REPORT

Sexual and Reproductive Health Commodities in Isiolo County, Kenya:

Availability, Stockouts and Affordability
2022 & 2025

sharp
Solutions for Supporting Healthy Adolescents

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Sexual and Reproductive Health Commodities in Isiolo County, Kenya

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 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 **Isiolo County**.

What we found

The evidence from 2022 to 2025 described below indicates a significant deterioration in the availability of essential SRH commodities in Isiolo County. While some sectors show marginal gains, the public sector—which serves the most vulnerable—is plagued by chronic stockouts lasting up to eight months, alongside new user fees for maternal health services. This finding highlights a critical breakdown in the healthcare safety net in Isiolo County, directly correlating with the systemic shifts caused by the USAID Stop Work Order (SWO) and the subsequent transition for domestic resource mobilisation to ensure commodity security.

The trends identified place Isiolo County's progress toward the Sustainable Development Goals (SDGs) on maternal and reproductive health at serious risk. Without urgent action to stabilise the SRH supply chain and eliminate financial barriers to care, the county risks reversing hard-won health gains achieved in previous years.

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.

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

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 Isiolo County, in which 29 health facilities were surveyed in 2022 (14 public, eight private, seven faith-based), and 28 health facilities in 2025 (13 public, 8 private, seven faith-based).

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).

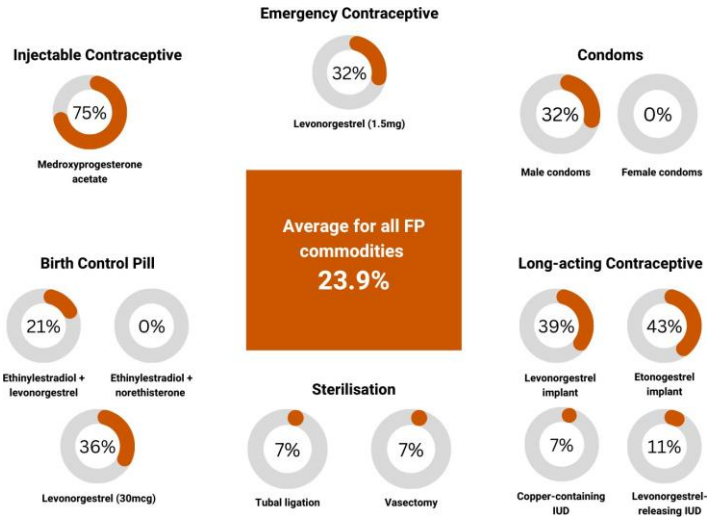
The available contraceptive methods are categorised by their administration and duration of efficacy to meet diverse user needs:

- **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

As can be seen in Figure 1, availability of almost all family planning commodities was concerningly low. When comparing the 2025 data to 2022, overall, availability of over half the family planning commodities surveyed decreased between the two data collection cycles (see Table 2). With the exception of medroxyprogesterone acetate, those that did increase in overall availability still remained limitedly available. Ethinylestradiol + levonorgestrel, for example, increased from 13.8% to 21.4%, levonorgestrel (1.5mg) (emergency contraceptive) from 3.4% to 32.1%, levonorgestrel implants from 34.5% to 39.3%, and levonorgestrel-releasing IUDs from 0% to 10.7%.

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



In 2022, only levonorgestrel (30mcg) and male condoms in public health facilities had an availability above 80%, meeting the WHO 80% or above availability benchmark; these availabilities decreased in 2025 to 38.5% for both commodities (see Table 2). In 2025, only medroxyprogesterone acetate (92.%) (injectable contraceptive) in the public sector met this threshold. Similar to the overall trend, in the public sector availabilities also tended to decrease. Only levonorgestrel (1.5mg) and levonorgestrel-releasing IUDs saw a slight increase in availability.

In the private sector, levonorgestrel (1.5mg), medroxyprogesterone acetate and ethinylestradiol + levonorgestrel saw the largest increases in availability. In 2022, for example, levonorgestrel (1.5mg) was unavailable in all private health facilities, while in 2025 50% stocked this commodity. In the faith-based sector, availability of all family planning commodities remained low, with highest availability (28.6%) found for both levonorgestrel commodities, medroxyprogesterone acetate, and etonogestrel implants.

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

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	13.8	21.4	14.3	0	25	62.5	0	14.3
Ethinylestradiol + norethisterone	0	0	0	0	0	0	0	0
Levonorgestrel (30 mcg)	65.5	35.7	85.7	38.5	50	37.5	42.9	28.6
Levonorgestrel (1.5 mg)	3.4	32.1	7.1	23.1	0	50	0	28.6
Medroxyprogesterone acetate	51.7	75	71.4	92.3	37.5	87.5	28.6	28.6
Implants: levonorgestrel	34.5	39.3	57.1	53.8	25	37.5	0	14.3
Implants: etonogestrel	51.7	42.9	64.3	61.5	50	25	28.6	28.6
Copper-containing IUD	27.6	7.1	21.4	7.7	25	0	42.9	14.3
Levonorgestrel-releasing IUD	0	10.7	0	15.4	0	12.5	0	0
Male condoms	55.2	32.1	85.7	38.5	50	37.5	0	14.3
Female condoms	17.2	0	21.4	0	0	0	28.6	0
Vasectomy services	14.3	7.1	50	0	0	25	0	0
Tubal ligation services	14.3	7.1	50	0	0	25	0	0

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 on page 9). Ethinylestratiol + levonorgestrel, ethinylestradiol + norethisterone, levonorgestrel (30mcg) and copper-containing IUDs experienced stockouts at all public facilities, with stockouts ranging from 63 to 117 days on average. Even male condoms, normally one of the most commonly available commodities, was stocked out at more than 70% of facilities, lasting on average 92 days.

