

REPORT

Sexual and Reproductive Health Commodities in Mandera County, Kenya: 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 (UNFPA, 2022). 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. Further, 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.

Despite all efforts, worldwide, almost 800 women a day die due to complications related to pregnancy and childbirth, and annually an estimated five million children do not reach the age of five, with half of these deaths occurring in sub-Saharan Africa (WHO, 2023; UN IGME, 2022). In sub-Saharan Africa, the maternal mortality rate (MMR) is estimated at 545 maternal deaths per 100,000 live births; 136 times higher than the MMR in Australia and New Zealand (four maternal deaths per 100,000 live births) (WHO, 2023). Research has estimated that the lives of four million women, newborns and children in sub-Saharan Africa could be saved per year if coverage of interventions including emergency obstetric care, breastfeeding counselling, and treatment for infections such as diarrhoea and pneumonia increased to 90% of families (Friberg et al., 2010). In 2020 alone, an estimated 374 million new cases of STIs occurred (WHO, 2021). For some of these STIs, such as syphilis, sub-Saharan Africa again suffers the highest burden globally.

Access to medicines and medical commodities forms a crucial building block of health systems. Without proper access to quality assured and safe medicines, people are not able to live in optimal health. SRH is a field of care which that forms the basis of healthy societies. The World Health Organization (WHO) Model List of Essential Medicines details medicines and commodities that are essential to the provision of quality SRH care (WHO, 2021). Access to essential commodities and services for SRH can prevent a significant proportion of deaths and disabilities. However, about 4.3 billion people will not have access to at least one essential reproductive health intervention over the course of their lives (WHO, 2022).

Kenya in Context

Kenya continues to face significant hurdles in the equitable provision of SRH services and commodities. While the national maternal mortality rate has seen a gradual decline, it remains high at 355 per 100,000 live births. Nationally, the uptake of modern contraceptives stands at 57% among currently married women and 59% for sexually active unmarried women aged 15–49. However, these national averages mask severe regional disparities; in Mandera, modern contraceptive use is critically low at just 1.8%, with similarly low rates in Marsabit (5.6%) and Isiolo (28.7%). In these counties, the unmet need for family planning remains a major crisis, reaching as high as 37.6%. Furthermore, among sexually active unmarried adolescents (15–19 years), the unmet need for family planning is estimated at 26% to 34%, highlighting a significant gap in youth-friendly services (KDHS, 2022).

This research therefore studied the availability, affordability and stockouts of 50 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 Isiolo, Marsabit and Mandera counties in Kenya. By providing a comprehensive overview of the commodity landscape in these underserved regions, this study generates the evidence required to develop targeted policies that improve health outcomes for women and adolescents in Kenya’s most vulnerable counties. This report specifically focuses results in **Mandera County**.

What we found

While Kenya has made notable progress in SRH on a national level, counties, including Mandera, continue to face a silent crisis. With the rural poverty line set at KES 4,358 per month, the life-saving SRH commodities surveyed as part of this reach were all too often unaffordable for most households.

Meanwhile, the findings described below reveal low availability and frequent stockouts of almost all the essential SRH commodities surveyed. These shortages can be directly linked to teenage pregnancies, preventable maternal deaths and HIV/AIDS infections.

2. RESEARCH METHODOLOGY

This study was conducted by Access to Medicines Platform Kenya 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 AMREF Ethics and Scientific Review Committee and National Commission for Science, Technology and Innovation (NACOSTI). This study used an adapted version of the HAI/WHO Methodology (WHO & HAI, 2008).

Teams of data collectors visited 86 health facilities in 2022 and 91 health facilities in 2025 from the public, private and faith-based sectors in Isiolo, Marsabit and Mandera to survey the availability, stockouts and patient prices of 50 medicines, services test kits, 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/clinics 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 primary 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 national rural poverty line of 3,947 KES (2022) and 4,358 KES (2025)¹ per month, or 131.6 KES and 142.89 KES, respectively, per day, was used to calculate affordability of commodities. If a commodity cost more than the daily poverty line, it was considered unaffordable. Table 1 provides an overview of the overall study sample. This report provides the results from Mandera County, in which 29 health facilities were surveyed in 2022 (22 public, eight private, 0 faith-based), and 35 health facilities in 2025 (22 public, 13 private, 0 faith-based).

¹ <https://statskenya.co.ke/at-stats-kenya/about/poverty-lines-in-kenya-measuring-food-and-overall-poverty/102/>

Table 1. Study sample in 2022 and 2025 (across all three counties)

	Overall		Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025	2022	2025
Urban	30	34	8	6	19	24	3	4
Rural	56	57	41	45	5	5	10	7
Total	86	91	49	51	24	29	13	11

3. FINDINGS

FAMILY PLANNING

Family planning (FP) products are essential tools that empower individuals to exercise autonomy over their fertility and reproductive health. Beyond clinical utility, the ability to make informed reproductive decisions is a fundamental right that underpins various human rights and serves as a cornerstone for improving broader public health indicators (Cook, 1983; WHO, 2014).

The available contraceptive methods are categorised by their administration and duration of efficacy to meet diverse user needs:

- **Short-acting methods:** These include daily oral contraceptive pills and quarterly injectable contraceptives, which require frequent user adherence or clinical visits.
- **Long-acting Reversible Contraceptives (LARCs):** Options such as implants and intrauterine devices (IUDs) offer highly effective, “set-and-forget” protection for periods ranging from three to ten years.
- **Permanent methods:** For those wishing to permanently end their fertility, voluntary surgical procedures—specifically vasectomy for men and tubal ligation for women—provide definitive solutions.
- **Dual-protection methods:** Male and female condoms remain unique within the contraceptive mix as the only methods providing simultaneous protection against unintended pregnancy and the transmission of HIV/AIDS and other sexually transmitted infections (STIs) (WHO, 2020).

