REPORT

Sexual and Reproductive Health Commodities in Marsabit County, Kenya:

Availability, Stockouts And Affordability 2022 & 2025

sharp

Solutions for Supporting Healthy Adolescents

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Sexual and Reproductive Health Commodities in Marsabit 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 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 **Marsabit County**.

What we found

The findings below underscore a stark reality: while Kenya's national SRH indicators are improving, the women and adolescents of Marsabit are being left behind. Examples of this include:

- Pervasive stockouts of family planning commodities in the public sector; etonogestrel implants and levonorgestrel-releasing IUDs were stocked out at 100% of public facilities, with gaps lasting up to 64 days.
- A sharp decline in the availability of life-saving maternal health commodities; oxytocin, the gold standard for preventing haemorrhage, dropped from 51.9% availability in 2022 to just 14.3% in 2025.
- Availability of HIV commodities is "suboptimal" and generally decreased; the most common regimen (Dolutegravir + Lamivudine + Tenofovir) reached only 37.5% availability in public facilities.
- There is a clear affordability gap in the private sector; While free or low-cost in public and faith-based sectors, an IUD in the private sector now costs the equivalent of 34.99 days of average income.

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, common treatment regimens (see Annex 2), 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 Marsabit County, in which 29 health facilities were surveyed in 2022 (14 public, 8 private, 7 faith-based), and 28 health facilities in 2025 (16 public, eight private, four 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).

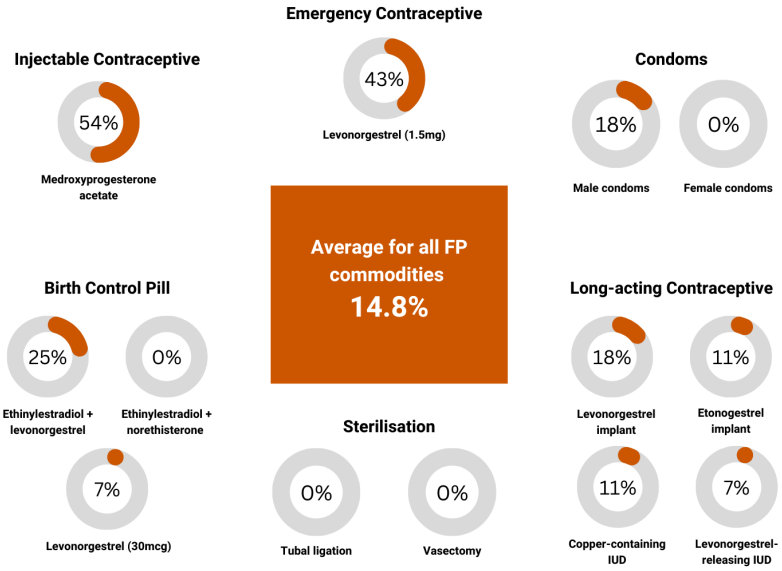
The available contraceptive methods are categorised by their administration and duration of efficacy to meet diverse user needs:

- **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

Figure 1 is an overview of overall availability of family planning commodities. Overall, availability of family planning commodities was critically low, with the exception of the emergency contraceptive (levonorgestrel 1.5mg) and medroxyprogesterone acetate, available at about half of facilities. Further, availability of the commodities decreased for more than half of the commodities between 2022 and 2025 (see Table 2). Even for those that did increase in overall availability, they still remained limitedly available. Levonorgestrel 1.5mg (emergency contraceptive), for example, increased from 11.1% to 42.9%, medroxyprogesterone acetate from 51.9% to 53.6%, and levonorgestrel implants from 7.4% to 17.9%.

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



In 2022, only etonogestrel implants in public health facilities had an availability above 80%, meeting the WHO 80% or above availability benchmark. Availability of this implant decreased in 2025 to 12.5%. In 2025, highest availability was now found for medroxyprogesterone acetate (50% of facilities). Similar to the overall trend, in the public sector availabilities also tended to decrease. Only levonorgestrel (1.5mg), levonorgestrel implants, and levonorgestrel-releasing IUDs saw a slight increase in availability.

