethisterone	0	0	0	5	0	12	0	0	0
Levonorgestrel 300mcg	0	0	0	10	0	20	0	0	0
Levonorgestrel 750mcg	0	0	0	19	0	40	0	0	0
Medroxyprogesterone acetate	0	0	0	27	0	85	0	0	0
Norethisterone enanthate	0	0	0	11	0	25	0	0	0
Male Condoms	0	0	0	6	0	28	0	0	0
Female Condoms	0	0	0	9	0	20	0	0	0
IUCD	0	0	0	50	0	100	0	0	0
Levonorgestrel Implant	0	0	0	63	0	150	0	0	0
Etonogestrel Implant	0	0	0	100	100	100	0	0	0
Diaphragm	0	0	0	NA	NA	NA	NA	NA	NA
Oxytocin injection	0	0	0	11	0	30	0	0	0
Misoprostol	0	0	0	46	1	125	0	0	0
Metronidazole	0	0	0	1	0	3	0	0	0
Methyldopa	0	0	0	1	0	10	0	0	0
Magnesium sulphate 500mg/ 2ml	0	0	0	20	20	20	0	0	0
Magnesium sulphate 500mg/ 10ml	0	0	0	0	0	1	0	0	0
Calcium gluconate	0	0	0	4	0	13	0	0	0
Clotrimazole pessary	0	0	0	11	2	40	0	0	0
Clotrimazole cream	0	0	0	23	1	90	0	0	0
Gentamicin injection	0	0	0	7	0	30	0	0	0
Ampicillin	0	0	0	13	4	25	0	0	0
Procaine benzylpenicillin	0	0	0	11	0	30	0	0	0
Benzathine benzylpenicillin G	0	0	0	13	0	30	0	0	0
Amoxicillin 125mg	0	0	0	14	1	25	0	0	0
Amoxicillin 250mg	0	0	0	1	0	8	0	0	0
Dexamethasone	0	0	0	10	0	27	0	0	0
Ferrous Salt Tablet	0	0	0	0	0	4	0	0	0
Folic Acid Tablet	0	0	0	0	0	5	0	0	0
Ferrous:Folic Tablet 60/400	0	0	0	0	0	0	0	0	0
Ferrous:Folic Tablet 150/500	NA	NA	NA	0	0	0	NA	NA	NA
Zinc 10mg/5ml syrup	0	0	0	9	0	33	NA	NA	NA
Zinc 20mg tablet	0	0	0	3	0	15	0	0	0
Zinc ORS co-pack	0	0	0	10	0	15	0	0	0
ORS 200ml	0	0	0	5	2	15	0	0	0
ORS 500ml	0	0	0	4	3	5	NA	NA	NA
ORS 1L	0	0	0	4	0	13	0	0	0
Safe delivery kit	0	0	0	2	0	5	0	0	0

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 LPGW in 2018 (145.45 Kwacha [ZMW]). HHFCE and income share per population quintile data were retrieved from the World Bank's 2017 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 5 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 and mission sectors, affordability of SRHCs was optimal because the commodities were free to the patient (see Annex 6). The affordability of SRHCs in the private sector, using the wages of a LPGW in Zambia in 2018 and the income share per population quintile, was shown to be problematic, especially in the 60% of the population with the lowest income (see Table 6). For instance, for the 10% of the population with the lowest income, only a treatment with ferrous salt: folic acid (150/500) was affordable. In the 41-60% quintile, still only 12 of the 38 surveyed commodities were affordable, which included the birth control pill (both formulations), male and female condoms, magnesium sulphate (500mg/2ml), calcium gluconate, the ferrous salt: folic acid combinations, and ORS formulations.

Table 6: Affordability of SRHC in the private sector.

	Number of days income needed for treatment in the private sector							LPG worker
	Lowest 10%	11-20%	21-40%	41-60%	61-80%	81-90%	Highest 10%	
Ethinyl/levonorgestrel	3.41	1.70	1.09	0.63	0.34	0.19	0.07	0.04
Ethinyl/norethisterone	3.28	1.64	1.05	0.61	0.32	0.19	0.07	0.04
Levonorgestrel 300mcg	5.76	2.88	1.84	1.06	0.57	0.32	0.12	0.07
Levonorgestrel 750mcg	11.23	5.62	3.60	2.07	1.11	0.63	0.24	0.13
Medroxyprogesterone acetate	16.45	8.23	5.27	3.04	1.62	0.93	0.35	0.19
Norethisterone enanthate	6.67	3.33	2.14	1.23	0.66	0.38	0.14	0.08
Male Condoms	3.75	1.87	1.20	0.69	0.37	0.21	0.08	0.04
Female Condoms	5.41	2.71	1.73	1.00	0.53	0.31	0.12	0.06
IUCD	30.30	15.15	9.71	5.59	2.99	1.71	0.65	0.34
Levonorgestrel Implant	37.88	18.94	12.14	6.99	3.74	2.14	0.81	0.43
Etonogestrel Implant	60.61	30.30	19.42	11.19	5.98	3.42	1.30	0.69
Diaphragm	NA	NA	NA	NA	NA	NA	NA	NA
Oxytocin injection	6.40	3.20	2.05	1.18	0.63	0.36	0.14	0.07
Misoprostol	28.02	14.01	8.98	5.17	2.77	1.58	0.60	0.32
Metronidazole	9.97	4.98	3.19	1.84	0.98	0.56	0.21	0.11
Methyldopa	78.80	39.40	25.25	14.54	7.78	4.44	1.69	0.89
Magnesium sulphate 500mg/2ml	212.73	106.36	68.16	39.26	21.01	12.00	4.57	2.41
Magnesium sulphate 500mg/10ml	3.00	1.50	0.96	0.55	0.30	0.17	0.06	0.03
Calcium gluconate	2.44	1.22	0.78	0.45	0.24	0.14	0.05	0.03
Clotrimazole pessary	41.11	20.55	13.17	7.59	4.06	2.32	0.88	0.47
Clotrimazole cream	13.81	6.91	4.43	2.55	1.36	0.78	0.30	0.16
Gentamicin injection	41.73	20.87	13.37	7.70	4.12	2.35	0.90	0.47
Ampicillin	155.56	77.78	49.84	28.71	15.36	8.77	3.34	1.76
Procaine benzylpenicillin	68.88	34.44	22.07	12.71	6.80	3.88	1.48	0.78
Benzathine benzylpenicillin G	7.91	3.96	2.54	1.46	0.78	0.45	0.17	0.09
Amoxicillin 125mg	123.80	61.90	39.67	22.85	12.22	6.98	2.66	1.40
Amoxicillin 250mg	9.74	4.87	3.12	1.80	0.96	0.55	0.21	0.11
Dexamethasone	5.98	2.99	1.92	1.10	0.59	0.34	0.13	0.07
Ferrous Salt	7.39	3.70	2.37	1.36	0.73	0.42	0.16	0.08
Folic Acid	8.54	4.27	2.74	1.58	0.84	0.48	0.18	0.10
Ferrous salt: Folic Acid 60/400	2.83	1.41	0.91	0.52	0.28	0.16	0.06	0.03
Ferrous salt: Folic Acid 150/500	0.64	0.32	0.20	0.12	0.06	0.04	0.01	0.01
Zinc 10mg/5ml syrup	5.52	2.76	1.77	1.02	0.54	0.31	0.12	0.06
Zinc 20mg	15.55	7.78	4.98	2.87	1.54	0.88	0.33	0.18
Zinc ORS co-pack	5.80	2.90	1.86	1.07	0.57	0.33	0.12	0.07
ORS 200ml	3.31	1.66	1.06	0.61	0.33	0.19	0.07	0.04
ORS 500ml	2.32	1.16	0.74	0.43	0.23	0.13	0.05	0.03
ORS 1L	2.14	1.07	0.69	0.40	0.21	0.12	0.05	0.02
Safe Delivery Kit	1.01	0.51	0.32	0.19	0.10	0.06	0.02	0.01