Availability

In 2025, overall availability of all family planning commodities was critically low (see Figure 1). In 2022, the most widely available FP commodity was the combined oral contraceptive pill ethinylestradiol + levonorgestrel, which was available in 17% of surveyed health facilities. By 2025, its availability had increased to 25.7% (see Table 2). Male condoms, however are now the most commonly available FP commodity, found in 31.4% of facilities. This represents a substantial increase from 13.3% in 2022. In 2022, seven of the 13 surveyed commodities were not available in health facilities, whereas by 2025 this number had fallen to three of the 13. This improvement includes the availability of levonorgestrel and etonogestrel implants, levonorgestrel (1.5 mg), vasectomy services, and tubal ligation services, none of which were available in 2022. Despite this progress, three commodities experienced a decline in availability between 2022 and 2025. Levonorgestrel (30 mcg) decreased from 10% availability to 0%, medroxyprogesterone acetate declined from 10% to 5.7%, and female condoms fell slightly from 3.3% to 2.9%.

Improvements in the availability of FP commodities are largely driven by increases within private sector health facilities. In 2022, only two of the 13 FP commodities were available in private facilities, whereas by 2025 this had risen to seven of the 13 commodities. This progress includes substantial increases in the availability of ethinylestradiol + levonorgestrel (from 0% to 53.8%), levonorgestrel (1.5 mg) (from 0% to 15.4%), etonogestrel and levonorgestrel implants (from 0% to 23.1% and 7.7% respectively), as well as the copper-containing IUD (from 0% to 30.8%).

In the public sector, by contrast, only the levonorgestrel implant, vasectomy services, and tubal ligation services have shown increases in availability, each rising from 0% to 4.5%. Availability of all other FP commodities in public facilities has either remained unchanged or declined.

Figure 1. Overall availability of family planning commodities (2025)

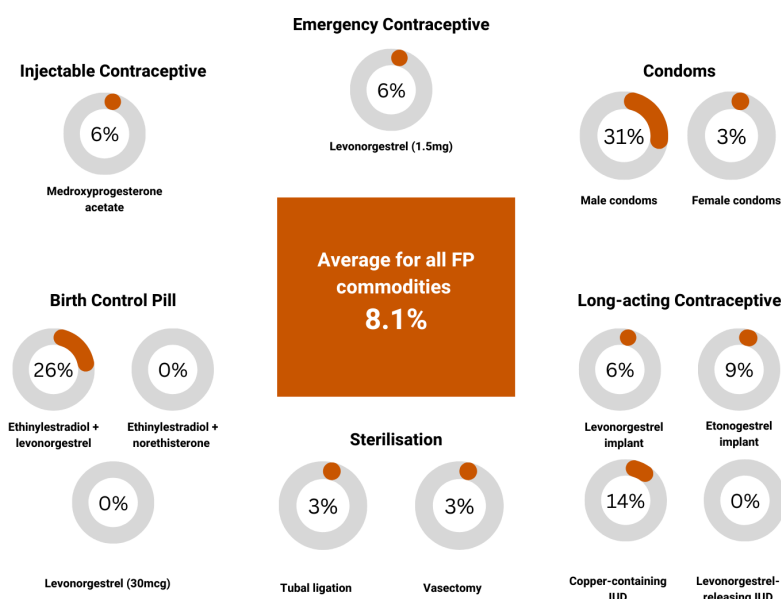


Table 2. Availability of family planning commodities in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)	
	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	16.7	25.7	22.7	9.1	0.0	53.8
Ethinylestradiol + norethisterone	0.0	0.0	0.0	0.0	0.0	0.0
Levonorgestrel (30 mcg)	10.0	0.0	13.6	0.0	0.0	0.0
Levonorgestrel (1.5 mg)	0.0	5.7	0.0	0.0	0.0	15.4
Medroxyprogesterone acetate	10.0	5.7	9.1	0.0	12.5	15.4
Implants: levonorgestrel	0.0	5.7	0.0	4.5	0.0	7.7
Implants: etonogestrel	0.0	8.6	0.0	0.0	0.0	23.1
Copper-containing IUD	3.3	14.3	4.5	4.5	0.0	30.8
Levonorgestrel-releasing IUD	0.0	0.0	0.0	0.0	0.0	0.0
Male condoms	13.3	31.4	13.6	13.6	12.5	61.5
Female condoms	3.3	2.9	4.5	4.5	0.0	0.0
Vasectomy services	0.0	2.9	0.0	4.5	-	0.0
Tubal ligation services	0.0	2.9	0.0	4.5	-	0.0

(No faith-based health facilities were surveyed in Mandera)

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. In 2025, stockouts in the public sector were very common (see Table 3). Ethinylestradiol + levonorgestrel and ethinylestradiol + norethisterone experienced stockouts at facilities, with the latter experiencing stockouts at all facilities. These stockouts lasted on average 25 days for ethinylestradiol + norethisterone to 20 days for ethinylestradiol + levonorgestrel. The private sector also experienced stockouts in 2025, specifically for male condoms, normally one of the most commonly available commodities. These were stocked out at more than 33.3% of facilities, lasting on average 20 days.

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		
	HFs with stock card (#)	HFs with a stockout (%)	Average # of stock-out days	HFs with stock card (#)	HFs with a stockout (%)	Average # of stock-out days
	2025			2025		
Ethinylestradiol + levonorgestrel	3	33.3	20	5	0	0
Ethinylestradiol + norethisterone	1	100.0	25	0	ND	ND
Medroxyprogesterone acetate	0	ND	ND	1	0	0
Implants: levonorgestrel	1	0.0	0	1	0	0
Implants: etonogestrel	0	ND	ND	3	0	0
Copper-containing IUD	1	0.0	0	3	0	0
Male condoms	1	0.0	0	3	33.3	20

HF: health facility; ND: no data

No stock data available across both sectors for levonorgestrel (30mcg) and (1.5mg), levonorgestrel-releasing IUD and male condoms

*No stock information available for 2022

Affordability

As in 2022, most of the family planning products were accessible in the public sector, as none of them cost more than the daily poverty line (see Table 4). In the private sector, male condoms saw an increase in price in 2025 compared to 2022, (equivalent to 0.17 days), whilst medroxyprogesterone acetate decreased slightly from 1.52 days in 2022 to 1.40 days in 2025. However, it is still considered unaffordable. This is the case in 2025 for most of the family planning commodities in the private sector. The most unaffordable were the levonorgestrel and etonogestrel implants at 10.50 days and the copper-containing IUD at 21 days.

