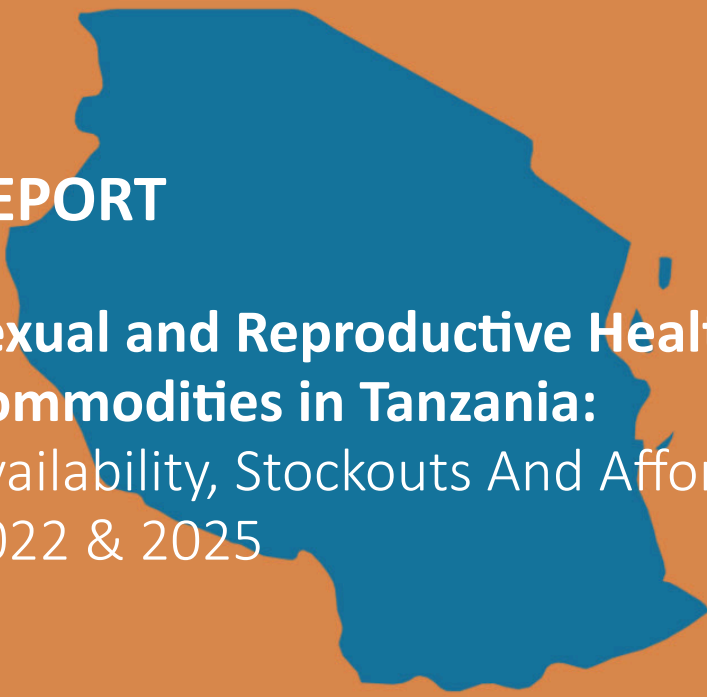




REPORT

Sexual and Reproductive Health Commodities in Tanzania:

Availability, Stockouts And Affordability
2022 & 2025

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Availability, Stockouts And Affordability 2022 & 2025

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1. INTRODUCTION

Good sexual and reproductive health (SRH) is “a state of complete physical, mental and social well-being in all matters relating to the reproductive system” for both men and women, including adolescents.¹ Maintaining good SRH means people need access to accurate information and to safe, effective, affordable and acceptable contraception methods of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections (STIs) 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 smooth pregnancy, safe delivery and healthy baby. Every individual has the right to make their own choices about their SRH and family planning.

Access to quality SRH services remains a major public health challenge in Tanzania. In 2020, the maternal mortality ratio was 238 per 100,000 live births, far above the national target of 100 by 2025. The main causes of maternal deaths are postpartum haemorrhage (31%), pre-eclampsia (14%) and anaemia (5%).^{2,3} Modern contraceptive use is low, particularly among adolescents. Use stands at 31% among married women and 36% among sexually active unmarried women, while unmet family planning needs are high (21% and 32%, respectively). Among adolescents, only 15% of married and 25% of sexually active unmarried girls use modern contraception, with unmet need reaching 55% among unmarried adolescents. By age 19, 46% of girls have been pregnant, often unintentionally. Unmet family planning needs contribute to unintended pregnancies, unsafe abortions, higher maternal risks, and school dropout, perpetuating poverty. Significant progress is needed to achieve the Sustainable Development Goals on maternal mortality of less than 70 per 100,000 live births and universal access to SRH services.⁴

Tanzania’s health system faces major constraints, including a 52% shortage of healthcare workers, with only 5.5 nurses and midwives and 1.1 physicians per 10,000 people.^{5,6} Although SRH commodities are free in public facilities and supply chain performance has improved, with 96% of clinics reporting continuous availability of essential medicines in 2019, access remains uneven, especially in rural areas.⁷ Stockouts persist, supervision is weak, and adolescent-friendly SRH services are limited.^{8,9} Finally, limited public health financing (27% of total health expenditure) and high out-of-pocket payments (26%) continue to burden households.^{10,11}

Underlying causes for poor SRH status vary. However, it is clear that stronger health systems, including adequate numbers of qualified health workers and access to essential sexual and reproductive health commodities (SRHC), are urgently needed to address the unmet needs. It is well-documented that availability and adequate access to proven low-cost SRHC have the potential to save many lives and contribute to the fundamental human right of access to healthcare without adverse economic effect on the individual, family, and society.¹²

This research was therefore conducted to study the availability, affordability and stockouts of 51 SRH commodities used for family planning, maternal healthcare, treatment of STIs, treatment of HIV/AIDS, in addition to several test kits and menstrual products, in Dodoma Rural, Manyara and Morogoro in Tanzania. This research is essential as it creates a clear overview of the availability and affordability of a comprehensive package of essential SRH commodities in Tanzania, which will contribute to the development of evidence-based policies to improve the SRH of women and adolescents.

2. RESEARCH METHODOLOGY

This research was conducted by the Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO) and Health Action International (HAI) as part of the Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) programme, funded by the European Union. The research was approved by the National Institute for Medical Research (NIMR) ethical clearance number: NIMR/HQ/R.8a/Vol.IX/5092. This study used an adapted version of the HAI/WHO Methodology (WHO & HAI, 2008).

Teams of data collectors visited 144 health facilities in 2022 and 136 in 2025 from the public, private and faith-based sectors to survey the availability, stockouts and patient prices of 51 medicines, tests, and menstrual hygiene products. An overview of all surveyed commodities can be found in Annex 1.

Public Sector: Facilities that are run and funded by the national government. Medicines in this sector are often low cost or free of charge.

Private Sector: Licensed retail pharmacies, private healthcare centres and private hospitals. The private sector does not include unlicensed drug stores, drug sellers in the informal sector, or health facilities operated by private companies, such as mining companies.

Faith-based Sector: Facilities that are run by religious organisations, such as church missions.

The study sample included health facilities from urban as well as rural areas, ranging from dispensaries to referral hospitals. Availability was only measured for commodities based on the health facility level where they should be available. For example, carbetocin is available from district hospitals and up. In addition, stock cards or stock databases were reviewed to record information on stockouts of the surveyed products over a 12-month period prior to data collection. Finally, price information, in combination with the international poverty line (IPL) of 5,095.32 TSH (2.15 USD) per day in 2022 and the IPL of 7,395.75 TSH (3.00 USD) per day in 2025, was used to calculate affordability of commodities. If a commodity cost more than a day's IPL 'income', it was considered unaffordable. Table 1 provides an overview of the study sample.