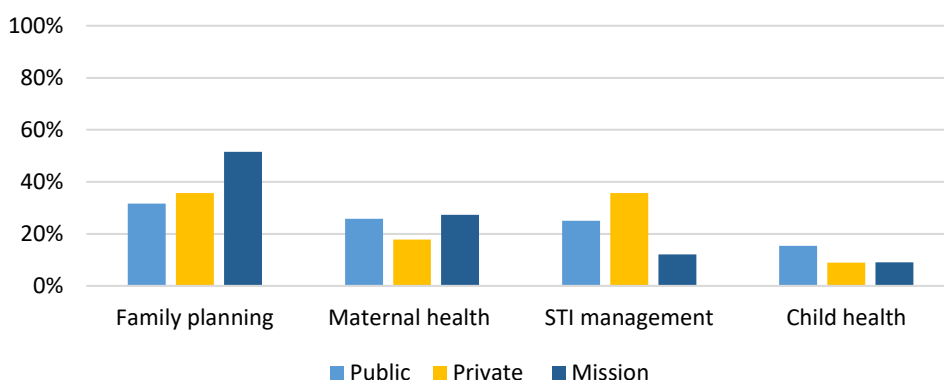
6. Stakeholder Interviews

This section provides findings from the perspectives of the interviewed health provider on access to SRHC. The respondents remained the same as those providing assistance in Part A of the survey. The response rate for the survey was 100% percent.

Respondents were asked which categories of SRH services face the most challenges related to access to commodities. They were given five options to choose from:

- Family planning.
- Maternal Health
- STI management
- Child health
- None

Figure 12: SRH services facing the most challenges related to access to commodities.

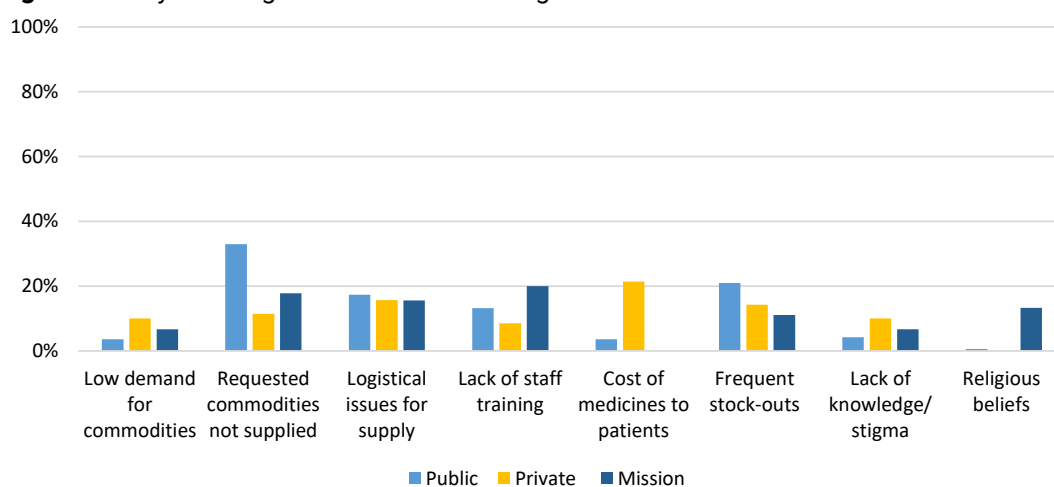


The most commonly mentioned SRH service that faced the most challenges related to access to commodities was family planning (35%), followed by STI management services (26%) and maternal health services (24%). As shown in Figure 12, the challenges with accessing commodities for family planning services were more commonly reported in the mission sector (52%) than in the public and private sectors (32% and 36%, respectively).

Respondents were also asked about what they thought were the key challenges related to accessing the SRHC. In the public sector, the most reported key challenge was that requested commodities were not supplied (33%), followed

by frequent stock-outs (21%). As can be seen in Figure 13, the challenge of requested commodities not being supplied was also a challenge in the mission sector (18%), but less of a problem in the private sector (13%). Another main challenge in the public sector was logistical issues for supply. In the private sector, the most reported challenge to access to the SRHC was the cost of the medicines to the patients (21%), while in mission sector lack of staff training (20%) and logistical supply issues (16%) were also the most reported key challenges. Annex 7 provides details on the challenges related to accessing specific essential commodities for needs such as family planning, STI management and newborn and child health services.

Figure 13: Key challenges related to accessing the essential medicines and commodities.

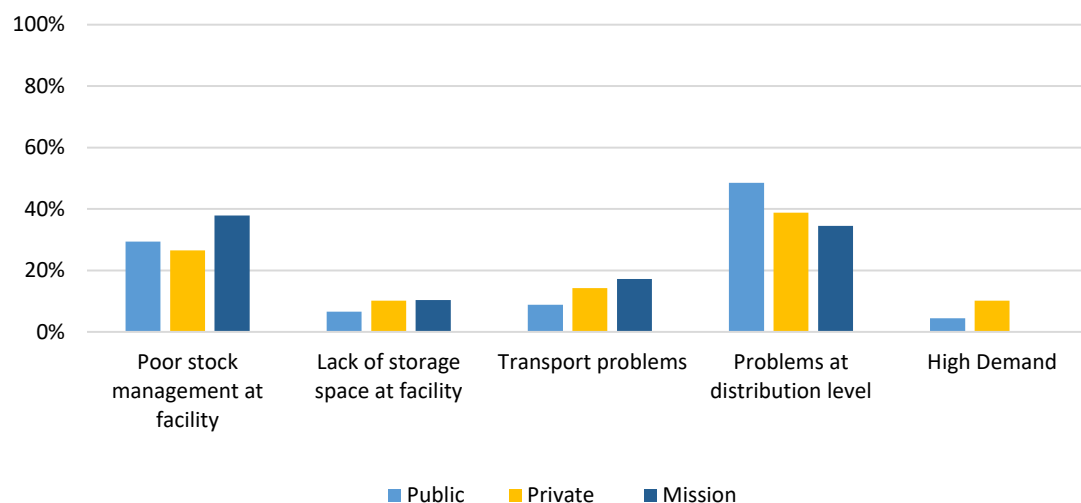


6.1. Perceptions on Causes of SRHC Stock-outs at Facilities

Most of the respondents believed that poor ordering and stock management at the health facilities and problems with the stock at the distribution level were the causes of stock-outs at the health facilities (see Figure 14).