The private sector also experienced stockouts in 2025, specifically for copper-containing IUDs (100%, lasting 240 days), levonorgestrel (30mcg) (66.7%, lasting 28 days on average), etonogestrel implants (33%, lasting 90 days on average), male condoms (25%, lasting the entire year), and levonorgestrel (1.5mg) (20%, lasting on average 30 days). In the faith-based sector, while fewer health facilities had stock cards for the family planning commodities, stockouts were also still common and lengthy (Table 3).

Affordability

As in 2022, all 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, almost all commodities saw an increase in price in 2025 compared to 2022, with only male condoms still being considered affordable (equivalent to 0.23 days). Levonorgestrel-releasing IUDs in particular were very expensive (equivalent to 34.99 days). In the faith-based sector, while prices increased for three commodities, only ethinylestradiol + levonorgestrel was considered unaffordable at 1.40 days.

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

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	0 days	-	1.14 days	1.05 days	-	1.40 days
Ethinylestradiol + norethisterone	-	-	-	-	-	-
Levonorgestrel (30 mcg)	0 days	0 days	0 days	2.10 days	0 days	0.70 days
Levonorgestrel (1.5 mg)	-	0 days	-	1.40 days	-	0.35 days
Medroxyprogesterone acetate	0 days	0 days	1.52 days	1.40 days	0.38 days	0.70 days
Implants: levonorgestrel	0 days	0 days	1.14 days	7.00 days	-	0 days
Implants: etonogestrel	0 days	0 days	0 days	3.50 days	1.14 days	0 days
Copper-containing IUD	0 days	0 days	1.90 days	-	0 days	0 days
Levonorgestrel-releasing IUD	-	0 days	-	34.99 days	-	-
Male condoms	0 days	0 days	0 days	0.23 days	-	0 days
Female condoms	0 days	-	-	-	0 days	-

-: No price data available

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

	Public						Private						Faith-based					
	HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022 2025 (#)		HFs with a stockout (%)		Average # of stockout days	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	2	3	50.0	100.0	30	90	2	5	0.0	0.0	0	0	1	2	0	50.0	0	90
Ethinylestradiol + norethisterone	0	2	ND	100.0	ND	63	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND
Levonorgestrel (30 mcg)	11	8	0.0	100.0	0	117	4	3	0.0	66.7	0	28	3	3	66.7	66.7	143	78
Levonorgestrel (1.5 mg)	0	9	ND	77.8	ND	152	0	5	ND	20.0	ND	30	0	2	ND	0.0	ND	0
Medroxyprogesterone acetate	10	12	40.0	58.3	258	63	3	7	0.0	0.0	0	0	2	3	50.0	33.3	60	39
Implants: levonorgestrel	8	11	0.0	54.5	0	107	2	3	50	0.0	365	0	0	1	ND	0.0	ND	0
Implants: etonogestrel	8	9	0.0	44.4	0	116	4	3	0.0	33.3	0	90	2	2	0.0	50.0	0	60
Copper-containing IUD	3	7	0.0	100.0	0	104	2	1	0.0	100.0	0	240	3	1	0.0	100.0	0	5
Levonorgestrel-releasing IUD	0	3	ND	0.0	ND	0	0	1	ND	0.0	ND	0	0	0	ND	ND	ND	ND
Male condoms	9	11	0.0	72.7	0	92	4	4	0.0	25.0	0	365	0	1	ND	0.0	ND	0
Female condoms	3	2	0.0	50.0	0	100	0	0	ND	ND	ND	ND	2	0	0.0	ND	0	ND

HF: Health Facilities ND: No 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).

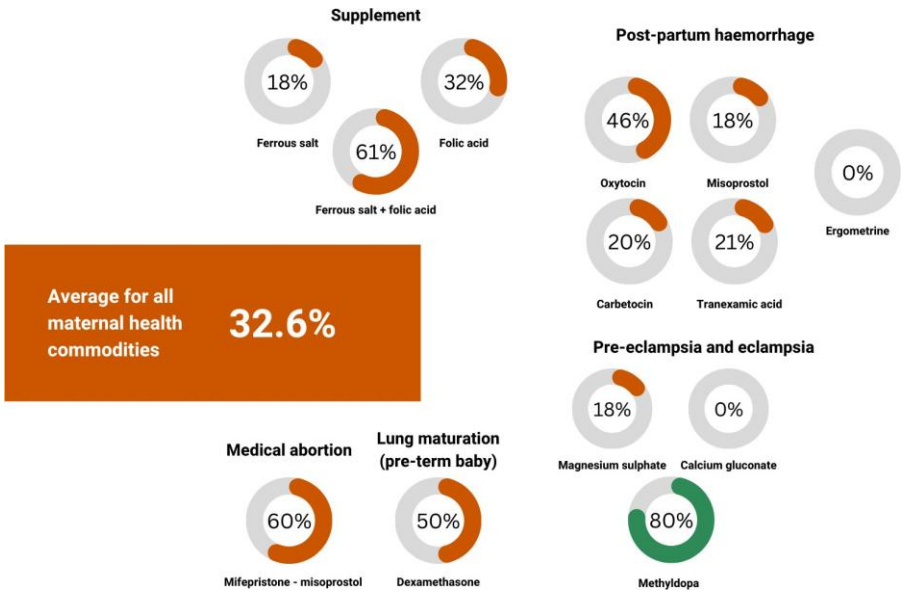
These commodities are categorised by their specific clinical interventions:

