



# REPORT SEXUAL AND REPRODUCTIVE HEALTH **COMMODITIES:** AVAILABILITY, AFFORDABILITY AND STOCK-OUTS

Uganda 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.



**HAI**  
HEALTH ACTION  
INTERNATIONAL

# REPORT

# SEXUAL AND REPRODUCTIVE

# HEALTH **COMMODITIES:**

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## STOCK-OUTS

### Uganda 2018

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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 Organisation



# 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 contraceptive methods of their choice. They must be empowered to protect themselves from sexually transmitted infections and, when necessary, receive timely and affordable treatment. If 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 that 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 when weak infrastructure and gross inequality underpins impoverishment, improvements to access can still 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)<sup>1,2</sup>.

The objective of the survey is to generate reliable information on the price, availability and affordability of selected important commodities in the SRH supply chain, with the ultimate goal of improving access to affordable medicines for all. The methodology uses a cross-sectional design with quantitative methods and a semi-structured questionnaire adapted from the standardised HAI–WHO methodology, *Measuring Medicine 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] Uganda) in July 2018 in Uganda.

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

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

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 Uganda*. 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 collection took place in July 2018 after data collectors were trained in Uganda.

Data collectors visited facilities at 'health post' levels and above belonging to public, private and mission sectors in both urban and rural areas. The selection of provinces to survey was random to provide a representative picture for the country. The districts selected for data collection by region are listed in Table 1.

**Table 1:** Regions and districts surveyed.

Region	District
Western	Kabarole, Hoima
South Western	Mbarara, Kabale, Ntungamo
Eastern	Kumi, Mbale, Soroti, Kamuli, Manafwa
Northern	Lira, Kole
West Nile	Nebbi, Pakwach, Arua
Central	Mukono, Kayunga, Luwero

A total of 145 facilities were surveyed across public, private and mission sectors. The distribution of these facilities is outlined below.

**Table 2:** Distribution of surveyed facilities.

	Urban	Rural	Total (N)
<b>Public</b>	25	30	55
<b>Private</b>	26	18	44
<b>Mission</b>	20	26	46
<b>Total</b>	71	74	145

# RESULTS

**Overall mean availability of SRHCs was noted to be 37%, as shown in Table 3. Public sector facilities had the lowest availability of SRHCs (34%), while availability in private and mission sector facilities was similar at 39%.**

## 1. Overall Availability of SRHC

The public sector facilities registered a drop in availability of SRHCs, from 41% availability reported in the 2017 SRHCs survey to the 34% reported in this survey<sup>3</sup>. No major variation in the availability of SRHCs among urban and rural facilities within the sectors was found, as illustrated in Table 3 below. The widest variation in availability of SRHCs between urban and rural facilities was noted in the mission sector (35% versus 44%, respectively), while the smallest variation was noted in the public sector (34% versus 35%, respectively). Please refer to Annex 1 for overall availability of specific commodities.

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

	Overall (%)	Urban (%)	Rural (%)
<b>Public</b>	34	35	34
<b>Private</b>	39	37	41
<b>Mission</b>	39	44	35
<b>Total</b>	<b>37</b>	<b>39</b>	<b>37</b>

## 2. Availability of SRHC by Service

Overall, there were no marked differences in availability of commodities for urban and rural facilities. However, a few differences were noted; for example, availability of zinc tablets varied markedly between urban and rural facilities (58% and 83%, respectively, among private facilities compared to 40% and 62%, respectively, among mission facilities). In addition, combined availability of amoxicillin varied among urban and rural public facilities (28% and 13%, respectively). Details of availability of commodities by sector and urban–rural differences are presented in Annexes 2–5.

### 2.1. Availability of Contraceptive Commodities

Generally, private sector facilities had a higher availability of contraceptives than facilities in the public and mission sectors, as can be seen in Figure 1. Male condoms (86%), implants (77%), intrauterine contraceptive device (IUCD) (64%) and injectable contraceptives (64%) exhibited the highest availability among private sector facilities. The availability of the injectables and implants provided here are a combination measure. For instance, availability of injectables here means that either medroxyprogesterone acetate or norethisterone enanthate was available at the facility, while ‘implants’ measures the availability of the levonorgestrel or etonogestrel implant at the facility.

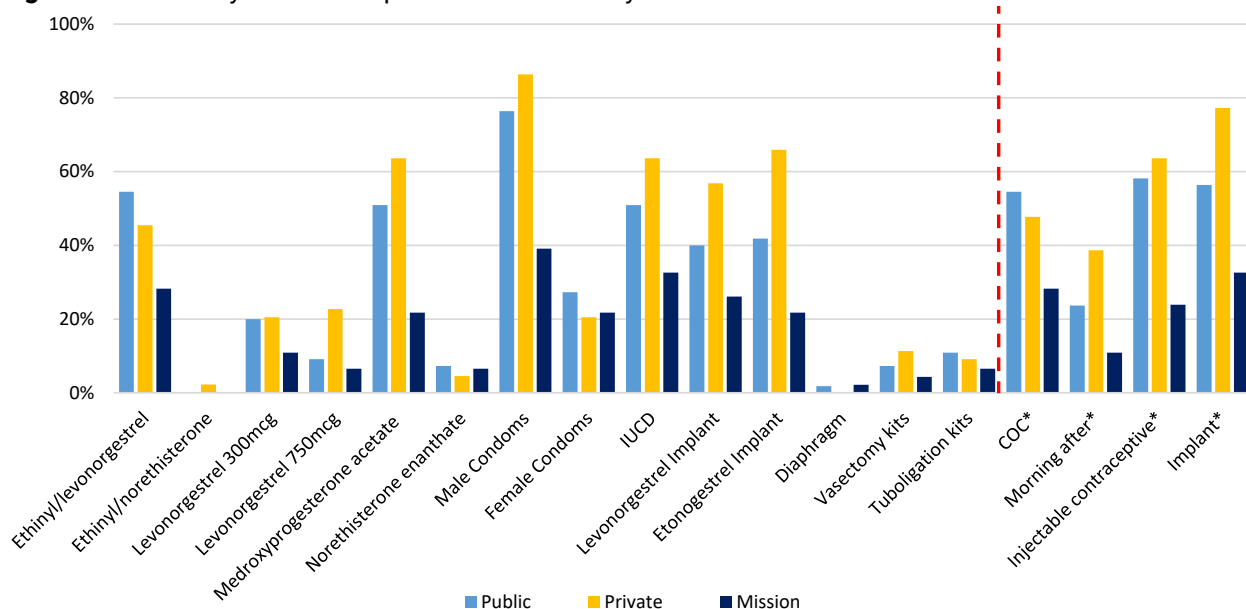
<sup>3</sup> Health Action International, *Measuring Prices, Availability and Affordability of Sexual and Reproductive Health Commodities in Uganda* (Amsterdam: 2017).



In the public sector, male condoms, injectables, IUCDs and implants also had the highest availability, as well as ethinyl/levonorgestrel, a birth control pill (55%). In the mission sector, availability for contraceptives was low, with highest availability found for male condoms (39%).

Contraceptives with the lowest availability included ethinyl/norethisterone (2% in the private sector, and 0% in public and mission sectors), diaphragms (0% in the private sector, and 2% in public and mission sectors) and norethisterone acetate (5% in private sector, and 7% in public and mission sectors).

**Figure 1: Availability of contraceptive commodities by sector.**



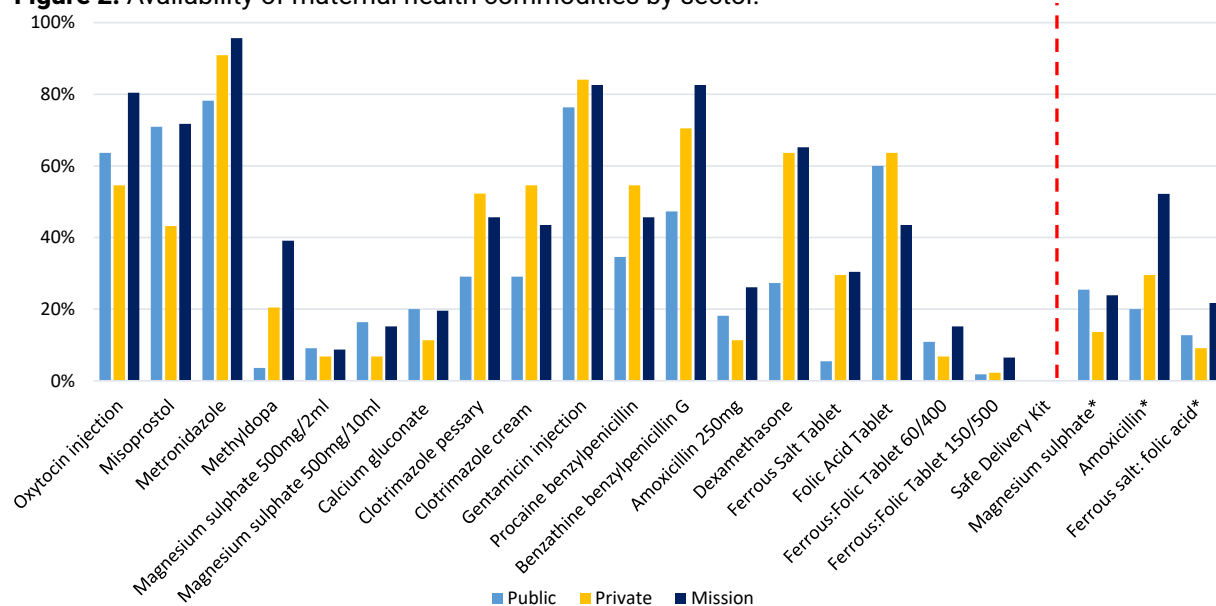
Combined Oral Contraceptives (COCs), known as the birth control pill, combines availability of ethinyl/levonorgestrel and/or ethinyl/norethisterone at the facility. Morning after pill combines availability of levonorgestrel 300mcg and/or 750mcg at the facility. Injectable contraceptive combines availability of medroxyprogesterone acetate and/or norethisterone enanthate at the facility

## 2.2. Availability of Maternal Health Commodities

Similar availability of maternal health commodities across the three sectors was found for a majority of the commodities, with the exception of oxytocin, misoprostol, methyldopa, clotrimazole pessary and cream, benzathine benzylpenicillin and dexamethasone injection (see Figure 2).

Oxytocin, used to induce labour in pregnancy, had highest availability in the mission sector (80%), while availability in the public and private sector was slightly lower (64% and 55%, respectively). Misoprostol, used to stop bleeding (post-partum

haemorrhage), had similar availability in the public and mission sectors (71% and 72%, respectively), while in the private sector it was noticeably lower (43%). In all three sectors, availability of metronidazole tablets and gentamicin injection, both used in the management of gynaecologic bacterial infections, was high; they were available at more than 75% of facilities. Folic acid and dexamethasone, used for prophylaxis of congenital abnormalities, like spina bifida, and for premature babies, experienced differences in availability across the sectors. Folic acid had a higher availability in the public and private sectors than in the mission sector (60% and 64%, respectively, versus 43%).

**Figure 2:** Availability of maternal health commodities by sector.

*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*

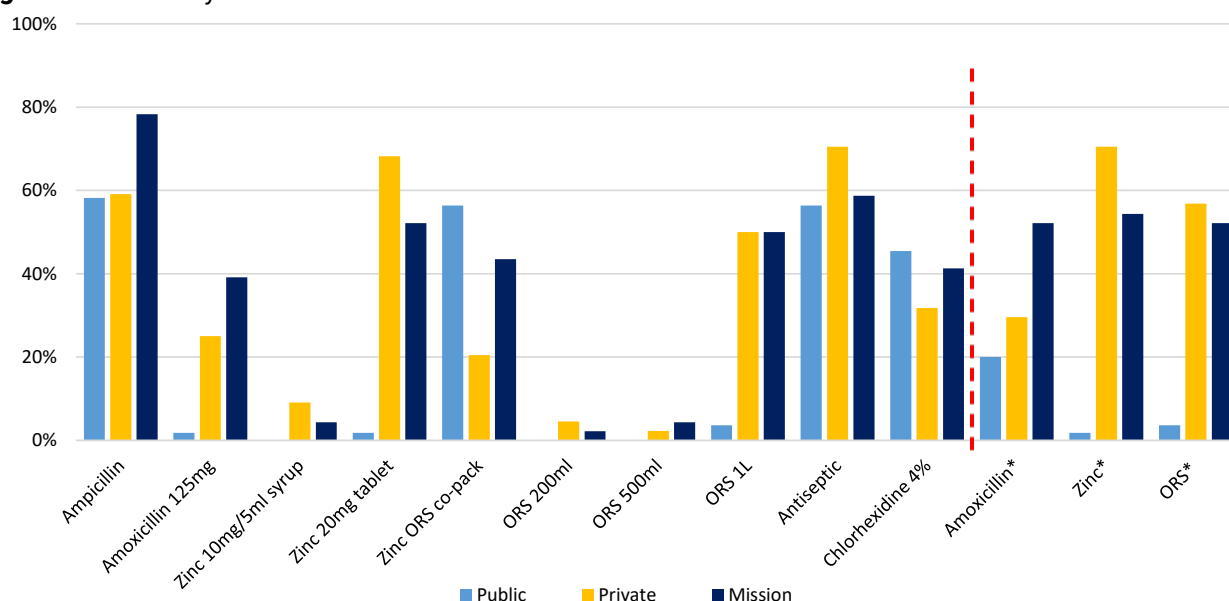
Dexamethasone had very low availability in the public sector (27%) and high availability in the private and mission sectors (64% and 65%, respectively).

