STOP STOCKOUTS



Contraceptive Supply Chain:
Stockouts and their Causes

April 2022 - June 2023

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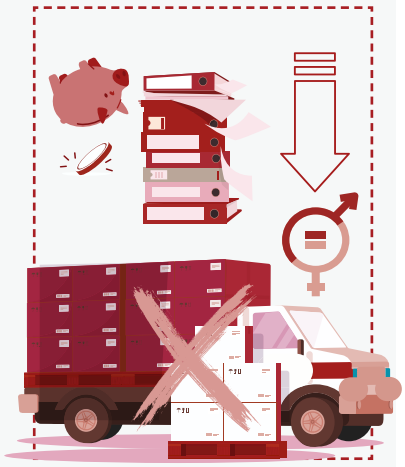
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Executive Summary

The Stop Stockouts Project (SSP) has been responding to contraceptive shortages since 2018.







In 2022, since finding that contraceptives make up the largest share of pharmaceutical medicines stockouts in South Africa, SSP aimed to not only continue to track stockouts but to also understand what has been driving this denial of women's reproductive rights. In 2023 SSP commissioned an investigation into the relationship between the supply chain and contraceptive stockouts. It used interviews with directors and managers at Departments of Health. This report is based on these findings, as well as five Quarters (April 2022-June 2023) of data from users and managers on availability of contraceptives from Ritshidze, a community-led health monitoring project. The report examines Kwa-Zulu Natal (KZN), the Eastern Cape (EC), and North West (NW) provinces in particular, as they showed the most significant contraceptive stockouts during the reporting period.

Crucially, our findings identify poor national procurement planning as the main driver of depletion of contraceptives, and contraceptive stockouts between 2015 - 2020. Poor planning, in this case, resulted from not anticipating a depletion in national stock due to donating contraceptive methods to a three-year international randomised clinical trial (ECHO, 2019), as well as not anticipating market anxiety relating to the anticipated outcome of the research examining the relationship between the use of (three-month injectable) Depo-Provera® and a potential increased risk of acquiring HIV. Additionally, this poor planning related to not anticipating widespread contraceptive stockouts, a lack of supplier competition, and a weakened national position to negotiate contracts.

Reliance on monopolies of international manufacturers and suppliers, and poor information and data systems compounded this cause. In addition to poor national procurement planning at the national level, at the provincial level we found on-going causes of stockouts to include: budgetary limitations, incompatible electronic information systems, dependence on manual paper-based systems, poor management of payment systems, stock controls, ordering, contracts, and lacks in adequate human resources, and storage. Budgetary constraints were raised as a particular challenge for the EC, NW and KZN, and were exacerbated by poor management of payment and ordering systems.

Poor planning that results in five years of limited access to contraception for women and girls is consequently a result of inadequate national leadership, and deficits in accountability and transparency. This situation points to a lack of prioritisation of gender equality, and women's sexual and reproductive health. This prolonged decrease in access to a variety of contraceptive methods also indicates a departure from a human rights approach to healthcare.



Injectable contraception was again reported as the largest and most consistent contraceptive stock shortage across all three provinces, over five quarters. This finding echoes our evidence since tracking this problem from 2018. Read collectively, our findings show a crisis in access to contraception. Arguably this could have contributed to higher rates of adolescent pregnancy.



External condoms were found to be the second least accessible contraceptive in KwaZulu-Natal and the Eastern Cape. In the North West however, the implant was the second most often reported short of stock. Our evidence identifies stockouts of external condoms are chronic in the Eastern Cape, and is due to international manufacturers and poor concentration of local suppliers.

Almost all women and girls surveyed did not receive the contraception they requested, in KwaZulu-Natal and the Eastern Cape. Interestingly, the majority surveyed in the North West did. We were not able to deduce reasons for this difference. Importantly, the drivers of contraceptive stockouts, outlined here, are not unique. They also cause limited access to other medical supplies and medicines. The report concludes with key recommendations identified to secure a reliable contraceptive supply and meet the reproductive rights of women and girls in the country.

Introduction

The Stop Stockouts Project, established in 2013, is a consortium of five civil society organisations: Doctors Without Borders (MSF), Rural Doctors Association of South Africa (RuDASA), Rural Health Advocacy Project (RHAP), SECTION27, and the Treatment Action Campaign (TAC). SSP aims to monitor and report on medicine and vaccine shortages and stockouts at primary healthcare facilities, to enable speedy resolution of these issues and ultimately assist those whose lives are threatened by chronic supply shortages in South Africa.

Ritshidze,[1] is a community-led clinic monitoring (CLM) system developed by organisations representing people living with HIV, including the Treatment Action Campaign, the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network (PWN), and the South African Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+). Ritshidze monitors more than 400 public healthcare facilities across 29 districts, in seven out of nine provinces in South Africa. Monitoring is authorised by each province's Department of Health. Ritshidze's 80 Community Monitors assess health service delivery at these facilities on a quarterly basis. The Northern Cape and Western Cape provinces are not surveyed because monitoring focuses on high-volume PEPFAR[2] supported clinics (which do not exist in the Northern Cape) and relies on authorisation for monitoring from each province (which the Western Cape has declined to provide).

Between 2020–2022, the Stop Stockouts Project received numerous reports of injectable long-acting hormonal contraception, the second most commonly used type of contraception in South Africa after condoms, and in 2022 partnered with Ritshidze, to gather data on access to contraception at primary health care facilities. Indicators on the availability of and access to contraceptives and sexual and reproductive health services (SRH) were added to the Medicines, User and Facility Manager surveys administered by Ritshidze monitors. Data collected by Ritshidze clinic monitors provides a patient perspective that in addition to routine health information reported by the National Department of Health, provides a more holistic picture of access to services and quality of care. In 2023, the SSP commissioned an investigation to better understand the relationship between contraceptive stockouts and the healthcare supply chain. The purpose of this evaluation was to provide an overall picture of contraceptive procurement and delivery, and begin to understand contributory factors to medicine stockouts. This report analyses interview data provided by managers and directors from the National Department of Health, and the KwaZulu-Natal, Eastern Cape, and North West Provincial Departments of Health. It also includes Ritshidze's survey data from patients accessing public health facilities for contraception and family planning services; facility managers and pharmacists from these provinces between April 2022 and June 2023.

The report tells the story of how contraceptives get to hospitals and clinics in South Africa, and provides an overview of the national system by mapping the supply chain. The report also identifies key actors, committees, units and structures involved in, and responsible for delivering contraceptives through South Africa's national programmes. Where possible, the report has highlighted key decision makers on procurement nationally and in the three focus provinces. Key findings from the quarterly surveys indicate that while overall access to medicines at primary health care facilities in South Africa has improved since SSP began reporting in 2013, contraceptives represent the largest share of reported stockouts in the public healthcare system. It is for this reason that we continue to examine contraceptive stockouts. We believe this information from healthcare workers, managers and patients, will strengthen engagement with the government on access to medicines as well as the government's efforts to prevent stockouts.

[1] https://ritshidze.org.za/the-model/
[2] The United States President's Emergency Plan for AIDS Relief

South African Legal & Policy Background

We set out this chapter to foreground the legal frameworks that ensure reproductive rights in South Africa. In order to exercise the right to freedom and security, a woman must be able to decide for herself whether, and when she wishes to become pregnant, to terminate and/ or when to give birth. This decision-making ability is undermined when she cannot access contraceptives due to stockouts in public facilities. If she is denied access to education about contraceptives due to discriminatory beliefs held by healthcare providers her right is also damaged.



South Africa's Constitution guarantees in section 27 the right to all to have access healthcare services, including sexual and reproductive health services. This places a duty on the government to protect, fulfil and promote the right to access reproductive health services. The Bill of Rights includes clauses that set out women's rights as human rights, making explicit reference to reproductive rights. Relevant legislation and policy to enable the realisation of these rights include:

Legislation & Policy	Purpose
Medicines and Related Substances Control Act, Act 101 of 1965	Provides for the provision of contraceptives and medicines used during termination of pregnancy.
Choice on Termination of Pregnancy Act 92 of 1996	Provides a legal framework for the provision of abortion services.
Standing National Committee for Confidential Enquires in Maternal Death 1997	Mandating reporting whenever maternal death occurs.
Sterilisation Act 44 of 1998	Provides for the right to sterilisation; Promotes autonomous decision making and protects patients through, for example, requiring voluntary, informed and written consent before a sterilisation.
National Health Act 61 of 2003	Details governance and oversight of healthcare services, including reproductive healthcare.
Children's Act 38 of 2005	Empowers adolescents to consent to access to reproductive services and to test for HIV.
The National Contraception Guidelines, 2019	Provides for informed voluntary contraception, and people's rights to exercise their reproductive choices.

South Africa's national policies pertaining to sexual and reproductive health have maintained a stated commitment to the Constitution's rights-based provisions.

Currently, policy stipulates that the following contraceptive methods should be available in the public health system: three-month injectable (Depo-Provera® or generically, Petogen), two-month injectable (Noristerat), the copper IUD, the implant, oral contraceptives, female sterilisation (tubal ligation), male sterilisation (vasectomy), as well as external, and internal condoms (NDoH, 2019).

Methodology

Contraceptive services are guided by five principles outlined in the policy, and are free in the public sector:

1. services should be universal and equitable;
2. contraceptive provision should be integrated into a broader package of reproductive healthcare services;
3. facilities should offer a broad variety of contraceptive methods;
4. patients should be provided with information and counselling on contraception and reproductive health; and
5. healthcare workers should be supported and have their technical and professional needs met[3] (Government of South Africa, 2012, 2003).





To tell the story of how contraceptives get to hospitals and clinics, and the barriers that prevent them from reaching the end users, the report answers the following questions.

1. What was the availability of contraceptive stocks?
2. What is the relationship between contraceptives users request and availability?
3. What are the processes followed to contract, procure and distribute contraceptives, and why are they failing?
4. What is common across the three provinces, and what is unique and why?

[3] This approach, first established in 2003 is maintained in current policy (Government of South Africa, 2012).

The three provinces: KZN, the EC and the NW, are the focus of this report as they had the largest percentage of contraceptive stockouts of the seven provinces surveyed by Ritshidze between April and June 2022 (SSP, 2022).

The study and this report are based on the triangulation of two datasets. The first being specific indicators related to availability and access to contraception on the Ritshidze online dashboard from April 2022 – June 2023; and the second comprising of a literature review, Focus Group Discussions (FGD) and Key Informant Interviews (KII) with National and Provincial Department of Health directors and managers.