- **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, in 2025 only methyldopa was available at 80% of all facilities (see Figure 2). When comparing the data to 2022, more maternal health commodities saw an increase in availability than a decrease (see Table 5). Disaggregating the availabilities per sector shows trends were less optimistic, especially in the public sector. Only mifepristone – misoprostol, used for medical abortions, and methyldopa significantly increased in availability (0% in 2022 to 100% in 2025, and 50% in 2022 to 100% in 2025, respectively in the public sector). Of note is that this availability represents a sample of only one higher-level health. Importantly, availability of commodities to PPH was dangerously low. Even oxytocin, the most commonly used treatment, was available at only 38.5% of public facilities. Availability of magnesium sulphate was also dangerously low, with a marked decrease from 35.7% in 2022 to 15.4% in 2025.

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



In the private sector, availability of PPH commodities was better than in the public sector. Availability of oxytocin remained stable at 62.5%, with availabilities of misoprostol and carbetocin increasing from 37.5% (2022) to 50% (2025) and 25.0% (2022) to 33.3% (2025), respectively. Nevertheless, the availability remains suboptimal. In this sector, magnesium sulphate also saw a significant decrease in availability, from 50.0% to 12.5%. In the faith-based sector, only oxytocin (28.6% vs 42.9%) and magnesium sulphate (14.3% vs 28.6%) saw increases in availability from 2022 to 2025.

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

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Oxytocin	44.8	46.4	42.9	38.5	62.5	62.5	28.6	42.9
Misoprostol	13.8	17.9	0.0	0.0	37.5	50.0	14.3	14.3
Carbetocin[a]	14.3	20.0	0.0	0.0	25.0	33.3	0.0	0.0
Tranexamic acid	31.0	21.4	0.0	7.7	50.0	37.5	71.4	28.6
(methyl)ergometrine[a]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mifepristone - misoprostol[a]	0.0	60.0	0.0	100.0	0.0	66.7	0.0	0.0
Magnesium sulphate	34.5	17.9	35.7	15.4	50.0	12.5	14.3	28.6
Calcium gluconate	33.3	0.0	16.7	0.0	40.0	0.0	100.0	0.0
Ferrous salt	17.2	17.9	7.1	0.0	25.0	37.5	28.6	28.6
Folic acid	31.0	32.1	7.1	7.7	37.5	37.5	71.4	71.4
Ferrous salt + folic acid	86.2	60.7	100.0	69.2	50.0	50.0	100.0	57.1
Dexamethasone	66.7	50.0	33.3	20.0	100.0	66.7	100.0	66.7
Methyldopa[a]	57.1	80.0	50.0	100.0	50.0	66.7	100.0	100.0

[a] Available from health centre level and up

Stockouts

Stockouts were very common for maternal health commodities in all three sectors, and worsened in 2025 compared to 2022 (see Table 6). In the public sector, carbetocin, calcium gluconate, ferrous salt and folic acid experienced stockouts at 100% of facilities. On top of that, these stockouts were very lengthy, lasting on average 148 to 240 days. Dexamethasone (66.7%), methyldopa (66.7%) ferrous salt + folic acid (42.9%), and magnesium sulphate (40.0%) were also very commonly stocked out in the public sector. In the private sector stockouts in 2025 were most common for calcium gluconate (100%), magnesium sulphate (66.7%), carbetocin (50.0%), ferrous salt + folic acid (40.0%) and methyldopa (40.0%). Stockouts for these commodities did not last as long as in the public sector, with averages ranging between 8 and 52 days. In the faith-based sector calcium gluconate and ferrous salt + folic acid experienced stockouts at all facilities, with carbetocin, tranexamic acid and ferrous salt stocked out at half.

Affordability

In 2022, all maternal health commodities for which price data was available were free in the public sector (see Table 7). In 2025 this was no longer the case. While oxytocin, magnesium sulphate, folic acid, and ferrous salt + folic acid were still available for free, dexamethasone (2.10 times the daily poverty line), tranexamic acid (2.80 days), mifepristone – misoprostol (3.50 days), and methyldopa (8.82 days) had to be paid for by the patient and were unaffordable. In the private sector affordability was an even bigger issue. Only a month's supply of folic acid was affordable, costing the equivalent of 0.63 days. The least affordable commodities were methyldopa (8.82 days), misoprostol (10.50 days) and magnesium sulphate (18.90 days). In the faith-based sector affordability was variable, with oxytocin, misoprostol, dexamethasone, folic acid, and ferrous salt + folic acid considered affordable (all costing less than the daily poverty line). Again, mifepristone – misoprostol, magnesium sulphate and dexamethasone were unaffordable.