More specifically, problems with the stocks at the distribution level were mostly reported by the respondents in public and private health sector facilities (49% and 39%, respectively). Poor ordering and stock management at the health facilities was the most reported cause by respondents in mission sector facilities (38%).

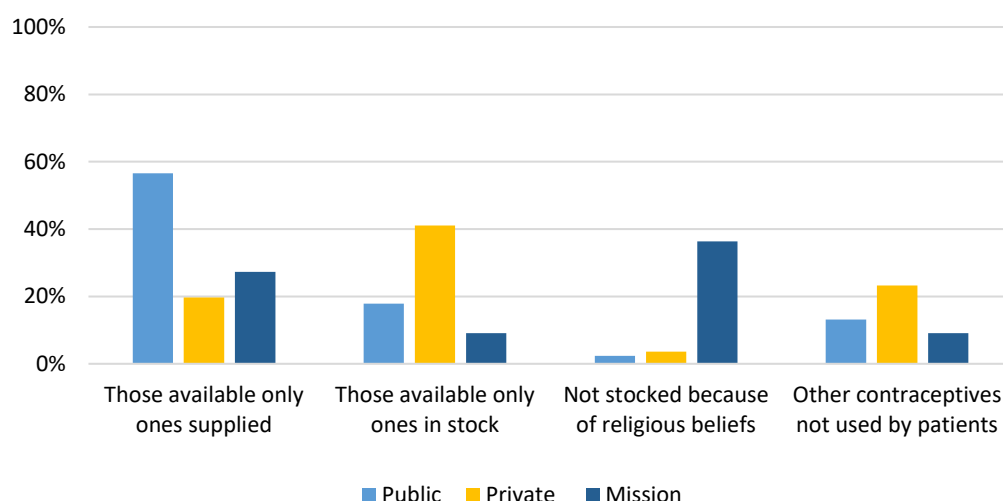
Figure 14: Causes of the stock-outs in the public, private and mission sectors.



6.2. Unavailability of Contraceptives at the Facility

Differences in the responses emerged when participants were asked for reasons why some contraceptives might not be available at the facilities. In the public sector, the primary

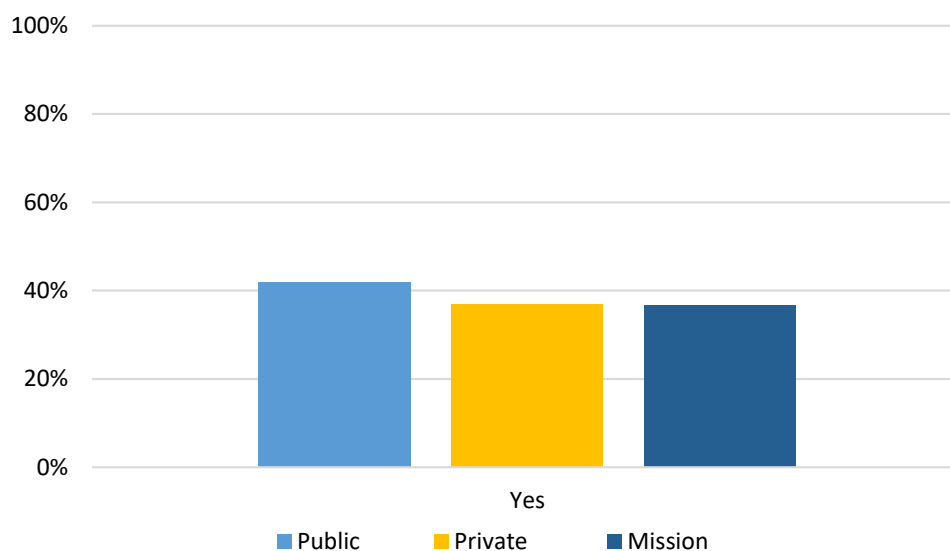
reason reported for why some contraceptives were only available at some facilities and not in others was because those available were the only ones supplied (57%). In the mission sector, the main reason given for the availability of some contraceptives and unavailability of others was because of religious beliefs (36%). See Figure 15 for more details.

Figure 15: Why some contraceptives are available at the facility while others are not.

6.3. Clients' Reluctance to Access SRHC

Respondents were asked if they thought clients that visited their facility were reluctant to visit for SRHC and SRH services. Respondents who replied, 'yes', were asked to provide their opinion on the reasons for this reluctance and

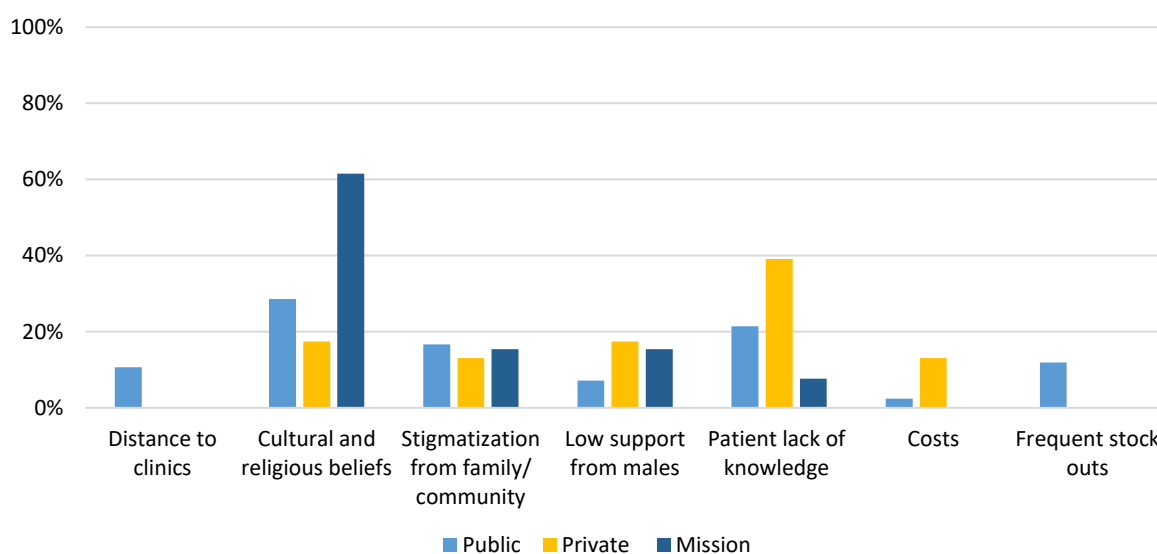
what they believed could be done to tackle this issue. Of the respondents, 40% believed that clients were reluctant to access SRHC (see Figure 16). In the public sector a slightly higher percentage of respondents believed clients were reluctant to access SRHC and SRH services compared to the mission and private sectors.