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

	Public		Private	
	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	0 days	0 days	-	1.05 days
Levonorgestrel (30 mcg)	0 days	-	-	-
Levonorgestrel (1.5 mg)	-	-	-	1.75 days
Medroxyprogesterone acetate	0 days	-	1.52 days	1.40 days
Implants: levonorgestrel	-	0 days	-	10.50 days
Implants: etonogestrel	-	-	-	10.50 days
Copper-containing IUD	-	0 days	-	21.00 days
Levonorgestrel-releasing IUD	-	-	-	-
Male condoms	0 days	0 days	0.04 days	0.17 days
Female condoms	0 days	0 days	-	-

No price data available for ethinylestradiol + norethisterone and levonorgestrel-releasing IUD across all sectors and years.

-: No price data available.

MATERNAL HEALTH

Maternal health commodities encompass a range of vital pharmaceutical and nutritional products designed to manage conditions throughout the pregnancy, childbirth, and postnatal periods. This continuum of care is critical, as women face heightened risks of preventable morbidities and mortality without timely access to appropriate treatment (WHO, 2023).

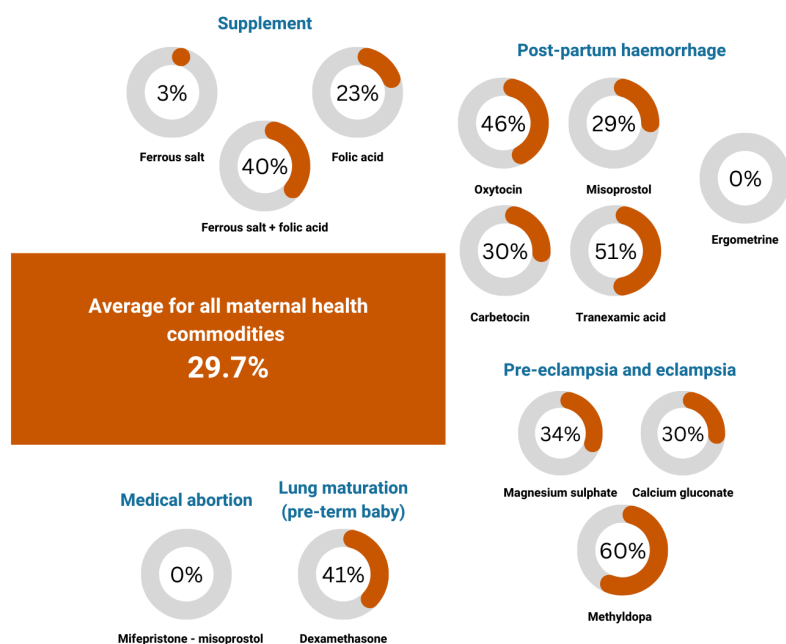
These commodities are categorised by their specific clinical interventions:

- **Antenatal Supplements:** Products such as iron and folic acid are essential for preventing deficiencies that lead to anaemia and adverse fetal outcomes, including neural tube defects.
- **Management of Post-Partum Haemorrhage (PPH):** As PPH remains the leading cause of maternal death in Sub-Saharan Africa, access to uterotonics and antifibrinolytics is life-saving. This includes oxytocin, misoprostol, carbetocin, and ergometrine to stimulate uterine contractions, as well as tranexamic acid to manage severe bleeding (Say, 2014).
- **Treatment of Hypertensive Disorders:** To manage pre-eclampsia and eclampsia—the second leading cause of maternal mortality—critical commodities include methyldopa for blood pressure regulation and magnesium sulphate for the prevention and treatment of seizures.

Availability

Overall, only two maternal health commodities (tranexamic acid and methyldopa) were available at more than half of facilities in 2025 (see Figure 2). Nevertheless, in 2025 most maternal health commodities showed increased availability compared to 2022 (see Table 5). Methyldopa was the only exception, decreasing from 100% availability in 2022 to 60% in 2025. Despite these improvements, no maternal health commodity was available in at least 80% of all facilities.

Figure 2. Overall availability of maternal health commodities (2025)



Disaggregated by sector, most commodities increased in availability between 2022 and 2025. Notable improvements include carbetocin, which increased from 0% to 100% availability in public facilities, misoprostol, which rose from 0% in 2022 to 53.8% in 2025 in private facilities, and magnesium sulphate, which increased from 0% to 46.2% in private facilities. Overall, availability of maternal health commodities was slightly higher in private facilities.

Methyl(ergometrine) and the mifepristone–misoprostol combination remained unavailable in both public and private facilities, as was the case in 2022. Ferrous salt also remained unavailable in public facilities. A limited number of commodities met or exceeded the 80% availability threshold within specific sectors, namely methyldopa and carbetocin in public facilities (both at 100%), and tranexamic acid in private facilities (84.6%).

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

	Overall (%)		Public (%)		Private (%)	
	2022	2025	2022	2025	2022	2025
Oxytocin	20.0	45.7	13.6	31.8	37.5	69.2
Misoprostol	3.3	28.6	4.5	13.6	0.0	53.8
Carbetocin ^a	0.0	30.0	0.0	100.0	-	22.2
Tranexamic acid	6.7	51.4	4.5	31.8	12.5	84.6
(methyl)ergometrine ^a	0.0	0.0	0.0	0.0	-	0.0
Mifepristone - misoprostol ^b	0.0	0.0	0.0	0.0	-	0.0
Magnesium sulphate	3.3	34.3	4.5	27.3	0.0	46.2
Calcium gluconate	0.0	29.6	0.0	18.8	-	45.5
Ferrous salt	0.0	2.9	0.0	0.0	0.0	7.7
Folic acid	0.0	22.9	0.0	4.5	0.0	53.8
Ferrous salt + folic acid	16.7	40.0	18.2	31.8	12.5	53.8
Dexamethasone	0.0	40.7	0.0	18.8	-	72.7
Methyldopa ^a	100.0	60.0	100.0	100.0	-	55.6

^aAvailable from health centre level and up

-: no health facilities surveyed at health centre level or up

Stockouts

In 2025, stockouts of maternal health commodities were common in both public and private sector facilities, with a higher prevalence in the public sector (see Table 6). In public facilities, carbetocin and magnesium sulphate were the most frequently stocked out commodities, unavailable in 50% and 33.3% of facilities respectively, for an average duration of five days for carbetocin and nine days for magnesium sulphate. Methyldopa recorded the longest average stockout duration (32 days), although it was stocked out in a smaller proportion of facilities (25%).