Table 1. Study sample in 2022 and 2025

	Overall		Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025	2022	2025
Urban	15	16	7	7	5	4	3	5
Rural	129	120	86	83	20	18	23	19
Total	144	136	93	90	25	22	26	24

3. RESULTS

FAMILY PLANNING

Family planning (FP) products are means by which individuals can control and organise their fertility. Autonomy in reproductive decision-making is a fundamental right that supports the exercise of several human rights and contributes to improving public health indicators (Cook, 1983; WHO, 2014). These products vary in terms of how they are administered and how long they remain effective: for example, the contraceptive pill must be taken daily, injectable contraceptives require a quarterly injection, while implants and intrauterine devices (IUDs) provide prolonged protection for up to five years. Condoms remain the only contraceptive method that offers dual protection against unwanted pregnancy, HIV/AIDS, and other sexually transmitted infections (WHO, 2020). In addition, vasectomy and tubal ligation are permanent surgical procedures that allow individuals to make an informed choice about permanently ending their ability to have children.

Availability

As in 2022, in 2025 there were no family planning commodities that had an overall availability above 80%, the availability threshold set by WHO (see Table 2). Compared to 2022, more than half of family planning commodities decreased in overall availability by 2025, including levonorgestrel 1.5mg (birth control pill, from 28.5% to 24.3%), etonogestrel implants (from 47.2% to 30.1%) and copper-containing IUDs (from 29.9% to 13.2%).

Table 2. Availability of family planning commodities in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	47.9	49.3	65.6	68.9	28	18.2	3.8	4.2
Ethinylestradiol + norethisterone	1.4	0.0	2.2	0.0	0.0	0.0	0.0	0.0
Levonorgestrel (30 mcg)	28.5	24.3	43	35.6	4.0	0.0	0.0	4.2
Levonorgestrel (1.5 mg)	21.5	24.3	30.1	36.7	8.0	0.0	3.8	0.0
Medroxyprogesterone acetate	52.1	51.5	74.2	74.4	16.0	4.5	7.7	8.3
Norethisterone enanthate	0.7	0.7	1.1	0.0	0.0	0.0	0.0	4.2
Implants: levonorgestrel	38.9	50.0	58.1	72.2	8.0	4.5	0.0	8.3
Implants: etonogestrel	47.2	30.1	66.7	44.4	20	4.5	3.8	0
Copper-containing IUD	29.9	13.2	44.1	17.8	4.0	4.5	3.8	4.2
Levonorgestrel-releasing IUD	0.7	0.0	1.1	0.0	0.0	0.0	0.0	0.0
Male condoms	66.7	69.1	89.2	94.4	36.0	27.3	15.4	12.5
Female condoms	13.9	12.5	20.4	16.7	4.0	9.1	0.0	0.0
Vasectomy services ^a	15.4	18.2	0.0	0.0	50.0	100	20.0	20.0
Tubal ligation services ^a	7.7	9.1	16.7	20	0.0	0.0	0.0	0.0

^aAvailable from district hospital level and up.

In the public sector, only one family planning commodity saw a noticeable increase in availability. Levonorgestrel implants were available in 58.1% of facilities in 2022, and 72.2% of facilities in 2025. Availability of four other commodities – ethinylestradiol + levonorgestrel, levonorgestrel 1.5mg, medroxyprogesterone acetate and male condoms – increased with about 5%. Most noticeable decreases were observed for etonogestrel implants (from 66.7% to 44.4%) and copper-containing IUDs (from 44.1% to 17.8%).

In the private sector, availability of all but three commodities/services decreased. On top of that, the increase in availabilities was minimal: copper-containing IUDs increased from 4.0% availability to 4.5% availability, and female condoms from 4.0% to 9.1%. Availability of family planning commodities in the faith-based remained critically low: highest availability was found for vasectomy services (20.0%) and male condoms (12.5%).

Stockouts

A stockout is defined as the number of days during a 12-month period when a product that is normally available and in stock was not available at the health centre. Stock information was recorded in 70.8% of all surveyed facilities in 2022, and 82.4% of facilities in 2025. Broken down into the surveyed sectors, the percentages are 68.8% (2022) and 81.1% (2025) for public, 68.0% (2022) and 81.8% (2025) for private, and 80.8% and 87.5% (2022 and 2025, respectively) for faith-based facilities.

In the public sector, stockouts increased for all but one family planning commodity between 2022 and 2025 (see Table 3 on page 8). Only male condoms did not experience more stockouts, decreasing from 4.5% to 3.8% of facilities. However, when stockouts of male condoms occurred, they did last on average longer in 2025 compared to 2022 (15 days versus 86 days, respectively). Ethinylestradiol + levonorgestrel, medroxyprogesterone acetate and levonorgestrel implants were stocked out at about 20% of public facilities, with stockouts ranging from 44 to 75 days on average. Four commodities experienced stockouts at around one-third to half of facilities, while norethisterone enanthate and levonorgestrel-releasing IUDs were the most commonly stocked out commodities (80.0% and 100.0%, respectively). In the private sector, stockouts occurred less often, with only ethinylestradiol + levonorgestrel and medroxyprogesterone enanthate experiencing stockouts (33.3% and 100.0%, respectively). However, important to note is the low number of stock cards for these family planning commodities in the private sector. Similarly, while no stockouts were recorded in the faith-based sector, this finding is based on one to two stock cards per commodity only.

Affordability

Like in 2022, all family planning commodities were free to the patient in the public sector in 2025 (see Table 4). These commodities were also free in the faith-based sector. In the private sector, while three commodities were not free in 2025 and prices increased compared to 2022, they were still considered affordable as they cost less than the equivalent to the daily international poverty line.