In the private sector, levonorgestrel (1.5mg) saw the largest increase, from 37.5% to 75.0%. The only other increase was seen for levonorgestrel-releasing IUDs. Nevertheless,this commodity was still only available at 12.5% of private facilities. Ethinylestradiol + norethisterone, levonorgestrel 30mcg, levonorgestrel and etonogestrel implants, female condoms, as well as vasectomy and tubal ligation services were unavailable at all private facilities. In the faith-based sector, availability of all family planning commodities remained low, with highest availability (75.0%) found for medroxyprogesterone acetate.

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	51.9	25.0	76.9	18.8	37.5	37.5	16.7	25.0
Ethinylestradiol + norethisterone	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Levonorgestrel (30 mcg)	44.4	7.1	53.8	12.5	37.5	0.0	33.3	0.0
Levonorgestrel (1.5 mg)	11.1	42.9	0.0	31.3	37.5	75.0	0.0	25.0
Medroxyprogesterone acetate	51.9	53.6	69.2	50.0	50.0	50.0	16.7	75.0
Implants: levonorgestrel	7.4	17.9	0.0	25.0	12.5	0.0	16.7	25.0
Implants: etonogestrel	55.6	10.7	84.6	12.5	25.0	0.0	33.3	25.0
Copper-containing IUD	33.3	10.7	38.5	12.5	25.0	12.5	33.3	0.0
Levonorgestrel-releasing IUD	0.0	7.1	0.0	6.3	0.0	12.5	0.0	0.0
Male condoms	40.7	17.9	46.2	12.5	37.5	25.0	33.3	25.0
Female condoms	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Vasectomy services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Tubal ligation services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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). Etonogestrel implants and levonorgestrel-releasing IUDs experienced stockouts at all public facilities, with stockouts ranging from 45 to 64 days on average. Ethinylestradiol + levonorgestrel and levonorgestrel 1.5mg were stocked out at half of facilities, lasting on average 238 and 49 days, respectively.

The faith-based sector also experienced stockouts in 2025, specifically for ethinylestradiol + levonorgestrel (100%, lasting 75 days), levonorgestrel 1.5mg (100%, lasting 42 days), etonogestrel implants (100%, lasting 30 days on average), and medroxyprogesterone acetate (50.0%, lasting on average 42 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						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	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	8	4	0.0	50.0	0	238	2	1	50.0	100.0	1	75
Levonorgestrel (30 mcg)	6	2	0.0	0.0	0	0	2	0	0.0	ND	0	0
Levonorgestrel (1.5 mg)	0	4	ND	50.0	ND	49	0	1	ND	100.0	ND	42
Medroxyprogesterone acetate	10	6	20.0	33.3	19	39	2	2	50.0	50.0	35	38
Implants: levonorgestrel	0	3	ND	0.0	ND	0	1	1	0.0	0.0	0	0
Implants: etonogestrel	11	2	54.5	100.0	61	45	1	1	0.0	100.0	0	30
Copper-containing IUD	5	2	0.0	0.0	0	0	2	0	0.0	ND	0	ND
Levonorgestrel-re-leasing IUD	0	1	ND	100.0	ND	64	0	0	ND	ND	ND	ND
Male condoms	11	1	54.5	0.0	40	0	2	1	0.0	0.0	0	0

HF: Health Facilities ND: No data available.

No stock data from the private sector in 2025

No 2025 stock data for ethinylestradiol + norethisterone and female condoms

Affordability

As in 2022, all family planning products were accessible in the public sector and faith-based 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).

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

	Public		Private		Faith-based	
	2022	2025	2022	2025	2022	2025
Ethinylestradiol + levonorgestrel	0 days	0 days	0.11 days	1.52 days	0 days	0 days
Levonorgestrel (30 mcg)	0 days	0 days	0.13 days	-	0 days	-
Levonorgestrel (1.5 mg)	-	0 days	-	1.22 days	-	-
Medroxyprogesterone acetate	0 days	0 days	0.95 days	1.40 days	0 days	0 days
Implants: levonorgestrel	-	0 days	-	-	0 days	0 days
Implants: etonogestrel	0 days	0 days	2.28 days	-	0 days	0 days
Copper-containing IUD	0 days	0 days	0 days	10.50 days	0 days	-
Levonorgestrel-releasing IUD	-	0 days	-	34.99 days	-	-
Male condoms	0 days	0 days	0.25 days	0.23 days	0 days	0 days

No price data available for ethinylestradiol + norethisterone and female condoms across all three sectors

-: No price data available

MATERNAL HEALTH

Maternal health commodities encompass a vital range of 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).