Figure 16: Client's reluctance to access SRHC in the public, private and mission sectors.

The reasons given by the respondents for clients' reluctance to access the services varied to some extent across sectors, although there were still similarities in responses (see Figure 17). For instance, the majority of respondents in mission sector facilities stated cultural beliefs and religion (62%) as the main contributor to clients' reluctance, and even though not as many respondents mentioned this in the public sector, still 29% of them thought cultural and religious beliefs contributed to clients' reluctance.

Lack of patient knowledge about SRHC was most commonly mentioned in the private sector (39%), and was also mentioned by 21% of respondents from the public sector. Notably, only respondents in the public sector reported that frequent stock-outs of SRHC (12%) and distance to the health facility (11%) were other causes of client's reluctance, while costs was mentioned only in the private sector (13%).

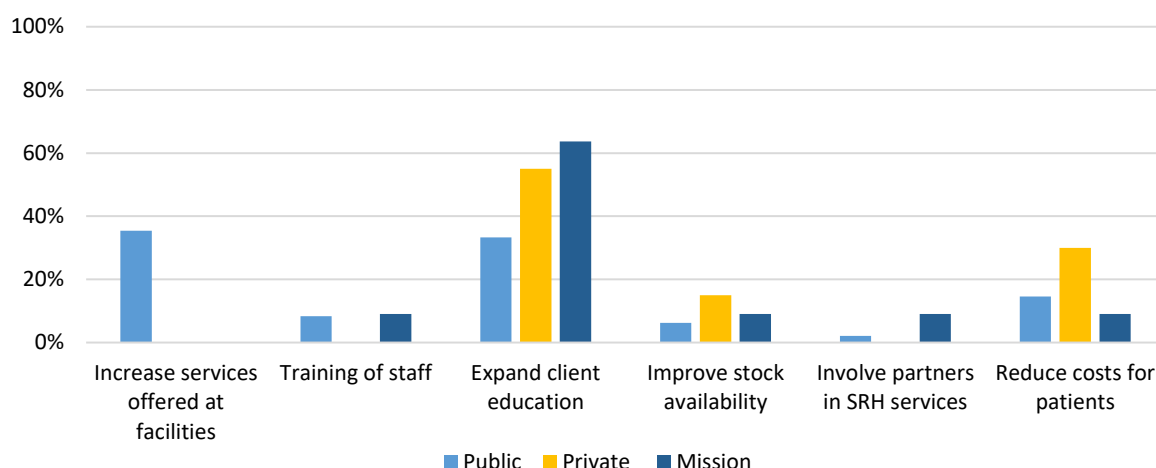
Figure 17: Reasons for client's reluctance to accessing SRHC in the public, private and mission sectors.



Respondents were also asked about strategies to tackle clients' reluctance to accessing SRHC. Need to expand on client education was prominent across the three sectors. Thirty-three percent of public, 55% of private, and 64% of mission sector respondents suggested the need to expand on provision of education to clients in order to tackle

the observed reluctance to access SRHC and SRH services. As shown in Figure 18, most respondents in the private sector facilities (30%) also suggested the need to reduce costs of SRHCs for the patients, while in the public sector services, such as outreach or adolescent-friendly services, offered at the facility should be expanded according to 35% of the respondents.

Figure 18: Suggestions given on how clients' reluctance can be tackled in the public, private and mission sectors.

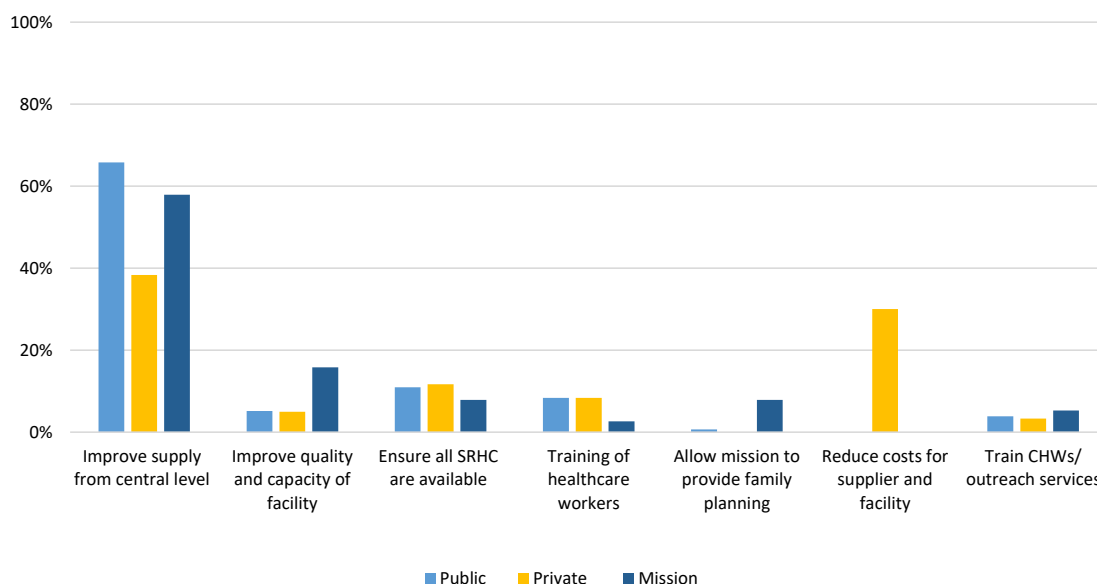


6.4. Improving Access to SRHC- Supply Side

Respondents were also asked what they thought could be done from the supply side to improve access to SRHC in Zambia. Overall, respondents' perspectives were that that improving the supply chain was key to improving access (see Figure 19). Improvements to the supply chain was most often recommended in public sector facilities (66%) and

mission sector facilities (58%), while in the private sector 38% of respondents recommended the improvement of the supply from the central level. In the private sector, reducing costs for manufacturers and the facility was also commonly recommended (30%).

Figure 19: Suggested strategies to improve access to SRHC on the supply side in the public, private and mission sectors.