It was observed that none of the facilities surveyed had safe delivery kits in stock. In fact, availability of safe delivery kits reduced exponentially from 58% in public, 19% in private, and 50% in mission facilities in the 2017 SRHC survey, to 0% across all sectors in the 2018 survey. Methyldopa, magnesium sulphate injection, amoxicillin, and calcium gluconate injection also had very low availability in the public sector (available at 25% or less of the surveyed facilities). These are key commodities used in the management of pre-eclampsia in

pregnant women. However, availability of these commodities was noted to have increased compared what was found during the 2017 survey cycle (below 18% overall).

### 2.3. Availability of Newborn and Child Health Commodities

Zinc and oral rehydration sachets (ORS), commodities used for the management of acute diarrhoea in children, had a critically low availability in public sector facilities (2% and 4%, respectively). However, zinc/ORS co-packs were available at 56% of public facilities, partly mitigating the low availability of the individual formulations. In addition, availability of paediatric amoxicillin (125 mg), used for management of acute pneumonia in children was also very low in the public sector (2%). Details are shown in Figure 3.

**Figure 3:** Availability of newborn and child health commodities.

*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*

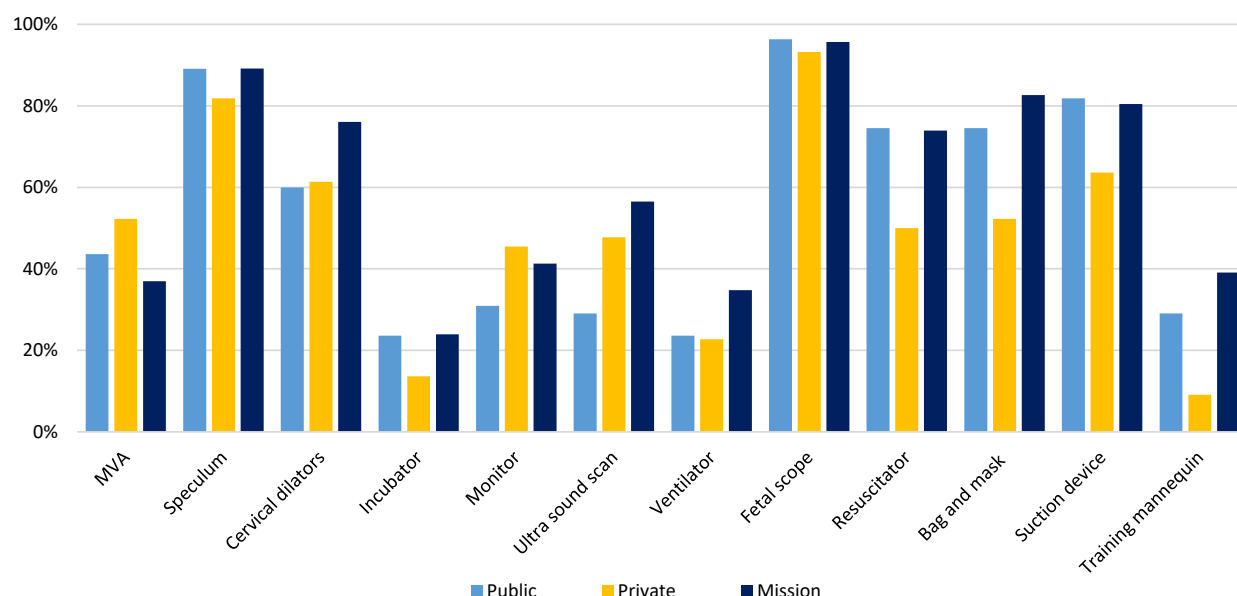
There were also some newborn and child health commodities with a higher availability in the public sector, which included ampicillin (58%) and antiseptic (56%) used for management and prophylaxis of neonatal sepsis, respectively. In private sector facilities, the commodities with the highest availability were zinc and antiseptic; both had a 70% availability. Mission sector facilities had highest availability for ampicillin (78%), and lowest availability for ORS 200ml (2%).

#### 2.4. Availability of SRH Instruments

Generally, SRH instruments exhibited higher availability compared to other categories of SRH commodities (see Figure 4). The foetal scope exhibited the highest availability across the three sectors (96% in public, 93% in private, and 96% in mission sector facilities). In the public, private and

mission facilities, incubators (24%, 14% and 24%, respectively), ventilators (24%, 23% and 25%, respectively) and training mannequins (29%, 9% and 39%, respectively) had the lowest availability.

Compared to the findings of the 2017 SRHC survey, fluctuating availability of SRH instruments can be observed. For instance, availability of cervical dilators increased to 60%, 64% and 76% among public, private and mission facilities, respectively, compared with the availability in 2017 (50% in public and private facilities, and 62% in mission facilities). Other instruments, such as the ultrasound scan, declined in availability from 2017 to 2018, from 42%, 58% and 60% among public, private and mission facilities, respectively, to 29%, 48% and 57% among public, private and mission facilities, respectively.

**Figure 4:** Availability of SRH instruments.

### 3. Stock-out Days

During this survey, it was noted that 120 facilities had stock cards for at least one SRH commodity; that is, 51 public, 24 private, and 45 mission facilities. 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.

On average, 17% of public facilities, 9% of private, and 4% of mission facilities had experienced a stock-out within a period of six months prior to

the survey date (details shown in Table 4). Private sector facilities had a lower average number of stock-out days per month of SRHCs (2) compared to public facilities (6). This could be attributed to supply chain constraints in the public facilities (for example, in the latter, commodities are delivered to the facility every two months). However, it is important to note that the average number of stock-out days per month greatly reduced in this survey compared to those of the 2017 survey (19, 17 and 20 in the public, private and mission facilities, respectively). This could be attributed to the aggressive efforts by the Ministry of Health and partners to increase availability of SRHCs in the recent past.

**Table 4:** Percentage of facilities reporting stock-outs in the six months prior to survey and the average number of stock-outs recorded per facility.

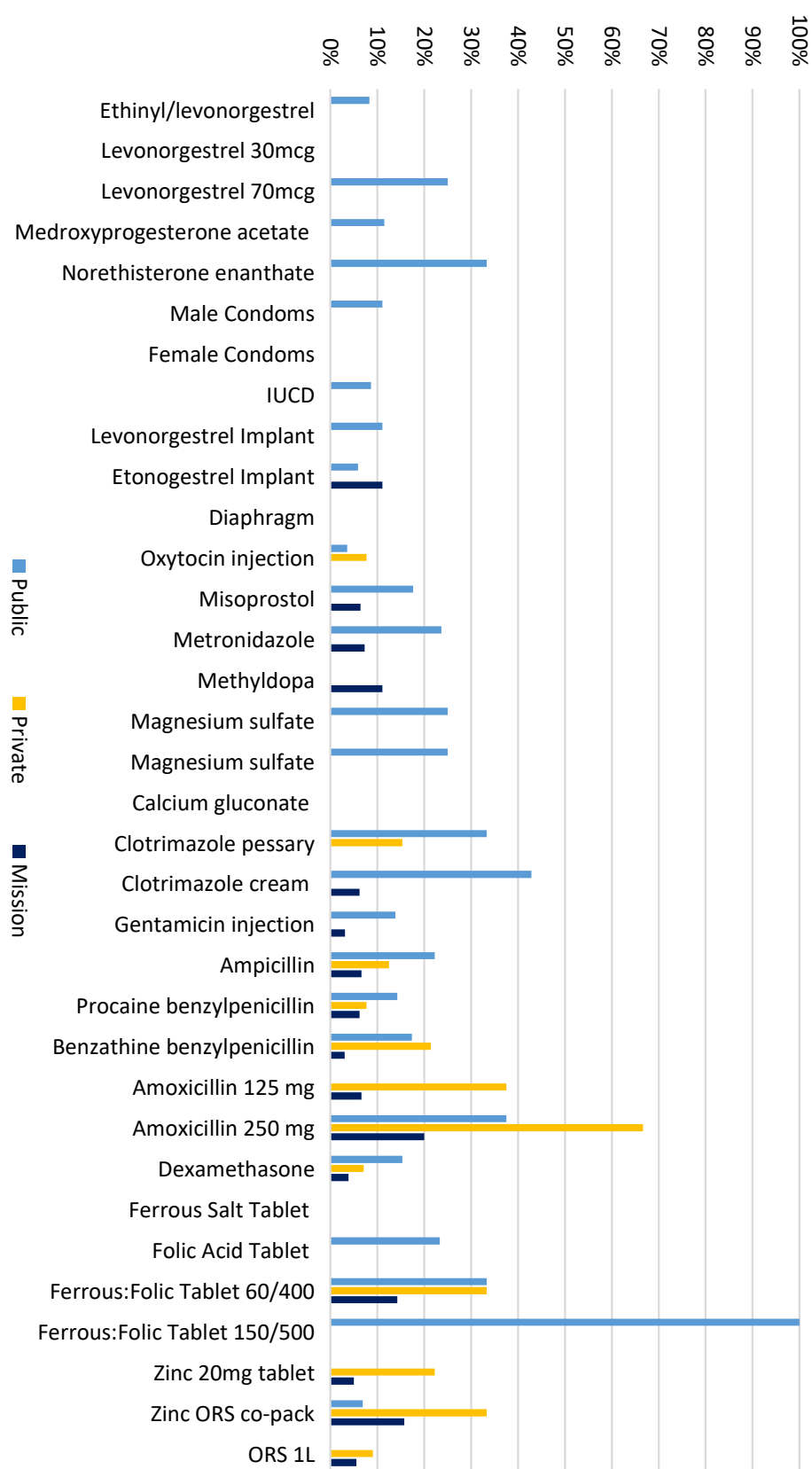
	Facilities reporting stock-outs (%)	Average number of stock-out days per month
<b>Public</b>	17	6
<b>Private</b>	9	2
<b>Mission</b>	4	3

Generally, the percentage of facilities with SRHC stock-outs was comparatively higher than those reported during the 2017 survey. Percentage of facilities experiencing SRHC stock-outs in the public sector ranged from 0% (8 commodities) to 100% (ferrous salt: folic acid tablets, 150/500). Stock-outs of SRHC in private sector facilities ranged from 0% (20 commodities) to 67% (amoxicillin 250 mg). Mission sector were noted to have the lowest SRHC stock-outs, ranging from 0% (21 commodities) to 20% (amoxicillin 250mg). Details are given in Figure 5, below.

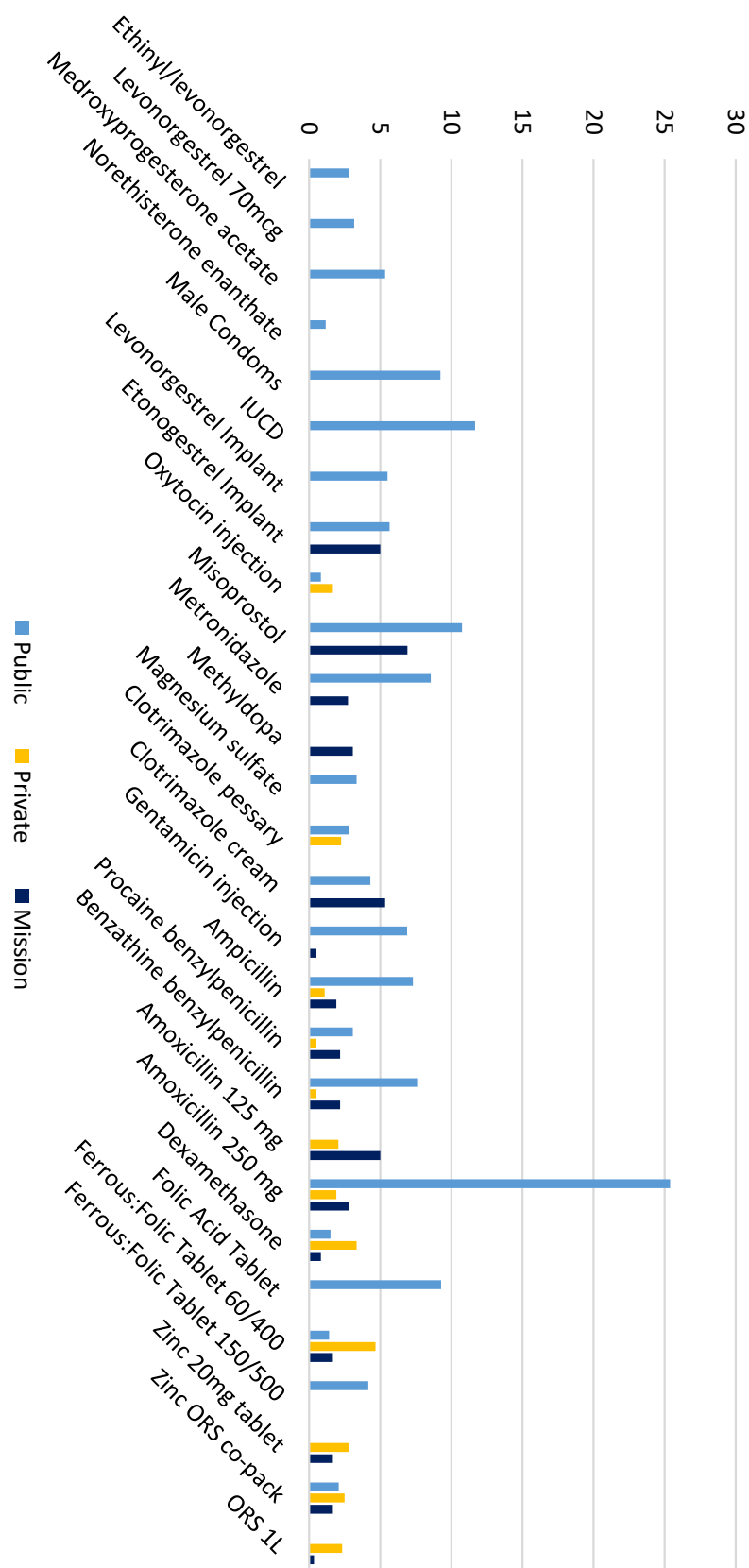
Amoxicillin 125mg and 250mg had the highest proportion of facility stock-outs in the private sector (38% and 67% respectively), while ferrous

salt:folic acid tablets 150/500mg exhibited the highest stock-outs in the public sector; stock-outs were experienced at 100% of facilities. There was an increase in proportion of facilities stocked out of amoxicillin compared to those noted during the 2017 survey (28% and 3% in the public and private sector facilities, respectively).