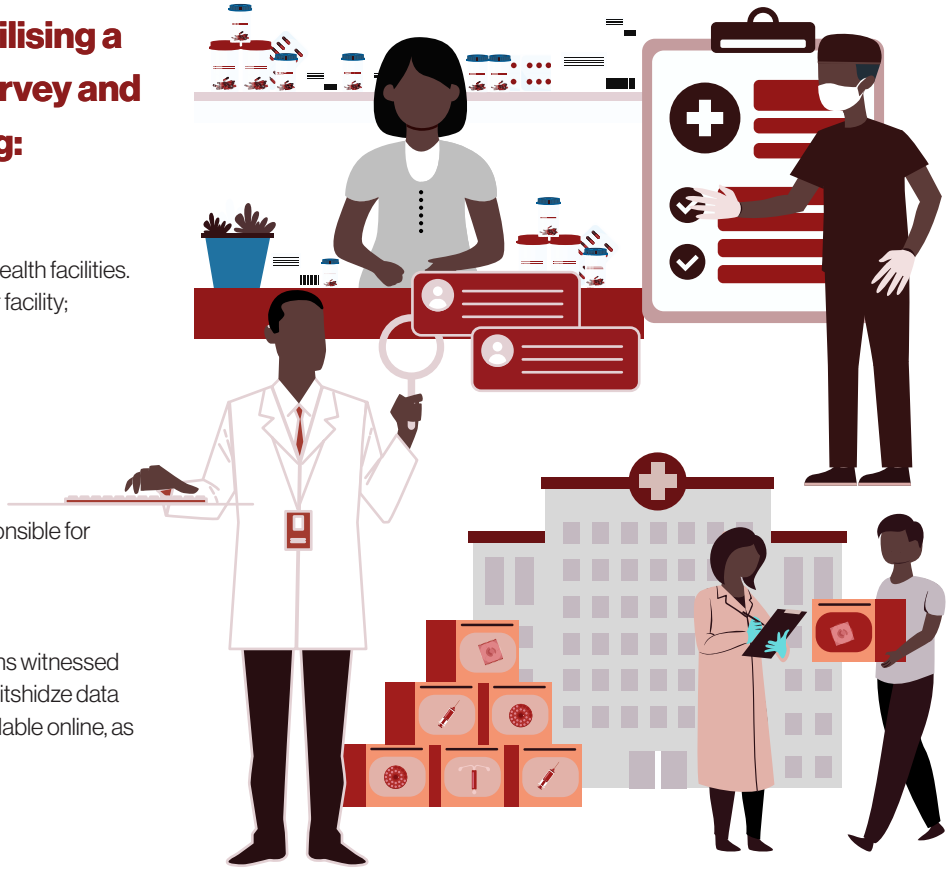
This mixed-methods approach was chosen to strengthen the interpretation of both forms of data. Initial findings from the survey data (April – June 2022) informed the geographical focus, and the questions asked in the FGDs and KIIs. The interview dataset allowed us to contextualise the findings of the survey data and develop illicit insights into the causes of consistent contraceptive stockouts.

The first dataset was collected by Ritshidze, a community-led clinic monitoring (CLM) system developed by organisations representing people living with HIV, including the Treatment Action Campaign (TAC), the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network (PWN), and the South African Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+).



Monitoring is carried out utilising a number of standardised survey and observation tools, including:

- **Public healthcare user surveys**
  patients are recruited for participation while at health facilities. Quarterly patient surveys target 50 patients per facility;
- **Facility Manager surveys**
  conducted with the Facility Manager;
- **Medicines surveys**
  conducted with the pharmacist or person responsible for medicine stocks at the facility; and
- **Observation surveys**
  observations of facility conditions and operations witnessed directly by Ritshidze Community Monitors. All Ritshidze data collection tools are publicly accessible and available online, as are the data collected.[4]



[4] https://data.ritshidze.org.za/?CC=ZA&year=2022&period=a&ind=g_0_s_0&SNU1=&SNU2=&facility=



Data relating to contraceptive availability utilised in this report, is from both Ritshidze's Public Healthcare User, Medicines and Facility Manager surveys. While visiting the facilities monitors aim to recruit fifty patients to participate in the user survey, which collects data on fourteen indicators relating to contraception delivered at family planning clinics. Managers of each facility participate in the Facility Manager and medicines surveys, which collects data on seven indicators relating to contraception relating mostly to service delivery at the family planning clinics. The data collection tools[5], and the data[6] itself are publicly available online.



The second dataset, aimed to provide an overall picture of contraceptive contracting, procurement, supply chain management, distribution of stock, and what contributes to consistent stockouts. This data is drawn from a literature review, Focus Group Discussions (FGD) and key informant interviews with Directors, Heads, and Managers at the National and Provincial Departments of Health overseeing the supply chain.

Literature searches were conducted using an initial set of key words, including: Supply chain, Procurement, Stockouts, injectable contraception, Africa, South Africa, KwaZulu-Natal, North West, Eastern Cape, Depot medroxyprogesterone Acetate, Depo-Provera, Noristerat and NET-EN. The review included the government reports, academic articles, news reports and other grey literature. Of the forty articles initially selected for review, thirteen were found to be especially relevant. Interviews and FDGs occurred virtually. Interviews were conducted confidentially, and no quotes are directly attributable in the report. This research was done informally without recording, ethical approvals or participant informed consent forms distributed. Rather participants received a brief request electronically, and electronic and oral consent was taken to confirm participation. Thematic analysis was applied to notes taken to assess the data, and focused on corroborating facts to map the processes followed to contract, procure and distribute contraceptives, with particular attention to Depot medroxyprogesterone Acetate (Depo-Provera®) and norethisterone enanthate (NET-EN) injectable contraceptives.



The sample includes key staff from Kwa-Zulu Natal, North West, and the Eastern Cape. Of the 21 informants working in provinces that we reached, six were pharmacists. These include Heads and Deputy Directors of Pharmacy for a province, a district, a tertiary hospital, and managers overseeing aspects of the supply chain at a medical depot. Others were managers who supervise medical depots including finance, operations, ordering, and contracts. Additionally, we reached Directors, and Managers of Finance, Deputy Directors of Clinical and Hospital Services, and Programmes. The three informants we reached at the national level represent Directors of the Affordable Medicines Directorate and Women's Health Programmes.

Table 1. Data Two: Sample size of interviews and FGDs

	No. of informants accessed	No. Managers and Directors	No. of participants (FGD and interviewed)
Kwa-Zulu Natal	7	2	2
North West	8	4	4
Eastern Cape	3	2	2
National	3	2	2
TOTAL	**21**	**10**	**10**

[5] https://ritshidze.org.za/category/tools/
[6] http://data.ritshidze.org.za/?CC=ZA&year=2022&period=Q3&ind=cc_facility_staff&SNU1=&SNU2=&facility=

Results

The results chapter provides an overview of the supply chain. The first section details national contracting and national causes of stockouts. The subsequent sections provide data over the reporting period for each province on:



I. Availability and access of contraceptives, and
II. Supply chain.

The third section, details procurement processes, and the different approaches provinces have taken to manage and distribute supplies, with a focus on budgetary and financial flows. In particular, it suggests the causes of stockouts at provincial level.

National Government

The results chapter provides an overview of the supply chain. The first section details national contracting and national causes of stockouts. The subsequent sections provide data over the reporting period for each province on:

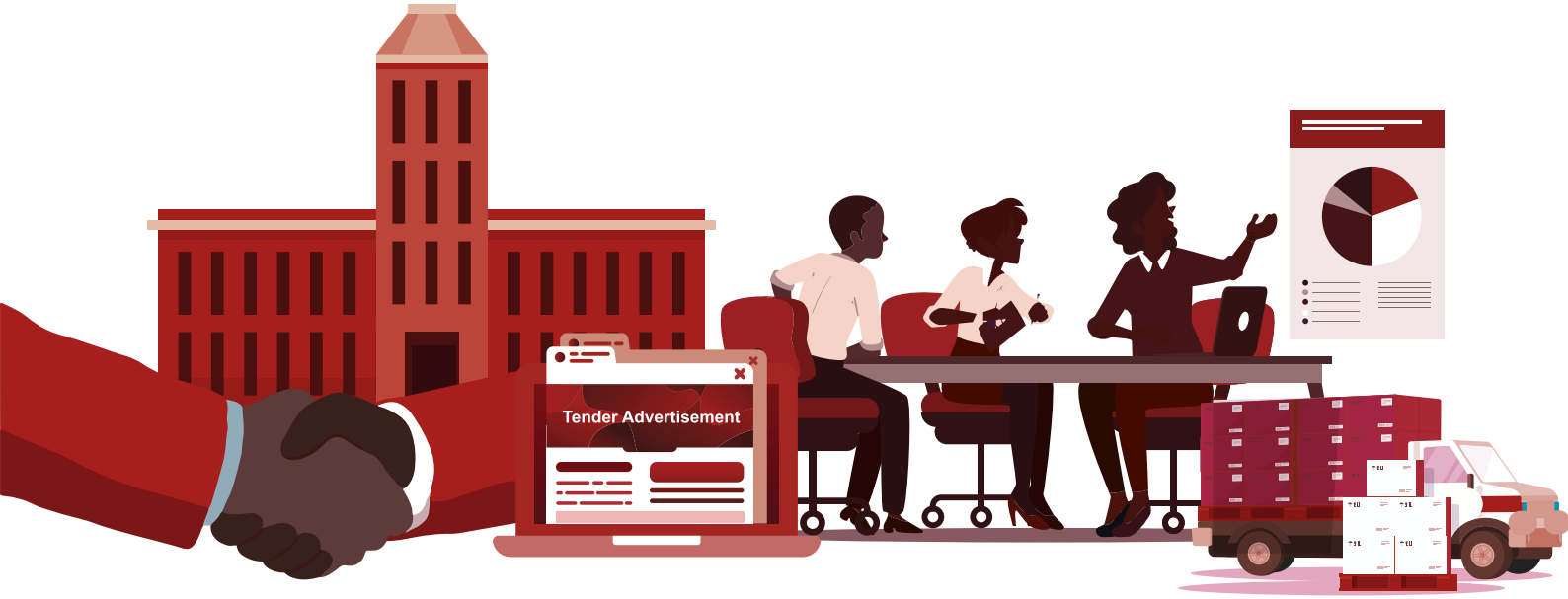
Contraceptives included in South Africa's National Programme to prevent pregnancy are manufactured overseas. Several research participants noted injectables Depot medroxyprogesterone Acetate (Depo-Provera®) and norethisterone enanthate (NET-EN) are produced by international companies including Pfizer, and Bayer, and that most supply comes from manufacturers based in China and India. Participants from Programmes at the National Department of Health (NDoH) elaborated on the context of international manufacturing, reporting South Africa's supply of Depo-Provera® was grossly affected by Pfizer's shift to produce Covid-19 vaccines during the global pandemic.

Participants, and literature reviewed, confirmed NDoH carries out procurement by advertising, awarding, and monitoring tenders of pharmaceutical medicines on the Essential Medicines List (EML) (Magadzire, et al, 2017).

Non-barrier contraceptives are a part of the EML. The NDoH took over this function from National Treasury approximately in 2019. According to one District Pharmaceutical Manager, currently there are fifteen tenders for pharmaceutical medicines. National Treasury continues to oversee securing additional transversal tenders and their contracts for surgical (non-medical) supplies, which for our interest includes condoms.

Provincial budget allocations come from the same nationally stipulated "equitable share" allocated according to the Division of Revenue Act (DORA). This supports the procurement of non-barrier contraceptives. While barrier methods are budgeted for through the ring-fenced "District Health Programmes Conditional Grants" rather than the "equitable share".

Contraceptives, like other drug supplies are contracted by NDoH, through its Affordable Medicines Directorate by advertising, negotiating prices and securing transversal tenders, suppliers, and managing their contracts. This is carried out nationally for a number of reasons, including ensuring pricing is value for money. Contracts usually run for a period of two to three years. According to Enoos (2023) twenty-three contracts are awarded to procure 1,171 medicines and health products for the public health system. NDoH also decides which contracted companies (suppliers) work with each provincial government. Several participants confirmed each province has two representatives (often Medical Depot Managers and Assistant Managers) on the Bid Specification Committee (BSC), and the Bid Evaluation Committee (BEC), that are overseen by the Directorate and responsible for developing supplier contracts. National pharmacists from the Correctional services, and the National Defense force undertake a separate procurement process with the Directorate for their constituencies.



NDoH bases the volume of supplies it secures on estimates submitted to the Directorate from each province (Magadzire, et al, 2017). The BSC and Directorate hold peer review sessions to interrogate the submitted product estimates of all provinces. The session considers annual demand history, patterns, demographics, and previous estimates to ensure provinces have not underestimated or overestimated supply needs. Prior to contract specifications being finalised the Directorate also conducts market intelligence, including to assess manufacturing capacity. After the advertisement, a meeting of the BEC is convened to further assess the bidding process before awards are made.