In the private sector, stockouts in 2025 were most common for ferrous salt and folic acid (20%), followed by misoprostol (14.3%) and oxytocin (11.1%). Although private facilities experienced stockouts less frequently overall, when they did occur the average duration tended to be longer than in the public sector.

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		
	HFs with stock card (#)	HFs with a stockout (%)	Average # of stockout days	HFs with stock card (#)	HFs with a stockout (%)	Average # of stockout days
	2025			2025		
Oxytocin	7	14.3	5	9	11.1	10
Misoprostol	4	0.0	0	7	14.3	10
Carbetocin	2	50.0	5	2	0.0	0
Tranexamic acid	7	28.6	7	10	10.0	20
(methyl)ergometrine	0	ND	ND	1	0.0	0
Magnesium sulphate	6	33.3	9	6	0.0	0
Calcium gluconate	4	25.0	18	4	0.0	0
Folic acid tablet	1	0.0	0	4	0.0	0
Ferrous salt + folic acid	6	0.0	0	5	20.0	10
Dexamethasone	5	0.0	0	5	0.0	0
Methyldopa	4	25.0	32	4	0.0	0

HF: health facility; ND: no data

No stock data available across both sectors for mifepristone – misoprostol and ferrous salt

*No stock information available for 2022

Affordability

As in 2022, in 2025 all of the maternal health commodities were affordable in the public sector, as none of them cost more than the daily poverty line (see Table 7). However, in the private sector, almost all of them were unaffordable. The most unaffordable are magnesium sulphate and methyldopa at 12.60 days and misoprostol at 3.50 days, implants at 10.50 days and the copper-containing IUD at 21 days. The affordability of oxytocin improved marginally, from 0.76 days in 2022 to 0.70 days in 2025, however the ferrous salt and folic acid increased in price from 1.14 days to 2.10 days.

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

	Public (%)		Private (%)	
	2022	2025	2022	2025
Oxytocin	0 days	0 days	0.76 days	0.70 days
Misoprostol	0 days	0 days	-	3.50 days
Carbetocin	-	0 days	-	1.40 days
Tranexamic acid	-	0 days	-	1.40 days
Magnesium sulphate	0 days	0 days	-	12.60 days
Calcium gluconate	-	0 days	-	1.40 days
Ferrous salt	-	-	-	2.10 days
Folic acid tablet	-	0 days	-	2.10 days
Ferrous salt and folic acid	0 days	0 days	1.14 days	2.10 days
Dexamethasone	-	0 days	-	0.21 days
Methyldopa	0 days	0 days	-	12.60 days

No price data available for (methyl)ergometrine and mifepristone - misoprostol across all sectors and years

-: No price data available

STI TREATMENT

Commodities for the treatment of sexually transmitted infections (STIs) comprise a specialised basket of medicines targeting prevalent bacterial, viral, and fungal pathogens. In Kenya, STI management primarily follows a syndromic approach—treating symptoms where laboratory diagnosis is unavailable—making the consistent supply of these medicines critical for preventing long-term reproductive complications (WHO, 2022).

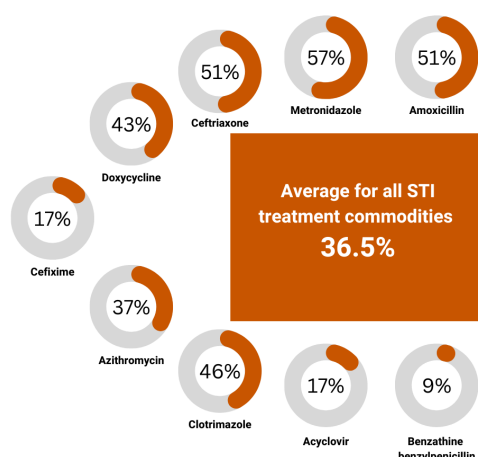
The surveyed commodities are categorised by the nature of the infection:

- **Antibiotics for Bacterial STIs:** Because major STIs, such as chlamydia, gonorrhea, and syphilis, are bacterial, the majority of the surveyed medicines are antibiotics. These include first-line treatments including ceftriaxone for gonorrhea, and doxycycline or benzathine penicillin—the gold standard for syphilis (WHO, 2024).
- **Antivirals for Viral Management:** The survey includes essential antivirals including acyclovir, used to manage the symptoms and reduce the transmission risk of genital herpes (HSV-2). Unlike bacterial infections, these viral STIs are managed rather than cured.
- **Antifungals for Reproductive Health:** To address common opportunistic infections that impact reproductive wellness, the survey includes antifungals, such as clotrimazole, primarily used to treat candidiasis (yeast infections) caused by *Candida albicans*.

Availability

Overall, only ceftriaxone, amoxicillin and metronidazole were available at more than half of facilities in 2025 (see Figure 3). Nevertheless, the overall availability of all STI treatment commodities increased in Mandera County from 2022 to 2025 (see Table 8). Having said this, overall, none of the commodities for the treatment of STIs met the WHO availability threshold of 80%. The biggest increase overall was for clotrimazole from 6.7% in 2022 to 45.7% in 2025.

Figure 3. Overall availability of STI treatment commodities (2025)



In the public sector one STI treatment commodity, cefixime, saw a decrease in availability from 4.5% in 2022 to 0% in 2025. However, in the public sector, clotrimazole, ceftriaxone, and doxycycline showed the largest increases in availability, each rising from 9.1% to 31.8% between 2022 and 2025.