Amoxicillin 250mg also registered the highest average number of stock-out days per month in public sector facilities; they were stocked out 25 days per month. In addition, public sector facilities experienced a higher number of stock-out days per month compared to the private and mission sectors, as illustrated in Figure 6.

**Figure 5:** Percentage of facilities reporting stock-outs of selected SRH commodities.



**Figure 6:** Average number of stock-out days per month.

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

This section measured the pricing of commodities at facilities. SRHC not included in the analysis below are those which are not typically sold in facilities, such as equipment and devices (e.g., incubators and monitors). Prices displayed are for individual units of a commodity; a unit is the single most effective amount of a commodity that can be used (e.g., one

tablet, a strip of 28 contraceptive tablets, 1ml or 1 vial). Table 5 gives an overview of SRH commodity prices.

In the public sector, all SRHC were free to the patient, while in the private and mission sectors, patients had to pay. The mean prices for SRHC in the private sector ranged from UGX 56<sup>4</sup> (female condoms) to UGX 11,000 (magnesium sulphate 500mg/2ml). In the mission sector, prices ranged from UGX 0 (ORS 200ml and female condoms) to UGX 8333 (levonorgestrel 750mcg).

**Table 5:** SRHC mean, minimum and maximum unit prices in public, private and mission facilities.

Commodity	Public Sector			Private Sector			Mission Sector		
	Mean Unit Price	Min Unit Price	Max Unit Price	Mean Unit Price	Min Unit Price	Max Unit Price	Mean Unit Price	Min Unit Price	Max Unit Price
Ethinyl/levonorgestrel	0	0	0	817	0	2000	282	0	2000
Ethinyl/norethisterone	NA	NA	NA	2000	2000	2000	NA	NA	NA
Levonorgestrel 300mcg	0	0	0	1500	0	3000	333	0	1000
Levonorgestrel 750mcg	0	0	0	5900	0	15000	8333	5000	15000
Medroxyprogesterone acetate	0	0	0	2275	0	5000	1400	0	3000
Norethisterone enanthate	0	0	0	1000	0	2000	1333	0	2000
Male condoms	0	0	0	382	0	1000	56	0	500
Female condoms	0	0	0	56	0	500	0	0	0
IUCD	0	0	0	7218	0	30000	5467	0	25000
Levonorgestrel implant	0	0	0	5860	0	30000	2667	0	25000
Etonogestrel implant	0	0	0	7448	0	20000	1400	0	10000
Diaphragm	0	0	0	NA	NA	NA	5000	5000	5000
Oxytocin injection	0	0	0	2750	0	5000	1846	0	5000
Misoprostol	0	0	0	3432	0	10000	4515	0	50000
Metronidazole	0	0	0	97	20	200	81	0	200
Methyldopa	0	0	0	261	100	500	192	0	500
Magnesium sulphate 500mg/ 2ml	0	0	0	11000	4000	20000	3181	700	6025
Magnesium sulphate 500mg/10ml	0	0	0	4833	500	10000	2714	0	8000
Calcium gluconate	0	0	0	3480	200	10000	3722	0	16000
Clotrimazole pessary	0	0	0	782	0	1667	984	0	5000
Clotrimazole cream	0	0	0	3438	2000	9000	2435	0	5000
Gentamicin injection	0	0	0	2024	200	5000	1347	0	4000
Ampicillin	0	0	0	2173	100	5000	1550	0	4000
Procaine benzylpenicillin	0	0	0	2854	500	10000	1976	0	4000
Benzathine benzylpenicillin G	0	0	0	3329	200	10000	2608	0	5000
Amoxicillin 125mg	0	0	0	114	50	200	114	0	200
Amoxicillin 250mg	0	0	0	160	100	200	133	0	350
Dexamethasone	0	0	0	2868	800	6000	1598	0	5000

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

<sup>4</sup> Currency Converter, 2018 <<https://www.oanda.com/currency/converter/>> [accessed 18 July 2018]

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

Affordability of the commodities was measured by collecting the pricing information of commodities at the facilities, and then comparing this with the household final consumption expenditure (HHFCE) of different quintiles of the population, and with the daily salary of the lowest-paid government worker (LPGW) in 2018 (6,255 Ugandan Shillings [UGX]<sup>5</sup>). 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). Please refer to Annex 6 for the treatment regimens used. As per WHO guidelines, a commodity is considered affordable if it costs no more than a day's income.

In the public sector, affordability of SRHC was optimal since commodities are currently provided for free to the patient (see Annex 7). Affordability of SRHC in the private sector ranged from optimal (0 days of income) for female condoms in the highest earning 10% of the population, to

168.95 days of income for magnesium sulphate 500mg in 2ml for the 10% of the population earning the least (see Table 6). A total of eight SRH commodities in the private sector cost the LPGW more than one day of income. This number was higher compared to the five commodities that were reported in the 2017 SRHC survey. However, this could be explained by the fact that in the 2017 SRHC survey, no treatment regimens were used for tablet commodities and affordability was calculated per one tablet. For the 10% of the population earning the least, only 8 of the 37 commodities were considered affordable. The number of commodities increased to 13 in the 11–20% of the population earning the least, while in the 10% of the population earning the most, there were still six commodities that could be considered unaffordable.

In the mission sector, affordability ranged from optimal (0 days of income) for ORS 200ml and female condoms for all incomes, to 48.86 days of income for the 10% of the population earning the least for magnesium sulphate 500mg in 2ml (see Table 7). Seven commodities in the mission sector facilities cost more than one day of income for the LPGW. For the 10% of the population with the lowest income 29 commodities were considered unaffordable.

<sup>5</sup> Ministry of Public Service, *Circular standing Instruction No.5 of 2018 salary structure for financial year 2018/2019* (Kampala: 2018).

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

Number of day's income needed for treatment in the private sector								
	HHFCE per quintile							LPG worker
	Lowest 10%	11-20%	21-40%	41-60%	61-80%	81-90%	Highest 10%	
Ethinyl/levonorgestrel	0.70	0.44	0.33	0.24	0.17	0.11	0.05	0.13
Ethinyl/norethisterone	1.71	1.08	0.81	0.59	0.41	0.28	0.13	0.32
Levonorgestrel 300mcg	1.28	0.81	0.61	0.45	0.31	0.21	0.10	0.24
Levonorgestrel 750mcg	5.03	3.19	2.40	1.75	1.21	0.81	0.38	0.94
Medroxyprogesterone acetate	1.94	1.23	0.93	0.68	0.47	0.31	0.15	0.36
Norethisterone enanthate	0.85	0.54	0.41	0.30	0.21	0.14	0.06	0.16
Male Condoms	0.33	0.21	0.16	0.11	0.08	0.05	0.02	0.06
Female Condoms	0.05	0.03	0.02	0.02	0.01	0.01	0	0.01
IUCD	6.16	3.90	2.94	2.15	1.48	0.99	0.46	1.15
Levonorgestrel Implant	5.00	3.16	2.38	1.74	1.20	0.81	0.38	0.94
Etonogestrel Implant	6.36	4.02	3.03	2.21	1.53	1.03	0.48	1.19
Diaphragm	NA	NA	NA	NA	NA	NA	NA	NA
Oxytocin injection	2.35	1.48	1.12	0.82	0.56	0.38	0.18	0.44
Misoprostol	2.93	1.85	1.40	1.02	0.70	0.47	0.22	0.55
Metronidazole	2.49	1.58	1.19	0.87	0.60	0.40	0.19	0.47
Methyldopa	20.05	12.69	9.56	6.98	4.82	3.24	1.51	3.76
Magnesium sulphate 500mg/2ml	168.95	106.89	80.58	58.85	40.60	27.28	12.74	31.65
Magnesium sulphate 500mg/10ml	74.24	46.97	35.41	25.86	17.84	11.99	5.60	13.91
Calcium gluconate	2.97	1.88	1.42	1.03	0.71	0.48	0.22	0.56
Clotrimazole pessary	4.00	2.53	1.91	1.39	0.96	0.65	0.30	0.75
Clotrimazole cream	2.93	1.86	1.40	1.02	0.70	0.47	0.22	0.55
Gentamicin injection	17.27	10.93	8.24	6.02	4.15	2.79	1.30	3.24
Ampicillin	37.09	23.46	17.69	12.92	8.91	5.99	2.80	6.95
Procaine benzylpenicillin	24.35	15.41	11.62	8.48	5.85	3.93	1.84	4.56
Benzathine benzylpenicillin G	2.84	1.80	1.35	0.99	0.68	0.46	0.21	0.53
Amoxicillin 125mg	1.45	0.92	0.69	0.51	0.35	0.23	0.11	0.27
Amoxicillin 250mg	2.05	1.30	0.98	0.71	0.49	0.33	0.15	0.38
Dexamethasone	2.45	1.55	1.17	0.85	0.59	0.40	0.18	0.46
Ferrous Salt	2.30	1.46	1.10	0.80	0.55	0.37	0.17	0.43
Folic Acid	2.20	1.39	1.05	0.77	0.53	0.36	0.17	0.41
Ferrous salt: Folic Acid 60/400	1.28	0.81	0.61	0.45	0.31	0.21	0.10	0.24
Ferrous salt: Folic Acid 150/500	5.12	3.24	2.44	1.78	1.23	0.83	0.39	0.96
Zinc 10mg/5ml syrup	0.69	0.44	0.33	0.24	0.17	0.11	0.05	0.13
Zinc 20mg	1.55	0.98	0.74	0.54	0.37	0.25	0.12	0.29
Zinc ORS co-pack	1.57	1.00	0.75	0.55	0.38	0.25	0.12	0.29
ORS 200ml	0.43	0.27	0.20	0.15	0.10	0.07	0.03	0.08
ORS 500ml	0.85	0.54	0.41	0.30	0.21	0.14	0.06	0.16
ORS 1L	0.39	0.25	0.19	0.14	0.09	0.06	0.03	0.07

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

Number of day's 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	0.24	0.15	0.11	0.08	0.06	0.04	0.02	0.05
Ethinyl/norethisterone	NA	NA	NA	NA	NA	NA	NA	NA
Levonorgestrel 300mcg	0.28	0.18	0.14	0.10	0.07	0.05	0.02	0.05
Levonorgestrel 750mcg	7.11	4.50	3.39	2.48	1.71	1.15	0.54	1.33
Medroxyprogesterone acetate	1.19	0.76	0.57	0.42	0.29	0.19	0.09	0.22
Norethisterone enanthate	1.14	0.72	0.54	0.40	0.27	0.18	0.09	0.21
Male Condoms	0.05	0.03	0.02	0.02	0.01	0.01	0	0.01
Female Condoms	0	0	0	0	0	0	0	0
IUCD	4.66	2.95	2.22	1.62	1.12	0.75	0.35	0.87
Levonorgestrel Implant	2.28	1.44	1.09	0.79	0.55	0.37	0.17	0.43
Etonogestrel Implant	1.19	0.76	0.57	0.42	0.29	0.19	0.09	0.22
Diaphragm	4.27	2.70	2.03	1.49	1.03	0.69	0.32	0.80
Oxytocin injection	1.58	1.00	0.75	0.55	0.38	0.25	0.12	0.30
Misoprostol	3.85	2.44	1.84	1.34	0.93	0.62	0.29	0.72
Metronidazole	2.08	1.32	0.99	0.73	0.50	0.34	0.16	0.39
Methyldopa	14.72	9.31	7.02	5.13	3.54	2.38	1.11	2.76
Magnesium sulphate 500mg/2ml	48.86	30.91	23.30	17.02	11.74	7.89	3.69	9.15
Magnesium sulphate 500mg/10ml	41.69	26.38	19.88	14.52	10.02	6.73	3.14	7.81
Calcium gluconate	3.18	2.01	1.51	1.11	0.76	0.51	0.24	0.60
Clotrimazole pessary	5.04	3.19	2.40	1.76	1.21	0.81	0.38	0.94
Clotrimazole cream	2.08	1.31	0.99	0.72	0.50	0.34	0.16	0.39
Gentamicin injection	11.50	7.27	5.48	4.00	2.76	1.86	0.87	2.15
Ampicillin	26.45	16.74	12.62	9.21	6.36	4.27	2.00	4.96
Procaine benzylpenicillin	16.86	10.67	8.04	5.87	4.05	2.72	1.27	3.16
Benzathine benzylpenicillin G	2.23	1.41	1.06	0.78	0.53	0.36	0.17	0.42
Amoxicillin 125mg	1.46	0.92	0.70	0.51	0.35	0.24	0.11	0.27
Amoxicillin 250mg	1.71	1.08	0.81	0.59	0.41	0.28	0.13	0.32
Dexamethasone	1.36	0.86	0.65	0.48	0.33	0.22	0.10	0.26
Ferrous Salt	1.44	0.91	0.68	0.50	0.34	0.23	0.11	0.27
Folic Acid	1.22	0.77	0.58	0.43	0.29	0.20	0.09	0.23
Ferrous salt: Folic Acid 60/400	1.33	0.84	0.64	0.46	0.32	0.22	0.10	0.25
Ferrous salt: Folic Acid 150/500	1.71	1.08	0.81	0.59	0.41	0.28	0.13	0.32
Zinc 10mg/5ml syrup	0.21	0.13	0.10	0.07	0.05	0.03	0.02	0.04
Zinc 20mg	1.13	0.72	0.54	0.40	0.27	0.18	0.09	0.21
Zinc ORS co-pack	1.34	0.85	0.64	0.47	0.32	0.22	0.10	0.25
ORS 200ml	0	0	0	0	0	0	0	0
ORS 500ml	0.21	0.13	0.10	0.07	0.05	0.03	0.02	0.04
ORS 1L	0.36	0.23	0.17	0.13	0.09	0.06	0.03	0.07