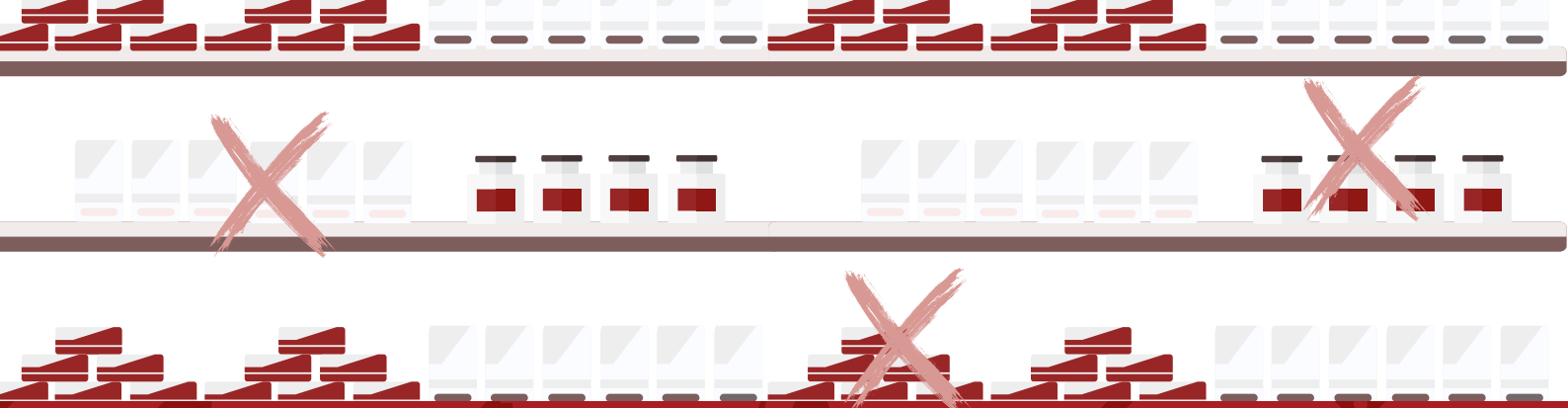
Informants explained, contraceptives (including injectables NET-EN and Depo-Provera®) are supplied "on contract," meaning they are not likely to be purchased outside of the nationally negotiated contracts. The Directorate invites National Programmes, for example, Women's Health to consult on the tender preparation process, to align any updates to National Clinical Guidelines and (additions, removals) to the EML list that have either already been approved by the EML Committee, or are being considered after being stipulated in NDoH Guidelines.

Contracts are usually awarded to two or three suppliers to avoid the risk of one supplier not delivering. However, if only one supplier submits a bid during the tender process, we were informed then NDoH can only award that supplier. Informants working at the provincial and national levels explained that sometimes suppliers choose not to apply for tenders, and to not have contracts. In these cases, companies do not apply because they know they are the sole suppliers in the country, and the State is dependent on them, so they don't need to negotiate for the tender, and can rather get paid 100% of the market rate. This lack of competition causes the price of an essential medicine to be inflated for the large quantity. One District Pharmaceutical Manager said this issue had been raised with Treasury previously and their reply was that there is nothing they can do, because, they cannot force companies to apply. This informant noted, currently there is one contract "HPO3" for non-barrier contraceptives, which is supplied by two companies.

After contracts are secured by national, provinces are able to purchase from suppliers and distribution of medical supplies and medicines commences. Management of contracted suppliers, is carried out by NDoH, where provinces report feedback on supplier performance to NDoH. In the case that a supplier is not fulfilling its contractual obligations provinces provide evidence of this to NDoH, who then communicates with the supplier and provides feedback. In the case that NDoH has attempted to correct any problems at least three times, and there is still no improvement in supply, only then is a province provided with a letter authorising them to "buy out of the contract". A few informants noted that provinces are not allowed to procure more than 10% from non-contracted suppliers. In these cases the contracted suppliers have to pay the suppliers who are assisting them to meet their contractual obligations.

When supplies are delivered to a facility be it a medical depot, district pharmacy supply centre, hospital or clinic the facility will check the supply and the invoice to make sure there are no discrepancies. Approaches to ordering essential medicines at the provincial level are multiple and complex. For instance, per item, each order is often 25 pages long. Orders include the tender, order, and the invoice.

The Government of South Africa supplying the Evidence for Contraceptive Options and HIV Outcomes (ECHO) randomised clinical trial to run its research from December 2015 - September 2017 (ECHO, 2019). The trial utilised Depo-Provera®, levonorgestrel implant, and the copper intrauterine device (IUD). This depleted the nation's stock.



After the completion of the data collection phase of ECHO, the supplier, anticipating the results, stopped manufacturing Depo-Provera®. This market anxiety resulted from the potential for the trial results to indicate an associated risk between use of the 3-month injectable contraceptive, Depo-Provera® and acquisition of HIV.

The stockouts impacted the supply of all contraceptives, including after July 2019, when the trial announced a lack of link between Depo-Provera® and HIV acquisition (ECHO, 2019). All contraceptive stock was impacted because Depo-Provera® is the most commonly used and there was increased reliance on, for example, NET-EN and the oral pill. Suppliers of contraceptives that were not part of the ECHO trial increased their prices and would not compromise in the absence of competition.

Crucially, participants from Programmes at the NDoH explained several factors contributed to the significant depletions and stockouts of contraceptives between 2015 –2020, including:

The Government of South Africa supplying the Evidence for Contraceptive Options and HIV Outcomes (ECHO) randomised clinical trial to run its research from December 2015 - September 2017 (ECHO, 2019). The trial utilised Depo-Provera®, levonorgestrel implant, and the copper intrauterine device (IUD). This depleted the nation's stock.

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KwaZulu-Natal

Patient surveys

Table 1: Patient survey on medicine shortages in the past 3 months

In the past 3 months did you or anyone you know leave the facility without the medicine they needed due to a stockout or shortage?

Period	Facilities	Surveys Completed (N)	Yes (%)	No (%)	Don't know
Apr to June 2022	129	4797	136 (3%)	4184 (87%)	10%
July to Sept 2022	131	7850	121 (2%)	4184 (53%)	6%
Oct to Dec 2022	132	7815	90 (1%)	7127 (91%)	8%
Jan to Mar 2023	125	7334	126 (2%)	6709 (91%)	7%
Apr to June 2023	126	7615	74 (1%)	7069 (93%)	6%

Table 1 shows patient responses to the question whether they had received the medicine that they needed. Generally, patients in KZN reported that they were able to leave health care facilities with the medicines that they needed.

Table 2: Patient survey on types of medicine not available at facilities in KwaZulu Natal

What type of medicine was not available in the past 3 months?

Period	Facilities	Surveys Completed (N)	HIV medicine	PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines or tests	None of the above	Don't know
Apr to June 2022	43	132	13 (10%	1 (1%)	1 (1%)	79 (60%)	3 (2%)	7 (5%)	0	15 (11%)	7 (5%)	10 (8%)
July to Sept 2022	37	121	23 (19%)	8 (7%)	13 (11%)	29 (24%)	4 (3%)	1 (1%)	10 (8%)	25 (21%)	16 (13%)	13 (11%)
Oct to Dec 2022	38	88	13 (15%)	3 (3%)	3 (3%)	34 (39%)	2 (2%)	7 (8%)	1 (1%)	21 (24%)	8 (9%)	3 (3%)
Jan to Mar 2023	22	124	70 (56%)	0	22 (18%)	0	1 (1%)	2 (2%)	12 (10%)	12 (10%)	6 (5%)	13 (10%)
Apr to June 2023	31	69	4 (6%)	6 (9%)	4 (6%)	25 (36%)	1 (1%)	2 (3%)	2 (3%)	9 (13%)	4 (6%)	13 (19%)

Table 2 shows the types of medicines not available at the facilities. Of the patients who reported that they had left a facility without their medicines between April and June 2022, 60% responded to the unavailability of contraceptives. Between July 2022 and June 2023, the percentage of patients reporting unavailability of contraceptives decreased to 39%.

Table 3: Patient survey on type of contraception not available

Type of contraception not available at the facility?

Period	Facilities	Surveys Completed (N)	External condoms	Internal condoms	Oral contraception	Injectable contraception	Subdermal implant	Intrauterine device	Other	Don't know
Apr to June 2022	26	78	2 (3%)	0	1 (1%)	76 (97%)	0	0	1 (1%)	0
July to Sept 2022	12	29	16 (55%)	11 (38%)	0	13 (45%)	1 (3%)	2 (7%)	0	1 (3%)
Oct to Dec 2022	17	34	4 (12%)	4 (12%)	1 (3%)	26 (76%)	1 (3%)	1 (3%)	0	1 (3%)
Jan to Mar 2023	8	22	5 (23%)	1 (5%)	0	16 (73%)	0	0	1 (5%)	0
Apr to June 2023	12	25	2 (8%)	0	1 (4%)	22 (88%)	0	0	0	0

Table 3 shows responses from 188 patients who were asked the type of contraceptives they were not able to access. Injectable contraceptives were the least accessible, followed by external condoms.

Table 4: Reasons why patients did not receive contraceptives from facilities

Why were you unable to get the contraceptives you wanted?

KZN	Facilities	Surveys Completed (N)	I am a sex worker	I am a person who uses drugs	my first choice was not available	I am part of the LGBTQIA+ community	I had to come back	I was too young	there was a stockout / shortage	there were no pregnancy tests available	Other	Don't know
Apr to June 2022	26	37	0	0	18 (47%)	0	6 (16%)	1 (3%)	10 (27%)	0	1 (3%)	4 (11%)
July to Sept 2022	19	37	0	0	12 (32%)	0	2 (5%)	2 (5%)	12 (32%)	0	5 (14%)	8 (22%)
Oct to Dec 2022	19	40	1 (3%)	1 (3%)	19 (48%)	0	11 (28%)	2	11 (28%)	0	2 (5%)	2 (5%)
Jan to Mar 2023	15	33	0	0	22 (67%)	0	1 (3%)	0	7 (21%)	0	2 (6%)	1 (3%)
Apr to June 2023	11	15	1 (7%)	1 (7%)	3 (20%)	1 (7%)	2 (13%)	0	0	0	1 (7%)	8 (53%)

Table 4 shows the results of 162 patient responses from 90 facilities in KZN to: Why didn't you get the contraceptive of you requested? 74 patients responded they were told their requested contraception was not available. 40 patients responded they were told there was a stockout.

Facility staff surveys

The tables and graphs below show data from facility managers on the availability of medicines, particularly contraceptives in their facilities, as well as their responses to contraceptive shortages or stockouts.

Table 5: Facility manager survey on medicine shortages

In the past 3 months did any patient leave your facility without the medicine they needed due to a stockout or shortage?

Period	Facilities (N)	Yes	No, because we gave them an alternative	No, but we gave them a short supply	No, but we gave them a short supply	Don't know
Apr to June 2022	120	9 (7%)	88 (73%)	21 (18%)	0	2 (2%)
July to Sept 2022	127	8 (6%)	61 (48%)	11 (9%)	47 (37%)	0
Oct to Dec 2022	128	4 (3%)	63 (49%)	12 (9%)	49 (38%)	0
Jan to Mar 2023	123	5 (4%)	50 (41%)	9 (7%)	58 (47%)	1 (1%)
Apr to June 2023	123	3 (2%)	54 (44%)	7 (6%)	58 (47%)	1 (1%)

Table 5 shows facility manager responses to a question regarding medicine shortages at their facilities. Whilst some managers responded that patients had not received the medicine that they needed, others responded that they had not experienced a stock out. Most however responded that they had either offered the patient an alternative or had a short supply.

Table 6: Facility staff survey on the types of medicines that were not available

What type of medicine was not available in the past 3 months?

Period	Facilities (N)	HIV treatment	HIV PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines or diagnostic tests	None of the above	Don't know
Apr to June 2022	124	6 (5%)	2 (2%)	4 (3%)	27 (22%)	0	7 (6%)	1 (1%)	6 (5%)	84 (68%)	2 (2%)
July to Sept 2022	130	9 (7%)	0	4 (3%)	2 (2%)	0	2 (2%)	2 (2%)	12 (9%)	106 (82%)	1 (1%)
Oct to Dec 2022	128	8 (%)	1 (1%)	1 (1%)	2 (2%)	1 (1%)	4 (3%)	1 (1%)	5 (4%)	107 (84%)	0
Jan to Mar 2023	122	3 (2%)	1 (1%)	4 (3%)	3 (2%)	1 (1%)	2 (2%)	1 (1%)	8 (7%)	106 (87%)	2 (2%)
Apr to June 2023	125	3 (2%)	2 (2%)	4 (3%)	3 (2%)	0	6 (5%)	3 (2%)	9 (7%)	104 (83%)	0

Table 6 shows the types of medicines that facility managers reported to have been out of stock over the monitoring period. Initially, contraceptives were the most unavailable but this changes over the following four quarters.

