POLICY BRIEF

SEXUAL AND REPRODUCTIVE HEALTH COMMODITIES(SRHC) IN ISIOLO COUNTY AVAILABILITY, STOCKOUTS AND AFFORDABILITY 2022 & 2025

INTRODUCTION

Sexual and Reproductive Health (SRH) is defined as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system. This right extends to all individuals—men, women, and adolescents—ensuring they can lead healthy lives and make informed decisions about their bodies. However, achieving optimal SRH outcomes is contingent upon more than just clinical care; it requires a robust ecosystem of Sexual and Reproductive Health and Rights (SRHR). This includes universal access to accurate information, services and commodities.

Globally, preventable causes related to pregnancy, childbirth, and STIs continue to claim millions of lives each year, with Sub-Saharan Africa bearing a disproportionate burden. In Kenya, although progress has been made, maternal mortality remains high at 355 deaths per 100,000 live births.Isiolo County, classified as an arid and semi-arid land (ASAL) county, continues to experience low modern contraceptive uptake (28.7%), high unmet need for family planning, and limited access to life-saving maternal health services—particularly among adolescents, rural women, and low-income households.

This policy brief presentskey evidence from a baseline 2022 and endline 2025 assessment of **50 SRH commodity** availability, stockouts, and affordability in Isiolo County recommending policy advocacy interventions to safeguard and strengthen access to essential SRH services.

OBJECTIVES

1. To Identify trends and gaps in commodity access over time
2. To inform county-level planning, budgeting, and supply chain decision-making
3. To support evidence-based policy actions to improve SRH outcomes for women and adolescents.

METHODOLOGY

Study Design and Ethical Oversight : This assessment was conducted by Access to Medicines Platform in collaboration with Health Action International under the SHARP project, funded by the European Union. The study received ethical clearance from the AMREF Ethics and Scientific Review Committee and was licensed by the National Commission for Science, Technology, and Innovation (NACOSTI).

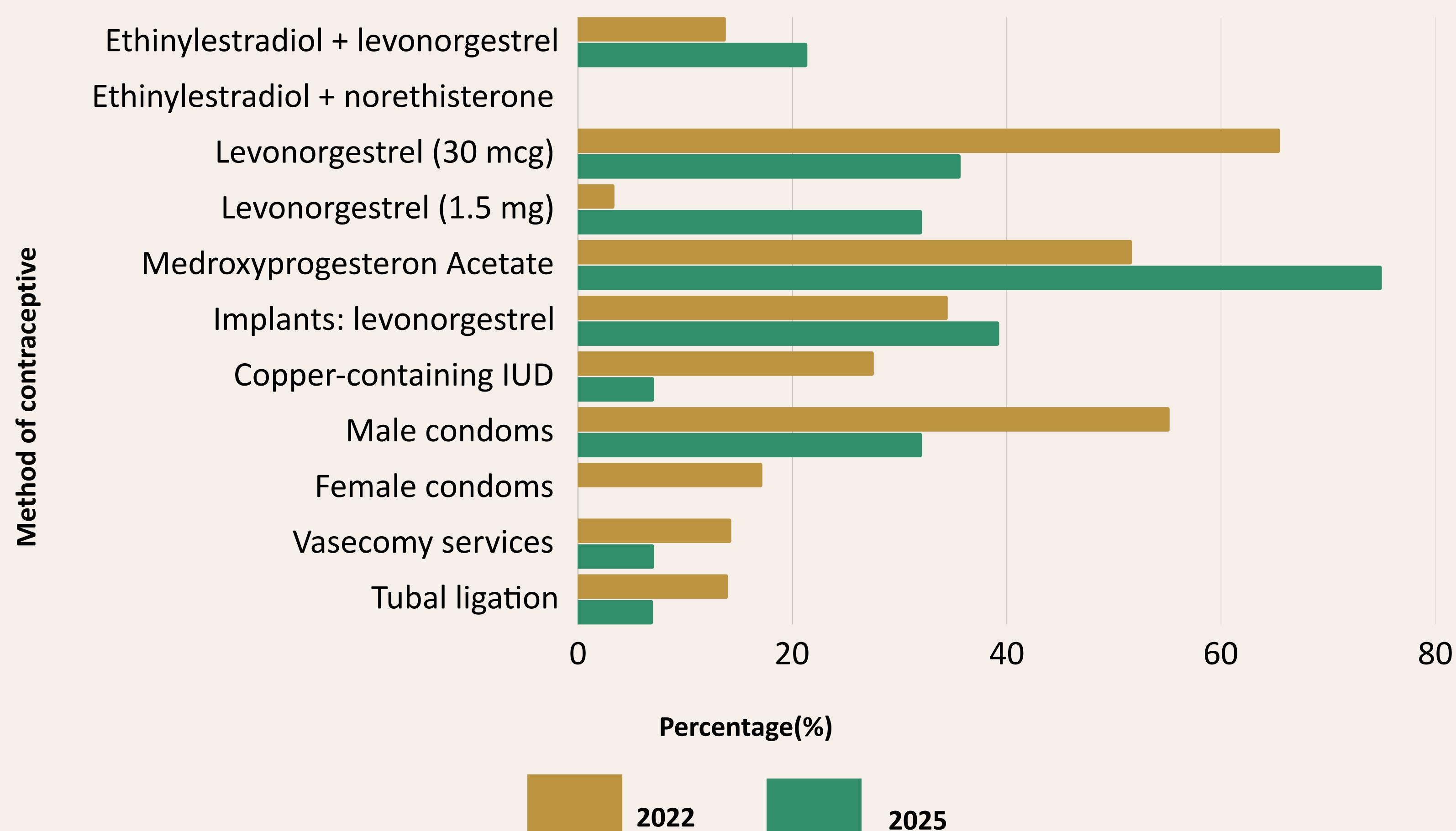
Analytical Framework: The research employed an adapted WHO/HAI methodology to evaluate the supply chain performance of 50 essential Sexual and Reproductive Health (SRH) commodities. These included family planning methods, maternal health medicines, STI treatments, HIV commodities, menstrual products, and diagnostic tests.