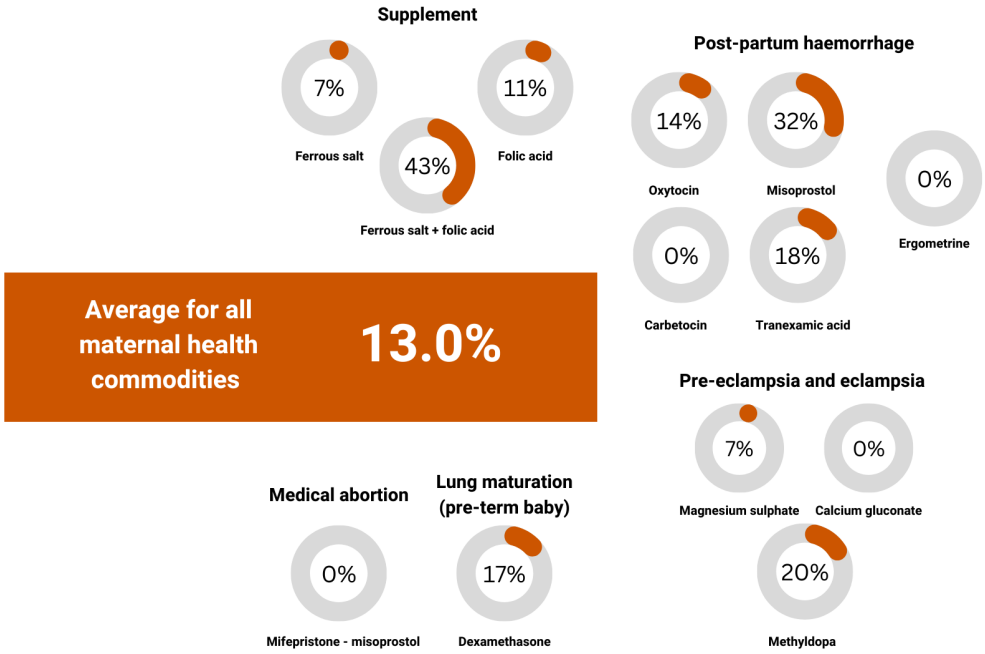
These commodities are categorised by their specific clinical interventions:

- **Antenatal Supplements:** Products such as iron and folic acid are essential for preventing deficiencies that lead to anemia and adverse fetal outcomes, including neural tube defects (WHO, 2012).
- **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, availability of maternal health commodities was also low in 2025, with highest availability found for misoprostol (32%) (see Figure 2). Further, the availability of all but three maternal health commodities decreased between 2022 and 2025 (see Table 5). Oxytocin, for example, decreased from 51.9% in 2022 to 14.3% in 2025. Carbetocin, ergometrine and mifepristone – misoprostol remained unavailable, and magnesium sulphate was available at even fewer health facilities (7.1%). Only misoprostol saw a noticeable increase, from 11.1% in 2022 to 32.1% in 2025.

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



Trends in the public sector were comparable. Oxytocin reduced significantly from 61.5% to 12.5%, availability of misoprostol increased slightly to 18.8%, while ferrous salt + folic acid also saw a noticeable decrease from 84.6% to 31.3%. In the private sector, misoprostol and ferrous salt + folic acid saw the largest increases in availability. Unfortunately, availability of all other maternal health commodities was seriously low. The faith-based sector did not do much better, with no commodity available at more than half of facilities.