Table 7: Facility staff survey on the types of contraceptives that were not available

What type of contraceptives were not available in the past 3 months?

Period	Facilities (N)	External condoms	Internal condoms	Oral contraception	Injectable contraception	Subdermal implant	Intrauterine device	Other	Don't know
Apr to June 2022	27	3 (11%)	2 (7%)	0	25 (93%)	1 (4%)	0	0	0
July to Sept 2022	2	1 (50%)	0	1 (50%)	1 (50%)	0	0	0	0
Oct to Dec 2022	2	1 (50%)	0	0	1 (50%)	0	0	0	0
Jan to Mar 2023	2	0	0	1 (50%)	2 (100%)	0	0	0	0
Apr to June 2023	3	0	0	0	2 (67%)	1 (33%)	0	0	0

Table 7 shows the responses of facility staff when asked which types of contraceptives where unavailable. In the first quarter, 25 of the 27 managers reported that injectable contraceptives followed by external condoms were the least accessible.

Table 8: Ability to insert and remove implants

Are staff trained and available on site for implant insertion & removal?

Period	Facilities	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	126	125	125 (100%)	2 (1%)	0
July to Sept 2022	4	4	4 (100%)	0	0
Oct to Dec 2022	123	123	123 (100%)	0	0
Jan to Mar 2023	0	0	0	0	0
Apr to June 2023	123	123	122 (99%)	1 (1%)	0

Table 8 shows data collected from facilities about the capacity to insert and remove implants. Most reported that their contraceptive clinics can provide this service for implants, while three responded they could not.

Table 9: Ability to insert and remove IUDs

Are staff trained and available on site for IUD insertion & removal?

KZN	Number of Facilities Assessed	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	108	108	107 (99%)	1 (1%)	0
July to Sept 2022	4	4	4 (100%)	0	0
Oct to Dec 2022	120	120	118 (98%)	2 (2%)	0
Jan to Mar 2023	0	0	0	0	0
Apr to June 2023	113	113	108 (96%)	5 (4%)	0

Table 9 shows data collected from facilities about the capacity to insert and remove IUDs. Most responded that their contraceptive clinics can provide this service for IUDs, while eight responded they could not.

Table 10: Facility staff survey on actions taken during periods of contraceptive shortages/stockouts

During periods of hormonal contraception stockouts, what options do you offer users?

KZN	Surveys Completed (N)	Refer people to another facility that has their contraception of choice	Tell people to come back when the commodity is back in stock	Recommend switching to a different contraception option	Other	Don't know
Apr to June 2022	2	2 (100%)	0	0	0	0
July to Sept 2022	2	0	1 (50%)	2 (100%)	0	0
Oct to Dec 2022	1	0	0	1 (100%)	0	0
Jan to Mar 2023	3	0	0	2 (67%)	1 (33%)	0
Apr to June 2023	2	2 (100%)	0	2 (100%)	0	0

Table 10 shows the actions of facility managers in response to contraceptive shortages. More often than not, facility managers recommended that patients switch to different contraception that was available.

Table 11: Whether facility managers have guidance on how to respond to stockouts

Have the facility managers received official guidance on how to respond to stockouts?

KZN	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	23	13 (57%)	9 (39%)	1 (4%)
July to Sept 2022	1	1 (100%)	0	0
Oct to Dec 2022	2	1 (100%)	1 (50%)	0
Jan to Mar 2023	1	1 (100%)	0	0
Apr to June 2023	2	1 (100%)	0	1 (50%)

Table 11 shows the outcome of 29 managers from KZN responses to the question: Have you received any official guidance from a Department of Health about how to manage contraceptive stockouts? 17 (58.6%) said yes they had, while 10 (34.4%) said they had not. Two (6.8%) responded that they did not know.

Table 12: Availability of termination of pregnancy services in the KwaZulu-Natal

Does the facility provide termination of pregnancy services to user?

KZN	Number of facilities assessed	Surveys completed (N)	Yes, on site	Yes, by referral	No	Don't know
Apr to June 2022	115	116	40 (34%)	62 (53%)	14 (12%)	0
July to Sept 2022	4	4	3 (75%)	0	1 (25%)	0
Oct to Dec 2022	124	124	25 (20%)	87 (70%)	12 (15%)	0
Jan to Mar 2023	0	0	0	0	0	0
Apr to June 2023	123	123	26 (21%)	87 (71%)	10 (8%)	0

Table 12 shows the number of facilities assessed each quarter on availability of termination of pregnancy services. Most facilities refer patients elsewhere for this service, while up to 34% reported providing the service on site in one quarter.

Supply Chain Management

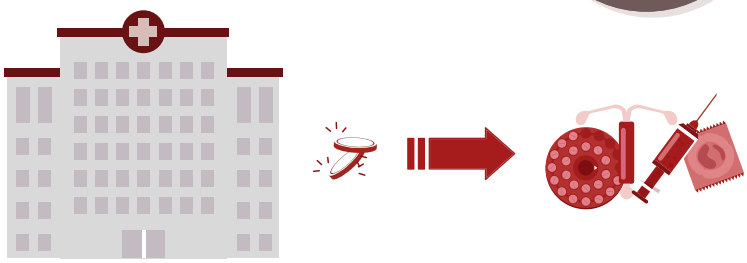
The supply chain including budgetary and financial flows, is detailed in this section.

Ordering supplies:

According to a former Assistant Manager of KZN's Medical Depot each year Primary Health Care facilities determine their contraceptive, and other supply needs. They do so by creating "Annual Procurement Plans" based on each facility's prior year usage, supplies offered, etc. A Head of Pharmacy of a regional hospital in KZN confirmed this, adding hospitals and clinics order monthly based on their needs. They added, when hospitals order they do so considering the needs of the clinics they serve.



Ordering and Distribution:



According to a former Assistant Manager of the Medical Depot, KZN uses two ordering systems for health supplies and commodities. The first is the standard format stock is ordered from suppliers by the KZN Medical Depot in Durban, delivered there, and then distributed to facilities. The second is the Medical Depot still orders with suppliers, but the stock is delivered directly to hospitals, and in some cases clinics. Then each facility sends electronic[7] paperwork (through Rx Solution) to the Medical Depot to confirm receipt of the supplies. The Medical Depot processes the paperwork for re-payment from hospital and clinic own supply budgets. The Head of Pharmacy of a regional hospital added that since 2018 there has been a third option. Major hospitals also order directly with suppliers. This enables clinics to make emergency orders with Major Hospitals to compensate for delays and stockouts at the Medical Depot. They also detailed that receiving facilities check the delivered supply against the invoice to make sure there are no discrepancies, and then courier all of the documents to the Medical Depot. It is likely that both electronic and paper-based trails are being utilised for this aspect of supply chain management. The pharmacist detailed that a month after supplies are received, hospitals will be given payment information from suppliers. The hospital then uses "a payment solution" to document and track record of payments.





According to KZN key informant interviews the main causes are:

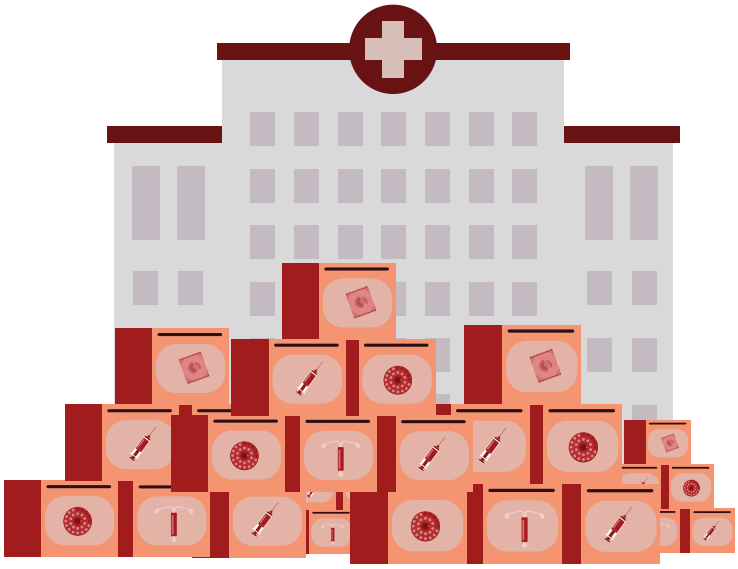
- distribution from one Depot in a rural province
- lack of storage at facilities
- overseas importation of supplies
- shortages of manufacturing ingredients
- budgetary limitations
- data information and paperwork systems
- contractual limitations
- limits of registered drugs and suppliers
- poor planning of incorporating new contraceptive methods into the national programme

[7] The supply chain began developing and then implementing an electronic ordering system in late 2022. They did this because they found the solely manual paper-based system was one cause of procurement delays. Rx Solution is used, it is a software program that supports the regulation of stock control within public health facilities.

Key informants explained there only being one Depot in the rural province creates delivery challenges. Large deliveries fill up the Depot, and the standard redistribution ordering system (from the Depot to hospitals and clinics) adds an additional week, or more partly due to the distances couriers must travel.



Contraceptives, we were told are bulky items and hospitals and clinics do not have the infrastructure to store the volumes they require. Lack of storage causes stock to become un-usable because even if it is stored on-premises informants explained it becomes inaccessible, and then expires. To address this challenge instead of ordering 1,000 doses of injectables, for example we were told facilities order 500. In addition to limiting the accessible supply, this also increases the distribution time.



In the past when contracted manufacturers faced issues with sourcing ingredients an additional delay resulted from a lack of both registered drugs, and suppliers who could distribute.[8]

While budgetary constraints were mentioned as a cause, the former Assistant Manager assured monies do not determine supplies. They reported that in KZN, shortfalls on these high volume orders was not adjusted to match budget allocations, rather monies would be moved from items underspending (in the equitable share budget).

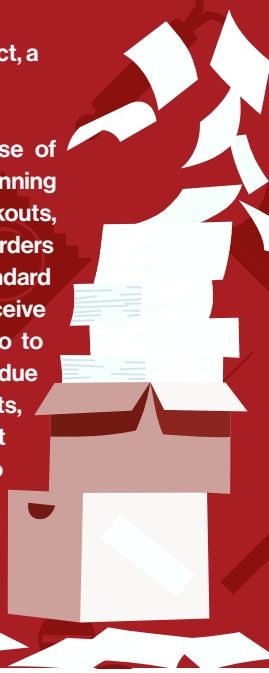
Contractual and Payment Systems:

Informants explained that once supplies are received at a facility a signed and endorsed stock invoice needs to be returned to the Depot for payment. Historically, KZN has only had a paper-based system for this. When human error causes invoices and other paperwork to get lost or un-sent the Depot cannot pay suppliers. Once suppliers have large sums un-paid they stop supplying until balances are settled. The former Assistant Manager said the recent electronic paperwork system may have improved this.

Informants noted contractual limitations as causes of stockouts. These include suppliers having 75 days to deliver on a new contract, which reportedly caused stockouts for up to three months. Additionally, poor planning to incorporate new methods into the national programme was noted as a contributing factor. When adjustments to existing drug volumes and contracts are not made adequately informants report this can cause stockouts.

Poor planning can cause purchases out of contract, a lengthy supplier process.

Relatedly, informants reported a sporadic cause of stockouts, lasting one or two months, is family planning health promotion campaigns. This causes stockouts, due to one, the volume of contraceptive orders for campaigns being incorporated into standard contraceptive ordering so facilities will not receive the standard amount, because a portion will go to supplying a campaign. Stockouts also caused due to the two to three year fixed length of contracts, where the volume of contraceptive orders cannot be adjusted. This contractual strictness also causes stockouts when changes in migration increase demand for contraceptives.