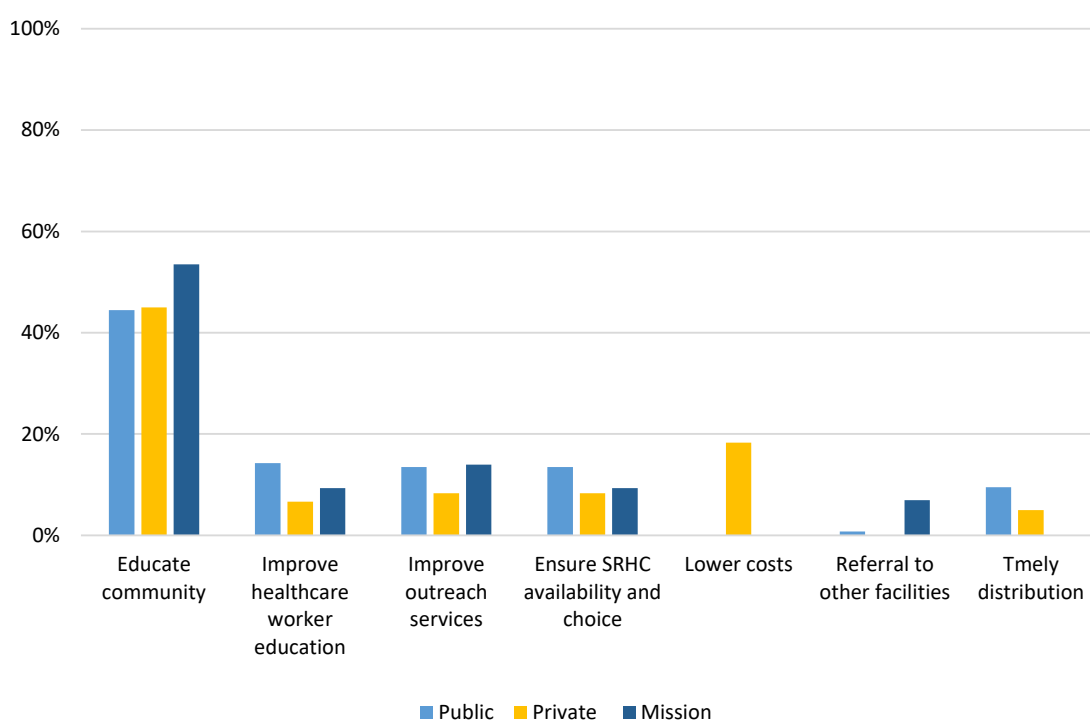


6.5. Improving Access to SRHC- Demand Side

Respondents were also asked what could be done to ensure access to SRH services from the demand side, and recommendations were given. About half of the respondents recommended the need to educate and sensitise communities on the importance of SRHCs and SRH services (see Figure 20). Other recommendations included the

improving healthcare workers' education (14%) and ensuring availability and choice of SRHC (13%) in the public sector, improving outreach services in the public and mission sectors (13% and 14%, respectively) and lowering the costs for the client in the private sector (18%). Figure 20 provides a summary of the recommendations made to improve access to SRHC on the demand side.

Figure 20: Suggested strategies to improve access to SRHC on the demand side in the public, private and mission sectors.



DISCUSSION AND RECOMMENDATIONS

The results in this study showed that availability of SRHC is a challenge in Zambia, as only 34% of the commodities were available in the facilities.

This study aimed to create a clear picture of Zambia's current situation regarding access to sexual and reproductive health commodities, and to identify the best way to improve access to these commodities. It is the second roll-out of a planned yearly survey³ as part of Health Action International's SRHC research under the Health Systems Advocacy (HSA) Partnership.

The results in this study showed that availability of SRHC is a challenge in Zambia, as only 34% of the commodities were available in the facilities. This finding is consistent with the preceding survey, where a 34% overall availability of services was also reported. In this study, 39% availability in the mission sector was highest, followed by 37% in the public sector, while the availability in the private sector was lower at 27%. The division across the sectors is again similar to the survey undertaken in 2017, as then availability in the public sector was highest (41%), followed by the mission sector (36%) and lowest availability in the private sector (25%). Furthermore, more than half of the 55 commodities researched were available at less than 25% of the facilities, and only 13 commodities were, on average, available at more than 50% of facilities. The study also

revealed that contraceptives are the most commonly available SRHC in Zambia.

Availability of contraceptives was inconsistent, with the birth control pill (any formulation), injectables (any formulation) and male condoms being most available. This finding is consistent with the UNFPA report⁴ that has shown that birth control pills and injectable contraceptives are the most commonly used contraceptives in Zambia. Nevertheless, availability of these contraceptives was still not optimal, as none of the sectors had 100% availability. The mission sector was less likely to have contraceptives available than the public and private sectors. For instance, although availability of ethinyl/levonorgestrel was most common, with about 81% availability in public sector facilities, this product was only available in 44% of mission facilities, and while male condoms were available in 89% of public and private facilities, this product was available in 64% of mission facilities. Other contraceptives, such as norethisterone enanthate and IUCDs, had low availability across sectors although contraceptives are crucial for family planning. This suboptimal availability of contraceptives makes it difficult to access the commodities, which likely contributes

³ Health Action International, *Sexual & Reproductive Health Commodities: Measuring Prices, Availability and Affordability Data Collection Report– Zambia* (Amsterdam: HAI, 2017)

⁴ United Nations, Department of Economic and Social Affairs, Population Division, *Trends in Contraceptive Use Worldwide 2015* (Geneva: United Nations, 2015), pp. 1-63.

to the 20% of married women aged 15-49, and 44.6% of unmarried women aged 15-24 in Zambia who were experiencing unmet needs for family planning^{5,6}.

Disparities in availability were also noticeable across areas, with the private and mission rural areas being more likely to have contraceptives available than the public rural areas. Nearly all contraceptives in the public sector had a higher availability in urban areas facilities than in facilities in rural areas. The regional disparities in availability of contraceptives observed in Zambia suggest a need for targeted strategies that specifically focus on availability of contraceptives in rural facilities.

Availability of maternal health commodities, consisting of commodities necessary for antenatal and post-natal care such as oxytocin, methyldopa, magnesium sulphate and misoprostol, were also inconsistently available across the sectors, with availability generally highest in the mission sector and lower in the private sector. These medicines are crucial to ensure a healthy pregnancy and life for both the mother and the baby. The irregular availability of these commodities therefore likely contributed to the 224 maternal deaths per 100,000 live births in Zambia⁷. The same is the case with medical devices, such as ultrasound scans, suction devices and incubators that had a low availability, especially in the public and private sectors, which have a significant impact on the health outcomes of mothers and babies as it affects the quality of

treatment offered to clients. Surprisingly, some newborn and child health commodities, such as calcium gluconate, ampicillin, and zinc syrup were hardly available across the sectors. The low availability of these commodities could also contribute to the neonatal and under-five mortality rates.

Stock-outs of SRHC in general were more common in the public and mission sectors than in the private sector: 21% and 22% of facilities, respectively, reported a stock-out versus 14% of facilities in the private sector. On average, if stock-outs occurred, stock-outs lasted at least five days for most of the commodities. Stock-outs lasted on average 9 days in the public and private sector, and 10 days in the mission sector. Moreover, in the private and mission sectors, three of the 24 SRHC for which stock-out data was collected were stocked out for 20 days or more per month. Such patterns of stock-outs in facilities where availability is already a challenge can thus have an even more significant impact on access to SRHC, as availability is already a problem. Notably, unavailability of stock cards at a number of facilities may have led to an underestimation of the stock-out situation.