In the private sector there was a decrease in availability of benzathine benzylpenicillin from 12.5% to 0% from 2022 to 2025. However, a number of commodities, namely amoxicillin (84.6%), ceftriaxone (84.6%) and metronidazole (100%) had availability above the 80% WHO availability threshold and had all increased significantly from 2022. Other notable increases were clotrimazole and acyclovir, which were unavailable in all private sector facilities in 2022 and have since raised to 69.2% and 38.5% availability.

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

	Overall (%)		Public (%)		Private (%)	
	2022	2025	2022	2025	2022	2025
Metronidazole	23.3	57.1	13.6	31.8	50.0	100.0
Clotrimazole	6.7	45.7	9.1	31.8	0.0	69.2
Benzathine benzylpenicillin	3.3	8.6	0.0	13.6	12.5	0.0
Amoxicillin	30.0	51.4	18.2	31.8	62.5	84.6
Acyclovir	3.3	17.1	4.5	4.5	0.0	38.5
Azithromycin	13.3	37.1	9.1	13.6	25.0	76.9
Ceftriaxone	20.0	51.4	9.1	31.8	50.0	84.6
Doxycycline	13.3	42.9	9.1	31.8	25.0	61.5
Cefixime	13.3	17.1	4.5	0.0	37.5	46.2

Stockouts

There were few stockouts of STI treatment commodities in the private sector in 2025 (see Table 9). Of the nine commodities sampled, only one, ceftriaxone, experienced a stockout, affecting 16.7% of private health facilities, with an average duration of 12 days.

In contrast, stockouts were more common in the public sector, where four of the nine STI treatment commodities were unavailable at some facilities. Cefixime was the most frequently stocked-out commodity, affecting 25% of facilities, followed by amoxicillin (22.2%) and metronidazole (12.5%). Stockouts of these commodities lasted between 15 and 20 days.

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		
	HF with stock card (#)	HFs with a stockout (%)	Average # of stock-out days	HF with stock card (#)	HFs with a stockout (%)	Average # of stock-out days
	2025			2025		
Metronidazole	7	0.0	0	8	12.5	20
Clotrimazole	7	0.0	0	8	0.0	0
Benzathine benzylpenicillin	2	0.0	0	0	NA	ND
Amoxicillin	7	0.0	0	9	22.2	18
Acyclovir	1	0.0	0	3	0.0	0
Azithromycin	3	0.0	0	7	0.0	0
Ceftriaxone	6	16.7	12	10	10.0	9
Doxycycline	6	0.0	0	5	0.0	0
Cefixime	0	ND	ND	4	25.0	15

HF: health facility; ND: no data

*No stock information available for 2022

Affordability

Like in 2022, in 2025 all STI treatment commodities were free to the patient, with the exception of ceftriaxone (see Table 10). However, a treatment of ceftriaxone was still affordable (0.35 days). There were also some minor decreases in cost of clotrimazole (from 0.15 days to 0 days) and doxycycline (from 0.05 days to 0 days).

In the private sector, while affordability of metronidazole and ceftriaxone improved, all other sampled commodities increased in price between 2022 and 2025, four of which were still considered unaffordable (amoxicillin, acyclovir, azithromycin and ceftriaxone). The most unaffordable was acyclovir, costing the equivalent of 8.40 days' work.

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

	Public		Private	
	2022	2025	2022	2025
Metronidazole	0 days	0 days	1.06 days	0.98 days
Clotrimazole	0.15 days	0 days	-	-
Benzathine benzylpenicillin	-	0 days	0.76 days	-
Amoxicillin	0 days	0 days	1.60 days	1.47 days
Acyclovir	1.14 days	-	-	8.40 days
Azithromycin	0 days	0 days	1.71 days	2.10 days
Ceftriaxone	0.19 days	0.35 days	1.52 days	1.05 days
Doxycycline	0.05 days	0 days	0.64 days	0.98 days
Cefixime	-	-	0.30 days	0.56 days

--: No price data available

HIV/AIDS

Sub-Saharan Africa continues to carry the disproportionate global burden of HIV/AIDS. While HIV remains a chronic condition without a definitive cure, the evolution of Antiretroviral Therapy (ART) has transformed the diagnosis from a terminal illness into a manageable long-term health condition.

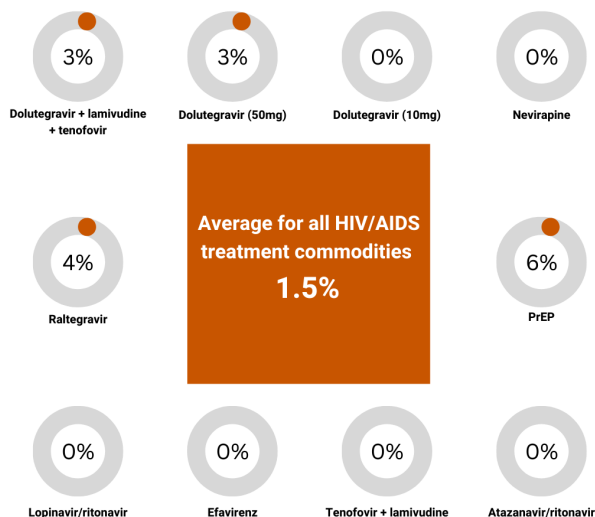
The essential commodities surveyed for HIV/AIDS management serve three critical functions:

- **Viral Suppression and Long-term Health:** Modern highly active antiretroviral therapies (HAART) effectively suppress the viral load, minimising symptoms and allowing people living with HIV to maintain robust immune function and lead long, healthy lives.
- **Prevention of Mother-to-Child Transmission (PMTCT):** Targeted antiretroviral regimens are highly effective in preventing the vertical transmission of HIV from pregnant and lactating women to their children, a cornerstone of maternal and neonatal health services.
- **Transmission Prevention (U=U):** Consistent access to these commodities ensures that individuals can achieve an undetectable viral load. In accordance with global health standards, an undetectable viral load renders the virus untransmittable, significantly reducing the incidence of new infections within the community.