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

	Public						Private						Faith-based					
	HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022 2025 (#)		HFs with a stock-out (%)		Average # of stockout days	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Oxytocin	6	7	0	14.3	0	90	5	6	0.0	16.7	0	60	2	2	0.0	0.0	0	0
Misoprostol	0	0	ND	ND	ND	ND	3	4	0.0	25.0	0	8	1	1	0.0	0.0	0	0
Carbetocin	0	1	ND	100	ND	240	1	2	0.0	50.0	0	12	0	2	ND	50.0	ND	30
Tranexamic acid	0	1	ND	0	ND	0	4	4	0.0	25.0	0	3	5	2	0.0	50.0	0	2
Mifepristone - misoprostol	0	2	ND	0	ND	0	0	3	ND	0.0	ND	0	0	0	ND	ND	ND	ND
Magnesium sulphate	5	5	0	40	0	90	4	3	0.0	66.7	0	8	1	1	0.0	0.0	0	0
Calcium gluconate	0	2	ND	100	ND	213	2	3	0.0	100.0	0	49	1	1	0.0	100.0	0	15
Ferrous salt	2	3	0	100	0	225	1	3	0.0	33.3	0	14	4	2	0.0	50.0	0	30
Folic acid	1	4	0	100	0	148	3	3	0.0	33.3	0	6	5	5	40.0	0.0	189	0
Ferrous salt + folic acid	12	7	0	42.9	0	206	4	5	0.0	40.0	0	52	4	5	0.0	100.0	0	102
Dexamethasone	2	3	0	66.7	0	75	7	6	0.0	16.7	0	90	1	3	0.0	0.0	0	0
Methyldopa	1	3	0	66.7	0	80	2	5	0.0	40.0	0	49	4	4	25.0	25.0	12	58

HF: Health Facilities ND: No data available

*No stock data available for (methyl)ergometrine

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

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Oxytocin	0 days	0 days	0.11 days	1.40 days	0.76 days	0 days
Misoprostol	-	-	1.14 days	10.50 days	5.70 days	1.00 days
Carbetocin	-	-	0 days	1.75 days	-	-
Tranexamic acid	-	2.80 days	12.16 days	2.80 days	-	5.60 days
Mifepristone - misoprostol	-	3.50 days	-	3.50 days	-	-
Magnesium sulphate	0 days	0 days	2.74 days	18.90 days	8.21 days	2.04 days
Calcium gluconate	0 days	-	0 days	-	-	-
Ferrous salt	0 days	-	0.07 days	-	1.25 days	-
Folic acid	0 days	0 days	1.14 days	0.63 days	1.14 days	0.70 days
Ferrous salt + folic acid	0 days	0 days	0.76 days	2.10 days	0 days	0.35 days
Dexamethasone	0 days	2.10 days	4.56 days	2.10 days	2.28 days	0.20 days
Methyldopa	0 days	8.82 days	9.57 days	8.82 days	13.68 days	7.22 days

-: No price data available.

No data available for ergometrine across any of the sectors

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, in 2025 four of nine STI treatment commodities had an 80% or higher availability. On top of that, the availability of STI treatment commodities generally increased in Isiolo County from 2022 to 2025 (Table 8). All three sectors met the WHO availability threshold of 80% for metronidazole, clotrimazole and amoxicillin. The private sector further had a 100% availability for azithromycin and ceftriaxone, and an 87.5% availability for doxycycline. In the faith-based sector, ceftriaxone and doxycycline also had a high availability at 85.7%.

Figure 3. Overall availability of STI treatment commodities

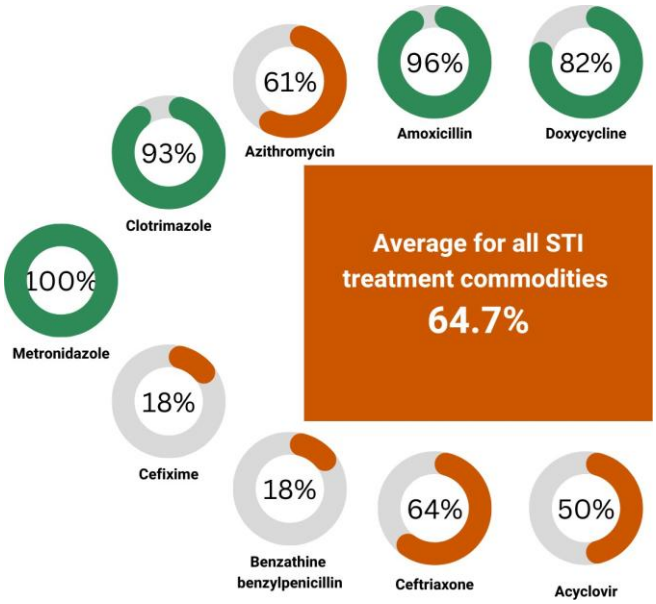


Table 8. Availability of STI treatment in 2022 and 2025, per sector

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Metronidazole	51.7	100.0	7.1	100.0	100.0	100.0	85.7	100.0
Clotrimazole	58.6	92.9	28.6	92.3	75.0	100.0	100.0	85.7
Benzathine benzylpenicillin	37.9	17.9	14.3	7.7	50.0	37.5	71.4	14.3
Amoxicillin	82.8	96.4	71.4	92.3	100.0	100.0	85.7	100.0
Acyclovir	31.0	50.0	21.4	46.2	37.5	50.0	42.9	57.1
Azithromycin	58.6	60.7	35.7	30.8	75.0	100.0	85.7	71.4
Ceftriaxone	34.5	64.3	21.4	30.8	50.0	100.0	42.9	85.7
Doxycycline	86.2	82.1	78.6	76.9	87.5	87.5	100.0	85.7
Cefixime	37.9	17.9	0.0	0.0	50.0	62.5	100.0	0.0

Stockouts

Similar to the trends seen for other commodities, stockouts of STI treatment commodities also worsened in 2025 compared to 2022 (see Table 9). In the public sector, more than half of facilities experienced stockouts of acyclovir, cefixime, azithromycin, ceftriaxone and benzathine benzylpenicillin. The stockouts of acyclovir, benzathine benzylpenicillin and ceftriaxone were especially lengthy, lasting on average 135 to 218 days. In the private sector, while stockouts still occurred, they were less frequent. Only stockouts of benzathine benzylpenicillin (60.0%) and cefixime (33.3%) were quite common. However, they lasted much shorter than in the public sector (41 and 7 days, respectively). In the faith-based sector, stockouts were especially frequent for cefixime azithromycin and benzathine benzylpenicillin, but again were not as lengthy as in the public sector.