In regards to prices and affordability, even though all SRHC were free to the patient in the public and mission sectors, in the private sector many contraceptives (such as implants), maternal health commodities (such as methyldopa) and newborn and child health commodities (such as ampicillin), far exceeded the one day of income that is used

⁵ United Nations, Department of Economic and Social Affairs, Population Division, *Trends in Contraceptive Use Worldwide 2015* (Geneva: United Nations, 2015), pp. 1-63.

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

⁷ World Health Organization, *Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (Geneva: WHO, 2015), pp.1-92.

as a measure to determine the affordability of a commodity. Given that Zambia's LPGW earns the equivalent of USD 14.4⁸, while in 2015, 57.5% of Zambia's population was living below the international poverty line of USD 1.90⁹, in this survey we have now 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 product¹⁰. 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 Zambia is 5.1 persons¹¹.

Consistent with the findings of the survey conducted in 2017, the mean prices of SRHC were significantly higher in urban private sector facilities than in rural private sector facilities. This finding could be due to the poverty levels most common in rural areas, which make it hard for the providers to have comparable prices with urban areas.

This research has established that although contraceptives have the highest availability for commodities across the sectors, family planning services face the most challenges according to

healthcare workers, followed by STI management and maternal health services. Based on the qualitative research, the study has found that generally, the key challenges affecting access to SRHC were; the fact that requested commodities were not supplied, logistical issues for supply, frequent stock-outs and lack of staff training on SRH. These challenges were also listed by the respondents in the previous survey.

To improve access to SRHC, the following priority recommendations are made:

- Improve the supply chain;
- Educate communities on the importance of SRHC and SRH services;
- Offer and/or improve follow-up services to patients;
- Improve client education and outreach;
- Increase the number of trained staff, and improve the knowledge of existing staff.

Generally, similar recommendations to improve access to SRHC were made in most of the facilities across the sectors, with the exception of some facilities in the private sector, where respondents also suggested the need to reduce costs.

⁸ OANDA, *Currency Converter*, 2018 <<https://www.oanda.com/currency/converter/>> [accessed 18 July 2018]

⁹ The World Bank, *Poverty & Equality Data Portal: Zambia*, 2017 <<http://povertydata.worldbank.org/poverty/country/ZMB>> [accessed 23 November 2017]

¹⁰ Laurens Niens et al., 'Practical Measurement of Affordability: an Application to medicines'. *Bulletin of the World Health Organization*, (Geneva: World Health Organisation, 2012), pp. 219-227.

¹¹ United Nations, Department of Economic and Social Affairs, Population Division. *Household Size and Composition Around the World*, (Geneva: United Nations, 2017), pp. 1-31.

CONCLUSION

This study has found that in Zambia, several factors such as the lack of availability of commodities, frequent stock-outs, unaffordability of SRHC and challenges at the community and facility levels all contribute to the difficulties people experience in accessing SRH services. These findings contributed to the 20% to 45% of women that still have unmet family planning needs. Improvements in accessing SRHC in Zambia are therefore necessary in order to achieve the Sustainable Development Goal of universal access to SRH services.

Notably, the findings in this study are similar to the previous study even though an additional four regions have been surveyed. For instance, the availability of the commodities was still similar compared to last year's results. This is not unexpected, as the effects the research might have on policies and consequently access to SRHC, are expected to take longer than a year to come to fruition.

The findings in this study also show that strategies on both the supply side and demand side might have a considerable impact on the health-seeking behaviour of clients, as well as the accessibility of SRHC and SRH services. Supply side strategies such as improving the efficiency of the supply chain, increasing the number of

staff, and improving the stock ordering at the facility may improve access to SRHC. Efficiency of the supply chain is critical in ensuring access to SRHC, as a sub-optimal pharmacy chain leads to problems with availability and stock-outs of the commodities. To improve the pharmacy chain, SRHC should be accurately ordered at the facility, and the delivery should be efficient, accurate and timely. Staff sensitisation and continued education is also needed to ensure clients feel comfortable in accessing SRH services in the facilities. To achieve this, it is important that staff is sufficiently knowledgeable about SRH and available services so they can offer quality care, be professional in their approach, and ensure no stigmatisation occurs within the facility. Finally, the costs of the commodities, particularly in the private sector are also an important access-limiting factor which require sustainable solutions. Standardising the prices of the SRHC in the private sector may potentially improve access to the commodities.

Demand side strategies such as community education and sensitisation might tackle many of the reasons given as to why many clients are reluctant to access SRH services. For instance, community education and sensitisation on SRH will improve the general knowledge and awareness about SRH, which will, in turn, reduce the fear of side effects and target the myths, superstitions and religious factors negatively influencing the use of SRH services.

Annex 1: SRHC Surveyed

Table 7: Full list of SRHC 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 sulphate (500mg in 2ml)
Magnesium sulphate (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
Foetal scope
Resuscitator
Bag and mask size 0
Suction device
Training mannequin for infant resuscitation

Annex 2: SRHC Availability

Table 8: 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	87	76	73	82	50	44
Ethinyl/norethisterone	10	1	9	0	0	4
Levonorgestrel 30mcg	54	29	20	9	3	26
Levonorgestrel 70mcg	21	12	55	73	17	11
Medroxyprogesterone acetate	86	87	30	27	3	44
Norethisterone enanthate	62	35	27	27	0	33
Male Condoms	92	87	86	100	33	70
Female Condoms	60	52	25	27	0	22
IUCD	57	19	5	9	17	11
Levonorgestrel Implant	60	71	9	18	17	41
Etonogestrel Implant	37	35	2	9	0	11
Diaphragm	0	1	0	0	0	0
Oxytocin injection	95	93	18	27	100	89
Misoprostol	19	7	30	18	50	22
Metronidazole	65	65	82	82	100	63
Methyldopa	40	19	36	27	50	33
Magnesium sulphate 500mg in 2ml	19	11	2	0	17	19
Magnesium sulphate 500mg in 10ml	38	25	5	9	50	41
Calcium gluconate	6	2	9	0	17	7
Clotrimazole pessary	13	4	57	36	17	4
Clotrimazole cream	46	38	55	55	50	22
Gentamicin injection	71	46	59	45	100	74
Ampicillin	13	4	7	0	17	11
Procaine benzylpenicillin	24	18	59	55	17	11
Benzathine benzylpenicillin G	89	80	66	55	100	93
Amoxicillin 125mg	27	21	34	45	33	19
Amoxicillin 250mg	75	71	70	36	67	74
Dexamethasone	37	13	32	9	50	19
Ferrous Salt Tablet	73	88	64	82	67	81
Folic Acid Tablet	63	75	77	73	67	56
Ferrous:Folic Tablet 60/400	6	2	5	9	0	4
Ferrous:Folic Tablet 150/500	0	0	2	0	0	0
Zinc 10mg/5ml syrup	0	1	14	0	0	0
Zinc 20mg tablet	95	87	57	73	100	96
Zinc ORS co-pack	6	14	18	9	0	4
ORS 200ml	11	1	14	9	0	7
ORS 500ml	2	0	7	0	0	0
ORS 1L	79	80	75	82	100	89
Safe Delivery Kit	22	16	5	9	33	19
Vasectomy kits	14	4	5	0	0	0
Tuboligation kits	17	4	7	0	0	15
Antiseptic	68	64	50	45	83	70
Chlorhexidine 4%	16	5	2	9	33	7
MVA	54	26	9	0	100	48
Speculum	73	56	16	9	100	85
Cervical dilators	54	27	11	0	67	52
Incubator	32	13	9	0	67	52
Monitor	19	7	7	0	67	22
Ultra sound scan	25	5	14	9	67	41
Ventilator	17	8	9	0	33	26
Foetal scope	81	80	16	18	100	89
Resuscitator	46	33	11	0	83	81
Bag and mask	63	45	9	9	83	81
Suction device	67	52	9	18	83	93
Training mannequin	43	26	9	0	33	74