Table 4. Affordability of family planning commodities in 2022 and 2025, by sector

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	0 days	0 days	0.01 days	0.15 days	0 days	0 days
Levonorgestrel (30 mcg)	0 days	0 days	0 days	-	-	0 days
Levonorgestrel (1.5 mg)	0 days	0 days	0 days	-	-	-
Medroxyprogesterone acetate	0 days	0 days	0 days	0.41 days	0 days	0 days
Implants: levonorgestrel	0 days	0 days	0 days	0 days	-	0 days
Implants: etonogestrel	0 days	0 days	0 days	0 days	0 days	-
Copper-containing IUD	0 days	0 days	0 days	0 days	0 days	0 days
Male condoms	0 days	0 days	0.02 days	0.05 days	0.05 days	0 days
Female condoms	0 days	0 days	0 days	0 days	-	-

No 2025 price data for ethinylestradiol + norethisterone, norethisterone enanthate and levonorgestrel-releasing IUD across all three sectors.

Table 3. Stockouts of family planning commodities at health facilities, and average number of stockout days per stockout in 2022 and 2025, per sector

	Public						Private						Faith-based					
	HF with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HF with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HF with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	49.0	69.0	14.3	21.7	106.0	75.0	5.0	3.0	0.0	33.3	0.0	60.0	1.0	0.0	0.0	ND	0.0	ND
Ethinylestradiol + norethisterone	2.0	11.0	0.0	63.6	0.0	51.0	0.0	0.0	ND	ND	ND	ND	0.0	1.0	ND	0.0	ND	0.0
Levonorgestrel (30 mcg)	32.0	46.0	6.3	32.6	77.0	76.0	1.0	0.0	0.0	ND	0.0	ND	0.0	1.0	ND	0.0	ND	0.0
Levonorgestrel (1.5 mg)	29.0	43.0	6.9	34.9	81.0	122.0	1.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	ND	ND
Medroxyprogesterone acetate	56.0	71.0	16.1	19.7	69.0	72.0	3.0	1.0	0.0	100.0	0.0	31.0	2.0	2.0	0.0	0.0	0.0	0.0
Norethisterone enanthate	0.0	5.0	ND	80.0	ND	75.0	0.0	0.0	ND	ND	ND	ND	0.0	1.0	ND	0.0	ND	0.0
Implants: levonorgestrel	46.0	70.0	8.7	22.9	69.0	44.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	ND	0.0	ND	0.0
Implants: etonogestrel	56.0	53.0	8.9	37.7	28.0	106.0	4.0	1.0	25.0	0.0	102.0	0.0	0.0	0.0	ND	ND	ND	ND
Copper-containing IUD	34.0	25.0	5.9	48.0	30.0	95.0	1.0	1.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0
Levonorgestrel-releasing IUD	2.0	3.0	50.0	100.0	19.0	83.0	0.0	0.0	ND	ND	ND	ND	0.0	0.0	ND	ND	ND	ND
Male condoms	67.0	80.0	4.5	3.8	15.0	86.0	5.0	5.0	20.0	0.0	13.0	0.0	3.0	2.0	0.0	0.0	0.0	0.0
Female condoms	18.0	16.0	5.6	12.5	112.0	82.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	ND	ND	ND	ND

HF: Health facility; ND: No data.

MATERNAL HEALTH

Maternal health commodities represent a diverse group of products used to treat health conditions that affect women during pregnancy, childbearing, and postnatally. In many contexts, during this period women are at an increased risk of negative health outcomes that can be avoided with the right treatment and care (WHO, 2023). Under maternal health commodities fall diverse medicines with different uses; examples are supplements used to prevent iron and folic acid deficiencies, and conditions associated with adverse pregnancy outcomes to the mother and foetus (WHO, 2012); medicines, such as oxytocin and misoprostol, used to prevent post-partum haemorrhage, the leading cause of maternal deaths in the Sub-Saharan Africa region (Say, 2014); and medicines to treat pregnancy-related hypertension, also called (pre)-eclampsia, including methyldopa and magnesium sulphate.

Availability

In 2022, none of the maternal health commodities reached an overall 80% availability (see Table 5). In 2025, three commodities did reach this threshold: oxytocin (81.6%), tranexamic acid (90.9%) and ferrous salt + folic acid (83.8%). On top of that, five other maternal health commodities saw their overall availability increase.

In the public sector, the availability of eight maternal health commodities increased significantly in 2025 compared to 2022. Oxytocin increased from 83.9% to 98.9%, while the increases in availability of tranexamic acid (50.0% to 100.0%), magnesium sulphate (79.6% to 94.4%), folic acid (58.1% to 85.6%), ferrous salt + folic acid (61.3% to 94.4%) and methyldopa (49.5% to 83.3%) mean they now meet the WHO threshold of 80%. Carbetocin remained unavailable, while ergometrine, mifepristone – misoprostol and ferrous salt were also no longer available at any public facilities in 2025.

Availability in the private sector generally worsened between 2022 and 2025. The availability of oxytocin, for example, decreased from 40.0% to 27.3%, the availability of tranexamic acid from 50.0% to 0%, and of ferrous salt + folic acid from 68.0% to 54.5%. Only slight increases were seen for misoprostol (16.0% to 18.2%), magnesium sulphate (20.0% to 22.7%), calcium gluconate (4.0% to 9.1%) and folic acid (36.0% to 54.5%). Their availabilities remained low in 2025.

In the faith-based sector availability of eight maternal health commodities increased from 2022 to 2025. Most noticeable increases were observed for tranexamic acid (60.0% to 100.0%), methyldopa (34.6% to 62.5%), folic acid (42.3% to 66.7%) and dexamethasone (50.0% to 71.4%). While available in 2022, carbetocin, ergometrine and ferrous salt were no longer available in faith-based facilities in 2025.

Table 5. Availability of maternal health commodities in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Oxytocin	71.5	81.6	83.9	98.9	40.0	27.3	57.7	66.7
Misoprostol	41.0	58.1	51.6	74.4	16.0	18.2	26.9	33.3
Carbetocin ^a	7.7	0.0	0.0	0.0	0.0	0.0	20.0	0.0
Tranexamic acid ^a	53.8	90.9	50.0	100.0	50.0	0.0	60.0	100.0
(methyl)ergometrine ^a	15.4	0.0	16.7	0.0	0.0	0.0	20.0	0.0
Mifepristone - misoprostol ^a	7.7	0.0	16.7	0.0	0.0	0.0	0.0	0.0
Magnesium sulfate	62.5	73.5	79.6	94.4	20.0	22.7	42.3	41.7
Calcium gluconate	4.2	35.3	2.2	46.7	4.0	9.1	11.5	16.7
Ferrous salt	6.3	0.0	5.4	0.0	8.0	0.0	7.7	0.0
Folic acid	51.4	77.2	58.1	85.6	36.0	54.5	42.3	66.7

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Ferrous salt + folic acid	62.5	83.8	61.3	94.4	68.0	54.5	61.5	70.8
Dexamethasone ^b	50.9	42.3	48.8	35.7	75.0	66.7	50.0	71.4
Methyldopa	43.1	70.6	49.5	83.3	28.0	27.3	34.6	62.5

^aAvailable from district hospital level and up.