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	51.9	14.3	61.5	12.5	37.5	12.5	50.0	25.0
Misoprostol	11.1	32.1	0.0	18.8	25.0	62.5	16.7	25.0
Carbetocin[a]	0.0	0.0	0.0	0.0	0.0	0.0	-	-
Tranexamic acid	22.2	17.9	0.0	12.5	50.0	37.5	33.3	0.0
(methyl)ergometrine[a]	0.0	0.0	0.0	0.0	0.0	0.0	-	-
Mifepristone - misoprostol[a]	0.0	0.0	0.0	0.0	0.0	0.0	-	-
Magnesium sulphate	11.1	7.1	15.4	6.3	0.0	0.0	16.7	25.0
Calcium gluconate	8.3	0.0	14.3	0.0	0.0	0.0	0.0	-
Ferrous salt	3.7	7.1	7.7	6.3	0.0	12.5	0.0	0.0
Folic acid	22.2	10.7	7.7	6.3	50.0	25.0	16.7	0.0
Ferrous salt + folic acid	63.0	42.9	84.6	31.3	12.5	62.5	83.3	50.0
Dexamethasone	16.7	16.7	0.0	14.3	25.0	20.0	100.0	-
Methyldopa[a]	50.0	20.0	100.0	50.0	33.3	0.0	-	-

[a]Available from health centre level and up

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

Stockouts

Stockouts were very common for maternal health commodities in the public sector, and worsened in 2025 compared to 2022 (see Table 6). In the public sector, misoprostol, 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 81 to 210 days. Oxytocin (66.7%) and magnesium sulphate (50.0%) were also very commonly stocked out in the public sector. In the faith-based sector, misoprostol and ferrous salt + folic acid experienced stockouts at all facilities, lasting on average 52 and 62 days, respectively.

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						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	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Oxytocin	10	3	20.0	66.7	18	120	3	1	0.0	0.0	0	0
Misoprostol	1	2	100.0	100.0	65	81	1	1	0.0	100.0	0	52
Tranexamic acid	0	2	ND	0.0	ND	0	2	0	0.0	ND	0	ND
Magnesium sulphate	4	2	50.0	50.0	50	120	2	1	50.0	0.0	12	0
Calcium gluconate	1	1	0.0	100.0	0	60	0	0	ND	ND	ND	ND
Ferrous salt	2	1	50.0	100.0	56	132	2	0	100.0	ND	28	ND
Folic acid	1	1	0.0	100.0	0	210	2	0	50.0	ND	1	ND
Ferrous salt + folic acid	10	3	0.0	33.3	0	120	5	1	20.0	100.0	30	62
Dexamethasone	3	1	100.0	0.0	45	0	3	0	33.3	ND	6	ND

HF: Health Facilities. ND: No data available.

No stock data from the private sector in 2025.

No 2025 stock data for carbetocin, (methyl)ergometrine, mifepristone – misoprostol and methyldop

Affordability

In both 2022 and 2025, all maternal health commodities for which price data was available were free in the public sector (see Table 7). In the private sector affordability was a significant problem. Only a treatment of oxytocin was considered affordable, costing the equivalent of 0.14 days. The least affordable commodities were misoprostol (7.00 days), and tranexamic acid (5.60 days). In the faith-based sector not a lot of maternal health commodities had price data available. Of the four that did, three were free to the patient (oxytocin, misoprostol and magnesium sulphate), while a month's supply of ferrous salt + folic acid cost 1.05 days.

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	0.76 days	0.14 days	0.92 days	0 days
Misoprostol	-	0 days	-	7.00 days	-	0 days
Tranexamic acid	-	-	-	5.60 days	-	-
Magnesium sulphate	0 days	0 days	-	-	-	0 days
Calcium gluconate	0 days	-	-	-	-	-
Ferrous salt	0 days	0 days	-	-	-	-
Folic acid	-	0 days	2.28 days	1.05 days	-	-
Ferrous salt + folic acid	0 days	0 days	-	2.10 days	0 days	1.05 days
Dexamethasone	-	0 days	4.56 days	2.62 days	2.28 days	-
Methyldopa	0 days	0 days	13.68 days	-	-	-

-: No price data available.

No data available for carbetocin, (methyl)ergometrine and mifepristone - misoprostol 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).

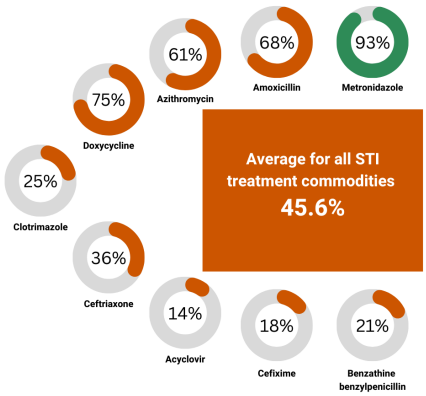
The surveyed commodities are categorised by the nature of the infection:

- **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, such as ceftriaxone for gonorrhea, and doxycycline or benzathine penicillin—the gold standard for syphilis (WHO, 2024).
- **Antivirals for viral management:** The survey includes essential antivirals like 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

As shown in Figure 3 (page 13), the overall availability of STI treatment commodities was variable in Marsabit County in 2025, ranging from 14% for Acycolvir to 93% for Metronidazole.