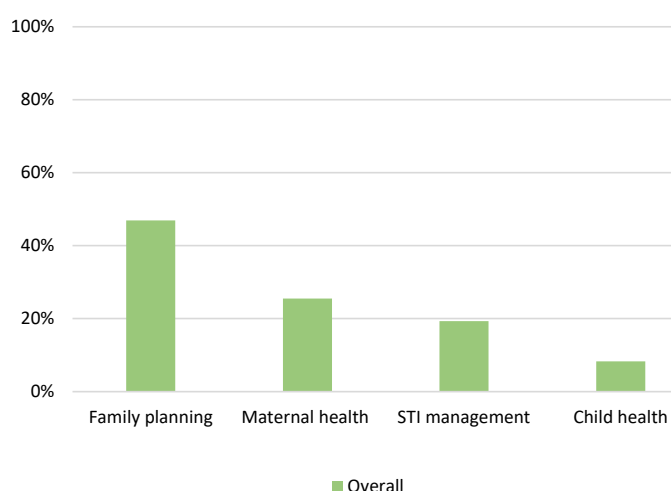
## 6. Stakeholder Interviews

The following section contains data analysed from Section B of the methodology, *SRHC: Measuring Prices, Availability and Affordability*. This section investigates access to SRHC from the perspective of the interviewed health provider. The respondents remained the same as those providing assistance in Part A of the survey (145 respondents). The response rate for the survey was 100%. Please refer to Annex 8 for a full breakdown of the qualitative aspects of access to SRHCs across the sectors.

### 6.1 Key Challenges to SRHC Access

Respondents were first asked which one of the four categories of SRH services outlined (family planning, maternal health, sexual transmitted infection management and child health) they believed faced the most challenges relating to access to SRHCs. Overall, 47% of the respondents indicated that family planning commodities faced the most challenges relating to access, followed by 26% of respondents who indicated maternal health commodities, while the lowest number of respondents indicated most challenges were faced with accessing child health commodities (8%). Details are shown in Figure 7.

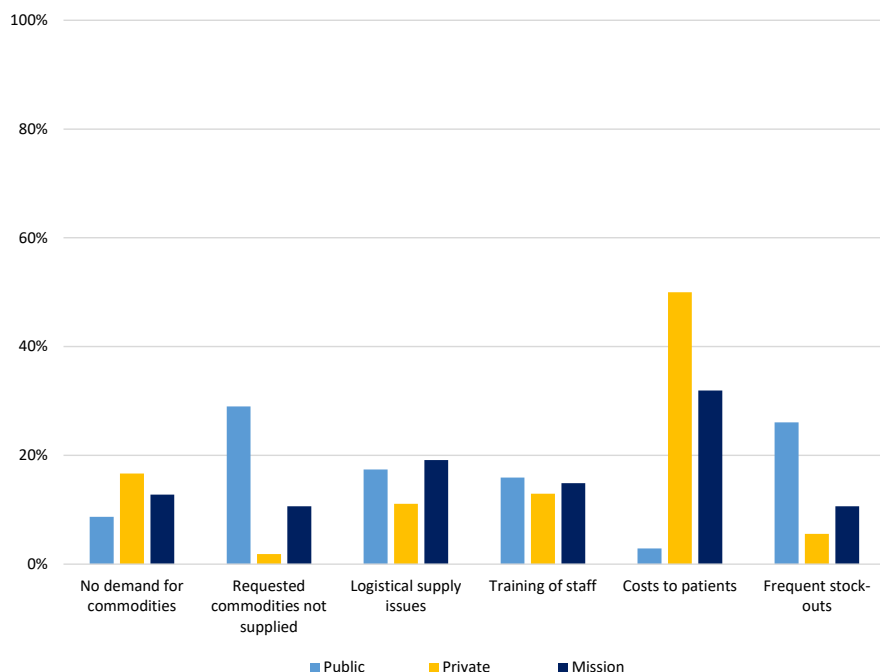
**Figure 7:** SRH services facing the most challenges related to access to commodities according to respondents.



Thereafter, based on the answer given to the above question, respondents were asked what they thought were the key challenges to SRHC access. They were provided with six options and given the opportunity to add further suggestions. Respondents could choose as many options as they thought applicable, and their choice of responses are summarised in Figure 8 below. For a breakdown of challenges per service, please refer to Annex 8.

The main challenge to accessing SRHCs in the private and mission sectors was the cost of medicines to patients (50% and 32%, respectively). In the public sector, there were two main challenges to access, ordered commodities were not being supplied (29%) and, consequently, there were frequent stock-outs (26%). Other issues highlighted as challenges to access to SRHCs that need to be addressed included training of staff, supply chain issues, and low demand for SRHCs (see Figure 8).



**Figure 8: Key challenges related to accessing SRHC.**

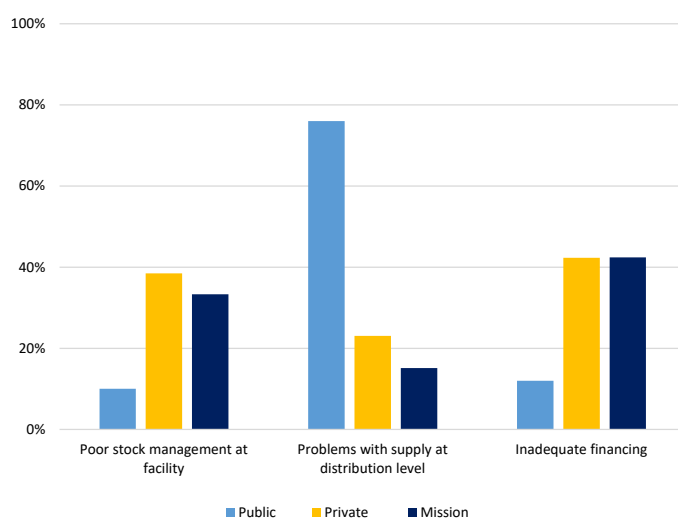
## 6.2 Reasons for Stock-outs of SRHCs at Facilities

Respondents were also asked about their opinion on the causes of SRHC stock-outs at their respective facilities. This question was asked only if stock cards were available at a given facility. In the public sector 76% of respondents highlighted the fact that commodities were not being supplied or being supplied in very limited quantities as the biggest reason contributing to stock-outs of SRHCs (see Figure 9).

On the other hand, inadequate financing (42%) and poor stock management at the facility (38%) were highlighted as being the largest contributors to SRHC stock-outs in private sector facilities. Mission sector facilities expressed the same major issues: Inadequate financing (42%) and poor stock management (33%).

## 6.3. Improving Access to SRHC

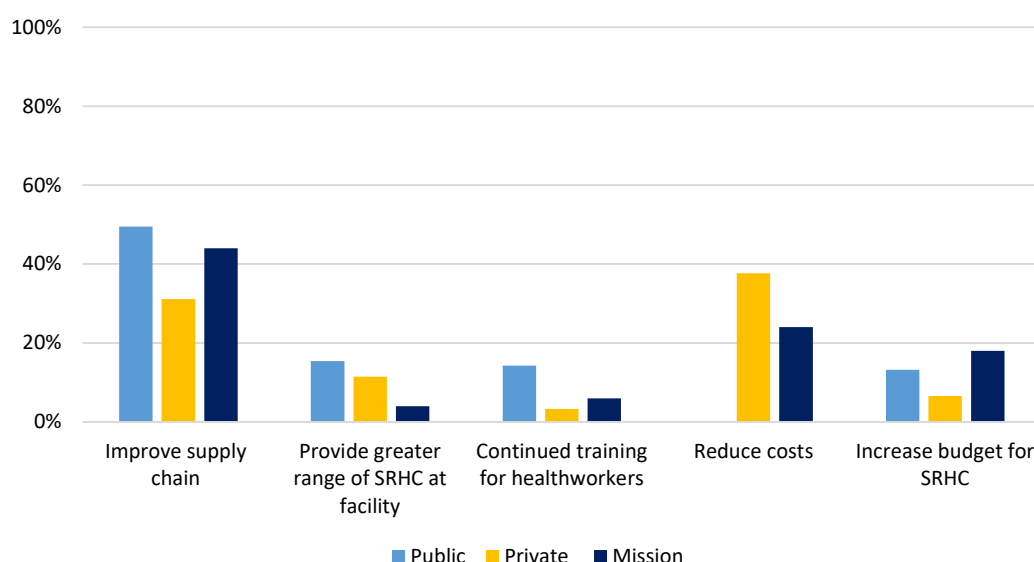
Respondents were also asked what they thought could be done to improve access to SRHC on the supply side. Responses differed across the

**Figure 9: Reasons for SRHC stock-outs at facilities.**

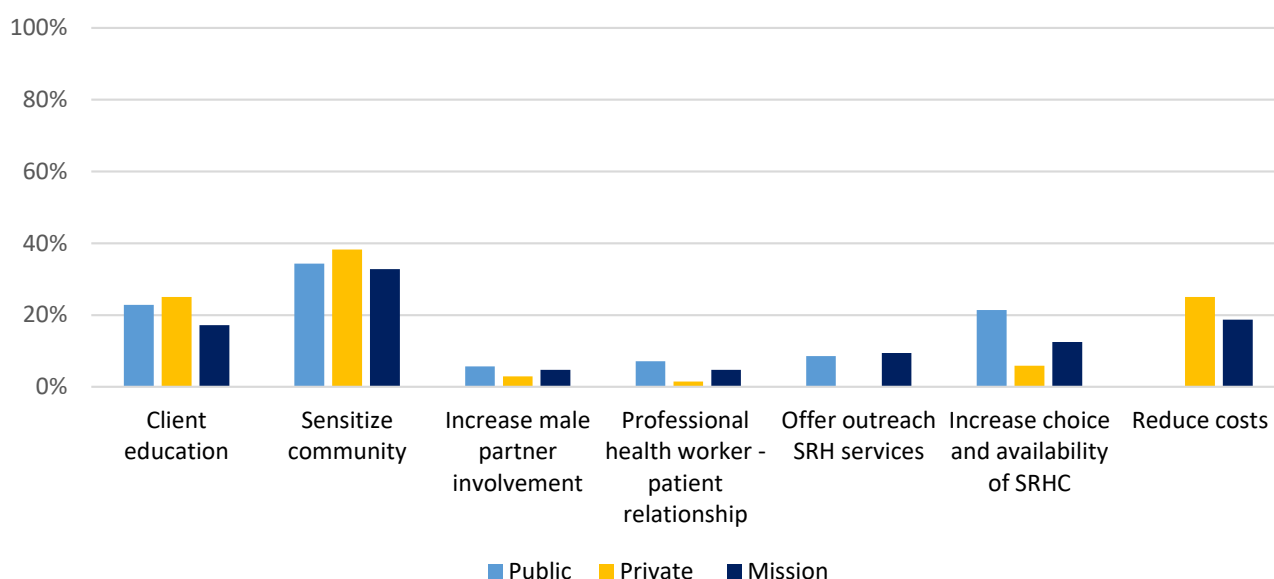
sectors, as shown in Figure 10. For instance, in the public (49%) and mission (44%) sectors, the highest ranking recommendation was to improve supply chain for SRHCs, specifically supplying commodities on time and according to what was ordered. The private sector's highest ranking recommendation, on the other hand, was to reduce the cost of SRHCs, or even, if possible, to provide the commodities for free (38%). Other recommendations raised included increasing the budgetary allocation for SRHCs, continued training of health workers and providing a greater range of SRHCs at the facilities.

Respondents were also asked what they thought could be done to improve access to SRHC on the demand side, and Figure 11 illustrates the summary of the main responses elicited. The most frequent responses were relatively comparable across sectors: Client education and sensitisation of communities about the range of services available (22% and 35%, respectively). In the public and mission sectors increasing the choice and availability of SRHCs was also commonly mentioned (21% and 13%, respectively), while in the private and mission sector, reducing the costs to patients was also thought to be important (25% and 19%, respectively).