^bAvailable from health centre level and up.

Stockouts

Stockouts in 2025 were variable in the public sector (see Table 6 on page 11). Compared to 2022, stockouts decreased slightly for oxytocin (from 5.0% to 1.2%), calcium gluconate (33.3% to 24.4%), folic acid (17.8% to 17.3%), and ferrous salt + folic acid (18.0% to 15.3%). While the length of these stockouts also decreased for calcium gluconate, folic acid, and ferrous salt + folic acid, for oxytocin it increased (from 45 days on average to 92 days on average). Stockouts worsened significantly for tranexamic acid (6.3% to 32.7%), ferrous salt (0.0% to 100%) and dexamethasone (10.0% to 55.6%).

In the private sector, stockouts worsened for all but two commodities (calcium gluconate and folic acid, which had no stockouts). Misoprostol and tranexamic acid were most often stocked out in private facilities (40.0% and 42.9%, respectively), with these stockouts lasting on average 23 days and 16 days, respectively. Stockouts of the remaining commodities occurred at around 10% to 20% of the facilities. Stockouts in the faith-based sector were very common, ranging from 7.7% of facilities (oxytocin) to 100% of facilities for ergometrine and mifepristone – misoprostol. Longest average stockouts occurred for magnesium sulphate (111 days) and tranexamic acid (186 days).

Affordability

In the public sector, while maternal health commodities were not free to the patient, all but one were affordable, costing less than the daily international poverty line in 2025. A treatment of methyldopa cost 1.28 days. In the private sector, methyldopa was also unaffordable, costing 4.46 days. Additionally, a treatment of magnesium sulphate was also unaffordable at 5.32 days. Similarly, in the faith-based sector these commodities cost 3.55 days and 4.32 days, respectively. Interestingly, tranexamic acid (1.64 days) and dexamethasone (1.30 days) were also unaffordable here.

Table 7. Affordability of maternal health commodities in 2022 and 2025, per sector

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Oxytocin	0 days	0 days	0.21 days	0.14 days	0.23 days	0.15 days
Misoprostol	0 days	0.01 days	0.98 days	0 days	0.74 days	0.23 days
Tranexamic acid	0.71 days	0.65 days	2.94 days	0.45 days	2.75 days	1.64 days
Magnesium sulfate	0.22 days	0.03 days	0 days	5.32 days	3.77 days	4.32 days
Calcium gluconate	0 days	0.09 days	1.37 days	0 days	0 days	0.17 days
Folic acid	0.04 days	0.16 days	0.79 days	0.47 days	0.40 days	0.35 days
Ferrous salt + folic acid	0.08 days	0.04 days	1.06 days	0.50 days	0.42 days	0.39 days
Dexamethasone	0.33 days	0.07 days	0.61 days	0.68 days	1.47 days	1.30 days
Methyldopa	3.15 days	1.28 days	15.70 days	4.46 days	6.84 days	3.55 days

No 2025 price data for carbetocin, (methyl)ergometrine, mifepristone – misoprostol and ferrous salt across all three sectors.

Table 6. Stockouts of maternal health commodities at health facilities and average number of stockout days per stockout in 2022 and 2025, per sector

	Public						Private						Faith-based					
	HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Oxytocin	60.0	85.0	5.0	1.2	45.0	92.0	6.0	7.0	0.0	14.3	0.0	41.0	10.0	13.0	0.0	7.7	0.0	1.0
Misoprostol	40.0	74.0	22.5	24.3	85.0	365.0	4.0	5.0	0.0	40.0	0.0	23.0	7.0	8.0	0.0	25.0	0.0	5.0
Tranexamic acid	16.0	52.0	6.3	32.7	120.0	40.0	2.0	7.0	0.0	42.9	0.0	16.0	5.0	9.0	0.0	22.2	0.0	186.0
(methyl)ergometrine	5.0	0.0	0.0	ND	0.0	ND	0.0	0.0	ND	ND	ND	ND	1.0	1.0	0.0	100.0	0.0	13.0
Mifepristone - misoprostol	2.0	0.0	50.0	ND	30.0	ND	0.0	0.0	ND	ND	ND	ND	0.0	1.0	ND	100.0	ND	25.0
Magnesium sulfate	62.0	84.0	3.2	14.3	56.0	57.0	4.0	5.0	0.0	20.0	0.0	60.0	7.0	9.0	0.0	11.1	0.0	111.0
Calcium gluconate	3.0	45.0	33.3	24.4	109.0	50.0	1.0	2.0	0.0	0.0	0.0	0.0	3.0	5.0	0.0	20.0	0.0	90.0
Ferrous salt	5.0	3.0	0.0	100.0	0.0	36.0	2.0	0.0	0.0	ND	0.0	ND	1.0	0.0	0.0	ND	0.0	ND
Folic acid	45.0	81.0	17.8	17.3	104.0	94.0	7.0	10.0	0.0	0.0	0.0	0.0	9.0	14.0	11.1	21.4	68.0	25.0
Ferrous salt + folic acid	50.0	85.0	18.0	15.3	83.0	43.0	11.0	11.0	0.0	9.1	0.0	14.0	12.0	14.0	0.0	14.3	0.0	25.0
Dexamethasone	20.0	27.0	10.0	55.6	28.0	106.0	6.0	5.0	0.0	20.0	0.0	30.0	4.0	8.0	0.0	25.0	0.0	23.0
Methyldopa	40.0	77.0	12.5	22.1	129.0	52.0	6.0	6.0	0.0	16.7	0.0	90.0	8.0	13.0	0.0	23.1	0.0	29.0

HF: Health facility; ND: No data.