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



Metronidazole met the 80% availability threshold in all three sectors (see Table 8). The private sector had a 100% availability for amoxicillin, azithromycin and ceftriaxone. While in the public sector many of the STI treatment commodities saw an increase in availability from 2022 to 2025, availability was still suboptimal. In the faith-based sector availability generally decreased in 2025 compared to 2022.

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

	Overall (%)		Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Metronidazole	88.9	92.9	84.6	87.5	100.0	100.0	83.3	100.0
Clotrimazole	44.4	25.0	23.1	31.3	62.5	12.5	66.7	25.0
Benzathine benzylpenicillin	18.5	21.4	0.0	37.5	62.5	0.0	0.0	0.0
Amoxicillin	63.0	67.9	38.5	50.0	75.0	100.0	100.0	75.0
Acyclovir	37.0	14.3	15.4	25.0	75.0	0.0	33.3	0.0
Azithromycin	51.9	60.7	38.5	37.5	62.5	100.0	66.7	75.0
Ceftriaxone	40.7	35.7	30.8	18.8	50.0	62.5	50.0	50.0
Doxycycline	48.1	75.0	23.1	68.8	75.0	100.0	66.7	50.0
Cefixime	25.9	17.9	7.7	6.3	62.5	37.5	16.7	25.0

Stockouts

Similar to the trends seen for the other services, stockouts of STI treatment commodities also worsened in 2025 compared to 2022 (see Table 9). In the public sector, more all facilities experienced stockouts of ceftriaxone, doxycycline and cefixime, while 80% also experienced stockouts of amoxicillin. The stockouts of amoxicillin were especially lengthy, lasting on average 216 days. In the faith-based sector, all facilities experienced stockouts for amoxicillin, azithromycin, ceftriaxone and cefixime. Again, stockouts of amoxicillin lasted on average the longest at 215 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						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	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
Metronidazole	10	9	20.0	66.7	29	79	5	2	0.0	50.0	0	167
Clotrimazole	4	2	25.0	0.0	40	0	4	1	0.0	0.0	0	0
Benzathine benzylpenicillin	1	1	0.0	0.0	0	0	0	0	ND	ND	ND	ND
Amoxicillin	7	5	42.9	80.0	54	216	5	1	20.0	100.0	22	215
Azithromycin	6	2	33.3	50.0	21	70	6	1	50.0	100.0	24	82
Ceftriaxone	8	1	62.5	100.0	26	65	3	1	0.0	100.0	0	42
Doxycycline	5	4	60.0	100.0	58	66	5	0	20.0	ND	20	ND
Cefixime	2	1	50.0	100.0	68	73	2	1	50.0	100.0	120	11

HF: Health Facilities ND: No data available

No stock data from the private sector in 2025

No 2025 stock data for acyclovir

Affordability

Like in 2022, in 2025 all STI treatment commodities were free to the patient in the public sector (see Table 10). In the private sector, while affordability of some commodities improved, three were still considered unaffordable (clotrimazole, azithromycin and ceftriaxone). In the faith-based sector, azithromycin and doxycycline were considered unaffordable at 1.05 days and 1.22 days, respectively.

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	0 days	0.80 days	0.65 days	-	0.65 days
Clotrimazole	0 days	0 days	-	1.40 days	0.38 days	0 days
Benzathine benzylpenicillin	-	0 days	-	-	-	-
Amoxicillin	-	0 days	1.05 days	0.98 days	-	0.97 days
Acyclovir	0 days	0 days	2.28 days	-	-	-
Azithromycin	-	0 days	1.71 days	1.05 days	0.38 days	1.05 days
Ceftriaxone	0 days	0 days	1.52 days	1.05 days	-	0 days
Doxycycline	0 days	0 days	1.06 days	0.98 days	0.53 days	1.22 days
Cefixime	0 days	0 days	0.15 days	0.24 days	-	0.28 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.