**Figure 10:** Recommendations to improve access to SRHCs on the supply side.



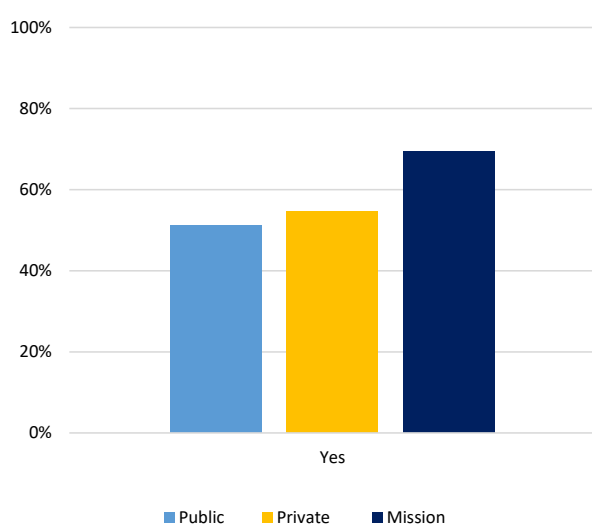
**Figure 11:** Recommendations to improve access to SRHCs on the demand side.



### 6.3 Reluctance of Clients to Access SRHCs

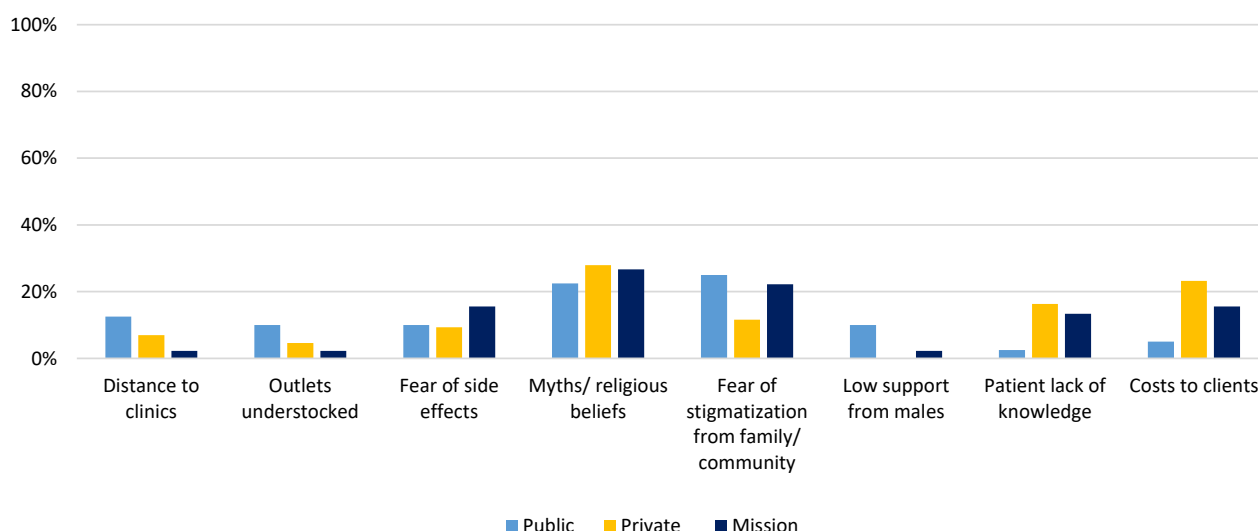
When respondents were asked about the reluctance of clients to access SRHCs, 70% of respondents from mission facilities believed clients to be reluctant to access SRHC services, followed by 55% of private sector respondents, and 51% of public sector respondents (Figure 12). The proportion of reluctance to accessing SRHCs noted during this study is lower than that reported during the 2017 SRHCs survey, where it was 80% overall. A possible contribution to the decrease could be because of the efforts by the Ministry of Health and partners to increase awareness about SRH issues in communities.

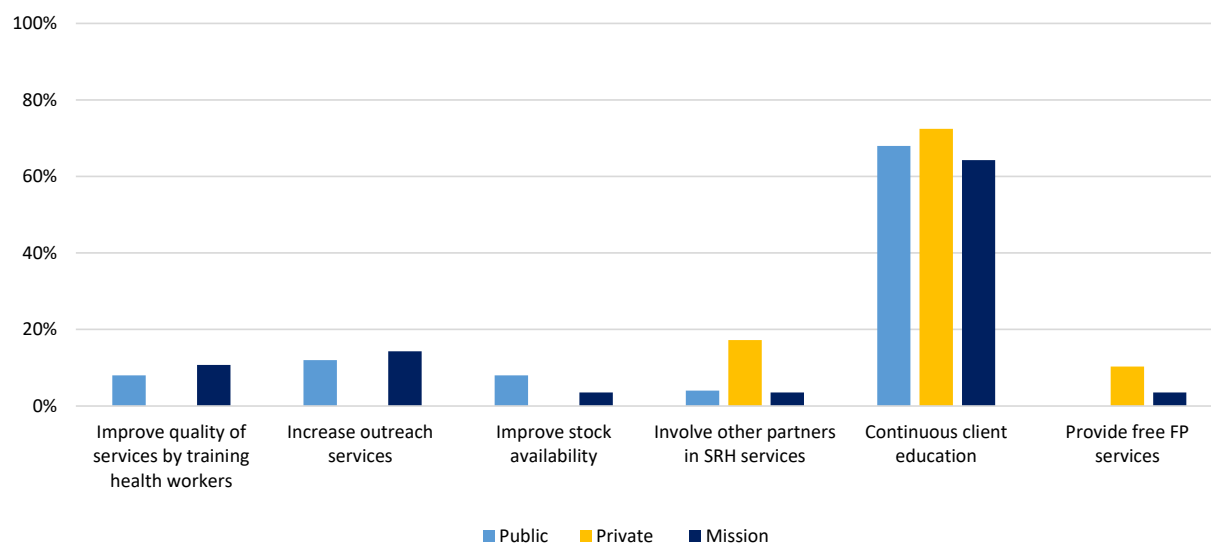
**Figure 12:** Clients' reluctance to access SRHCs.



Potential reasons for reluctance of clients to access SRHCs were proposed by the health workers. Myths, superstitions and religious beliefs was a commonly mentioned reason: 23% of respondents from the public sector, 28% from the private sector and 27% from the mission sector believed this was one of the reasons for client reluctance. In public and mission sectors, fear of stigmatisation by family and the community was also believed to contribute to the reluctance (25% and 22%, respectively). Patient lack of knowledge and costs to clients were thought to contribute to the reluctance by healthcare workers from the private and mission sectors, but not by public sector healthcare workers, as can be seen in Figure 13. When respondents were asked how client reluctance could be tackled, the majority believed that client education was the most important tool to use (see Figure 14).

**Figure 13:** Why clients are reluctant to access SRHC.



**Figure 14:** How to tackle client reluctance.

# DISCUSSION AND RECOMMENDATIONS

**This study is the second roll-out of a planned yearly survey as part of HAI's SRHC research under the Health Systems Advocacy (HSA) Partnership, and aims to create an overview of the current access to SRHC situation in Uganda.**

Overall availability of SRHCs was low (37%), with comparable findings across the public, private and mission sector facilities. This year's findings are consistent with the survey conducted in 2017, when overall availability was 39%<sup>6</sup>. Male condoms had the highest percentage availability among contraceptive commodities in the public sector (76%), which is lower than last year's availability (90%). Interestingly, this research showed that availability of contraceptives was generally higher in private sector facilities than in the other sectors, while last year, availability was generally higher in the public sector. The availability of an injectable contraceptive, which is the most commonly used contraceptive in Uganda<sup>7</sup>, also decreased compared to 2017, going from 86% availability to 58% availability in the public sector. The decrease in availability of contraceptives in the public sector should be noted; this sub-optimal availability has consequences for the unmet family planning needs of women in Uganda, and contributes to the high rate of unwanted pregnancies.

With regards to maternal health commodities, oxytocin, misoprostol, metronidazole tablets, gentamicin injection, and folic acid had the highest availability among public sector facilities. In the private and mission sectors, similar results were found. Oxytocin and misoprostol saw a marked increase in availability in the mission sector compared to the 2017 survey, both

increasing their availability by 17%.

Dexamethasone, which had a low availability in the 2017 survey, decreased further in the public sector, from 36% in 2017 to 27% in this year's research, while in the private and mission sectors, availability increased from 55% to 64%, and from 43% to 65%, respectively. Gentamicin, used to treat pneumonia and maternal and neonatal sepsis, had same availability as last year, ranging from 76% to 84%. None of the facilities surveyed had safe delivery kits in stock, while last year about half of facilities in the public and mission sectors had such a kit available.

Commodities for management of acute diarrhoea in children, such as zinc and ORS, had the lowest availability among the public sector facilities, while availability of paediatric amoxicillin (125 mg) was also low (2%). Interestingly, a combi-pack of zinc and ORS was available at 56% of public facilities. However, compared to last year's availability of this combi-pack, a 23% decrease in availability was observed.

Fluctuations the availability of instruments could be seen compared with last year, with some instruments increasing in availability (e.g., cervical dilators) while others decreased in availability (e.g., ultrasound scan).

<sup>6</sup> Health Action International, *Sexual & Reproductive Health Commodities: Measuring Prices, Availability and Affordability Data Collection Report–Uganda 2017* (Amsterdam: Health Action International, 2017), p. 1-35.

<sup>7</sup> United Nations, Department of Economic and Social Affairs, Population Division, *Trends in Contraceptive Use Worldwide 2015* (Geneva: United Nations, 2015), p. 1-63.

On average, 16.8% of public facilities, 8.6% of private, and 3.6% of mission facilities had experienced a stock-out within a period of six months prior to the survey date. Average stock-outs at facilities saw an increase compared to the 2017 survey. Amoxicillin 250mg had the highest average number of stock-out days per month in the public sector facilities (25 days). In addition, public sector facilities had higher number of stock-out days compared to the private and mission sectors. Stock-outs are still a common occurrence, and can have a significant impact on access to SHRC, especially for those commodities that are already experiencing low availability.

In the public sector, all SRHC commodities were free. However, in private and mission sectors, affordability was problematic, especially for the proportion of the population with lower incomes. The price of commodities far exceeded the one day of income that is used as a measure to determine the affordability of a commodity. Given that Uganda's LPGW earns the equivalent of USD 1.67 per day<sup>8</sup>, while in 2016, 27% of the population was living below the poverty line of USD 1.25<sup>9</sup>, in this survey we have also used the HHFCE per share of the population to calculate affordability. This measure was used because we are interested in knowing what people actually have available to spend, and it is believed that HHFCE is a better reflection of a household's resources than, for example, gross domestic product<sup>10</sup>. There is a significant discrepancy between the HHFCE of the population and the wage of a LPGW. One explanation for this is that the HHFCE has been calculated per capita, so even a baby will have a HHFCE, while the wage of a LPGW might be used to provide for an entire family. Note that the average family size in Uganda is 4.7 persons<sup>11</sup>.

The main service that the respondents identified as being most affected by access to SRHCs is family planning. The main challenge to accessing SRHCs in the private and mission sectors was the cost of medicines to patients (26% of responses). However, the public sector particularly experienced two challenges; that is, commodities ordered are not supplied or being supplied in insufficient quantities (26%), hence leading to frequent stock-outs. Inadequate financing and poor ordering and stock management were also highlighted as being main contributors to stock-outs of SRHCs in the private sector facilities. Client education and sensitisation of communities about the range of services available were the most recommended interventions to improve access to SRHCs from the demand side, while from the supply side, healthcare workers agreed that the supply chain should be optimised.

Based on the SRHC research, the following recommendations to improve access to SRH and SRHC are made:

1. The Ministry of Health and partners should consistently make deliberate efforts to educate clients and sensitise communities about SRH services and commodities.
2. The government of Uganda should actively seek out strategies to reduce the cost of high-cost SRHCs, such as magnesium sulphate, through, for instance, offering subsidies.
3. Strategies to improve the SRHC supply chain must be actively sought to ensure that commodities are delivered on time and in the quantities ordered.
4. Healthcare workers need to receive additional training on SRHCs, especially in the private and mission sector facilities.

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

<sup>9</sup> Uganda Bureau of Statistics, *Uganda National Household Survey 2016/17*, 2017

<[http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/UNHS\\_VI\\_2017\\_Version\\_I\\_%2027th\\_September\\_2017.pdf](http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/UNHS_VI_2017_Version_I_%2027th_September_2017.pdf)> [accessed 23 November 2017]

<sup>10</sup> 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.