[8] All drugs and suppliers need to be registered and licenced by South African Health Products Regulatory Authority (SAHPRA) before they can participate in the country's supply chain.

Eastern Cape

Patient surveys

Table 13: Patient survey on medicine shortages in the past 3 months

In the past 3 months did you or anyone you know leave the facility without the medicine they needed due to a stockout or shortage?

Eastern Cape	Number of Facilities Assessed	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	46	1774	199 (11%)	1539 (87%)	124 (7%)
July to Sept 2022	49	2465	167 (7%)	1798 (73%)	493 (20%)
Oct to Dec 2022	47	2578	195 (8%)	1995 (77%)	387 (15%)
Jan to Mar 2023	50	2665	128 (5%)	2262 (85%)	267 (10%)
Apr to June 2023	46	2528	114 (5%)	2075 (82%)	329 (13%)

Table 13 shows patient responses to the question whether they had received the medicine that they needed. Generally, patients in the Eastern Cape reported that they not were able to leave health care facilities with the medicines that they needed.

Table 14: Patient survey on types of medicine not available at facilities in the Eastern Cape

What type of medicine was not available in the past 3 months?

Eastern Cape	Facilities	Surveys Completed (N)	HIV medicine	PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines or tests	None of the above	Don't know
Apr to June 2022	36	117	22 (19%)	2 (2%)	0	50 (43%)	20 (17%)	11 (9%)	4 (3%)	18 (15%)	6 (5%)	7 (6%)
July to Sept 2022	41	165	13 (8%)	7 (4%)	5 (3%)	64 (39%)	25 (15%)	20 (12%)	5 (3%)	19 (12%)	14 (8%)	19 (12%)
Oct to Dec 2022	38	194	14 (7%)	9 (5%)	2 (1%)	111 (57%)	26 (13%)	5 (3%)	1 (1%)	25 (13%)	5 (3%)	8 (4%)
Jan to Mar 2023	30	126	8 (6%)	1 (1%)	1 (1%)	32 (25%)	36 (29%)	6 (5%)	1 (1%)	22 (17%)	18 (14%)	10 (8%)
Apr to June 2023	30	110	5 (5%)	5 (5%)	2 (2%)	32 (29%)	16 (15%)	10 (9%)	3 (3%)	14 (13%)	24 (22%)	7 (6%)

Table 14 shows the types of medicines not available at the facilities in the Eastern Cape. Of the patients who reported that they had left a facility without their medicines between April and June 2022, 43 % responded unavailability of contraceptives. Between July 2022 and June 2023, the percentage of patients reporting unavailability of contraceptives decreased to 29%.

Table 15: Patient survey on type of contraception not available

Type of contraception not available at facility?

Eastern Cape	Facilities	Surveys Completed (N)	External condoms	Internal condoms	Oral contraception	Injectable contraception	Subdermal implant	Intrauterine device	Other	Don't know
Apr to June 2022	19	50	5 (10%)	6 (12%)	7 (14%)	42 (84%)	3 (6%)	1 (2%)	0	3 (6%)
July to Sept 2022	23	64	44 (69%)	2 (3%)	3 (5%)	15 (23%)	2 (3%)	0	3 (5%)	1 (2%)
Oct to Dec 2022	26	111	77 (69%)	2 (2%)	0	35 (32%)	1 (1%)	1 (1%)	1 (1%)	0
Jan to Mar 2023	17	32	20 (63%)	5 (16%)	1 (3%)	11 (34%)	2 (6%)	0	2 (6%)	2 (6%)
Apr to June 2023	13	32	16 (50%)	1 (3%)	1 (3%)	13 (41%)	1 (3%)	0	3 (9%)	0

Table 15 shows the responses from 289 patients who were asked what types of contraceptives were not available at the facilities in the Eastern Cape. In the first quarter, injectable contraceptives followed by internal condoms were the least accessible. In the last four quarters, external condoms, followed by injectable contraceptives were the least accessible.

Table 16: Reasons why patients did not receive contraceptives from facilities in the Eastern Cape

Why were you unable to get the contraceptives you wanted?

Eastern Cape	Facilities	Surveys Completed (N)	I am a sex worker	I am a person who uses drugs	my first choice was not available	I am part of the LGBTQIA+ community	I had to come back	I was too young	there was a stockout / shortage	there were no pregnancy tests available	Other	Don't know
Apr to June 2022	26	37	0	0	18 (47%)	0	6 (16%)	1 (3%)	10 (27%)	0	1 (3%)	4 (11%)
July to Sept 2022	19	37	0	0	12 (32%)	0	2 (5%)	2 (5%)	12 (32%)	0	5 (14%)	8 (22%)
Oct to Dec 2022	19	40	1 (3%)	1 (3%)	19 (48%)	0	11 (28%)	2	11 (28%)	0	2 (5%)	2 (5%)
Jan to Mar 2023	15	33	0	0	22 (67%)	0	1 (3%)	0	7 (21%)	0	2 (6%)	1 (3%)
Apr to June 2023	11	15	1 (7%)	1 (7%)	3 (20%)	1 (7%)	2 (13%)	0	0	0	1 (7%)	8 (53%)

Table 16 shows the results of 588 users responses from 113 facilities in the Eastern Cape to the question: Why didn't you receive the contraceptive you requested? 468 patients responded they were told there was a stockout. 47 responded they did not know. 34 patients responded they were told their first choice was not available.

Facility staff surveys

The tables and graphs below show data from facility managers on the availability of medicines, particularly contraceptives in their facilities, as well as their responses to contraceptive shortages or stockouts.

Table 17: Facility manager survey on medicine shortages

In the past three months, did any patient leave your facility without the medication they needed due to a stock out or a shortage?

Eastern Cape	Facilities (N)	Yes	No, because we gave them an alternative	No, but we gave them a short supply	No, but we gave them a short supply	Don't know
Apr to June 2022	46	10 (22%)	30 (65%)	5 (11%)	0	1 (2%)
July to Sept 2022	48	7 (15%)	21 (44%)	4 (8%)	15 (31%)	1 (2%)
Oct to Dec 2022	47	5 (11%)	21 (45%)	4 (9%)	15 (32%)	2 (4%)
Jan to Mar 2023	49	5 (10%)	21 (43%)	10 (20%)	13 (27%)	0
Apr to June 2023	46	10 (22%)	16 (35%)	9 (20%)	11 (24%)	0

Table 17 shows facility manager responses to a question regarding medicine shortages at their facilities. Whilst some managers responded that patients had not received the medicine that they needed, others responded that they had not experienced a stock out. Most however responded that they had either offered the patient an alternative or gave them a short supply.

Table 18: Facility staff survey on the type of medicines that were not available

What type of medicine was not available in the past 3 months?

Eastern Cape	Facilities (N)	HIV treatment	HIV PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines or diagnostic tests	None of the above	Don't know
Apr to June 2022	46	6 (13%)	0	4 (9%)	10 (22%)	6 (13%)	6 (13%)	3 (7%)	17 (40%)	20 (43%)	0
July to Sept 2022	49	9 (18%)	1 (2%)	3 (6%)	2 (4%)	10 (20%)	5 (10%)	2 (4%)	13 (27%)	22 (45%)	0
Oct to Dec 2022	47	7 (15%)	0	2 (4%)	5 (11%)	11 (23%)	4 (9%)	2 (4%)	4 (9%)	26 (55%)	0
Jan to Mar 2023	48	9 (19%)	2 (4%)	4 (8%)	3 (6%)	12 (25%)	3 (6%)	6 (13%)	6 (13%)	25 (52%)	0
Apr to June 2023	46	9 (20%)	2 (4%)	5 (11%)	7 (15%)	6 (13%)	9 (20%)	5 (11%)	6 (13%)	21 (46%)	0

Table 18 shows the types of medicines that facility managers reported to have been out of stock over the monitoring period.

Table 19: Facility survey on the types of contraceptives that were not available

What type of contraceptives were not available in the past 3 months?

Eastern Cape	Facilities (N)	External condoms	Internal condoms	Oral contraception	Injectable contraception	Subdermal implant	Intrauterine device	Other	Don't know
Apr to June 2022	45	45 (100%)	43 (96%)	42 (93%)	45 (100%)	36 (80%)	18 (40%)	0	0
July to Sept 2022	1	1 (100%)	1 (100%)	0	1 (100%)	1 (100%)	0	0	0
Oct to Dec 2022	47	45 (96%)	43 (91%)	40 (85%)	45 (96%)	36 (77%)	21 (45%)	0	0
Jan to Mar 2023	0	0	0	0	0	0	0	0	0
Apr to June 2023	45	41 (91%)	37 (82%)	41 (91%)	44 (98%)	33 (73%)	15 (33%)	0	0

Table 19 shows the responses of facility staff when asked which types of contraceptives where unavailable. In the first quarter, all surveyed facilities reported shortages of external condoms and injectable contraceptives.

Table 20: Ability to insert and remove implants

Are staff trained and available on site for implant insertion & removal?

Eastern Cape	Number of Facilities Assessed	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	36	36	36 (100%)	0	0
July to Sept 2022	1	1	1 (100%)	0	0
Oct to Dec 2022	36	36	35 (97%)	1 (3%)	0
Jan to Mar 2023	0	0	0	0	0
Apr to June 2023	32	32	29 (91%)	3 (9%)	0

Table 20 shows data collected quarterly from facilities on the capacity to insert and remove contraceptive implants. The majority of facilities assessed reported having staff who were trained to perform this task.

Table 21: Ability to insert and remove IUDs

Are staff trained and available on site for IUD insertion & removal?

Eastern Cape	Number of Facilities Assessed	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	108	108	107 (99%)	1 (1%)	0
July to Sept 2022	4	4	4 (100%)	0	0
Oct to Dec 2022	120	120	118 (98%)	2 (2%)	0
Jan to Mar 2023	0	0	0	0	0
Apr to June 2023	113	113	108 (96%)	5 (4%)	0

Table 21 shows data from facilities on the availability of staff trained to insert and remove IUDs. Most facilities assessed reported having trained staff available to perform this task.

Table 22: Facility staff survey on actions taken during periods of contraceptive shortages/ stockouts

During periods of hormonal contraception stockouts, what options do you offer users?

Eastern Cape	Surveys Completed (N)	Refer people to another facility that has their contraception of choice	Tell people to come back when the commodity is back in stock	Recommend switching to a different contraception option	Other	Don't know
Apr to June 2022	10	3 (30%)	1 (10%)	0	0	0
July to Sept 2022	2	1 (50%)	0	1 (50%)	0	0
Oct to Dec 2022	5	3 (60%)	2 (40%)	2 (40%)	0	0
Jan to Mar 2023	2	2 (100%)	0	0	0	0
Apr to June 2023	7	1 (14%)	0	6 (86%)	1 (14%)	0

Table 22 shows the actions of facility managers in response to contraceptive shortages. Facility staff chose to either refer patients to other facilities that had their contraceptive of choice, or they recommended switching to a different contraception.

Table 23: Whether facility managers have guidance on how to respond to stockouts

Have the facility managers received official guidance on how to respond to stockouts?

Eastern Cape	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	10	6 (60%)	4 (40%)	0
July to Sept 2022	2	1 (50%)	0	1(50%)
Oct to Dec 2022	5	3 (60%)	2 (40%)	0
Jan to Mar 2023	2	0	1 (50%)	1 (50%)
Apr to June 2023	7	3 (43%)	4 (57%)	0

Table 23 shows responses from facility managers on whether or not they received guidance on how to respond to stockouts.

Table 24: Availability of termination of pregnancy services in the Eastern Cape

Does the facility provide termination of pregnancy services to user?