No 2025 stock data for carbetocin across all three sectors.

STI TREATMENT

Commodities for the treatment of STIs represent a basket of medicines to treat common STIs, such as chlamydia, gonorrhoea and syphilis. Since many STIs are caused by bacteria, the majority of surveyed medicines are antibiotics (WHO, 2022). Often, multiple types of antibiotics can be used to treat a certain STI. In addition, one antiviral and one antifungal medicine were surveyed, which can be used to treat genital herpes and *Candida albicans* (yeast infection), respectively.

Availability

Overall availability of many of the STI treatment commodities increased from 2022 to 2025 (see Table 8). In 2025, metronidazole, clotrimazole, amoxicillin, ceftriaxone and doxycycline all reached the 80% availability threshold. Similarly, in the public sector increases in availability were seen for six of nine STI treatment commodities. Acyclovir saw the biggest increase, with the availability rising from 18.6% to 73.8%. The same five commodities that had an overall availability of 80% or higher, also did so in the public sector. Availability of benzathine benzylpenicillin (21.1%) and cefixime (24.4%) was lowest.

In the private sector, half of the STI treatment commodities increased in availability, and half decreased. Specifically, metronidazole was available in all facilities in 2025, increasing from an 88.0% availability in 2022. While the availability of amoxicillin and doxycycline decreased slightly, these commodities were still available at more than 80% of private facilities. In the faith-based sector all commodities saw an increase, with six of nine STI treatment commodities having an availability of around 75% or higher.

Table 8. Availability of STI treatment commodities in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Metronidazole	93.8	86.8	97.8	81.1	88.0	100.0	84.6	95.8
Clotrimazole	71.5	80.1	71.0	85.6	80.0	63.6	65.4	75.0
Benzathine benzylpenicillin	50.7	35.3	44.1	21.1	68.0	59.1	57.7	66.7
Amoxicillin	85.4	89.7	87.1	93.3	88.0	86.4	76.9	79.2
Acyclovir	21.8	71.2	18.6	73.8	25.0	66.7	37.5	57.1
Azithromycin	68.1	75.7	67.7	75.6	68.0	77.3	69.2	75.0
Ceftriaxone	83.3	86.0	84.9	91.1	88.0	72.7	73.1	79.2
Doxycycline	89.6	89.7	91.4	88.9	92.0	86.4	80.8	95.8
Cefixime	10.4	27.2	8.6	24.4	20.0	36.4	7.7	29.2

Stockouts

Compared to 2022, stockouts of STI commodities in the public sector worsened in 2025 (see Table 9). Only for amoxicillin and acyclovir were fewer stockouts recorded (from 16.2% to 6.1%, and from 33.3% to 18.0%, respectively). The stockouts of amoxicillin lasted much longer in 2025 (170 days) compared to 2022 (47 days). Many of the commodities were stocked out at about 20% of facilities, with these stockouts ranging from 39 to 49 days on average. Benzathine benzylpenicillin and cefixime experienced the most stockouts, at about 50% of public facilities. In the private sector stockouts also increased, with most commodities experienced stockouts at around 15% of facilities. Acyclovir and cefixime were stocked out at about 25% of facilities. In the faith-based sector, stockouts worsened only for benzathine benzylpenicillin, acyclovir and cefixime.

Table 9. Stockouts of STI treatment commodities at health facilities and average number of stockout days per stockout in 2022 and 2025, per sector

	Public						Private						Faith-based					
	HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Metronidazole	74.0	87.0	12.2	27.6	70.0	40.0	16.0	16.0	6.3	0.0	60.0	0.0	18.0	20.0	5.6	5.0	1.0	6.0
Clotrimazole	58.0	78.0	10.3	19.2	146.0	43.0	13.0	12.0	0.0	8.3	0.0	4.0	16.0	15.0	6.3	0.0	25.0	0.0
Benzathine benzylpenicillin	36.0	34.0	11.1	50.0	45.0	139.0	13.0	13.0	0.0	15.4	0.0	46.0	14.0	14.0	7.1	14.3	12.0	8.0
Amoxicillin	68.0	82.0	16.2	6.1	47.0	170.0	13.0	17.0	7.7	5.9	32.0	14.0	18.0	15.0	11.1	0.0	70.0	0.0
Acyclovir	9.0	50.0	33.3	18.0	99.0	49.0	9.0	11.0	11.1	27.3	60.0	50.0	3.0	10.0	0.0	30.0	0.0	24.0
Azithromycin	58.0	74.0	15.5	21.6	78.0	39.0	12.0	16.0	0.0	12.5	0.0	16.0	17.0	16.0	11.8	6.3	23.0	12.0
Ceftriaxone	70.0	80.0	11.4	21.3	40.0	50.0	14.0	14.0	0.0	14.3	0.0	37.0	16.0	17.0	6.3	0.0	45.0	0.0
Doxycycline	73.0	86.0	8.2	19.8	100.0	47.0	16.0	16.0	0.0	12.5	0.0	17.0	18.0	20.0	11.1	5.0	53.0	10.0
Cefixime	8.0	37.0	25.0	51.4	100.0	74.0	4.0	8.0	0.0	25.0	0.0	38.0	2.0	8.0	0.0	12.5	0.0	3.0

HF: Health facility; ND: No data.

Affordability

Affordability of STI treatment commodities generally improved in 2025 (see Table 10). In the public and private sectors, only a treatment of acyclovir was unaffordable (1.23 days and 1.69 days, respectively). In the faith-based sector, next to acyclovir, a treatment of clotrimazole was also unaffordable (1.24 days).