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



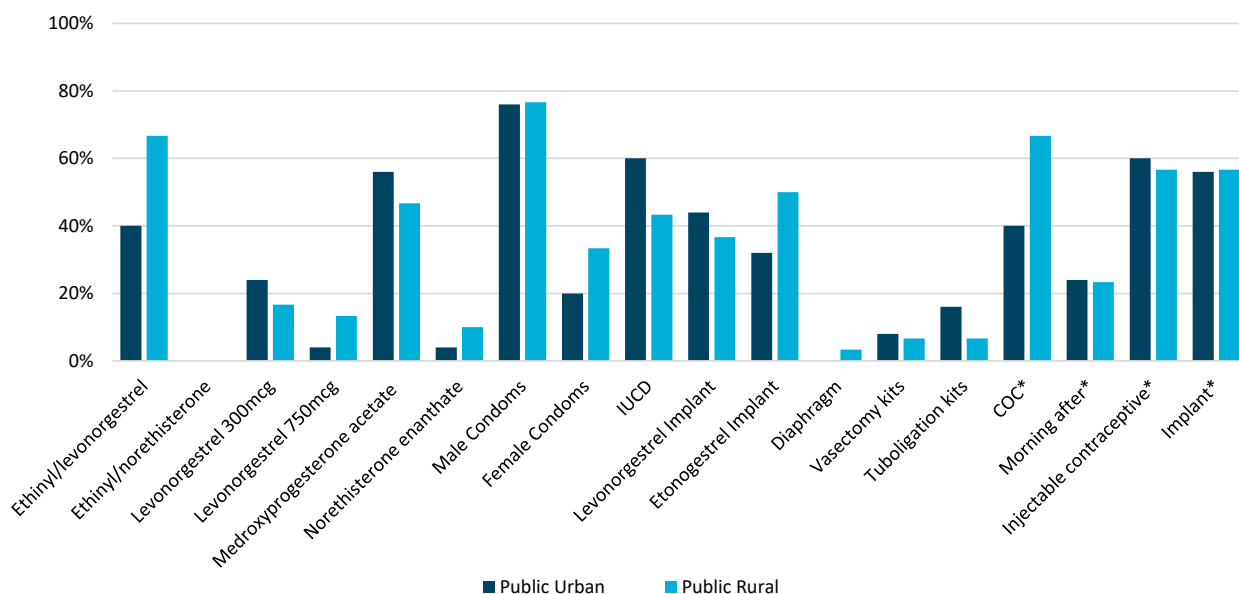
## Annex 1: List of Commodities Surveyed with Mean Availability

**Table 8:** Commodities surveyed and the overall mean availability in Uganda.

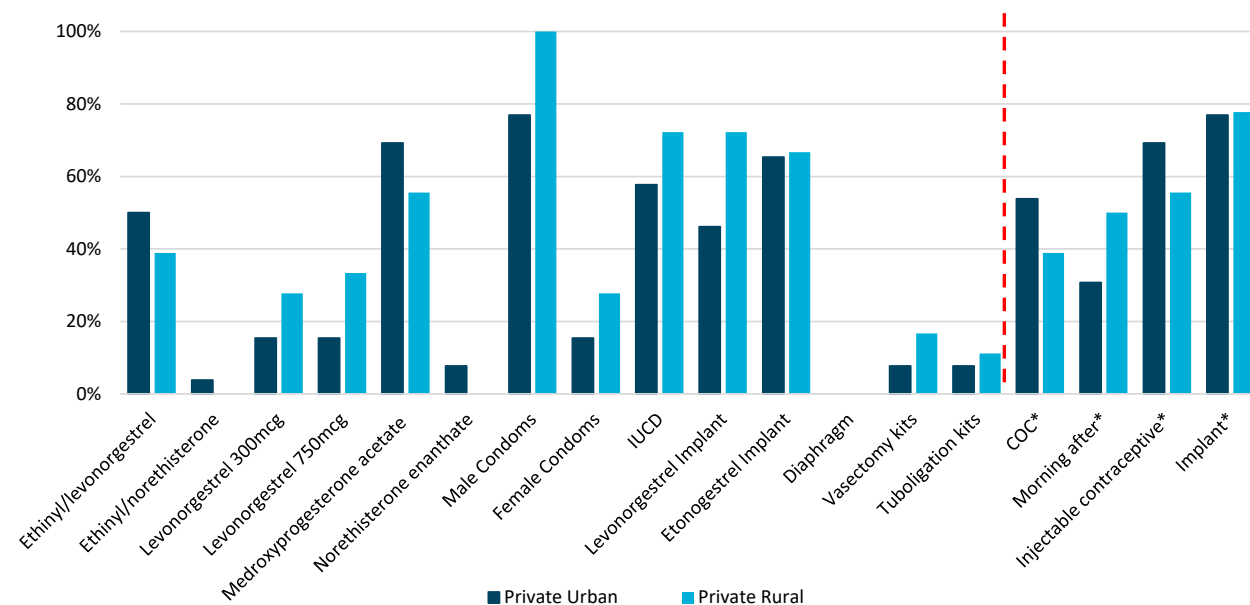
Commodity	Mean availability (%)	Classification
Foetal scope	95	Medicines that meet the WHO guideline of at least 80% availability
Metronidazole	88	
Speculum	87	
Gentamicin injection	81	
Suction device	76	Significant availability (66-79%)
Bag and mask (size 0)	70	
Male Condoms	68	
Resuscitator	67	
Oxytocin injection	66	
Benzathine benzylpenicillin G	66	
Cervical dilators	66	
Ampicillin	65	Moderate availability (51-65%)
Misoprostol	63	
Antiseptic (chlorhexidine/alcohol)	61	
Folic Acid Tablet	56	
Dexamethasone	50	Low availability (36-50%)
Intrauterine contraceptive device	49	
Medroxyprogesterone acetate	46	
Procaine benzylpenicillin	44	
MVA	44	
Ethinyl/levonorgestrel	43	
Etonogestrel Implant	43	
Ultra sound scan	43	
Levonorgestrel Implant	41	
Clotrimazole pessary	41	
Clotrimazole cream	41	
Zinc ORS co-pack	41	
Chlorhexidine 4%	40	
Monitor	39	
Zinc 20mg tablet	38	
ORS 1L	32	Seriously low availability (21-35%)
Ventilator	27	
Training mannequin for infant resuscitation	26	
Female Condoms	23	
Amoxicillin 125mg	21	
Ferrous Salt Tablet	21	
Incubator	21	
Methyl dopa	20	Critically low availability (20% or less)
Amoxicillin 250mg	19	
Levonorgestrel 300mcg	17	
Calcium gluconate	17	
Magnesium sulphate	13	
Levonorgestrel 750mcg	12	
Ferrous salt: Folic acid Tablet 60/400	11	
Tuboligation kit	9	
Magnesium sulphate	8	
Vasectomy kit	8	
Norethisterone enanthate	6	
Zinc 10mg/5ml syrup	4	
Ferrous salt: Folic acid Tablet 150/500	3	
ORS 200ml	2	
ORS 500ml	2	
Ethinyl/norethisterone	1	
Diaphragm	1	
Safe Delivery Kit	0	

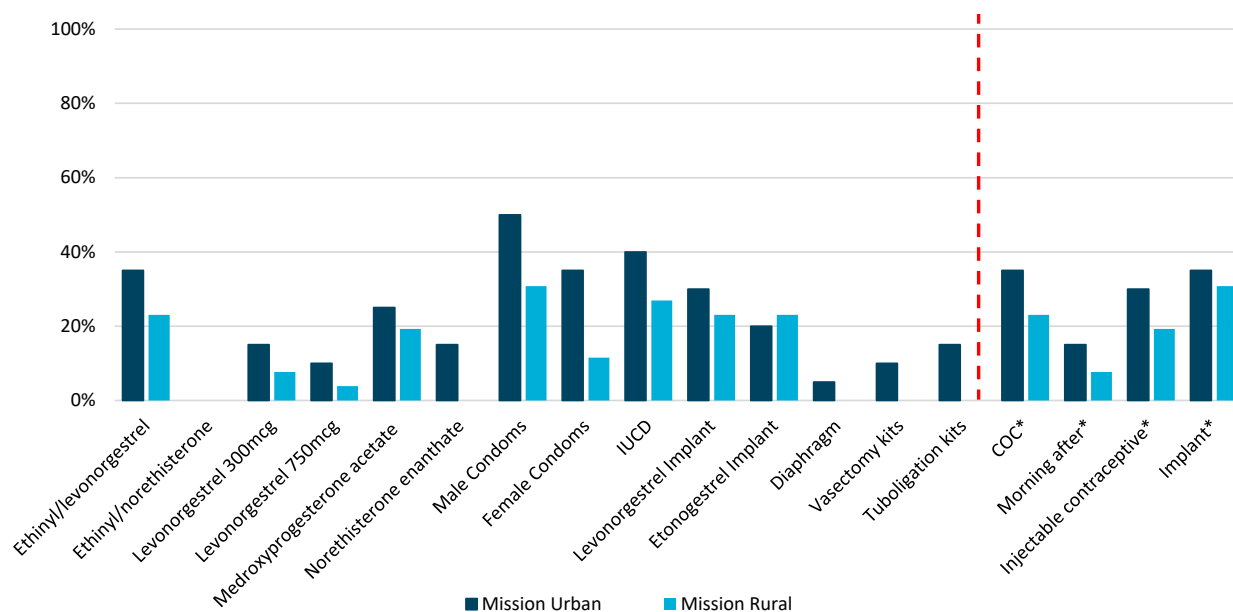
## Annex 2: Availability Of Contraceptives per Sector, by Urban And Rural Areas

**Figure 15:** Percentage availability of contraceptives in the public sector, by area.



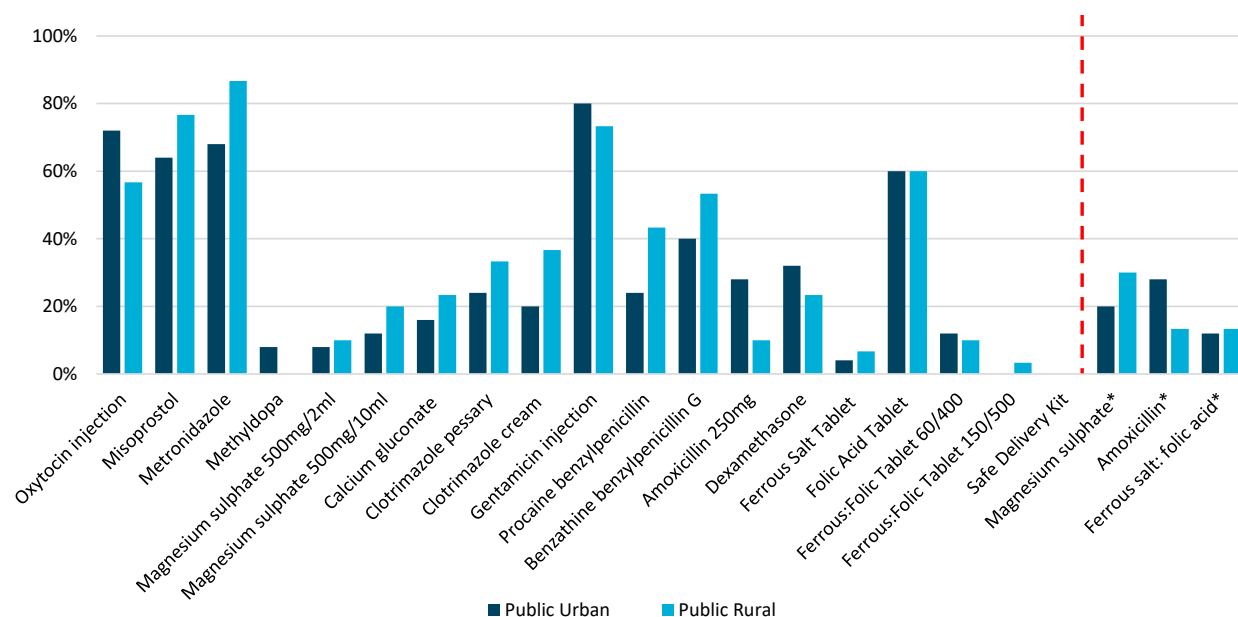
**Figure 16:** Percentage availability of contraceptives in the private sector, by area.



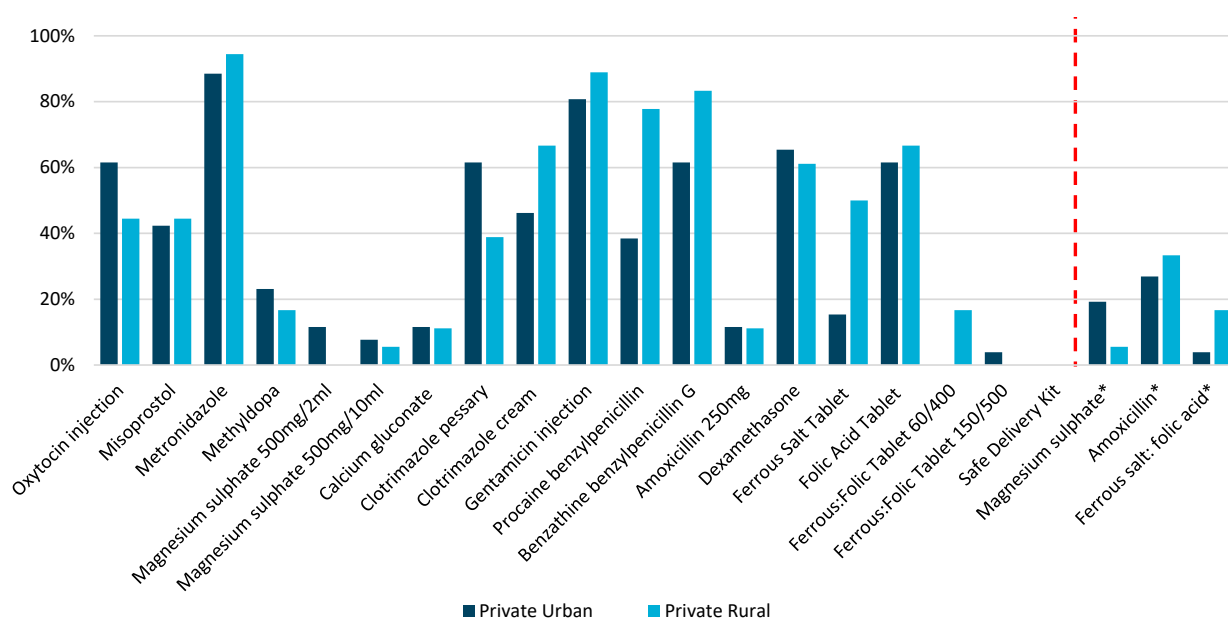
**Figure 17:** Percentage availability of contraceptives in the mission sector, by area.