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

	Public						Private						Faith-based					
	HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022/2025 (#)		HFs with a stockout (%)		Average # of stockout days		HFs with stock card 2022 2025 (#)		HFs with a stockout (%)		Average # of stockout days	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Metronidazole	2	13	0.0	7.7	0	76	8	7	0.0	0.0	0	0	6	7	0.0	0.0	0	0
Clotrimazole	4	10	0.0	30.0	0	99	6	7	0.0	14.3	0	36	7	6	0.0	16.7	0	7
Benzathine benzylpenicillin	2	6	0.0	83.3	0	138	4	5	0.0	60.0	0	41	5	3	0.0	33.3	0	30
Amoxicillin	9	10	11.1	20.0	365	90	8	7	0.0	14.3	0	22	6	7	0.0	0.0	0	0
Acyclovir	3	4	0.0	50.0	0	135	3	3	0.0	0.0	0	0	3	5	33.3	20.0	365	54
Azithromycin	5	8	60.0	62.5	242	74	6	8	0.0	12.5	0	39	6	7	0.0	42.9	0	21
Ceftriaxone	3	6	66.7	66.7	228	218	5	7	0.0	0.0	0	0	3	6	0.0	16.7	0	8
Doxycycline	10	10	20.0	0.0	228	0	7	7	0.0	0.0	0	0	7	7	0.0	14.3	0	17
Cefixime	0	2	ND	50.0	ND	11	4	6	0.0	33.3	0	7	7	1	0.0	100.0	0	12

HF: Health Facilities ND: No data available

Affordability

Like in 2022, in 2025 all STI treatment commodities in the public sector were free to the patient, with the exception of ceftriaxone. However, a treatment of ceftriaxone was still affordable (0.35 days). In the private sector, while affordability of some commodities improved, four were still considered unaffordable (clotrimazole, amoxicillin, azithromycin and ceftriaxone). In the faith-based sector, ceftriaxone was the only commodity considered unaffordable at 1.40 days.

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

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Metronidazole	-	0 days	1.33 days	0.98 days	0.74 days	0.33 days
Clotrimazole	0 days	0 days	2.28 days	1.40 days	0.19 days	0 days
Amoxicillin	0 days	0 days	2.39 days	1.47 days	0 days	0.98 days
Acyclovir	0 days	0 days	6.72 days	-	2.28 days	0 days
Azithromycin	0 days	0 days	1.14 days	1.57 days	0.38 days	0.70 days
Ceftriaxone	0 days	0.35 days	1.90 days	1.57 days	-	1.40 days
Doxycycline	0 days	0 days	1.06 days	0.98 days	0.53 days	0.73 days
Cefixime	-	-	0.49 days	0.35 days	0.11 days	-

-: No price data available

No price data available for benzathine benzylpenicillin across any of the sectors

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.

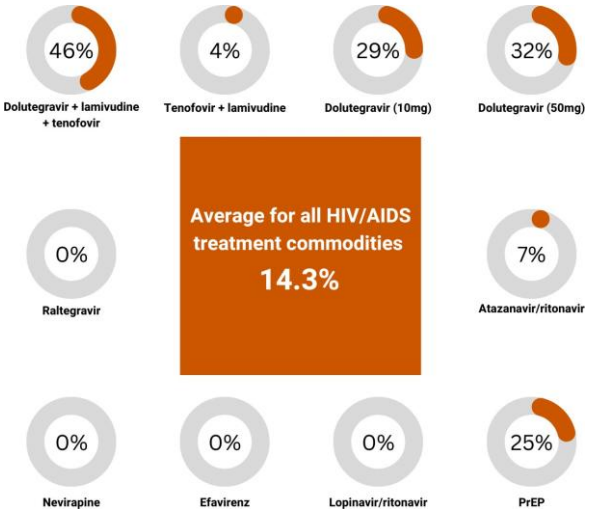
The essential commodities surveyed for HIV/AIDS management serve three critical functions:

- **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 remained low in 2025 (see Figure 4). For PrEP, dolutegravir + lamivudine + tenofovir, dolutegravir (50mg) an dolutegravir (10mg) overall availability increased compared to 2022. Unfortunately, overall availability of five other HIV/AIDS commodities decreased from 2022 to 2025.

Figure 4. Overall availability of HIV/AIDS commodities



In the public sector, availability of PrEP (35.7% to 38.5%), dolutegravir + lamivudine + tenofovir (57.1% to 61.5%) and dolutegravir (50mg) (35.7% to 38.5%) increased slightly from 2022 to 2025 (see Table 11). However, the overall trend in the public sector is not positive, as the availabilities of tenofovir + lamivudine, atazanavir/ritonavir, lopinavir/ritonavir and efavirenz decreased noticeably. In the private sector in 2025, as in 2022, none of the HIV/AIDS commodities were available at the surveyed facilities. In the faith-based sector, PrEP (28.6%), dolutegravir + lamivudine + tenofovir (71.4%) and dolutegravir 50mg (57.1%) and 10mg (42.9%) were the only HIV/AIDS commodities available.