Sampling and Data Collection: Data were collected across public, private, and faith-based sectors in Isiolo County, ensuring representation from both urban and rural settings. The sample included 29 facilities in 2022 and 28 in 2025, spanning various levels of care from primary dispensaries to secondary referral hospitals.

Key Performance Indicators (KPIs): To provide a comprehensive view of the landscape, the study measured three primary pillars:

- **Availability**: Defined as the physical presence of a commodity on the day of the survey.
- **Stockouts**: A retrospective 12-month review of stock cards and records to determine the frequency and duration of supply interruptions.
- **Affordability**: Benchmarked against the national rural poverty line—**KES 3,947 (2022)** and **KES 4,358 (2025).** A commodity was deemed unaffordable if its cost exceeded a single day's income for an individual at the poverty line.

RESULTS/FINDINGS



FAMILY PLANNING COMMODITIES

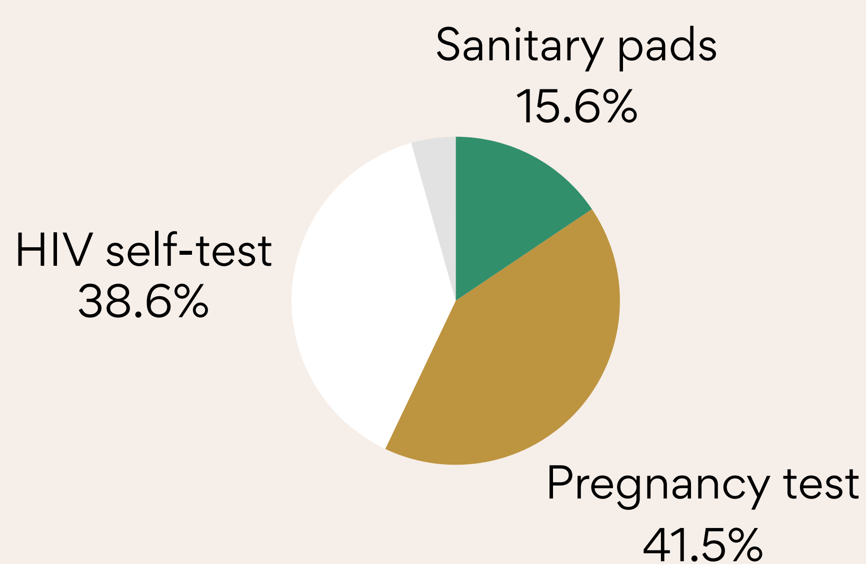
- Availability of family planning commodities declined between 2022 and 2025. In 2025, **only one** commodity (injectable medroxyprogesterone acetate) met the WHO **80%** availability benchmark in the public sector.
- Availability of long-acting reversible contraceptives (IUDs and implants) remained critically low. Permanent methods (vasectomy and tubal ligation) were almost non-existent across sectors.
- Public facilities experienced chronic stockouts, lasting **up to 8 months**. Even basic commodities such as male condoms and oral contraceptives were frequently unavailable.
- Stockouts were also present in private and faith-based facilities, undermining referral and continuity of care.
- In the private sector, prices increased significantly, making most methods unaffordable.
- Levonorgestrel-releasing IUDs cost the equivalent of **35 days** of income for someone living below the poverty line.