Eastern Cape	Number of facilities assessed	Surveys completed (N)	Yes, on site	Yes, by referral	No	Don't know
Apr to June 2022	42	42	6 (14%)	15 (36%)	21 (50%)	0
July to Sept 2022	1	1	0	1 (100%)	0	0
Oct to Dec 2022	47	47	5 (11%)	32 (68%)	10 (21%)	0
Jan to Mar 2023	0	0	0	0	0	0
Apr to June 2023	45	45	9 (20%)	26 (58%)	10 (22%)	0

Table 24 shows the number of facilities assessed each quarter on availability of termination of pregnancy services. Most facilities refer patients elsewhere for this service, while up to 14% reported providing the service on site in one quarter.

Supply Chain Management

The supply chain including budgetary and financial flows, is detailed in this section.

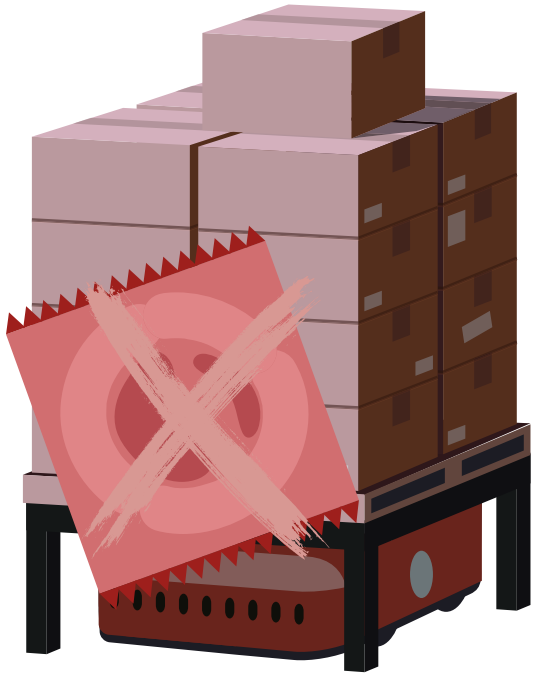
Informants reported two Medical Depot's in the Eastern Cape. One in Mthatha catering for the rural areas, and one in Gqeberha. In 2020 secondary storage facilities were introduced in East London at Cecilia Makiwane Hospital. The Province uses an electronic stock control system called "Medsas" which manages and tracks procurement, payments and demand. However, participants also reported the systems to be "very manual and paper oriented".



Ordering supplies:

A Director of Finance and Supply Chain detailed three systems for ordering. The first is the standard approach: stock is ordered from suppliers by the Medical Depots, delivered to them, and distributed to facilities. The second is stock goes directly to the Central Chronic Medicines Dispensing and Distribution programme (CCMDD) and is distributed. The third approach is 'direct delivery.' In this case, the Medical Depot still actions the orders on behalf of the hospitals and clinics, but the orders are delivered directly to them. The invoices and delivery notes are verified at the receiving facility and then the paperwork is couriered to the Depot for payment.

A Manager of District Health Programmes explained for at least five years, since before the Covid-19 pandemic, the province has been struggling with stockouts of condoms. They reported that at present, once a request for condoms is ordered through the "transversal contract (RT) ", it takes up to three months for supplies to reach facilities from the secondary storage centres in the province.

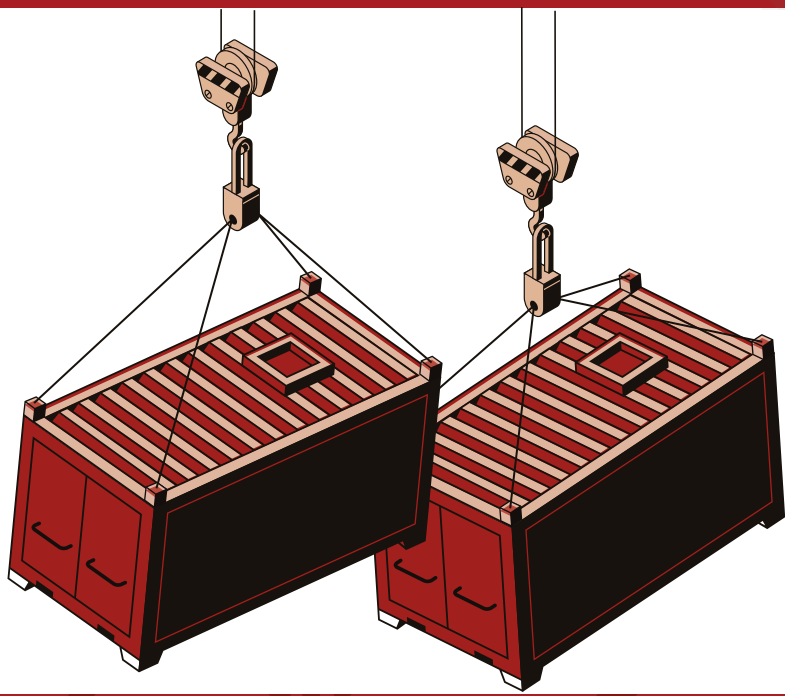


According to EC key informant interviews the main causes are:

- reputation for non-payment of suppliers
- budgetary limitations
- finances, payments, and accounts
- data information and paperwork systems
- challenges with distribution of supplies within the country
- overseas importation of supplies
- shortages of manufacturing ingredients

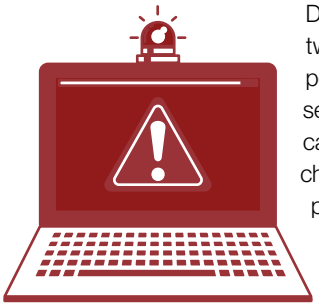
Importing Supply:

A manager of District Health Programmes reported the significant, and consistent stockout of condoms results from several factors, including: demand exceeding supply; pricing is at US dollar rates causing delays in national contracting; supplies imported from Thailand and India; issues with poor quality of supply and regulation challenges by the Bureau of Standards (SABS). Another factor raised is that the EC lacks local suppliers (likely of distribution and packaging) of condoms and this causes a 3-6 month delay in local (national) delivery. This was explained to be due, in part, because local suppliers prioritise the provinces they are based in, for example, KZN, Gauteng and the Western Cape.



Budget Crisis and Payment Systems:

A Director of Finance and Supply Chain noted a significant cause of stockouts in the EC has to do with budget, cash flow, and payments. They noted a "mixture of technology, technological issues, human resources, and skills issues" contribute. As well as gradual decline in the equitable share of the available budget. For instance, they noted, IT and connectivity problems make it so submission of invoices, authorisation of payments, and payments themselves cannot be processed. The Director detailed that, salaries make up almost two-thirds of the budget, are ring-fenced, and pointed that this protection contributes to a sense of entitlement leading to absenteeism causing human resource challenges in supply chain efficiencies. With regard to cash and payments flow challenges, they reported, many hospitals and clinics that utilise the direct delivery method do not send the required documentation so that payments can be issued, resulting in, at best, suppliers invoices being settled two-months after issue.



Participants reported the EC equitable share budget to be inadequate. One said, "you get half of what you actually need", so the task is to "save and build efficiencies by saving on staff and maintenance". Generally, the government must have cash and budget to order supplies, however medical and surgical supplies don't operate under those constraints. It was reported that instead the budget is re-prioritised favouring food and securities, at the expense of the medical and surgical supply budget. This all has led to the EC having a significant debt that rolls over annually, and a reputation amongst suppliers for delayed payment. In trying to manage the financial constraint Finance prioritises paying small and medium enterprises (SMEs) where large multi-nationals can wait for six months without payments. It was reported that recently, these large suppliers have begun to close accounts, put supply on hold until payments are serviced, and even refuse to participate in tendering bids as a result. To illustrate the extremity of the budgetary crisis the Director explained, on 31 March 2023, day one of the current financial year, the EC had R5 billion in outstanding payments which left the province with between R2 – 4 billion left in its equitable share budget.



North West

Patient surveys

This section provides survey data, on what contraceptives were short of stock, from managers and patients in the same reporting quarters. What staff tell patients during contraceptive stockouts is also detailed.

Table 25: Patient survey on the types of medicines that were not available at North West facilities

What type of medicine was not available in the past 3 months?

North West	Facilities	Surveys Completed (N)	HIV medicine	PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines or tests	None of the above	Don't know
Apr to June 2022	13	13	5 (38%)	0	0	4 (31%)	4 (31%)	3 (23%)	0	4 (31%)	3 (23%)	1 (8%)
July to Sept 2022	14	14	0	2 (14%)	2 (14%)	6 (43%)	3 (21%)	1 (7%)	0	7 (50%)	2 (14%)	0
Oct to Dec 2022	13	13	1 (8%)	1 (8%)	2 (15%)	1 (8%)	3 (23%)	1 (8%)	3 (23%)	4 (31%)	4 (31%)	1 (8%)
Jan to Mar 2023	9	9	1 (11%)	0	0	1 (11%)	0	1 (11%)	1 (11%)	2 (22%)	3 (33%)	1 (11%)
Apr to June 2023	17	17	5 (29%)	0	3 (18%)	3 (18%)	2 (12%)	2 (12%)	4 (24%)	6 (35%)	3 (18%)	0

Table 25 shows patient responses to the question "what types of medicines were not available at the facility". Except for the thirds and fourth quarter, contraceptives were consistently unavailable.

Table 26: Patient survey on the types of contraceptives that were not available at North West facilities

What type of contraception was not available?

North West	Facilities	Surveys Completed (N)	External condoms	Internal condoms	Oral contraception	Injectable contraception	Subdermal implant	Intrauterine device	Other	Don't know
Apr to June 2022	13	13	13 (100%)	10 (77%)	13 (100%)	13 (100%)	12 (92%)	7 (54%)	1 (8%)	1 (8%)
July to Sept 2022	0	0	0	0	0	0	0	0	0	0
Oct to Dec 2022	13	13	13 (100%)	11 (85%)	13 (100%)	13 (100%)	11 (85%)	5 (38%)	0	0
Jan to Mar 2023	0	0	0	0	0	0	0	0	0	0
Apr to June 2023	18	18	18 (100%)	14 (78%)	18 (100%)	18 (100%)	18 (100%)	13 (72%)	0	0

Table 26 shows data from patient surveys in the North West in response to type of contraception that is unavailable. For the quarters in which there is data available, most patients surveyed reported that most to all types of contraception were not available.

Table 27: Reasons why patients did not receive contraceptives from facilities in the North West

Why were you unable to get the contraceptives you wanted?

North West	Facilities	Surveys Completed (N)	I am a sex worker	I am a person who uses drugs	my first choice was not available	I am part of the LGBTQIA+ community	I had to come back	I was too young	there was a stockout / shortage	there were no pregnancy tests available	Other	Don't know
Apr to June 2022	9	43	0	0	7 (16%)	0	14 (33%)	0	40 (93%)	1 (2%)	0	0
July to Sept 2022	7	37	0	0	18 (49%)	0	6 (16%)	0	26 (70%)	1 (3%)	0	1 (3%)
Oct to Dec 2022	8	63	1 (2%)	0	11 (17%)	0	2 (3%)	0	60 (95%)	0	0	0
Jan to Mar 2023	5	8	0	0	0	0	0	0	6 (75%)	0	1 (13%)	1 (13%)
Apr to June 2023	14	52	0	0	19 (37%)	0	13 (25%)	1 (2%)	21 (40%)	3 (6%)	1 (2%)	1 (2%)

Table 27 shows that contraceptive stockouts/ shortages were the most common reason for patients to not get their contraception of choice.

Facility staff surveys

The tables and graphs below show data from facility managers on the availability of medicines, particularly contraceptives in their facilities, as well as their responses to contraceptive shortages or stockouts.

Table 28: Facility staff survey on their responses during medicine shortages

In the past three months, did any patient leave your facility without the medication they needed due to a stock out or a shortage?