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

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	17.2	25.0	35.7	38.5	0.0	0.0	0.0	28.6
Dolutegravir + lamivudine + tenofovir	37.9	46.4	57.1	61.5	0.0	0.0	42.9	71.4
Tenofovir + lamivudine	27.6	3.6	42.9	7.7	0.0	0.0	28.6	0.0
Atazanavir/ritonavir	20.7	7.1	42.9	15.4	0.0	0.0	0.0	0.0
Lopinavir/ritonavir	17.2	0.0	35.7	0.0	0.0	0.0	0.0	0.0
Raltegravir	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dolutegravir (50mg)	20.7	32.1	35.7	38.5	0.0	0.0	14.3	57.1
Pediatric dolutegravir (10mg)	24.1	28.6	42.9	38.5	0.0	0.0	14.3	42.9
Efavirenz	17.2	0.0	35.7	0.0	0.0	0.0	0.0	0.0
Nevirapine	10.3	0.0	21.4	0.0	0.0	0.0	0.0	0.0

Stockouts

In the public sector, PrEP stockouts occurred at 28.6% of facilities, lasting on average 81 days (see Table 12). Lopinavir/ritonavir and efavirenz experienced stockouts at all facilities, even though the stockout of lopinavir/ritonavir lasted only two days. Nevirapine was stocked out at 75.0% of facilities, lasting on average 100 days. Dolutegravir was stocked out at 16.7% of facilities, lasting only six days on average. In the faith-based sector, tenofovir + lamivudine (100% of facilities) and PrEP (33.3% of facilities) experienced stockouts, lasting on average 22 and 30 days on average.

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

	Public						Private						Faith-based					
	HFs with stock card 2022/2025 (#)		HFs with a stockout (%)		Average # of stockout days		HFs with stock card 2022/2025 (#)		HFs with a stockout (%)		Average # of stockout days		HFs with stock card 2022/2025 (#)		HFs with a stockout (%)		Average # of stockout days	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	5	7	20.0	28.6	30	81	0	1	ND	100.0	ND	30	0	3	ND	33.3	ND	30
Dolutegravir + lamivudine + tenofovir	8	7	12.5	0.0	60	0	0	0	ND	ND	ND	ND	3	5	0.0	0.0	0	0
Tenofovir + lamivudine	6	3	0.0	0.0	0	0	0	0	ND	ND	ND	ND	2	1	0.0	100.0	0	22
Atazanavir/ritonavir	5	3	0.0	0.0	0	0	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND
Lopinavir/ritonavir	5	1	0.0	100.0	0	2	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND
Raltegravir	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND
Dolutegravir (50mg)	4	6	0.0	16.7	0	6	0	0	ND	ND	ND	ND	1	4	0.0	0.0	0	0
Pediatric dolutegravir (10mg)	6	5	0.0	0.0	0	0	0	0	ND	ND	ND	ND	1	3	0.0	0.0	0	0
Efavirenz	5	1	0.0	100.0	0	60	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND
Nevirapine	2	4	0.0	75.0	0	100	0	0	ND	ND	ND	ND	0	0	ND	ND	ND	ND

HF: Health Facilities ND: No data available

Affordability

As in 2022, all HIV/AIDS commodities were free to the patient in both the public and faith-based sectors.

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

	Public (%)		Faith-based (%)	
	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	0 days	0 days	-	0 days
Dolutegravir + lamivudine + tenofovir	0 days	0 days	0 days	0 days
Tenofovir + lamivudine	0 days	0 days	0 days	-
Atazanavir/ritonavir	0 days	0 days	-	-
Lopinavir/ritonavir	0 days	-	-	-
Dolutegravir (50mg)	0 days	0 days	0 days	0 days
Pediatric dolutegravir (10mg)	0 days	0 days	0 days	0 days
Efavirenz	0 days	-	-	-
PrEP (emtricitabine + tenofovir)	0 days	0 days	-	0 days

-: No price data available

No price data available for raltegravir and nevirapine across any of the sectors

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

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, compared to 2022, in 2025 only the availability of HIV self-tests increased from 27.6% to 53.6% (see Table 14). The availability of sanitary pads and pregnancy tests decreased slightly from 24.1% to 21.4% and 58.6% to 57.1%, respectively. HPV DNA tests remained scarcely available. In the public sector availability of sanitary pads decreased noticeably from 21.4% to 7.7%. Pregnancy tests and HIV-self tests did increase in

availability (35.7% to 46.2% and 21.4% to 30.8%, respectively). In the private sector availability of sanitary pads, pregnancy tests and HIV-self tests all increased. Only the HPV DNA test remained unavailable. The faith-based sector had the highest availability of HIV self-tests at 85.7%.

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

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Sanitary pads	24.1	21.4	21.4	7.7	25.0	50.0	28.6	14.3
Pregnancy test	58.6	57.1	35.7	46.2	75.0	87.5	85.7	42.9
HIV self-test	27.6	53.6	21.4	30.8	25.0	62.5	42.9	85.7
HPV DNA test	6.9	3.6	14.3	0.0	0.0	0.0	0.0	14.3

Stockouts

While in 2022 public facilities did not experience stockouts of sanitary pads and pregnancy tests, in 2025 stockouts did occur (see Table 15 on page 20). Specifically, 33.3% of public facilities experienced stockouts of sanitary pads, lasting on average 243 days, while 25.0% of facilities experienced stockouts of pregnancy tests, which lasted on average 60 days. HIV self-test were stocked out at 16.7% of facilities, a slight decrease compared to 2022. Sanitary pads and HIV self-tests were stocked out at some private sector facilities as well.