MATERNAL HEALTH COMMODITIES

- Life-saving maternal health commodities were dangerously scarce, especially in public facilities, oxytocin was available in less than **40%** of public facilities.
- Availability of magnesium sulphate declined sharply, despite its critical role in preventing eclampsia-related deaths.
- Commodities for managing postpartum haemorrhage (PPH)—the leading cause of maternal death—were largely unavailable. Stockouts were widespread and prolonged across all sectors.
- In 2025, user fees were introduced in public facilities for several maternal health commodities making methyldopa, tranexamic acid, and mifepristone–misoprostol financially inaccessible.
- Private-sector prices were even higher, pushing women toward delayed or unsafe care.
- In 2025 only methyldopa was available at **80%** of all facilities

Table: Availability of maternal health commodities in 2022 and 2025, per sectors

	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



MENSTRUAL PRODUCTS AND TESTS

- Overalll, compared to 2022, in 2025 only the availability of HIV self-tests increased from **27.6%** to **53.6%**
- In both 2022 and 2025, menstrual health products experienced frequent and prolonged stockouts. However, stockout duration and frequency increased at endline, reflecting the discontinuation of external support and lack of county budget allocation for menstrual health commodities.
- Only the HPV DNA test remained unavailable. The faith-based sector had the highest availability of HIV self-tests at **85.7%.** While in 2022 public facilities did not experience stockouts of sanitary pads and pregnancy tests, in 2025 stockouts did occur. 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**.
- All tests and pads were free in the public sector. 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)