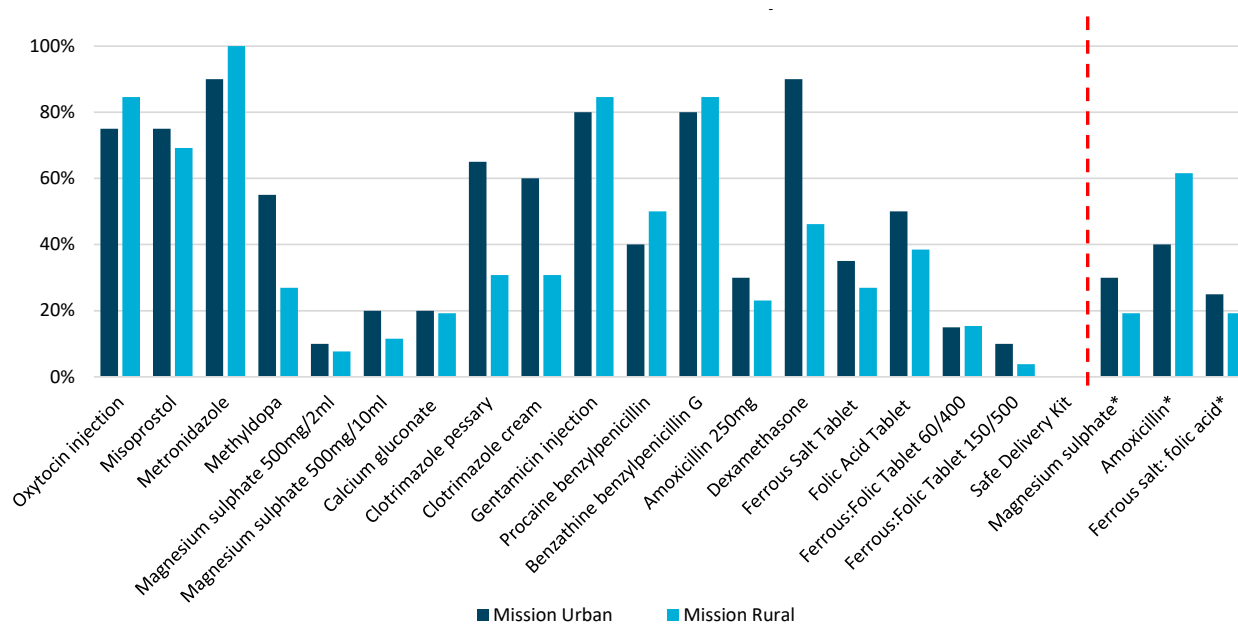
### Annex 3: Availability of Maternal Health Commodities per Sector, by Urban and Rural areas

**Figure 18:** Percentage availability of Maternal Health commodities in the public sector, by area.



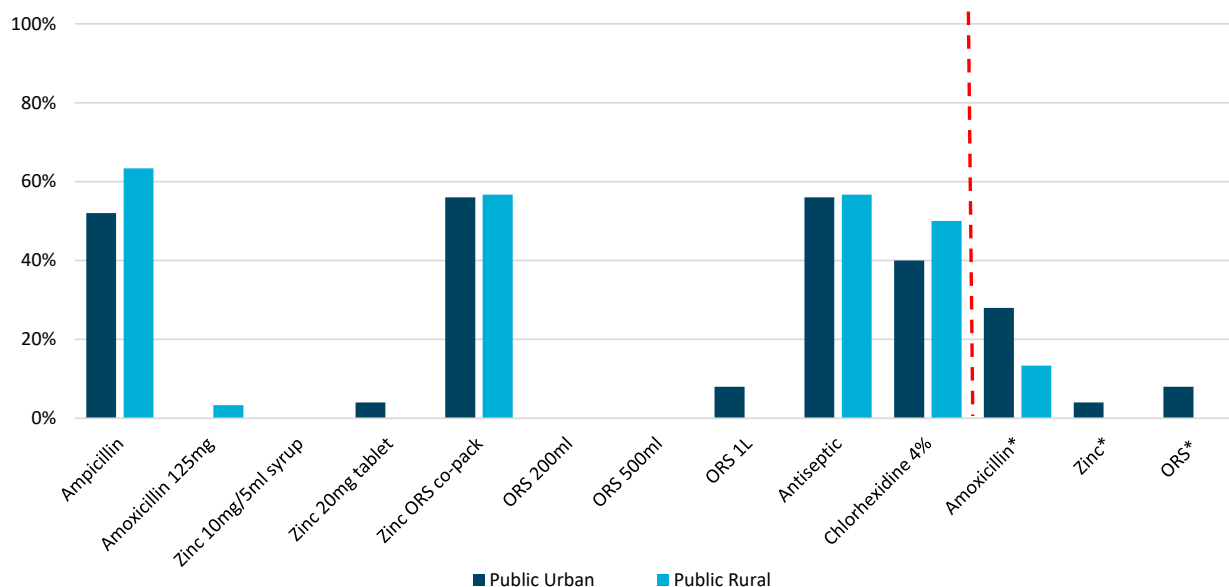
**Figure 19:** Percentage availability of Maternal Health commodities in the private sector, by area.



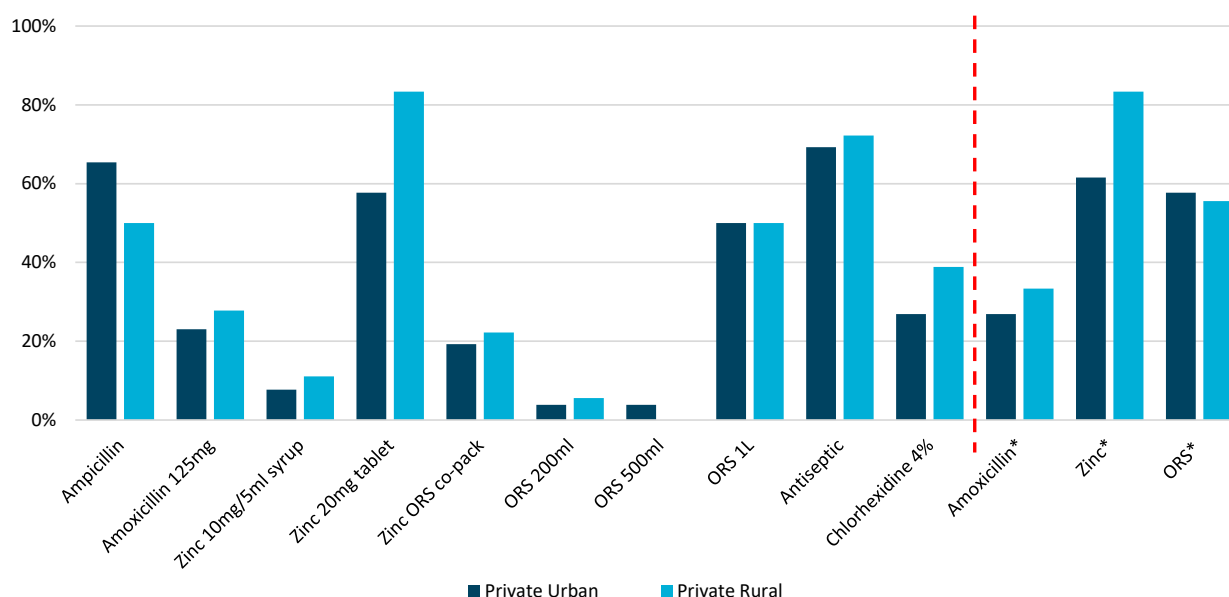
**Figure 20:** Percentage availability of Maternal Health commodities in the mission sector, by area.

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

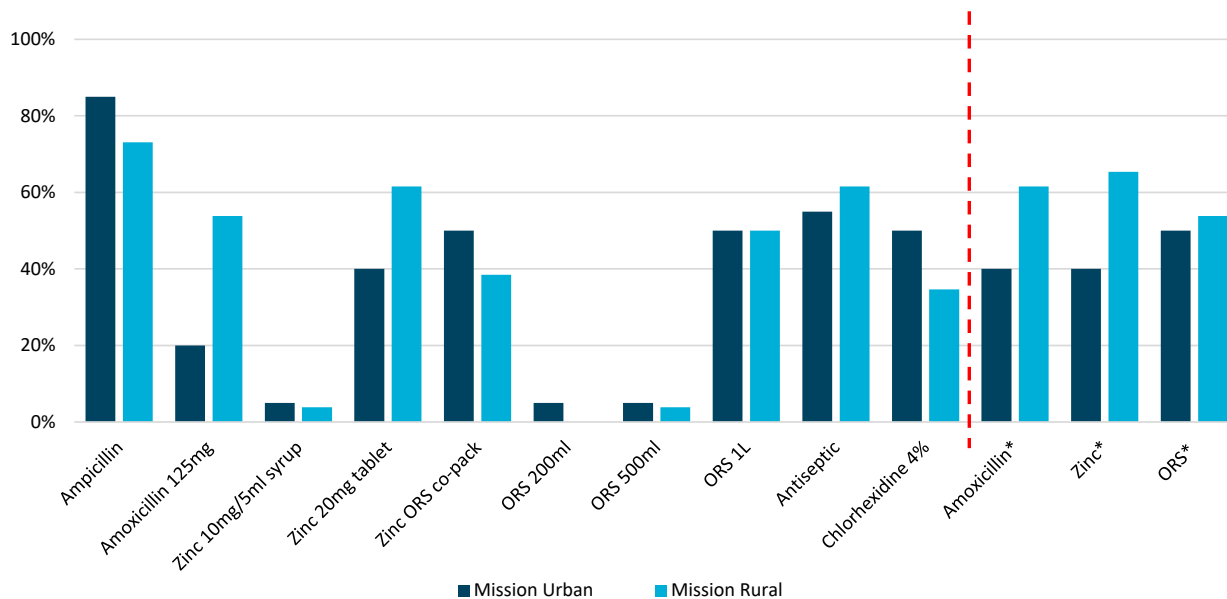
**Figure 21:** Percentage availability of newborn and child health commodities in the public sector, by area.



**Figure 22:** Percentage availability of newborn and child health commodities in the private sector, by area.

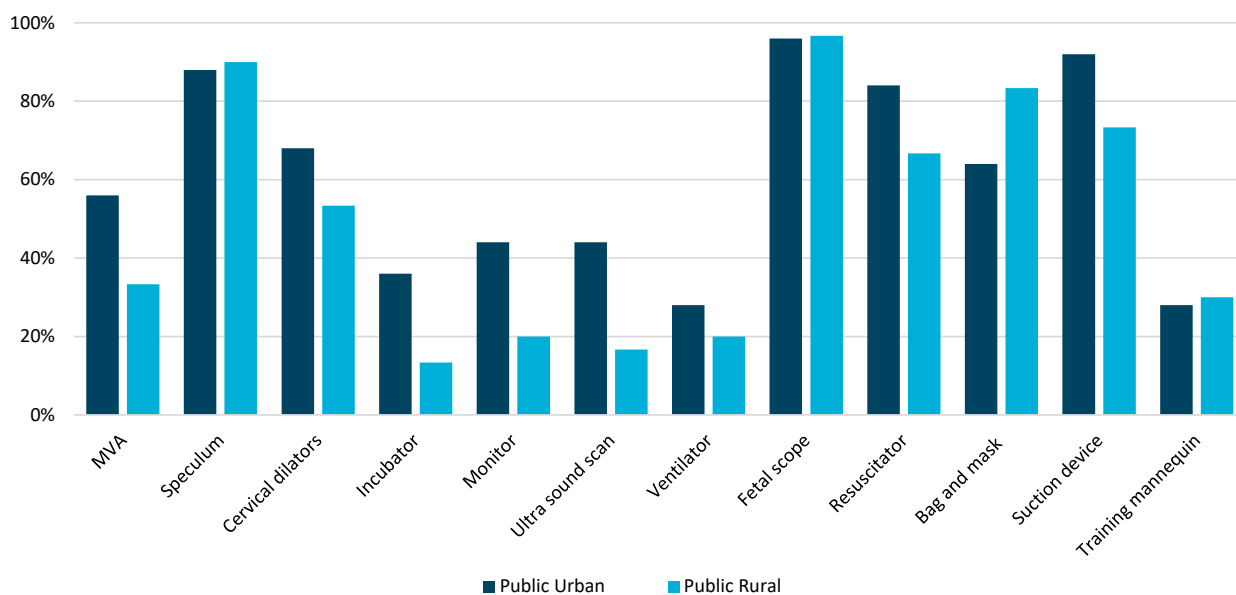




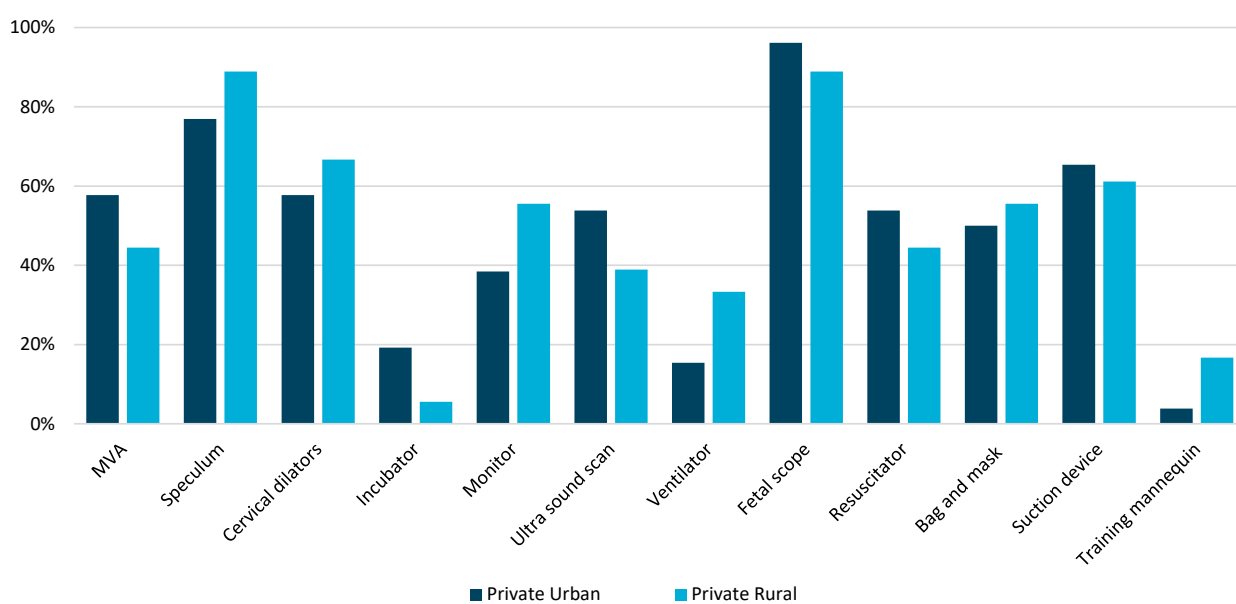
**Figure 23:** Percentage availability of newborn and child health commodities in the mission sector, by area.