Annex 3: Stock-out Data

Table 9: 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	28.0	25.0	7.1	6	9	19
Levonorgestrel 30mcg	10.0	0	0	3	NA	NA
Levonorgestrel 70mcg	25.4	33.3	11.1	11	7	5
Medroxyprogesterone acetate	33.3	50.0	25.0	16	1	10
Norethisterone enanthate	25.0	0	26.7	7	NA	8
Male Condoms	13.2	20.0	40.0	10	17	6
Female Condoms	11.4	29.4	16.7	4	4	3
IUCD	5.3	20.0	0	10	1	NA
Levonorgestrel Implant	13.0	NA	0	12	NA	NA
Etonogestrel Implant	6.5	40.0	18.2	18	25	30
Oxytocin injection	6.3	0.0	0	7	NA	NA
Misoprostol	NA	NA	NA	NA	NA	NA
Metronidazole	4.6	0	0	4	NA	NA
Methyldopa	17.6	0	45.5	6	NA	8
Magnesium sulphate	26.8	13.3	32.0	7	3	5
Magnesium sulphate	13.0	12.5	26.7	15	30	13
Calcium gluconate	10.0	0	0.0	7	NA	NA
Clotrimazole pessary	10.5	0	7.1	2	NA	30
Clotrimazole cream	44.4	0	25.0	15	NA	2
Gentamicin injection	27.3	50.0	50.0	12	3	20
Ampicillin	40.0	41.7	61.5	11	7	9
Procaine benzylpenicillin	21.3	30.0	26.9	11	2	7
Benzathine benzylpenicillin G	33.3	0	75.0	3	NA	3
Amoxicillin 125 mg	25.0	10.0	25.0	16	3	2
Amoxicillin 250 mg	11.7	8.3	10.3	12	30	12
Dexamethasone	63.9	33.3	60.0	16	5	9
Ferrous Salt Tablet	30.6	0	33.3	7	NA	6
Folic Acid Tablet	13.8	12.5	50.0	10	10	11
Ferrous:Folic Tablet 150/500	13.8	14.3	29.6	7	10	6
Zinc 10mg/5ml syrup	23.5	16.7	27.3	9	15	5
Zinc 20mg tablet	14.3	NA	NA	4	NA	NA
Zinc ORS co-pack	NA	NA	NA	NA	NA	NA
ORS 500ml	0.0	0.0	NA	NA	NA	NA
ORS 1L	5.6	11.1	0	5	1	NA
Average	10.7	14.1	21.6	9	9	10

Annex 4: SRHC Prices

Table 10: SRHC prices in the public, private and mission sector, by area.

	Mean Prices					
	Public		Private		Mission	
	Urban	Rural	Urban	Rural	Urban	Rural
Ethinyl/levonorgestrel	0	0	6	4	0	0
Ethinyl/norethisterone	0	0	5	NA	NA	0
Levonorgestrel 30mcg	0	0	9	10	0	0
Levonorgestrel 70mcg	0	0	20	15	0	0
Medroxyprogesterone acetate	0	0	31	5	0	0
Norethisterone enanthate	0	0	11	12	NA	0
Male Condoms	0	0	7	3	0	0
Female Condoms	0	0	9	10	NA	0
IUCD	0	0	100	0	0	0
Levonorgestrel Implant	0	0	83	0	0	0
Etonogestrel Implant	0	0	100	NA	NA	0
Diaphragm	NA	0	NA	NA	NA	NA
Oxytocin injection	0	0	12	5	0	0
Misoprostol	0	0	45	57	0	0
Metronidazole	0	0	1	0	0	0
Methyldopa	0	0	2	1	0	0
Magnesium sulphate 500mg in 2ml	0	0	20	NA	0	0
Magnesium sulphate 500mg in 10ml	0	0	0	NA	0	0
Calcium gluconate	0	0	4	NA	0	0
Clotrimazole pessary	0	0	10	18	0	0
Clotrimazole cream	0	0	22	26	0	0
Gentamicin injection	0	0	7	6	0	0
Ampicillin	0	0	13	NA	0	0
Procaine benzylpenicillin	0	0	12	10	0	0
Benzathine benzylpenicillin G	0	0	14	9	0	0
Amoxicillin 125mg	0	0	16	8	0	0
Amoxicillin 250mg	0	0	1	0	0	0
Dexamethasone	0	0	10	10	0	0
Ferrous Salt Tablet	0	0	0	0	0	0
Folic Acid Tablet	0	0	1	0	0	0
Ferrous:Folic Tablet 60/400	0	0	0	0	NA	0
Ferrous:Folic Tablet 150/500	NA	NA	0	NA	NA	NA
Zinc 10mg/5ml syrup	NA	0	9	NA	NA	NA
Zinc 20mg tablet	0	0	3	1	0	0
Zinc ORS co-pack	0	0	9	15	NA	0
ORS 200ml	0	0	6	5	NA	0
ORS 500ml	0	NA	4	NA	NA	NA
ORS 1L	0	0	4	3	0	0
Safe Delivery Kit	0	0	3	0	0	0

Annex 5: Treatment Units

Table 11: SRHC treatment regimens.

	Treatment Regimen	
	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 sulphate 500mg/ 2ml	18 vials	NA
Magnesium sulphate 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 6: SRHC Affordability

Table 12: Affordability of SRHC in the public sector.