Availability

Availability of HIV/AIDS commodities was very low in 2025 (see Figure 4). For PrEP (3.3% to 5.7%), and raltegravir (0% to 3.7%) overall availability increased slightly compared to 2022 (see Table 11). Unfortunately, overall availability of six other HIV/AIDS commodities decreased from 2022 to 2025, with three of them (tenofovir + lamivudine, tazanavir/ritonavir and lopinavir/ritonavir) completely unavailable in 2025, in both public and private sector health facilities.

Figure 4. Overall availability of HIV/AIDS commodities (2025)



In the public sector, availability of PrEP (4.5% to 9.1%) and raltegravir (0% to 6.3%) increased slightly from 2022 to 2025. However, the overall trend in the public sector is not positive, as the availabilities of tenofovir + lamivudine, efavirenz and atazanavir/ritonavir decreased noticeably. In the private sector in 2025, like in 2022, none of the HIV/AIDS commodities were available at the surveyed facilities.

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

	Overall (%)		Public (%)		Private (%)	
	2022	2025	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	3.3	5.7	4.5	9.1	0.0	0.0
Dolutegravir + lamivudine + tenofovir	3.3	2.9	4.5	4.5	0.0	0.0
Tenofovir + lamivudine	3.3	0.0	4.5	0.0	0.0	0.0
Atazanavir/ritonavir	3.3	0.0	4.5	0.0	0.0	0.0
Lopinavir/ritonavir	0.0	0.0	0.0	0.0	0.0	0.0
Raltegravir	0.0	3.7	0.0	6.3	0.0	0.0
Dolutegravir (50mg)	3.3	2.9	4.5	4.5	0.0	0.0
Pediatric dolutegravir (10mg)	0.0	0.0	0.0	0.0	0.0	0.0
Efavirenz	3.3	0.0	4.5	0.0	0.0	0.0
Nevirapine	0.0	0.0	0.0	0.0	0.0	0.0

Stockouts

In the public sector, no stockouts occurred at any of the public sector facilities sampled. Noteworthy is the low number of health facilities with a stock card available for the three commodities.

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		
	HF with stock card (#)	HFs with a stockout (%)	Average # of stockout days
	2025		
PrEP (emtricitabine + tenofovir)	2	0.0	0
Dolutegravir + lamivudine + tenofovir	1	0.0	0
Dolutegravir (50mg)	1	0.0	0

HF: health facility; ND: no data

*No stock information available for 2022

Affordability

As in 2022, all HIV/AIDS commodities were free to the patient in the public sector facilities sampled.

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

	Public	
	2022	2025
PrEP (emtricitabine + tenofovir)	0 days	0 days
Dolutegravir + lamivudine + tenofovir	0 days	0 days
Atazanavir/ritonavir	0 days	-
Raltegravir	-	-
Dolutegravir (50mg)	0 days	0 days
Pediatric dolutegravir (10mg)	-	-
Efavirenz	0 days	-

No price data available for tenofovir + lamivudine, lopinavir/ritonavir, raltegravir and dolutegravir (10mg) across all sectors and years

No price data for any of the commodities in the private sector

-: No price data available

MENSTRUAL PRODUCTS AND TESTS

Beyond pharmaceutical interventions, access to essential SRH commodities includes menstrual hygiene products and diagnostic kits, both of which are critical for social equity and early clinical intervention:

- **Menstrual Health Management (MHM):** Consistent access to appropriate menstrual commodities is a prerequisite for gender equality in education and the workforce. By enabling women and girls to navigate their daily lives with dignity and without interruption, these products directly correlate with higher school attendance, improved classroom participation, and sustained economic productivity (McMahon et al., 2011; Miiro et al., 2018). In regions like Isiolo and Mandera, where poverty levels are high, the lack of affordable MHM products often results in significant “period poverty,” further marginalising adolescent girls.
- **Rapid Diagnostic Kits:** Pregnancy tests and HIV self-test kits serve as vital entry points into the formal health system. These commodities empower individuals with “point-of-care” knowledge of their health status, facilitating:
- **Early Antenatal Care (ANC):** Timely pregnancy confirmation allows for earlier initiation of nutritional supplements and monitoring.
- **The “Test and Treat” Pipeline:** HIV self-testing reduces barriers to screening, enabling individuals to seek immediate antiretroviral therapy (ART) or preventive services like PrEP (Pre-Exposure Prophylaxis).

Availability

Overall, availability of most menstrual products and tests increased between 2022 and 2025, with availability of sanitary pads increasing from 3.3% to 20%, pregnancy tests increasing from 20% to 48.6% and HIV self-tests from 10% to 40%. (see Table 14). HPV DNA tests, however, remained unavailable across all sector facilities. In the public sector availability of sanitary pads and pregnancy tests increased noticeably from 4.5% to 18.2% and 31.8% respectively. HIV-self tests also increased in availability (9.1% to 31.8%). Most notable increases in availability of menstrual products and tests between 2022 and 2025 were in the private sector. Sanitary pads increased from 0% to 23.1%, pregnancy tests from 62.5% to 76.9% and HIV self-tests from 12.5% to 53.8%.

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

	Overall (%)		Public (%)		Private (%)	
	2022	2025	2022	2025	2022	2025
Sanitary pads	3.3	20.0	4.5	18.2	0.0	23.1
Pregnancy test	20.0	48.6	4.5	31.8	62.5	76.9
HIV self-test	10.0	40.0	9.1	31.8	12.5	53.8
HPV DNA test	0.0	0.0	0.0	0.0	0.0	0.0

Stockouts

In 2025, public facilities did not experience stockouts of the sampled menstrual products or tests (see Table 15). In contrast, private facilities faced notable stockouts of both sanitary pads and HIV self-tests. All private health facilities reported stockouts of sanitary pads, which lasted an average of 30 days, while half of private facilities experienced stockouts of HIV self-tests, lasting on average seven days. Pregnancy tests, however, were consistently available at private facilities, with no reported stockouts.