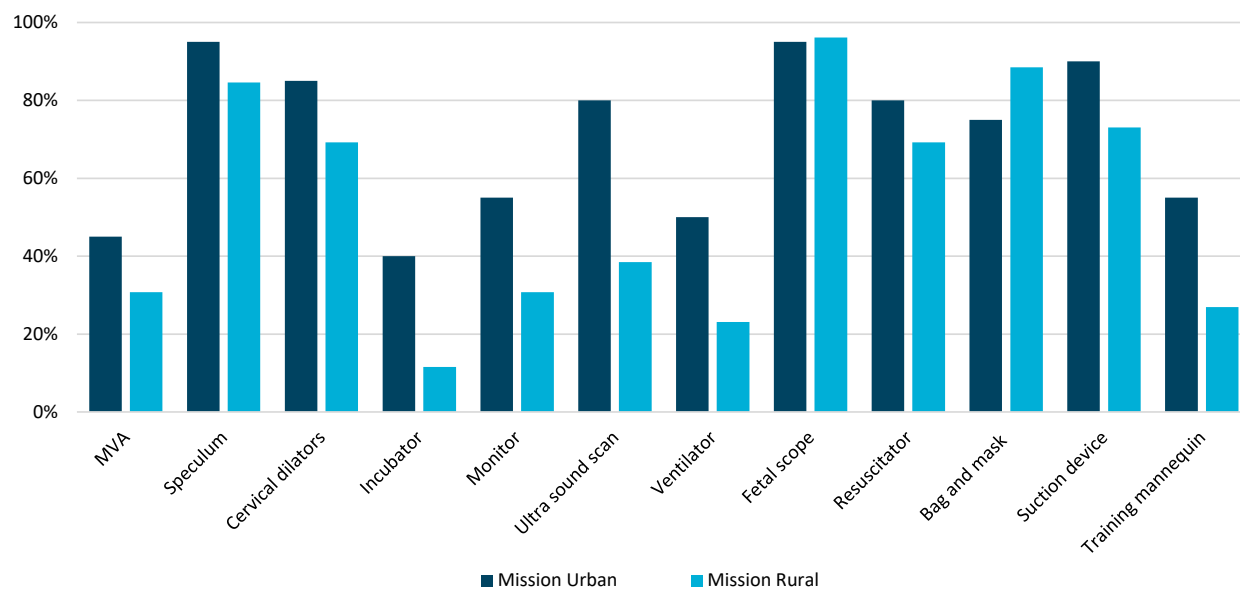
## Annex 5: Availability of SRH Instruments per Sector, by Urban and Rural Areas

**Figure 24:** Percentage availability of SRH Instruments in the public sector, by area.



**Figure 25:** Percentage availability of SRH Instruments in the private sector, by area.



**Figure 26:** Percentage availability of SRH Instruments in the mission sector, by area.

## Annex 6: Treatment Regimens

**Table 9:** Treatment regimens used per commodity for affordability calculations.

Commodity	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
Norethisteroneenanthate	1 vial	NA
Male condoms	1 pack	NA
Female condoms	1 pack	NA
Intrauterine contraceptive device	1 device	NA
Levonorgestrel implant	1 device	NA
Etonogestrel implant	1 device	NA
Diaphragm	1 device	NA
Oxytocin injection	1 vial	NA
Misoprostol	1 tablet	NA
Metronidazole	6 tablets	5
Methyldopa	3 tablets	30
Magnesium sulfate 500mg/ 2ml	18 vials	NA
Magnesium sulfate 500mg/10ml	18 vials	NA
Calcium gluconate	1 ampoule	1
Clotrimazole pessary	1 tablet	6
Clotrimazole cream	1 tube	NA
Gentamicin injection	1 ampoule	10
Ampicillin	4 vials	5
Procaine benzylpenicillin	1 vial	10
Benzathinebenzylpenicillin 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

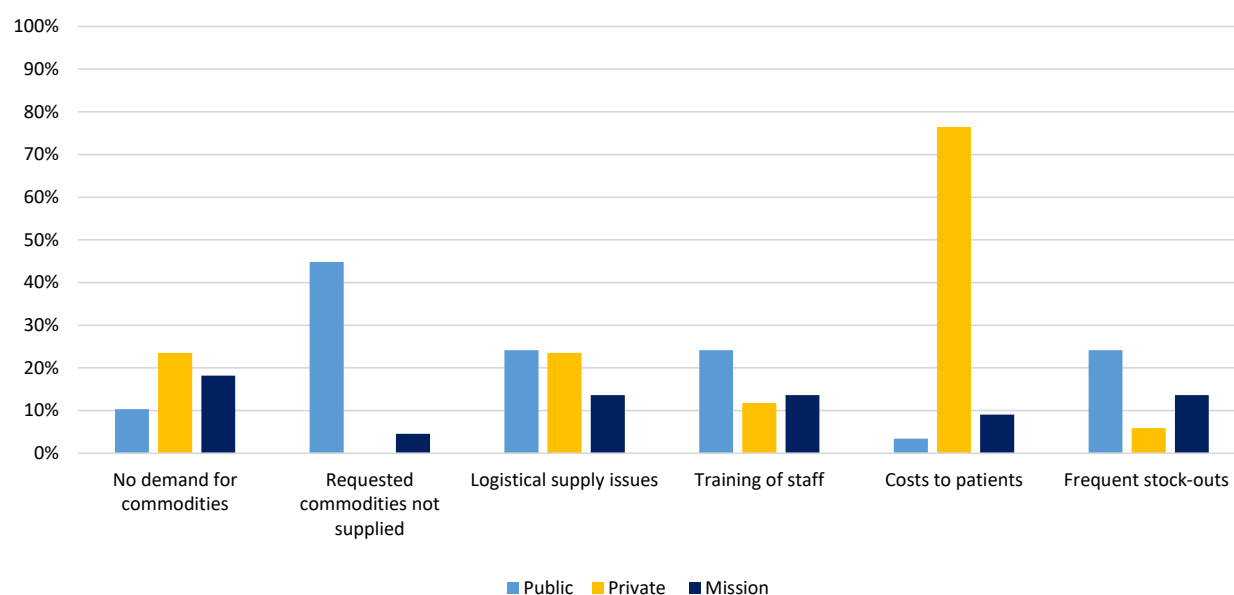
## Annex 7: Affordability of SRHC in the Public Sector

**Table 10:** Affordability of SRHC in the Public Sector.

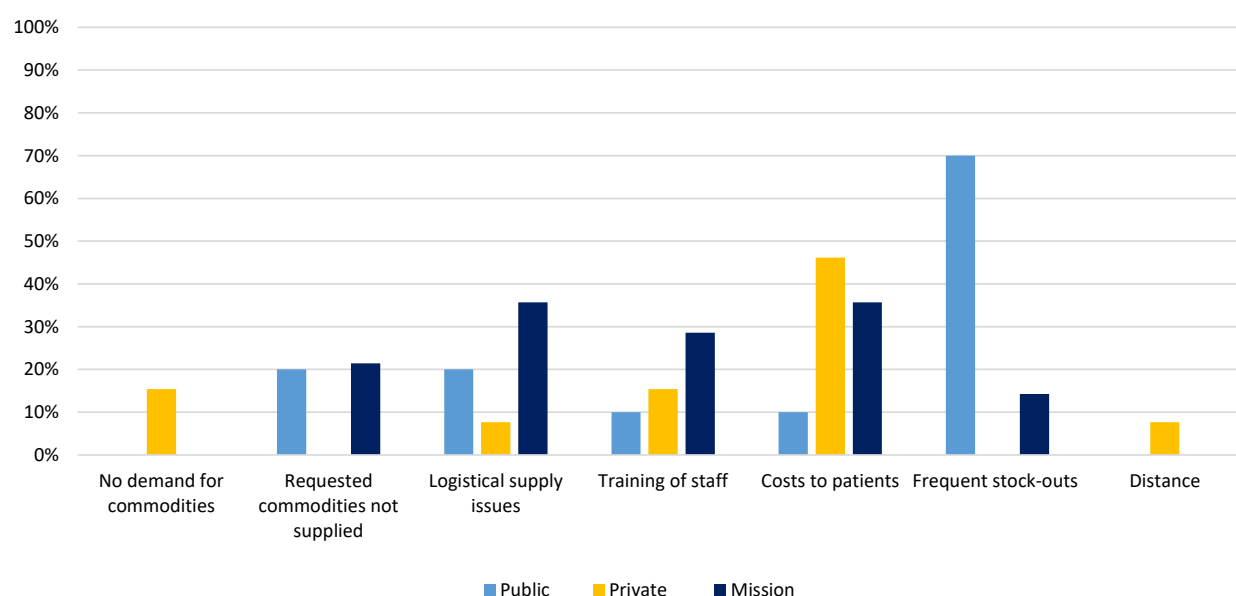
	Mean Prices					
	Public		Private		Mission	
	Urban	Rural	Urban	Rural	Urban	Rural
Ethinyl/levonorgestrel	0	0	6	4	0	0
Ethinyl/norethisterone	0	0	5	NA	NA	0
Levonorgestrel 30mcg	0	0	9	10	0	0
Levonorgestrel 70mcg	0	0	20	15	0	0
Medroxyprogesterone acetate	0	0	31	5	0	0
Norethisterone enanthate	0	0	11	12	NA	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

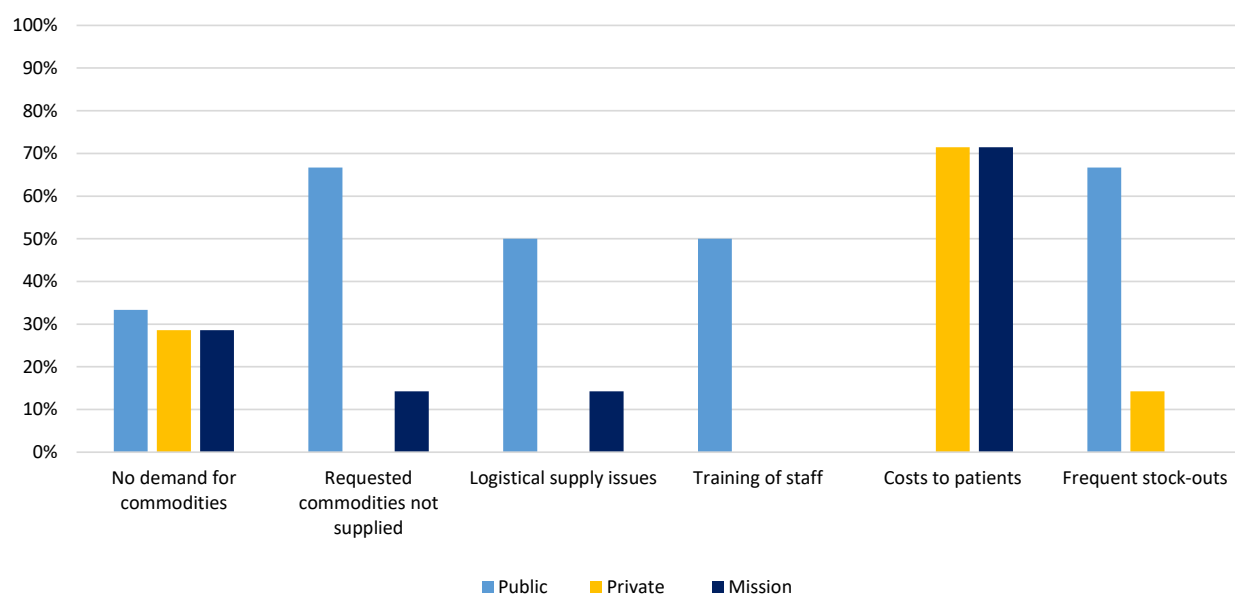
## Annex 8: Qualitative Aspects of Access to SRHCs

**Figure 27:** Key challenges related to accessing family planning services.



**Figure 28:** Key challenges related to accessing maternal health services.



**Figure 29:** Key challenges related to accessing STI management services.**Figure 30:** Key challenges related to accessing child health services.