Table 10. Affordability of STI treatment commodities in 2022 and 2025, per sector

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Metronidazole	1.69 days	0.44 days	0.91 days	0.55 days	0.52 days	0.40 days
Clotrimazole	0.18 days	0.34 days	0.21 days	0.38 days	0.11 days	1.24 days
Benzathine benzylpenicillin	0.25 days	0.27 days	0.52 days	0.39 days	0.59 days	0.38 days
Amoxicillin	2.64 days	0.21 days	1.80 days	0.28 days	0.47 days	0.28 days
Acyclovir	1.64 days	1.23 days	13.18 days	1.69 days	1.72 days	1.13 days
Azithromycin	0.94 days	0.40 days	0.85 days	0.67 days	0.70 days	0.51 days
Ceftriaxone	0.45 days	0.37 days	0.62 days	0.48 days	0.67 days	0.47 days
Doxycycline	0.90 days	0.20 days	1.55 days	0.28 days	0.40 days	0.27 days
Cefixime	0.20 days	0.21 days	0.14 days	0.30 days	0.39 days	0.16 days

HIV/AIDS

Unfortunately, Sub-Saharan Africa still faces the highest burden of HIV/AIDS globally. The condition, which is caused by a virus, is incurable to date. Luckily, highly effective antiretroviral therapies are on the market, which can minimise symptoms for an extensive time period, and can prevent pregnant women living with HIV from transmitting the disease to their children. With proper disease management and treatment, people living with HIV/AIDS are able to live a normal life.

Availability

Like in 2022, availability of HIV/AIDS commodities in 2025 was variable (see Table 11). In the public sector, availability increased with around 10% for PrEP, dolutegravir + lamivudine + tenofovir, atazanavir/ritonavir, and paediatric dolutegravir (10mg). While lopinavir/ritonavir was available in 33.3% of public facilities in 2022, in 2025 it was no longer available in any of the facilities. In the private sector, availability decreased for all but two HIV/AIDS commodities. With the exception of atazanavir/ritonavir, all commodities were available at only 14% or less of private facilities. Availability in the faith-based sector was also variable, with some of the commodities increasing in availability, such as PrEP, dolutegravir + lamivudine + tenofovir, nevirapine, and both formulations of dolutegravir, while others decreased or remained unavailable.

Table 11. Availability of HIV/AIDS commodities in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	20.8	27.9	23.7	33.3	12.0	9.1	19.2	25.0
Dolutegravir + lamivudine + tenofovir	60.4	66.9	74.2	83.3	24.0	13.6	46.2	54.2
Tenofovir + lamivudine	4.2	1.5	5.4	1.1	0.0	4.5	3.8	0.0
Atazanavir/ritonavir	53.8	54.5	33.3	40.0	100.0	100.0	60.0	60.0
Darunavir/ritonavir	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lopinavir/ritonavir	53.8	0.0	33.3	0.0	50.0	0.0	80.0	0.0
Dolutegravir (50mg)	29.9	31.6	36.6	37.8	12.0	9.1	23.1	29.2
Paediatric dolutegravir (10mg)	25.0	32.4	29.0	41.1	12.0	4.5	23.1	25.0
Efavirenz	0.7	0.7	1.1	1.1	0.0	0.0	0.0	0.0
Nevirapine	41.7	42.6	53.8	55.6	20.0	9.1	19.2	25.0

^a Available from district hospital level and up

Stockouts

While stockouts of PrEP, dolutegravir + lamivudine + tenofovir and dolutegravir (50mg) remained low in the public sector, stockouts of tenofovir + lamivudine (40.0%), darunavir/ritonavir (100.0%) and lopinavir/ritonavir (100%) were especially concerning (see Table 12 on page 16). In the public sector, only a few health facilities had stock cards for the HIV/AIDS treatment commodities; they reported no stockouts. While not many faith-based facilities had stock cards either, they did report stockouts of PrEP (16.7% of facilities), dolutegravir 50mg (33.3%), tenofovir + lamivudine (100%) and lopinavir/ritonavir (100%).

Affordability

In both 2022 and 2025, all HIV/AIDS commodities were free to patients in all three sectors (see Table 13).

Table 13. Affordability of HIV/AIDS commodities in 2022 and 2025, per sector

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	0 days	0 days	0 days	0 days	0 days	0 days
Dolutegravir + lamivudine + tenofovir	0 days	0 days	0 days	0 days	0 days	0 days
Atazanavir/ritonavir	0 days	0 days	0 days	0 days	0 days	0 days
Dolutegravir (50mg)	0 days	0 days	0 days	0 days	0 days	0 days
Paediatric dolutegravir (10mg)	0 days	0 days	0 days	0 days	0 days	0 days
Efavirenz	0 days	0 days	-	-	-	-
Nevirapine	0 days	0 days	0 days	0 days	0 days	0 days

No 2025 price data for tenofovir + lamivudine, darunavir/ritonavir and lopinavir/ritonavir across all sectors.

Table 12. Stockouts of HIV/AIDS commodities at health facilities and average number of stockout days per stockout in 2022 and 2025, per sector

	Public						Private						Faith-based					
	HF with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HF with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HF with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)	
PrEP (emtricitabine + tenofovir)	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
	19.0	31.0	5.3	3.2	59.0	35.0	3.0	2.0	0.0	0.0	0.0	0.0	3.0	6.0	0.0	16.7	0.0	28.0
Dolutegravir + lamivudine + tenofovir	54.0	71.0	5.6	0.0	22.0	0.0	6.0	3.0	0.0	0.0	0.0	0.0	8.0	9.0	0.0	0.0	0.0	0.0
Tenofovir + lamivudine	2.0	5.0	0.0	40.0	0.0	41.0	0.0	1.0	ND	0.0	ND	0.0	2.0	2.0	0.0	100.0	0.0	24.0
Atazanavir/ritonavir	8.0	12.0	0.0	25.0	0.0	54.0	3.0	1.0	0.0	0.0	0.0	0.0	4.0	3.0	0.0	0.0	0.0	0.0
Darunavir/ritonavir	1.0	2.0	100.0	100.0	12.0	75.0	0.0	0.0	ND	ND	ND	ND	1.0	0.0	0.0	ND	0.0	ND
Lopinavir/ritonavir	19.0	5.0	5.3	100.0	365.0	67.0	1.0	0.0	0.0	ND	0.0	ND	4.0	1.0	0.0	100.0	0.0	35.0
Dolutegravir (50mg)	29.0	33.0	3.4	6.1	89.0	52.0	3.0	2.0	0.0	0.0	0.0	0.0	5.0	6.0	0.0	33.3	0.0	30.0
Paediatric dolutegravir (10mg)	22.0	38.0	4.5	18.4	8.0	73.0	3.0	1.0	0.0	0.0	0.0	0.0	5.0	4.0	0.0	0.0	0.0	0.0
Nevirapine	38.0	54.0	18.4	13.0	107.0	32.0	5.0	2.0	0.0	0.0	0.0	0.0	3.0	4.0	0.0	0.0	0.0	0.0

HF: Health facility; ND: No data.
No 2025 stock data for efavirenz across all sectors.