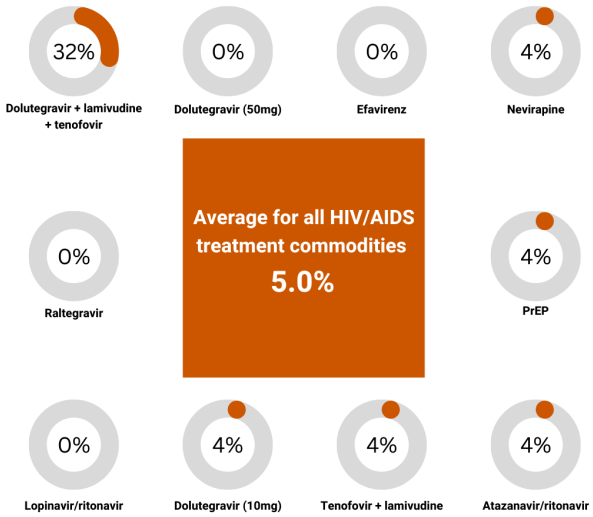
The essential commodities surveyed for HIV/AIDS management serve three critical functions:

- **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

In 2025, availability of HIV/AIDS commodities was critically low for all but dolutegravir + lamivudine + tenofovir (see Figure 4). Availability also generally decreased in 2025 compared to 2022 and remained low (see Table 11).

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



In the public sector, none of the availabilities increased from 2022 to 2025. Highest availability was found for dolutegravir + lamivudine + tenofovir at 37.5%, which is still very low. In the private sector in 2025, only dolutegravir + lamivudine + tenofovir was available at all, and only at 12.5% of facilities. The same was found for the faith-based sector, where dolutegravir + lamivudine + tenofovir was available at 50.0% of facilities.

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)	11.1	3.6	15.4	6.3	0.0	0.0	16.7	0.0
Dolutegravir + lamivudine + tenofovir	33.3	32.1	53.8	37.5	0.0	12.5	33.3	50.0
Tenofovir + lamivudine	7.4	3.6	7.7	6.3	0.0	0.0	16.7	0.0
Atazanavir/ritonavir	7.4	3.6	7.7	6.3	0.0	0.0	16.7	0.0
Lopinavir/ritonavir	3.7	0.0	0.0	0.0	0.0	0.0	16.7	0.0
Raltegravir	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dolutegravir (50mg)	14.8	0.0	7.7	0.0	12.5	0.0	33.3	0.0
Pediatric dolutegravir (10mg)	3.7	3.6	7.7	6.3	0.0	0.0	0.0	0.0
Efavirenz	11.1	0.0	15.4	0.0	0.0	0.0	16.7	0.0
Nevirapine	11.1	3.6	15.4	6.3	0.0	0.0	16.7	0.0

Stockouts

In the public sector, stock information was available for only four HIV/AIDS commodities, and only three or less facilities had stock cards available (see Table 12). In 2025, only dolutegravir + lamivudine + tenofovir experienced a stockout at 33.3% of facilities, lasting on average 83 days. In the faith-based sector data was available only for dolutegravir + lamivudine + tenofovir, with stockouts at both facilities with a stock card, which lasted on average 45 days.

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						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	
	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025	2022	2025
PrEP (emtricitabine + tenofovir)	3	1	66.7	0.0	73	0	1	0	0.0	ND	0	ND
Dolutegravir + lamivudine + tenofovir	7	3	14.3	33.3	15	83	2	2	0.0	100.0	0	45
Atazanavir/ritonavir	1	1	0.0	0.0	0	0	1	0	0.0	ND	0	ND
Pediatric dolutegravir (10mg)	1	1	0.0	0.0	0	0	0	0	ND	ND	ND	ND

HF: Health Facilities. ND: No data available.

No stock data from the private sector in 2025.

No 2025 stock data for tenofovir + lamivudine, lopinavir/ritonavir, raltegravir, dolutegravir, evafirenz and nevirapine.

Affordability

As in 2022, all HIV/AIDS commodities were free to the patient in all three sectors (see Table 13).

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

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

-: No price data available.