North West	Facilities (N)	Yes	No, because we gave them an alternative	No, but we gave them a short supply	No, but we gave them a short supply	Don't know
Apr to June 2022	13	1 (8%)	6 (46%)	6 (46%)	0	0
July to Sept 2022	15	1 (7%)	11 (73%)	2 (13%)	1 (7%)	0
Oct to Dec 2022	13	1 (8%)	3 (23%)	2 (15%)	6 (46%)	1 (8%)
Jan to Mar 2023	8	3 (38%)	1 (13%)	1 (13%)	2 (25%)	1 (8%)
Apr to June 2023	18	4 (22%)	9 (50%)	3 (17%)	2 (11%)	0

Table 28 shows facility manager responses to a question regarding medicine shortages at their facilities. Whilst some managers responded that patients had not received the medicine that they needed, others responded that they had nor experienced a stock out. Most however responded that they had either offered the patient an alternative or gave them a short supply.

Table 29: Facility staff survey on the type of medicines that were not available

What type of medicine was not available in the past 3 months?

North West	Facilities (N)	HIV treatment	HIV PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines or diagnostic tests	None of the above	Don't know
Apr to June 2022	13	5 (38%)	0	0	4 (31%)	4 (31%)	3 (23%)	0	4 (31%)	3 (23%)	1 (8%)
July to Sept 2022	14	2 (14%)	0	2 (14%)	6 (43%)	3 (21%)	1 (7%)	0	7 (50%)	2 (14%)	0
Oct to Dec 2022	13	1 (8%)	1 (8%)	2 (15%)	1 (8%)	3 (23%)	1 (8%)	3 (23%)	4 (31%)	4 (31%)	1 (8%)
Jan to Mar 2023	9	1 (11%)	0	0	1 (11%)	0	1 (11%)	1 (11%)	2 (22%)	3 (33%)	1 (11%)
Apr to June 2023	17	5 (29%)	0	3 (18%)	3 (18%)	2 (12%)	2 (12%)	4 (24%)	6 (35%)	3 (18%)	0

Table 29 shows the types of medicines that facility managers reported to have been out of stock over the monitoring period.

Table 30: Facility staff survey on the types of contraceptives that were not available

What types of contraceptives were not available?

North West	Facilities (N)	External condoms	Internal condoms	Oral contraception	Injectable contraception	Subdermal implant	Intrauterine device	Other	Don't know
Apr to June 2022	4	0	0	4 (100%)	1 (25%)	2 (50%)	0	1	0
July to Sept 2022	5	1 (20%)	1 (20%)	1 (20%)	5 (100%)	1 (20%)	0	0	0
Oct to Dec 2022	1	0	0	0	1 (100%)	0	0	0	0
Jan to Mar 2023	1	0	0	1 (100%)	0	0	0	0	0
Apr to June 2023	3	1 (33%)	0	1 (33%)	0	2 (67%)	1 (33%)	0	0

Table 30 shows limited data from North West on the types of contraceptives that were not available from the Facility Staff Surveys each quarter.

Table 31: Ability to insert and remove implants

Are staff trained and available on site for implant insertion & removal?

North West	Number of Facilities Assessed	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	36	36	36 (100%)	0	0
July to Sept 2022	1	1	1 (100%)	0	0
Oct to Dec 2022	36	36	35 (97%)	1 (3%)	0
Jan to Mar 2023	0	0	0	0	0
Apr to June 2023	32	32	29 (91%)	3 (9%)	0

Table 31 shows data collected from facilities over four quarters about the capacity to insert and remove Implants. Most reported their contraceptive clinics can provide this service for Implants.

Table 32: Ability to insert and remove IUDs

Are staff trained and available on site for IUD insertion & removal?

North West	Number of Facilities Assessed	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	108	108	107 (99%)	1 (1%)	0
July to Sept 2022	4	4	4 (100%)	0	0
Oct to Dec 2022	120	120	118 (98%)	2 (2%)	0
Jan to Mar 2023	0	0	0	0	0
Apr to June 2023	113	113	108 (96%)	5 (4%)	0

Table 32 shows collected from facilities over four quarters about the capacity to insert and remove IUDs. Most responded that their contraceptive clinics can provide this service for IUDs.

Table 33: Facility staff survey on actions taken during periods of contraceptive shortages/ stockouts

During periods of hormonal contraception stockouts, what options do you offer users?

North West	Surveys Completed (N)	Refer people to another facility that has their contraception of choice	Tell people to come back when the commodity is back in stock	Recommend switching to a different contraception option	Other	Don't know
Apr to June 2022	4	0	2 (50%)	3 (75%)	0	0
July to Sept 2022	6	0	1 (17%)	6 (100%)	0	0
Oct to Dec 2022	1	1 (100%)	0	0	0	0
Jan to Mar 2023	1	0	1 (100%)	0	0	0
Apr to June 2023	3	2 (67%)	2 (67%)	1 (33%)	0	0

Table 33 shows the actions of facility managers in response to contraceptive shortages. Facility staff chose to advise patients to come back at a later stage, or they recommended switching to a different contraception.

Table 34: Whether facility managers have guidance on how to respond to stockouts

Have the facility managers received official guidance on how to respond to stockouts?

North West	Surveys Completed (N)	Yes	No	Don't know
Apr to June 2022	4	1 (25%)	3 (75%)	0
July to Sept 2022	6	1 (17%	4 (67%)	1 (17%)
Oct to Dec 2022	1	0	1 (100%)	0
Jan to Mar 2023	0	0	0	0
Apr to June 2023	3	0	3 (100%)	0

Table 34 shows in the NW a total of fourteen managers responded to the question: Have you received any official guidance from a Department of Health about how to manage contraceptive stockouts? 2 (14.2%) said yes they had, while 11 (78.5%) said they had not. 1 (7.1%) responded that they did not know.

Table 35: Availability of termination of pregnancy services in the North West

Does the facility provide termination of pregnancy services to user?

North West	Number of facilities assessed	Surveys completed (N)	Yes, on site	Yes, by referral	No	Don't know
Apr to June 2022	13	13	4(31%)	6 (46%)	3 (23%)	0
July to Sept 2022	0	0	0	0	0	0
Oct to Dec 2022	13	13	3 (23%)	9 (62%)	1 (8%)	0
Jan to Mar 2023	0	0	0	0	0	0
Apr to June 2023	16	16	3 (19%)	6 (38%)	6 (38%)	1 (6%)

Table 35 shows the number of facilities assessed each quarter on availability of termination of pregnancy services. Most facilities refer patients elsewhere for this service, while up to 31% reported providing the service on site in one quarter.

Supply Chain Management

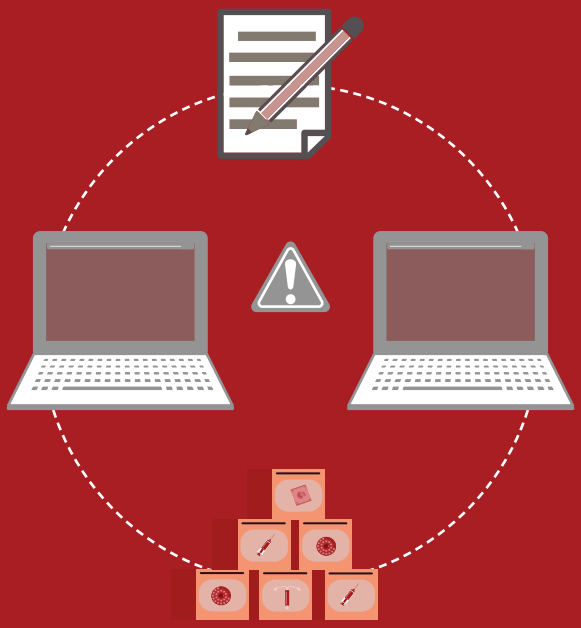
The supply chain, including budgetary and financial flows, is detailed in this section.

According to key informants there is one Medical Depot in Mafikeng and two sub-district pharmacy supply centres. In August 2022 the North West came out of CoGTA administration[9]. Relatedly, to the administration of the province, a District Pharmaceutical Manager reported, drug availability before the 2018 strike was approximately 98% and went down to 45% during the strike. Though Provincial Health improved after the strike, drug availability only went back to 70%. They noted that the current administration seems to find this achievement acceptable.



Ordering Systems:

It was reported during the period of administration changes occurred the process to pay suppliers, electronic financial systems "the Basic Accounting System (BAS)" which aimed to replace the "Walker" system. Reportedly, however, this process remains incomplete and the supply chain is operating under both systems, which are not compatible. Additionally, at the Depot, the Drug management Supply System, "Oracle" is used for ordering, managing, receiving and dispatching stock. The seven major hospitals use emailing in combination with "Rx Solution" (which isn't fully automated). At the Community Health Centre, clinic level only a paper-based system is in use. This diversity and lack of automation of systems, it was explained, requires manual capturing of orders at the Medical Depot level. Participants in the NW noted the lack of compatibility and automation of the data systems is a cause of delays and stockouts. A Managing District Pharmacist also reported that in 2021, while under administration the province attempted the adoption of an electronic system. However, they reported the two systems being implemented, (Rx and Oracle) were not compatible, the process was top down, and the attempt was soon abandoned and (presumably the facility level) reverted back to paper-based systems. Participants added that the existing data systems are only partially automated - they still require printing, inputting of data, and emailing manually, leaving more risk for human error.



A focus group made up of managers from the Medical Depot detailed ordering patterns and supply volumes are based on usage figures from the prior 6 months. Participants found it important to note that these numbers are also influenced by stockouts.

[9] CoGTA refers to the National Department of Cooperative Governance and Traditional Affairs, which is brought in to intervene in provincial service delivery when it has been deemed malfunctioning.

Ordering supplies:

We were informed that ordering has three routes. The first, is the standard method, the Depot orders from suppliers, and as hospitals, clinics and sub-district pharmacy's order supplies, which happens every other week, the stock[10] is delivered. This method usually takes 2 to 4 weeks to be received. The second is especially for bulky items where the Depot makes the order, but the stock is directly dispatched to facilities. Since 2021, direct delivery has also been implemented, where hospitals place orders directly with suppliers and receive stock, this method takes 1 to 2 weeks to be received. Most contraceptives are procured using the direct delivery method, as they are bulky items, although some reserve injectable and oral contraceptive stock is kept at the Depot as well. A Managing District Pharmacist noted that the aim is to keep at least one and a half months reserve stock at all times.

Since 2021, the budget has remained with the Medical Depot. It oversees all payments to suppliers. In this system only a Depot has budget to purchase supplies, so clinic, hospital and sub-district pharmacy budgets are not charged. The paperwork processed for payments is the responsibility of receiving units at hospitals and sub-district supply centres. They stamp invoices when stock is accepted, an officer signs a proof of delivery form which then goes to the Depot's Finance Unit who then pay suppliers.

According to informants from the NW the main causes of stockouts are:

- lasting effects of the 2018 health workers strike
- lockdowns due to Covid-19
- budgetary limitations, including unreliable release of the budget
- payments, and accounts
- data information and paperwork systems
- network and connectivity outages
- inadequate human resources and lack of will to correct this
- unreliable suppliers



A Managing District Pharmacist informed that prior to the health worker strike, the NW, normally had three months of reserve stock to supply hospitals, clinics and pharmacies. After the strike pharmacists argued for the Depot to replenish the reserves with the existing budget, but not all needed supplies were purchased. The administration rather "under-ordered." This has resulted in the NW staying 7 months behind in stock to-date. They explained, the Province remains without reserve, stock goes in, and immediately goes out.

Participants affirmed that Covid-19 lockdowns delayed supplies, which led to stockouts of drugs including contraceptives, noting the demand for contraceptives was high.