Affordability

Like in 2022, all tests and pads were free in the public sector (see Table 16). In the private sector, sanitary pads and HIV self-tests were unaffordable, costing more than the daily national poverty line (1.84 days and 2.10 days, respectively). Similarly, the HIV self-test was also unaffordable in the faith-based sector.

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

	Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025
Sanitary pads	0 days	0 days	-	1.84 days	0 days	0 days
Pregnancy test	0 days	0 days	0 days	0.70 days	0 days	0.35 days
HIV self-test	0 days	0 days	0.19 days	2.10 days	0 days	1.75 days
HPV DNA test	0 days	-	-	-	-	-

-: No price data available

No price data available for benzathine benzylpenicillin across any of the sectors

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						Faith-based					
	HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022/2025 (#)		HFs with a stock-out (%)		Average # of stockout days		HFs with stock card 2022 2025 (#)		HFs with a stock-out (%)		Average # of stockout days	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Sanitary pads	3	6	0.0	33.3	0	243	2	3	0.0	66.7	0	10	2	1	0.0	0.0	0	0
Pregnancy test	3	8	0.0	25.0	0	45	6	6	0.0	0.0	0	0	6	4	0.0	0.0	0	0
HIV self-test	5	6	20.0	16.7	90	60	2	5	0.0	20.0	0	365	3	6	0.0	0.0	0	0

HF: Health Facilities ND: No data available

No stock data available for HPV DNA test kits

4. SUMMARY AND RECOMMENDATIONS

KEY FINDINGS

Evidence from 2022 to 2025 indicates a significant deterioration in the availability of essential SRH commodities in Isiolo County. While some sectors show marginal gains, the public sector—which serves the most vulnerable—is plagued by chronic stockouts lasting up to eight months, alongside new user fees for maternal health services. This finding highlights a critical breakdown in the healthcare safety net in Isiolo County, directly correlating with the systemic shifts caused by the USAID Stop Work Order (SWO) and the subsequent transition for domestic resource mobilisation to ensure commodity security. Because USAID historically bridged the gap for high-cost SRH commodities (contraceptives, maternal health kits), their absence created a vacuum that the public sector has failed to fill. The eight-month stockouts mentioned suggest a total collapse of the "last-mile" delivery system rather than a temporary delay.

This section highlights the most critical gaps and presents actionable recommendations for the County Government to safeguard Universal Health Coverage (UHC) and reduce preventable maternal and neonatal deaths. Overall, availability declined for more than half of all family planning commodities between 2022 and 2025. Availability of male condoms and select oral contraceptives in public health facilities dropped sharply from over 80% in 2022 to just 38.5% in 2025. Similarly, availability of magnesium sulphate, essential for the management of (pre-)eclampsia, fell from 35.7% to an alarming 15.4%. While the availability of sexually transmitted infection (STI) medicines showed general improvement, persistent and prolonged stockouts of benzathine benzylpenicillin and ceftriaxone in public facilities—lasting up to 218 days—continue to undermine effective treatment and prevention efforts.

These findings further demonstrate that, while some sectors saw "marginal gains," the public sector bore the brunt of the crisis. This indicates a growing inequity. Those who can afford private care may still access commodities, but the most vulnerable populations—who rely exclusively on public facilities—are being denied basic rights due to empty shelves. Most concerning is the introduction of new user fees for maternal health. For years, Kenya's "Linda Mama" program aimed to eliminate financial barriers to maternal care. The introduction of fees, combined with stockouts, creates a "double burden": patients must now pay for services that should be free, while often being forced to buy the necessary commodities (syringes, oxytocin, etc.) from private pharmacies because the hospital is out of stock.

The evidence suggests that Isiolo County is experiencing a "post-USAID transition crisis." The lack of a robust, state-funded contingency plan following the Stop Work Order has effectively privatized SRH access, leaving the public sector incapacitated and the most vulnerable residents at significant risk.

Taken together, these trends place Isiolo County's progress toward the Sustainable Development Goals (SDGs) on maternal and reproductive health at serious risk. Without urgent action to stabilise the SRH supply chain and eliminate financial barriers to care, the county risks reversing hard-won health gains achieved in previous years.

General Trends and Availability

- **Overall Decline:** Availability of family planning commodities decreased for more than half of the products surveyed.
- **Failed Benchmarks:** In 2022, only two commodities met the WHO 80% availability benchmark in public facilities; by 2025, only medroxyprogesterone acetate (92%) met this threshold.

- **Sector Performance:** Public and faith-based sectors saw generally low or decreasing availability. The private sector saw some increases, notably for levonorgestrel (1.5mg), which increased from 0% to 50% availability.
- **Maternal Health:** While more maternal health items saw increases than decreases, only methyldopa was available at 80% of facilities. Availability for commodities treating postpartum haemorrhage is dangerously low, with oxytocin available at only 38.5% of public facilities.

Stockouts and Supply Chain Gaps

- **Widespread Stockouts:** In 2025, stockouts in the public sector were very common and lengthy.
- **Severe Impacts:** 100% of public facilities experienced stockouts of several family planning pills and IUDs, with durations ranging from 63 to 117 days.
- **Critical Maternal Gaps:** Maternal health commodities like magnesium sulphate and carbetocin saw 100% stockout rates in the public sector, lasting 148 to 240 days.

Affordability and Financial Barriers

- **Erosion of Free Care:** In 2022, all maternal health products were free in the public sector; by 2025, essential items like dexamethasone and methyldopa became "unaffordable," requiring out-of-pocket payments.
- **Private Sector Costs:** Almost all private sector commodities increased in price, with, for example, levonorgestrel-releasing IUD costing the equivalent of 34.99 days of the daily rural poverty line.
- **STI Treatment:** Most STI treatments remain free or affordable in the public sector, though ceftriaxone is now priced at 0.35 days of income.