TESTS AND KITS

Access to appropriate menstrual hygiene commodities enables women and girls to continue their daily life activities undisturbed during their menstruation, for example to go to work and school, and therefore can contribute to higher school attendance or participation in class (McMahon et al. 2011; Miirio et al. 2018;). Pregnancy tests and HIV self-tests enable people to know about their health status and, in line with that, receive the appropriate care or treatment for their condition.

Availability

Compared to 2022, the overall availability tests and kits decreased in 2025 (see Table 14). Only pregnancy tests increased noticeably, from 26.4% in 2022 to 59.1% in 2025. Similarly, in the public sector the availability of pregnancy tests increased by 40%, while the safe delivery kit, HIV self-test and HPV test decreased in availability by around 5% to 8% in 2025. In both the private and faith-based sector, the pregnancy test was available in around half of the facilities, with the other tests/kits having a low availability, particularly in the private sector.

Table 14. Availability of tests and kits in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Pregnancy test	26.4	59.1	22.6	62.2	36.0	54.5	30.8	54.2
Safe delivery kit	23.6	21.3	33.3	28.9	8.0	0.0	3.8	12.5
HIV self-test	45.1	43.4	55.9	50.0	24.0	9.1	26.9	50.0
HPV test	19.4	15.4	28.0	20.0	4.0	4.5	3.8	8.3

Stockouts

Stockouts of the tests and kits were variable across the sector (see Table 15 on page 18). While pregnancy tests did not experience stockouts in the private sector, in both the public and faith-based sectors, about 15% of facilities did. Stockouts of these tests lasted longer in the public sector (65 days) than in the faith-based sector (27 days). There was a noticeable increase in stockouts of HPV tests in the public sector, increasing to 26.1%. Stockouts of this test also remained common in the faith-based sector, where 75.0% of facilities experienced such a stockout.

Affordability

Price data was only available for the pregnancy test (see Table 16). In the public sector, this test cost 1.13 days of the international poverty line, making it unaffordable. In the faith-based sector, it cost 0.27 days.

Table 16. Affordability of tests and kits in 2022 and 2025, per sector

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Pregnancy test	0 days	1.13 days	0.20 days	-	2.94 days	0.27 days

Table 15. Stockouts of tests and kits at health facilities and average number of stockout days per stockout in 2022 and 2025, per sector

	Public						Private						Faith-based					
	HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)		HFs with stock cards 2022/2025 (#)		HFs with stockouts (%)		Average # of stockout days (#)	
Pregnancy test	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
	26.0	50.0	30.8	16.0	54.0	65.0	6.0	11.0	0.0	0.0	0.0	0.0	5.0	13.0	0.0	15.4	0.0	27.0
Safe delivery kit	28.0	15.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	ND	0.0	ND	0.0	2.0	ND	0.0	ND	0.0
HIV self-test	49.0	39.0	6.1	17.9	21.0	29.0	6.0	4.0	0.0	50.0	0.0	35.0	3.0	10.0	33.3	10.0	53.0	14.0
HPV test	19.0	23.0	5.3	26.1	31.0	28.0	1.0	1.0	0.0	0.0	0.0	0.0	1.0	4.0	100.0	75.0	56.0	6.0

HF: Health facility; ND: No data.

4. RECOMMENDATIONS

Improve Availability of SRH Commodities

- Strengthen national procurement systems to ensure a consistent supply of essential SRH commodities, particularly for family planning, maternal health medicines, STI treatments, and diagnostic tests.
- Expand the range of contraceptive methods (method mix) available in health facilities, including implants, intrauterine devices (IUDs), and emergency contraception.
- Increase distribution of HIV prevention and treatment commodities, including PrEP and antiretroviral medicines, especially in private and faith-based facilities where availability remains limited.
- Improve availability of diagnostic tests and screening tools, such as pregnancy tests, HPV tests, and HIV self-tests, to support early diagnosis and treatment.
- Strengthen partnerships with private and faith-based health facilities to ensure they offer adequate supplies of SRH commodities.
- Expand community-based distribution and outreach services to ensure SRH commodities reach underserved and rural populations of young people.

Improve Affordability of SRH Commodities

- Expand government subsidies and financing mechanisms to reduce out-of-pocket payments for essential SRH medicines and diagnostic services.
- Integrate essential SRH commodities into national health insurance schemes, including the Community Health Fund and other social health protection programs.
- Implement price regulation or guidance for key SRH medicines in private and faith-based health facilities to prevent excessive pricing.
- Increase government investment in public procurement of essential SRH medicines, particularly maternal health medicines, such as magnesium sulphate and methyldopa, which were found to be unaffordable in some sectors.
- Ensure essential diagnostic services, including pregnancy tests and cervical cancer screening, are affordable or free for vulnerable populations.
- Tax Holidays and exemptions considerations for investors in the production of pharmaceutical products that will lead to the low prices of the essential SRHR Services.
- Increasing domestic health financing to cover all SRH commodities.

Address Stockouts of SRH Commodities

- Strengthen national and regional supply chain management systems, including forecasting, procurement planning, and distribution & redistribution of SRH commodities.
- Improve facility-level stock monitoring systems to enable timely identification and reporting of commodity shortages.
- Introduce digital logistics management information systems to track commodity availability and trigger early warning alerts for stockouts.
- Provide training for health facility staff on inventory management and commodity forecasting to minimise stock management errors.
- Establish buffer stock mechanisms for critical SRH commodities to reduce the impact of supply disruptions.
- Modernise Health Data management to support the forecast and budgeting.