Number of days income needed for treatment in the public sector								
	Income 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	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	0	0	0	0	0	0	0	0
Oxytocin injection	0	0	0	0	0	0	0	0
Misoprostol	0	0	0	0	0	0	0	0
Metronidazole	0	0	0	0	0	0	0	0
Methyldopa	0	0	0	0	0	0	0	0
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	0	0	0	0	0	0	0	0
Clotrimazole cream	0	0	0	0	0	0	0	0
Gentamicin injection	0	0	0	0	0	0	0	0
Ampicillin	0	0	0	0	0	0	0	0
Procaine benzylpenicillin	0	0	0	0	0	0	0	0
Benzathine benzylpenicillin G	0	0	0	0	0	0	0	0
Amoxicillin 125mg	0	0	0	0	0	0	0	0
Amoxicillin 250mg	0	0	0	0	0	0	0	0
Dexamethasone	0	0	0	0	0	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	NA	NA	NA	NA	NA	NA	NA	NA
Zinc 10mg/5ml syrup	0	0	0	0	0	0	0	0
Zinc 20mg	0	0	0	0	0	0	0	0
Zinc ORS co-pack	0	0	0	0	0	0	0	0
ORS 200ml	0	0	0	0	0	0	0	0
ORS 500ml	0	0	0	0	0	0	0	0
ORS 1L	0	0	0	0	0	0	0	0

Table 13: Affordability of SRHC in the mission sector.

Number of days income needed for treatment in the mission sector								
	Income 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	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	0	0	0	0	0	0	0	0
Methyldopa	0	0	0	0	0	0	0	0
Magnesium sulfate 500mg/2ml	0	0	0	0	0	0	0	0
Magnesium sulfate 500mg/10ml	0	0	0	0	0	0	0	0
Calcium gluconate	0	0	0	0	0	0	0	0
Clotrimazole pessary	0	0	0	0	0	0	0	0
Clotrimazole cream	0	0	0	0	0	0	0	0
Gentamicin injection	0	0	0	0	0	0	0	0
Ampicillin	0	0	0	0	0	0	0	0
Procaine benzylpenicillin	0	0	0	0	0	0	0	0
Benzathine benzylpenicillin G	0	0	0	0	0	0	0	0
Amoxicillin 125mg	0	0	0	0	0	0	0	0
Amoxicillin 250mg	0	0	0	0	0	0	0	0
Dexamethasone	0	0	0	0	0	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	NA	NA	NA	NA	NA	NA	NA	NA
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	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	0	0	0	0	0	0	0

Annex 7: SRHC Access: Qualitative Data Analysis

Figure 21: Challenges related to accessing family planning services.

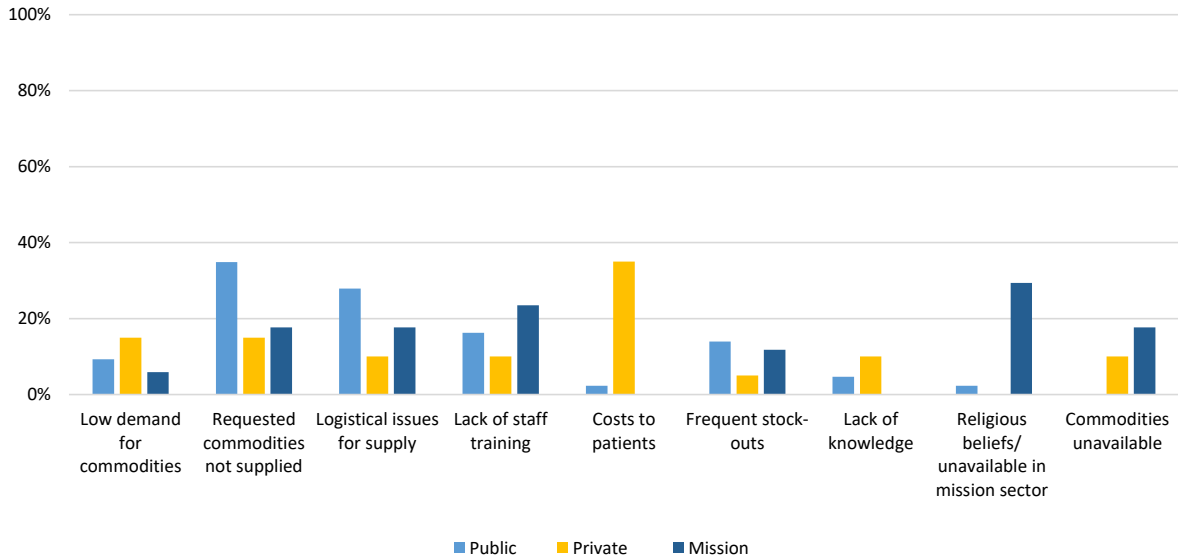


Figure 22: Challenges related to accessing STI management services.

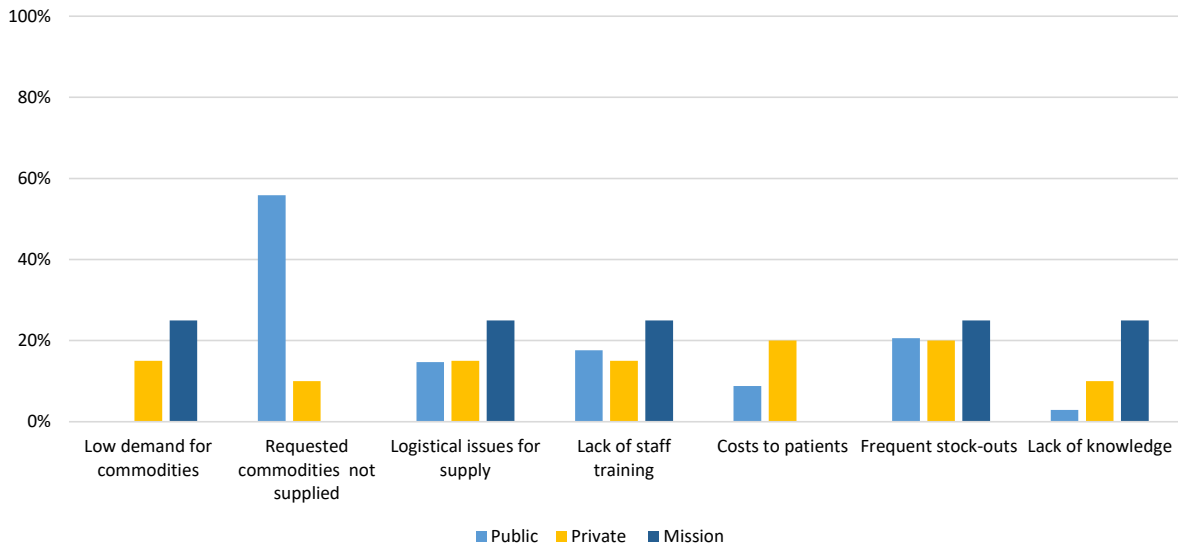


Figure 23: Challenges related to accessing newborn and child health services.