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

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 the availability of pregnancy tests increased from 14.8% to 21.4%, and for HIV self-tests from 27.6% to 53.6% (see Table 14). HPV DNA tests remained unavailable. In the public sector availability of sanitary pads decreased from 30.8% to 25.0%, and for pregnancy tests from 15.4% to 12.5%. HIV self-tests saw a slight increase from 15.4% to 18.8%, but remained scarcely available. In the private sector availability of sanitary pads and pregnancy tests increased, while HIV self-tests and HPV DNA tests remained unavailable. In the faith-based sector only pregnancy tests were available (at 25.0% of facilities).

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	22.2	21.4	30.8	25.0	12.5	25.0	16.7	0.0
Pregnancy test	14.8	21.4	15.4	12.5	0.0	37.5	33.3	25.0
HIV self-test	7.4	10.7	15.4	18.8	0.0	0.0	0.0	0.0
HPV DNA test	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Stockouts

While in 2022 public facilities experienced stockouts of sanitary pads, pregnancy tests and HIV self-tests, in 2025 stockouts did not occur (see Table 15).

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					
	HFs with stock card 2022/2025 (#)		HFs with a stockout (%)		Average # of stockout days	
	2022	2025	2022	2025	2022	2025
Sanitary pads	6	3	33.3	0.0	30	0
Pregnancy test	6	1	66.7	0.0	24	0
HIV self-test	3	2	66.7	0.0	8	0

HF: Health Facilities ND: No data available

No stock data available for the private and faith-based sectors

No stock data available for HPV DNA test

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). This was an increase compared to 2022. Similarly, the HIV self-test was also unaffordable in the faith-based sector (1.75 days).

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 kit	0 days	0 days	0 days	0.70 days	0 days	0.35 days
HIV self-test kit	0 days	0 days	0.19 days	2.10 days	0 days	1.75 days
HPV DNA test kit	0 days	-	-	-	-	-

-: No price data available.

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

4. SUMMARY

The findings of this research underscore a stark reality: while Kenya's national SRH indicators are improving, the women and adolescents of Marsabit and other counties are being left behind. With a national rural poverty line of just KSh 4,358 per month, the "affordability" of life-saving medicines, such as oxytocin or modern contraceptives, is not merely a health metric—it is a matter of economic and human rights. A maternal mortality rate of 355 per 100,000 is unacceptable when the tools to prevent these deaths—uterotonics, antihypertensives, and family planning—exist but are kept out of reach by stockouts and high costs. For the 49 SRH commodities surveyed, availability must be treated as a non-negotiable component of Universal Health Coverage (UHC). True success in Kenya's health sector will not be measured by national averages, but by the closing of the gap between Nairobi and Marsabit. We call upon policy-makers to move beyond data collection and into aggressive implementation, ensuring that no woman dies while giving life, and no adolescent is denied the right to a healthy future due to their geography or economic status.

1. Family Planning (FP) Commodities

- **Availability Crisis:** Overall availability decreased for more than half of FP commodities between 2022 and 2025. Medroxyprogesterone acetate (injectable) was the most available (50–75%), while implants and emergency contraceptives remain scarce in public facilities.
- **Severe Stockouts:** Stockouts are pervasive in the public sector; etonogestrel implants and levonorgestrel-releasing IUDs were stocked out at 100% of public facilities, with gaps lasting up to 64 days.
- **Affordability Gap:** While free or low-cost in public and faith-based sectors, private sector prices have surged. An IUD in the private sector now costs the equivalent of 34.99 days of average income.

2. Maternal Health Commodities

- **Declining Access:** Availability of life-saving maternal health products fell sharply. Oxytocin, the gold standard for preventing haemorrhage, dropped from 51.9% availability in 2022 to just 14.3% in 2025.
- **Critical Stockouts:** Misoprostol, calcium gluconate, and folic acid experienced 100% stockout rates in public facilities, with some shortages lasting over 200 days.
- **Private Sector High Costs:** Misoprostol is considered highly unaffordable in the private sector, costing approximately seven days of income.

3. STI and HIV/AIDS Commodities

- **Antibiotic Vulnerability:** While metronidazole is widely available, other critical antibiotics including amoxicillin suffered from extreme stockouts in the public sector, lasting an average of 216 days.
- **HIV Treatment Scarcity:** Availability of HIV commodities is "suboptimal" and generally decreased. The most common regimen (Dolutegravir + Lamivudine + Tenofovir) reached only 37.5% availability in public facilities.