ADVOCACY RECOMMENDATIONS

Based on these findings and established health systems advocacy frameworks, the following recommendations are proposed for Isiolo County stakeholders:

1. Strengthen Supply Chain & Commodity Security	
Improve forecasting	The County Health Management Team (CHMT) should implement more rigorous data-driven forecasting to prevent the lengthy stockouts observed.
Redistribution protocols	Establish a formal system to redistribute overstocked commodities to facilities facing stockouts to maximise existing resources.
Prioritise PPH commodities	Urgent intervention is needed to ensure **oxytocin** and **magnesium sulphate** are consistently available at 100% of facilities to prevent maternal mortality.
2. Protect Affordability & UHC	
Eliminate point-of-use payments	Revert to the 2022 status where maternal health commodities were free in public facilities to prevent unaffordable costs for patients. This can be done by upgrading level 2 facilities to level 3, which operate 24 hours and have maternity services, to leverage the Primary Health Care Funds reimbursed through Social Health Insurance Fund. These funds offers all health services at no cost to all citizens, provided they are registered to the health insurance fund.

3. Policy & Governance	
Ring-fencing budgets	Advocate for the County Government to ring-fence specific budget lines for SRH commodities to ensure replenishment is not disrupted by broader fiscal challenges. This can be done through a policy direction to ringfence a percentage of the Facility Improvement funds (FIF) for procurement of essential commodities, including for SRH at facility level.
Ring-fence SRH budgets	Establish a protected fund within the County Health Budget specifically for the procurement and distribution of "Tracer" SRH commodities to prevent the current 200+ day stockouts.
Emergency procurement of maternal health supplies	Immediately address the dangerously low levels of oxytocin and magnesium sulphate to prevent maternal mortality.
Strengthen supply chain digitisation	Improve the use of stock cards and digital reporting; the faith-based sector currently lacks sufficient stock cards, leading to lengthy, unmonitored stockouts.
Last-mile distribution reform	Address the disparity where stockouts in the public sector last significantly longer (148-240 days) than in the private sector (8-52 days) for the same commodities in sub-counties, such as Merti and Garbatulla.
4. Health Information & improvement in service delivery	
Strengthen health information systems	To improve availability, the CHMT should support health facilities to strengthen the accuracy, timeliness, and completeness of health information on stock status and consumption. This can be achieved through availing of data documentation, reporting and ordering tools.
Strengthen facility-level commodity governance and data use	The County and Sub-County health management teams should conduct regular meetings with facility-in-charges on commodity management and data use for decision-making in order to avoid wastage and stock-out of commodities.
Integrate SRH Commodity Oversight into Supportive Supervision	To systematically identify gaps that might hinder availability and access, the 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.
5. Adolescent & Youth Sexual and Reproductive Health (AYSRH) Policy Framework	
Develop a costed county strategy to end the "Triple Threat"	Mandate the CHMT to lead the development and implementation of a fully costed county strategy to address adolescent unintended pregnancies, sexually transmitted infections, and HIV. The strategy should clearly define roles, financing mechanisms, and accountability structures
Institutionalise Youth-friendly Services (YFS)	Establish a clear legal and policy framework to integrate youth-friendly SRH services into county health systems, including mandatory training of healthcare providers on youth-friendly service delivery and standards of care.
Restore and repurpose YFS infrastructure	Re-establish a dedicated youth-friendly centre to replace the facility repurposed during the COVID-19 response, ensuring adolescents and young people have safe, confidential, and accessible entry points to SRH services.

Target adolescent mothers through group antenatal care and counselling	Institutionalise the mapping and enrolment of adolescent mothers into group antenatal care (ANC) and tailored counselling programs to reduce repeat early pregnancies and mitigate maternal mortality risks.
Guarantee financial protection and skilled deliveries	Ensure automatic enrolment of adolescent mothers into the Social Health Authority (SHA) or equivalent schemes to guarantee access to skilled delivery services and continuity of quality maternal and reproductive healthcare.
Improved policy framework that mainstreams SRHR for adolescents and young people	This could include action by the County Health Management Team 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 and repurposing of a new youth friendly centre to replace the one that was turned into a COVID-19 centre. 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 SHA to guarantee skilled deliveries and access to quality health care.
6. Integration of Social Accountability Framework	
Citizen-centred approach	The CHMT should adopt a transparent, citizen-centred approach to SRH management to build public trust and improve service delivery.
Transparency and reporting	Establish clear mechanisms for reporting on commodity performance and stock availability, ensuring data is accessible to the public.
Civic engagement	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.
Awreness and advocacy	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.
7. Cultural & Religious Leader Engagement	
Address cultural barriers	Counteract social-cultural barriers by integrating SRH advocacy into religious and traditional frameworks.
Training for religious leaders	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.”

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ANNEX 1

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

HIV/AIDS		
34	Pre-Exposure Prophylaxis: (emtricitabine (FTC) + tenofovir (TDF))	Prevention of HIV infection
35	Dolutegravir + lamivudine + tenofovir (DTG + 3TC + TDF)	Antiretroviral, management of HIV/AIDS
36	Tenofovir + lamivudine (TDF + 3TC)	Antiretroviral, management of HIV/AIDS
37	Atazanavir/ritonavir (ATV/r)	Antiretroviral, management of HIV/AIDS
38	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


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Solutions for Supporting Healthy Adolescents