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

	Public			Private		
	HFs with stock card (#)	HFs with a stockout (%)	Average # of stockout days	HFs with stock card (#)	HFs with a stockout (%)	Average # of stockout days
	2025			2025		
Sanitary pads	3	0.0	0	1	100.0	30
Pregnancy test	7	0.0	0	6	0.0	0
HIV self-test	4	0.0	0	4	50.0	7

HF: health facility; ND: no data.

*No stock information available for 2022

Affordability

Like in 2022, all tests and pads were free in the public sector (see Table 16). In the private sector, however, sanitary pads and HIV self-tests remained unaffordable, costing substantially more than the daily national poverty line, 7.35 and 4.20 days' worth of income, respectively. The cost of HIV self-tests increased markedly between 2022 and 2025, rising from 1.52 days to 4.20 days' equivalent, while the cost of pregnancy tests decreased slightly, from 0.76 to 0.70 days' equivalent.

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

	Public (%)		Private (%)	
	2022	2025	2022	2025
Sanitary pads	0 days	0 days	-	7.35 days
Pregnancy test kit	0 days	0 days	0.76 days	0.70 days
HIV self-test kit	0 days	0 days	1.52 days	4.20 days

-: No price data available

No price data available for HPV DNA test across any of the sectors

4. RECOMMENDATIONS AND CONCLUSIONS

While Kenya has made progress in maternal health nationally, the Northern Frontier counties, which includes Mandera, continue to face a silent crisis. With rural poverty line of KSH 4,358, most households in these counties cannot afford lifesaving SRH commodities. Current data shows that in Mandera county only 1.8% of married women use modern contraceptive methods. According to KDHS 2022, total fertility rate in Mandera remained high at 7.7% compared to the national average of 3.4%, use of modern methods of FP was at 2% compared to the national average of 57%, skilled births were at 55% compared to national average of 89% an indication that national averages mask the reality of the real situation in our counties. The 2022 KDHS and this endline SRH commodities survey reinforced the following identified gaps:

- **The Affordability Barrier:** In a region where nearly 70% of the population lives below the rural poverty line, a single stockout in a public facility forces a woman to choose between food and life-saving medicine.
- **The Commodity Gap:** Our research surveyed 49 essential products. We found that stockouts of Oxytocin (for bleeding) and Magnesium Sulphate (for seizures) are directly linked to preventable maternal deaths.
- **The Youth Crisis:** Adolescent unmet need for family planning is as high as 34%. Without access to condoms and self-test kits, we are facing a “triple threat” of unintended pregnancy, STIs, and HIV.
- **Supply Chain Fragility:** Last-mile delivery is failing. Commodities often sit in regional stores while rural dispensaries run dry.
- **The “Pink Tax” of Poverty:** Menstrual hygiene is not a luxury. The lack of affordable products is a leading cause of school absenteeism for girls in Kenya.
- **Preventable Deaths:** Post-partum haemorrhage (PPH) is the top killer in Sub-Saharan Africa. Kenyan counties have the lowest access to the four key “Uterotonics” (Oxytocin, Misoprostol, Carbetocin, and Ergometrine).

Recommendations for Policy and Legislative Action

<p>A. Enact the “Facility Improvement Financing” (FIF) Act</p>	<p>Advocacy Point: Revenue collected at hospitals is often “swallowed” by the County General Fund, leaving facilities with no cash for emergency supplies.</p> <p>Recommendation: The Assembly must pass/strengthen the FIF Act to allow health facilities to retain 100% of their revenue. This “ring-fences” money specifically for restocking the 50 essential SRH commodities among other essential commodities.</p>
<p>B. Institutionalise “last-mile” successes</p>	<p>Recommendation: Budget for and establish climate-controlled satellite stores at the sub-county level. This infrastructure is essential for commodities requiring strict cold-chain management, reducing the restocking lead time for rural dispensaries from several weeks to under 48 hours.</p> <p>Recommendation: Prioritise the “Cold-Chain Integration” model to stabilise the supply of both heat-sensitive commodities (like Carbetocin) and essential supplements (such as ferrous salts and folic acid). The consistent absence of these items in public facilities represents a preventable barrier to managing maternal anemia and postpartum hemorrhage.</p>

<p>C. Domestic resource mobilisation for SRH</p>	<p>Recommendation: Allocate a minimum of 10% of the County Health Budget specifically to the “Health Products and Technologies” (HPT) unit, ensuring this budget is protected from reallocation during drought cycles.</p> <p>Recommendation: Leverage reimbursements from PHC fund for health centres and dispensaries to allocate a percentage for commodities security.</p>
<p>D. Regulate menstrual product affordability</p>	<p>Advocacy Point: Sanitary pads cost 7.35 days of income in the private sector.</p> <p>Recommendation: Expand the public distribution of free sanitary pads to reach more than the current 18.2% of facilities to prevent school dropouts and “period poverty”. This could be through the FIF or legislative proposals to ringfence funds for menstrual hygiene management.</p>
<p>E. Strengthen legislative oversight of stockouts</p>	<p>Advocacy point: The findings indicate that public sector stockouts for maternal health (like methyldopa) last over a month.</p> <p>Recommendation: The County Assembly Health Committee should require monthly “Stock-on-Hand” reports for the 13 priority SRH commodities to ensure accountability and rapid restocking.</p>
<p>F. Protect and scale access to family planning commodities on the public sector</p>	<p>Advocacy Point: Address the reliance on the private sector for family planning.</p> <p>Recommendation: The County Assembly should allocate funds to match private sector availability of implants and IUDs in public dispensaries to ensure the poor are not forced to pay up to 21 days’ wages for basic rights.</p>
<p>G. Eradicate HIV commodity “blind spots”</p>	<p>Advocacy Point: HIV treatment availability is at a near-collapse for certain regimens.</p> <p>Recommendation: Mandate an immediate audit of the HIV supply chain to restore the three “completely unavailable” regimens. HIV/AIDS commodities must be prioritized in the 2026/2027 Programme Based Budget.</p>
<p>H: Improve service delivery systems for SRH</p>	<p>Recommendation: Identify gaps that might hinder availability and access, the County Health Management Team (CHMT) should integrate supportive supervision for SRH commodities and services into their routine supportive supervision exercises. Integration of regular commodity assessments into supportive supervision visits to ensure proper commodity management practices can limit wastage and stock-outs.</p>