4. Menstrual Products and Diagnostics

- **Diagnostic Gains:** Availability of HIV self-tests increased noticeably from 27.6% to 53.6%.
- **Period Poverty:** Availability of sanitary pads in the public sector decreased to 25%. In the private sector, pads are now considered unaffordable, costing nearly two days of income.

5. RECOMMENDATIONS

To bridge the equity gap in Kenya's Northern counties, the following policy shifts are recommended for National and County health leadership:

1. Decentralised supply chain & "hard-to-reach" logistics	**Recommendation:** Move from a "push" system to a "pull" system for commodities in Arid and Semi-Arid Lands (ASAL). **Action:** The Kenya Medical Supplies Authority (KEMSA) and County Health Management Teams (CHMTs) must establish sub-county hubs to reduce the distance between stores and rural facilities. Given the nomadic nature of these regions, "last-mile" delivery should include mobile outreach clinics that carry the full package of 49 essential SRH commodities. **Action:** Call for the full operationalisation of County Health Products and Technologies Units (HPTUs) to monitor stock levels in real-time and prevent 200-day stockouts of essential antibiotics
2. Affirmative action on FP financing (ring-fencing)	**Recommendation:** Direct domestic resource mobilisation to protect family planning budgets from being reallocated during emergencies (e.g., droughts or floods). **Action:** Counties should implement Financial Tracking Systems to ensure that funds allocated for SRH are "ring-fenced." With rural poverty at KSh 4,358 per month, commodities in public facilities must remain zero-rated or fully subsidised through the Primary Healthcare Fund (Social Health Authority). **Recommendation:** Protect SRH budgets from being diverted to other sectors. **Action:** Advocate for "ring-fencing" of SRH funds within the County Integrated Development Plans (CIDPs) to ensure life-saving maternal commodities like Oxytocin are consistently procured and remain free at the point of use. **Recommendation:** Treat the 14% availability of oxytocin as a public health emergency. **Action:** Establish a maternal health Rapid Response Initiative (RRI) to provide emergency procurement of uterotonics for high-burden counties to reduce the maternal mortality rate from its current 355 per 100,000.

3. Integration of the "triple threat" Framework	**Recommendation:** Harmonise the delivery of HIV, STI, and pregnancy prevention commodities to address Kenya's "Triple Threat" (teenage pregnancy, new HIV infections, and gender-based violence). **Action:** Procurement should prioritise dual-protection technologies (like condoms) and self-test kits (HIV and pregnancy) as standard entry points in every primary care visit, particularly for adolescents who face high unmet needs (up to 34%). **Action:** Development of a costed action plan on ending the triple threat among adolescents with key strategic interventions at facility, community and CHMT level.
4. Strengthened multi-stakeholder governance	**Recommendation:** To ensure a consistent supply of SRH commodities, the CHMT should formalise a collaborative ecosystem. **Action:** Institutionalising Oversight. Budget for and convene quarterly SRH Commodity Security Technical Working Groups (TWGs) to monitor stock levels, identify gaps, and streamline distribution. **Action:** Actively facilitate strategic public-private partnerships and inter-agency collaborations to harmonise resource allocation, prevent duplication of effort, and leverage external expertise for supply chain efficiency.
5. Integration of Social Accountability Framework	**Recommendation:** The CHMT should adopt a transparent, citizen-centred approach to SRH management to build public trust and improve service delivery: **Action:** Improve transparency & reporting by establishing clear mechanisms for reporting on commodity performance and stock availability, ensuring data is accessible to the public. **Action:** Foster meaningful civic engagement/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. **Action:** 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.

6. Cultural & religious leader engagement	**Recommendation:** Counteract social-cultural barriers by integrating SRH advocacy into religious and traditional frameworks. **Action:** 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."
7. Private sector price regulation	**Recommendation:** Address the extreme price hikes in the private sector that render IUDs and menstrual pads unaffordable for the poor. **Action:** Lobby for the subsidisation of private-sector SRH products through a "Total Market Approach," ensuring that those who cannot access public clinics are not financially exploited.

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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