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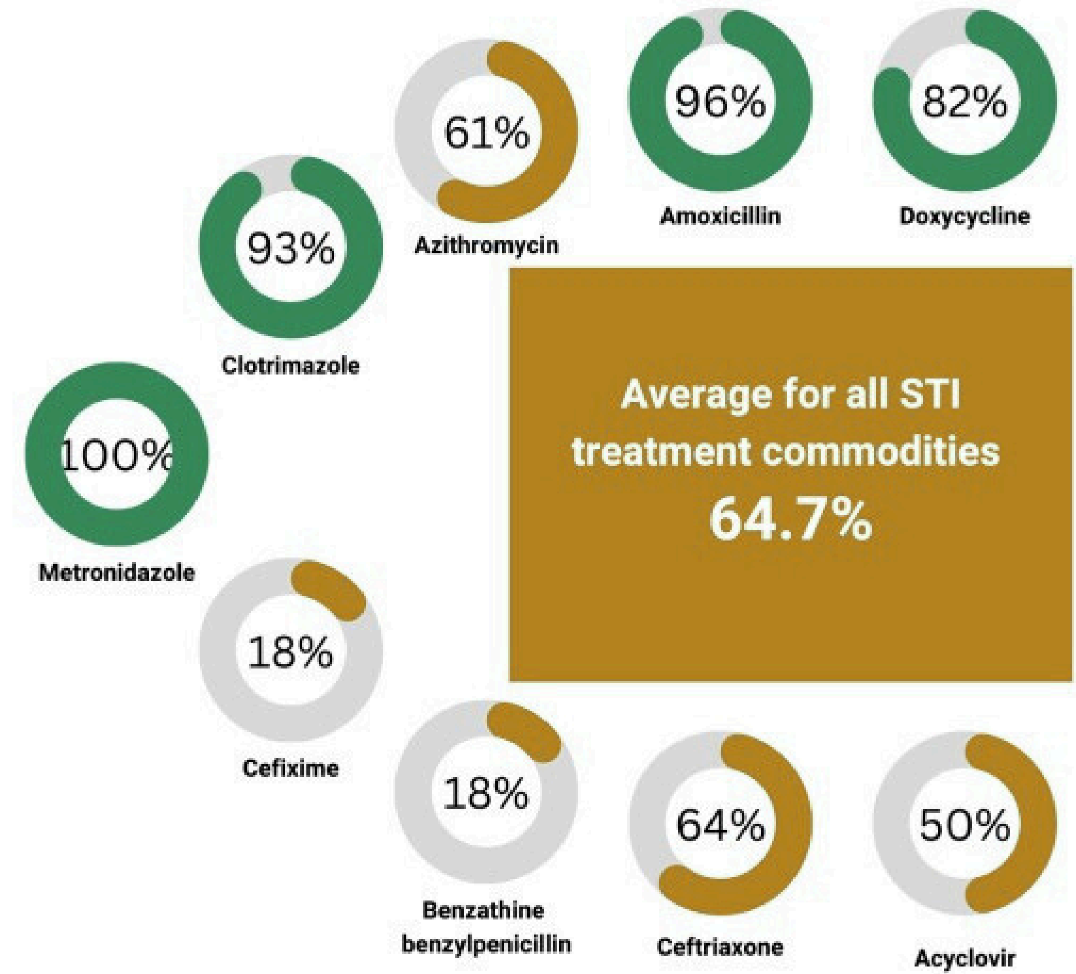
STI'S TREATMENT

- STI treatment commodities showed relative improvement compared to FP and maternal health.
- First-line antibiotics (metronidazole, amoxicillin, clotrimazole) met WHO availability thresholds across sectors.However, syphilis treatment (benzathine penicillin) availability declined.
- Public facilities experienced frequent and prolonged stockouts of key STI medicines. Stockouts lasted up to 7 months, undermining syndromic STI management.
- Overall, in 2025 4 of 9 STI treatment commodities had an 80% or higher availability in the public sector. The private sector further had a 100% availability for azithromycin and ceftriaxone, and an 87.5% availability for doxycycline.

HIV COMMODITIES

- Availability of HIV/AIDS commodities remained low in 2025. For PrEP, dolutegravir + lamivudine + tenofovir, dolutegravir (50mg) an dolutegravir (10mg) overall availability increased compared to 2022.
- 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.
- In the public sector, PrEP stockouts occurred at 28.6% of facilities, lasting on average 81 days.

Figure 3. Overall availability of STI treatment commodities



SUMMARY:TRENDS AT A GLANCE

Commodity Area	Availability Trend	Stockout Trend	Affordability Trend	What Changed Between 2022 and 2025
Family Planning	⬇ Declined	⬆ Increased (longer duration)	⬇ Worsened in private sector	Fewer methods met WHO availability benchmarks; long-acting and permanent methods remained scarce; private-sector prices rose sharply
Maternal Health	⬇ Significantly declined	⬆ Severe and prolonged	⬇ Worsened (user fees introduced)	Life-saving commodities such as oxytocin and magnesium sulphate became less available; fees reintroduced in public facilities
Menstrual Health Products	⬇ Declined from already low baseline	⬆ Increased	⬇ Worsened	Donor-supported supplies reduced or ceased; no routine county procurement or budget allocation
HIV Commodities	⬇ Slight decline	⬆ Emerging stockouts	— Stable in public sector	Reduced donor cushioning exposed early system strain; testing and ART continuity increasingly vulnerable
STI Treatment	— Relatively stable	⬆ Increased in public sector	⬇ Worsened in private sector	First-line antibiotics remained available, but syphilis treatment availability declined

POLICY RECOMMENDATIONS

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. 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.
- 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.

4. 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.

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 Youth-Friendly Service 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 ANC 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.

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."

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