<p>I. Improved policy framework that mainstreams SRHR for adolescents and young people</p>	<p>Recommendation: Action by the CHMT to lead in the development and implementation of a costed county strategy for ending the triple threat. This will also specifically provide a legal framework for integrating provision of youth friendly services, including training of health care providers on youth friendly service provision. Additionally, this strategy could require the mapping of adolescent mothers for group ANC and counselling to mitigate continued early pregnancies and maternal mortality risks, and enrolment into Social Health Authority to guarantee skilled deliveries and access to quality health care.</p>
<p>J. Integration of Social Accountability Framework</p>	<p>Recommendation: The CHMT should adopt a transparent, citizen-centred approach to SRH management to build public trust and improve service delivery, including:</p> <ul style="list-style-type: none"> • <i>Transparency & Reporting:</i> Establish clear mechanisms for reporting on commodity performance and stock availability, ensuring data is accessible to the public. • <i>Civic Engagement:</i> Foster meaningful public participation by involving community members and civil society in decision-making processes regarding SRH priorities and budget allocations and enhancing the community score card approach to improve service delivery. • <i>Awareness & Advocacy:</i> Launch targeted public awareness campaigns to inform citizens of their rights to SRH services, creating a feedback loop that holds the health system accountable for service gaps
<p>K. Cultural and religious leader engagement</p>	<p>Recommendation: Counteract social-cultural barriers by integrating SRH advocacy into religious and traditional frameworks.</p> <p>Recommendation: Provide specific training for religious leaders in Isiolo, Mandera, and Marsabit on the “Birth Spacing” concept in Islam and Christianity, framing SRH commodities as tools for maternal and child survival rather than just “population control.”</p>

5. REFERENCES

Cook RJ. The human right to family planning. *Draper Fund report*. (1983); 12:18-19.

Friberg IK, Kinney MV, Lawn JE, Kerber KJ, Odubanjo MO, Bergh AM, et al. Sub-Saharan Africa's mothers, newborns, and children: how many lives could be saved with targeted health interventions? *PLoS Med*. 2010; 7(6): e1000295

Kenya National Bureau of Statistics, Ministry of Health, the DHS Program ICF. Kenya Demographic and Health Survey 2022. (2023). Key Indicators Report. Nairobi, Kenya, and Rockville, Maryland, USA: KNBS and ICF.

McMahon SA, Winch PJ, Caruso BA, Obure AF, Ogutu EA, Ochari IA, Rheingans RD. 'The girl with her period is the one to hang her head' Reflections on menstrual management among schoolgirls in rural Kenya. *BMC international health and human rights*. (2011) ;11:1-10.

Miiró G, Rutakumwa R, Nakiyingi-Miiró J, Nakuya K, Musoke S, Namakula J, Francis S, Torondel B, Gibson LJ, Ross DA, Weiss HA. Menstrual health and school absenteeism among adolescent girls in Uganda (MENISCUS): a feasibility study. *BMC women's health*. (2018); 18:1-13.

Say L, Chou D, Gemmill A, Tunçalp O, Moller A, Daniels P, Gulmezoglu A, Temmerman M, Alkema L. Global Causes of Maternal Death: a WHO Systematic Analysis. (2014). *The Lancet Global Health* 2(6): E323-E333.

United Nations Population Fund. *Sexual and Reproductive Health*. (2025). [cited 2025 dec 22]. Available from: <https://www.unfpa.org/sexual-and-reproductive-health-1>.

World Health Organization. *Daily iron and folic acid supplementation in pregnant women*. (2012). Geneva: World Health Organization.

World Health Organization. *Family planning/contraception methods*. (2020) [cited 2023 feb 16]. Available from: <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception>.

World Health Organization. *Framework for ensuring human rights in the provision of contraceptive information and services*. (2014). Geneva: World Health Organization.

World Health Organization. *Maternal Health*. [cited 2023 Feb 16]. Available from: https://www.who.int/health-topics/maternal-health#tab=tab_1.

World Health Organization. *Sexually Transmitted Infections (STIs)*. (2022) [cited 2023 Feb 16]. Available from: [https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-\(stis\)](https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis)).

World Health Organization. *World Health Organization Model List of Essential Medicines*. 24th List. (2025). Geneva: Switzerland.

World Health Organization, Health Action International. *Measuring Medicine Prices, Availability, Affordability and Price Components*. 2nd Edition. (2008). Geneva: Switzerland.

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	Lopinavir/ritonavir (LPV/r)	Antiretroviral, management of HIV/AIDS
39	Raltegravir (RAL)	Antiretroviral, management of HIV/AIDS
40	Dolutegravir (DTG)	Antiretroviral, management of HIV/AIDS
41	Paediatric dolutegravir (DTG)	Antiretroviral, management of HIV/AIDS
42	Efavirenz (EFV)	Antiretroviral, management of HIV/AIDS
43	Nevirapine	Antiretroviral, management of HIV/AIDS
PERSONAL HYGIENE & KITS		
44	Sanitary pads	Management of menstruation
45	Vasectomy services	Male sterilisation
46	Tubal ligation services	Female sterilisation
47	Pregnancy test	-
48	HIV self-test	-
49	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	Lopinavir/ritonavir (LPV/r)	4 tablets per day, 30 days
39	Raltegravir (RAL)	30 tablets
40	Dolutegravir (DTG)	30 tablets
41	Paediatric dolutegravir (DTG)	30 tablets
42	Efavirenz (EFV)	2 tablets per day, 30 days
43	Nevirapine	30 tablets
PERSONAL HYGIENE & KITS		
44	Sanitary pads	3 pads per day, 7 days
45	Pregnancy test	1 test
46	HIV self-test	1 test
47	HPV DNA test	1 test