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ANNEX 1

	Commodity	Use
FAMILY PLANNING		
1	Ethinylestradiol + levonorgestrel	Birth control pill; contraceptive
2	Ethinylestradiol + norethisterone	Birth control pill; contraceptive
3	Levonorgestrel (30 mcg)	Birth control pill; contraceptive
4	Levonorgestrel (1.5 mg)	Emergency contraceptive
5	Medroxyprogesterone acetate	Injectable contraceptive
6	Implants: levonorgestrel	Long-acting contraceptive
7	Implants: etonogestrel	Long-acting contraceptive
8	Copper-containing IUD	Long-acting contraceptive
9	Levonorgestrel-releasing IUD	Long-acting contraceptive
10	Male condoms	Contraceptive; STI protection
11	Female condoms	Contraceptive; STI protection
MATERNAL HEALTH		
12	Oxytocin	Prevention of post-partum haemorrhage
13	Misoprostol	Prevention of post-partum haemorrhage; induce labour; induce medical abortion
14	Carbetocin	Prevention of post-partum haemorrhage; induce labour
15	Tranexamic acid	Prevention of post-partum haemorrhage
16	(methyl)ergometrine	Prevention of post-partum haemorrhage
17	Mifepristone - misoprostol	Medical abortion
18	Magnesium sulphate	Treatment of pre-eclampsia and eclampsia
19	Calcium gluconate	Antidote for magnesium toxicity (used in combination with magnesium sulphate)
20	Ferrous salt	Supplement, prevent iron deficiency
21	Folic acid	Supplement, prevent folic acid deficiency
22	Ferrous salt + folic acid	Supplement, prevent iron and folic acid deficiency
23	Dexamethasone	Accelerating lung maturation in preterm babies
24	Methyldopa	Management of pregnancy-induced hypertension
SEXUALLY TRANSMITTED INFECTIONS		
25	Metronidazole	Antibiotic, STI treatment
26	Clotrimazole	Antifungal, STI treatment
27	Benzathine benzylpenicillin	Antibiotic, STI treatment
28	Amoxicillin	Antibiotic, STI treatment
29	Acyclovir	Antiviral, STI treatment
30	Azithromycin	Antibiotic, STI treatment
31	Ceftriaxone	Antibiotic, STI treatment
32	Doxycycline	Antibiotic, STI treatment
33	Cefixime	Antibiotic, STI treatment

HIV/AIDS		
34	Pre-Exposure Prophylaxis: (emtricitabine (FTC) + tenofovir (TDF))	Prevention of HIV infection
35	Dolutegravir + lamivudine + tenofovir (DTG + 3TC + TDF)	Antiretroviral, management of HIV/AIDS
36	Tenofovir + lamivudine (TDF + 3TC)	Antiretroviral, management of HIV/AIDS
37	Atazanavir/ritonavir (ATV/r)	Antiretroviral, management of HIV/AIDS
38	Darunavir/ritonavir (DRV/r)	Antiretroviral, management of HIV/AIDS
39	Lopinavir/ritonavir (LPV/r)	Antiretroviral, management of HIV/AIDS
40	Raltegravir (RAL)	Antiretroviral, management of HIV/AIDS
41	Dolutegravir (DTG)	Antiretroviral, management of HIV/AIDS
42	Paediatric dolutegravir (DTG)	Antiretroviral, management of HIV/AIDS
43	Efavirenz (EFV)	Antiretroviral, management of HIV/AIDS
44	Nevirapine	Antiretroviral, management of HIV/AIDS
PERSONAL HYGIENE & KITS		
45	Vasectomy services	Male sterilisation
46	Tubal ligation services	Female sterilisation
47	Pregnancy test	-
48	Safe delivery kit	-
49	HIV self-test	-
50	HPV DNA test	-

ANNEX 2

	Commodity	Treatment Regimen used to calculate affordability
FAMILY PLANNING		
1	Ethinylestradiol + levonorgestrel	1 strip
2	Ethinylestradiol + norethisterone	1 strip
3	Levonorgestrel (30 mcg)	1 strip
4	Levonorgestrel (1.5 mg)	1 tablet
5	Medroxyprogesterone acetate	1 injection
6	Implants: levonorgestrel	1 implant
7	Implants: etonogestrel	1 implant
8	Copper-containing IUD	1 IUD
9	Levonorgestrel-releasing IUD	1 IUD
10	Male condoms	1 condom
11	Female condoms	1 condom
MATERNAL HEALTH		
12	Oxytocin	1 vial
13	Misoprostol	5 tablets
14	Carbetocin	1 vial
15	Tranexamic acid	2 vials
16	(methyl)ergometrine	3 vials
17	Mifepristone - misoprostol	1 strip of 5 pills
18	Magnesium sulphate	9 vials
19	Calcium gluconate	1 vial
20	Ferrous salt	30 tablets
21	Folic acid	30 tablets
22	Ferrous salt + folic acid	30 tablets
23	Dexamethasone	3 vials
24	Methyldopa	6 tablets per day, 30 days
SEXUALLY TRANSMITTED INFECTIONS		
25	Metronidazole	2 tablets per day, 7 days
26	Clotrimazole	1 tablet
27	Benzathine benzylpenicillin	2 vials
28	Amoxicillin	3 tablets per day, 7 days
29	Acyclovir	3 tablets per day, 10 days
30	Azithromycin	1 tablet per day, 3 days
31	Ceftriaxone	1 vial
32	Doxycycline	2 tablets per day 7 days
33	Cefixime	1 tablet

HIV/AIDS		
34	Pre-Exposure Prophylaxis: (emtricitabine (FTC) + tenofovir (TDF))	30 tablets
35	Dolutegravir + lamivudine + tenofovir (DTG + 3TC + TDF)	30 tablets
36	Tenofovir + lamivudine (TDF + 3TC)	30 tablets
37	Atazanavir/ritonavir (ATV/r)	30 tablets
38	Darunavir/ritonavir (DRV/r)	30 tablets
39	Lopinavir/ritonavir (LPV/r)	4 tablets per day, 30 days
40	Raltegravir (RAL)	30 tablets
41	Dolutegravir (DTG)	30 tablets
42	Paediatric dolutegravir (DTG)	30 tablets
43	Efavirenz (EFV)	2 tablets per day, 30 days
44	Nevirapine	30 tablets
PERSONAL HYGIENE & KITS		
45	Pregnancy test	1 test
46	HIV self-test	1 test
47	HPV DNA test	1 test