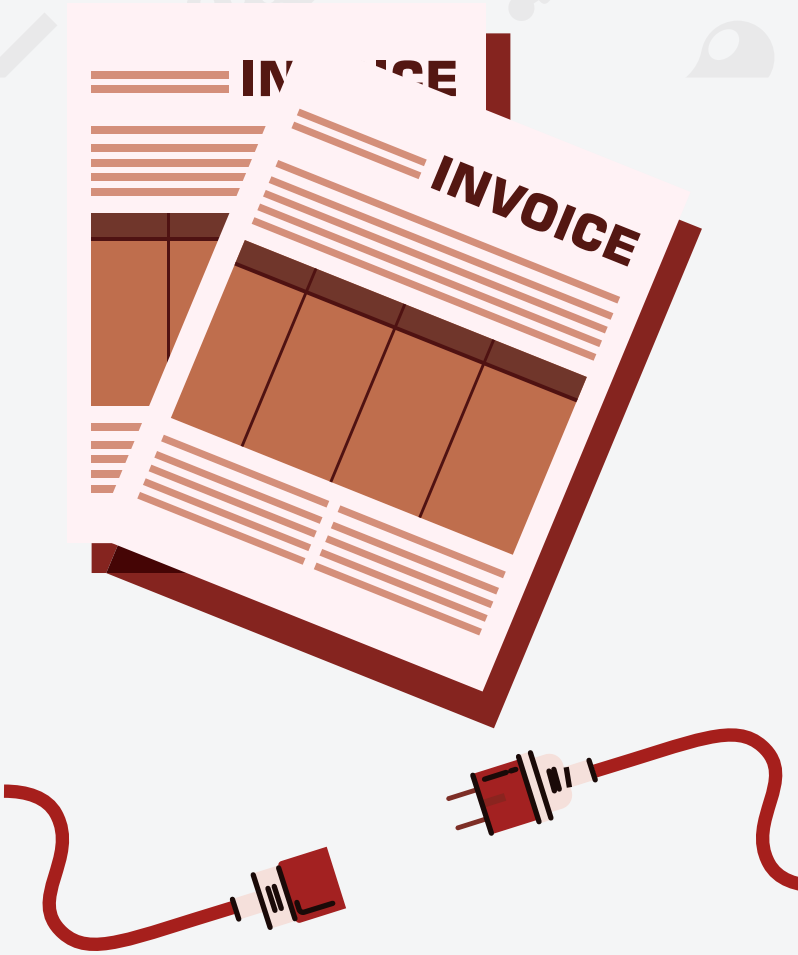
[10] A Head of District Pharmacy noted that there are 24 Community Health Centres, 7 hospitals, 32 pharmacies, and 380 clinics in the North West, that the Medical Depot services.

Budget:

A focus group made up of managers from the Medical Depot pointed out that at the end of the financial year, the budget is depleted, and not all companies can be paid, which leads to invoices being recorded as accruals for the new financial year. A Managing District Pharmacist took the position that the number one cause of stockouts in the NW is problems of payment. They detailed that this is caused by budget constraints, which are compounded by unprocedural handling of invoices and payments. They explained the annual budget does not adequately consider population growth, and usage. At present they estimate the annual budget does not cover 9 months of orders.

A Managing District Pharmacist informed that, ten years ago an independent assessment of the province's payment system was conducted. It found that it took about 5 days for pharmaceutical invoices to be sent, while these payments took about 100-145 days. At present, invoices are meant to be sent on a specific date on a monthly basis. If the invoice is not received on that day it will not be accepted until the following month. This delays payments and the release of stock. Another issue with invoicing reported has resulted since the direct delivery method was implemented in 2021. Facilities are not submitting their invoices after receiving stock, which causes a backlog of payments, failure to deduct from hospital, and clinic budgets. This results in suppliers going un-paid, and stopping supply. The Depot is not able to authorise ordering outside of a contract, so in these cases the supply stops.

Participants managing the Depot also cited network problems as a significant issue delaying payments. For instance, during loadshedding and when the provincial servers are down, which normally lasts a day and a half, but can last up to two weeks, the Depot experiences an inability to capture invoices and pay suppliers.



Focus group participants reported inadequate human resources as a long term problem. They explained that nurses at clinics oversee stock management without the specialised training to do so. For the last six to ten years the Depot has been running a training program for auxiliary staff and general workers to address this shortage, however the Province has not advertised and filled the requisite positions at the Depot and facility levels leaving staff discouraged.



Discussion

Availability

Despite noted improvement in access to injectable contraception in the quarter after the period from April to June 2022, injectable contraception remained the largest and most consistent stock shortage across all three provinces, over five quarters as reported by PHC clinic users. This finding echoes our tracking of this problem since 2018 (SSP, 2022). Our findings read collectively show crisis in access to contraception.

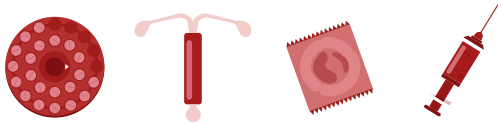
Almost all women and girls surveyed did not receive the contraception they requested, in KwaZulu-Natal and the Eastern Cape. Interestingly, the majority surveyed in the North West did. We were not able to deduce reasons for this difference. To understand the nuances of meaning of the persistent lack of access to injectables, it is important to raise the generational context of usage. Injectables were introduced in the 1970s in South Africa. By 1993 70-80% of Black contraceptive users were using injectables (Sai et al., 1993 cited in Baldwin-Ragaven et al., 1999). Recent data shows injectables contribute to over 45 percent of all contraceptive use, while the corresponding data for IUD's, oral contraceptives, implant and female sterilisation remain low, at 10 percent or less (National Department of Health et al., 2019). This dominance is not unique to South Africa: injectable contraceptives count for around 40 percent of all contraceptive use across southern and eastern Africa (Tsui et al., 2017). Research in South Africa with Women Living With HIV suggests the lack of available method mix, and quality contraceptive counselling undermines women's ability to make informed choices (Towriss et al., 2019).[11] This is affirmed by research elsewhere in Africa (Senderowicz, 2019).

External condoms were found to be the second least accessible contraceptive in KwaZulu-Natal and the Eastern Cape. In the North West however, the implant was the second most often reported short of stock. Our evidence identifies stockouts of external condoms is chronic in the Eastern Cape, and is due to international manufacturers and poor concentration of local suppliers. Reliance on limited global supplies and international producers is found to escalate risks of poor planning, causing stockouts (Modisakeng, et al., 2020; Magadzire et al., 2017). This was found to be exacerbated during the Covid-19 pandemic (Callahan, et al., 2023). Further reflection on these findings suggests prioritisation of local manufacturing, and at the least expanding local packaging and distribution centres is required to restore condom access, which is essential to overcoming the HIV/AIDS pandemic we face.

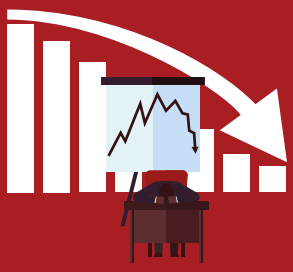
Our findings revealed that most facility managers surveyed reported that their contraceptive clinic staff are capable of both inserting and removing the implant and IUD. This shows significant progress compared to when the implant was first introduced in 2014. Still, shortages and unreliability of stock, including of the implant, as indicated by our findings from North West, prevent women from making truly free contraceptive choices. Under conditions of shortage, clinicians can only recommend what is available, women's reproductive rights are undermined, and the State fails to comply with its obligation.

Lack of truly free contraceptive choice, can result in women needing abortion services. Our findings show that the majority of primary care facilities surveyed refer users for abortion. This likely increases individual (transport, loss of school, wages) and social costs (hospital admission) of the service, as well as prolongs the unsupportable pregnancy (McLeod, 2016). In the EC more facilities reported abortion services are not available at all, than are available on-site. In the North West an equal number of facilities reported abortion services are not available at all, as did that it is available on-site. In KZN just more than half of facilities reported services were available on-site than those who reported services are not available at all. This data clearly demonstrates the gap between the law, policy and reality of lived-experience, especially if you are an adolescent, economically disenfranchised girl. Reliable reproductive drug supplies, accessible health services, including quality contraceptive counselling, and abortion services are the foundation of gender equality, security, and socio-economic rights.





[11] WLWH refers to women living with HIV.



Causes

Our findings strongly suggest poor national supply chain planning as the main driver of depletion of access to contraceptives, including stockouts, between 2015-2020.

Our findings strongly suggest poor national supply chain planning as the main driver of depletion of access to contraceptives, including stockouts, between 2015-2020. Our findings relate to the State's supplying a significant randomised clinical trial, and poorly anticipating its impact. Poor planning that results in five years of limited access to contraception for women and girls is consequently a result of inadequate leadership, and deficits in accountability and transparency. This situation points to a lack of prioritisation of gender equality, and women's sexual and reproductive health. This prolonged decrease in access to a variety of contraceptive methods also indicates a departure from a human rights approach to healthcare.

The finding of poor national planning adds to research that has shown how inadequate forecasting relating to policy changes leads to shortages and stockouts of essential medicines (Magadzire et al., 2017). Poor national planning is established in research as a contributor to stockouts, along with the role of information and data systems (Zuma 2022; Ambe and Badenhorst-Weiss 2012; NDoH, 2010).

At the provincial level our findings establish causes of stockouts include: budgetary limitations, incompatible electronic information systems, dependence on manual paper-based systems, poor management of payment systems, stock controls, ordering, contracts, and lack of adequate human resources, and storage.

These findings are consistent with existing literature on stockouts of essential medicines. For instance, data from the National Department of Health pointed out the lack of integrated information systems led to inaccuracies in quantifications of supply, including discrepancies between usage information obtained from suppliers and facility and depot data (NDoH, 2010). Similarly, Zuma found that manual data systems can lead to ordering inaccuracies and difficulty in identifying stockouts (2022). In KwaZulu-Natal and the North West our study reveals ordering patterns and supply volumes are based on usage figures from the prior year, and prior six months respectively. Importantly, we found these numbers are influenced by stockouts. Similarly, use of standard stock in family planning health promotion campaigns exacerbate shortages of contraceptive stock.

Interestingly, our reporting reveals facilities in KwaZulu-Natal have been the most informed by official department of health guidance on how to manage contraceptive stockouts, followed by the Eastern Cape. North West province facilities reported the receiving the least official guidance compared to the other two provinces. Some official feedback to facilities on how to manage stockouts is promising. More transparency can empower ownership, and creative problem solving.

Budgetary constraints were raised as a particular challenge. NDoH (2010) noted that provincial pharmaceutical budgets are not defined, leading to financial planning and monitoring problems. In the Eastern Cape we find this leads to re-prioritisation toward food and securities, at the expense of the medical and surgical supply allocation. Our findings show the incompatibility of electronic data systems within provinces and between them, as well as the continued need for manual and partially manual data systems significantly contribute to poor finance management. Poor invoicing, lack of timely payments compound already constrained budgets. We reveal the data system and payments problem is further compounded by network outages, and inflexible payment schedules.

Our findings indicate poor finance management in all three provinces centres on the 'direct delivery' systems. Lack of timely payments, in the case of the Eastern Cape and North West results in significant accruing balances for following financial years. This in turn causes suppliers in general to delay and even halt supplies due to lack of payment, even deciding not to contest bids. The latter is particularly dangerous as contraceptive manufacturing is controlled by a limited number of global monopolies.

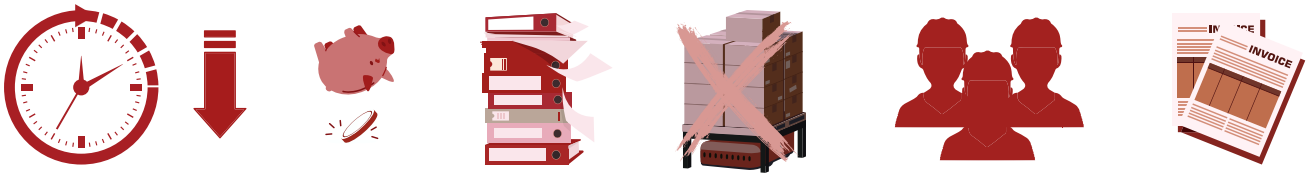
Contraceptives are bulky items and hospital and clinic facilities do not have the infrastructure to store the volumes they require. Zuma (2022) confirms our findings that inadequate storage space significantly constrains effective medicine stock management. Participants from KwaZulu-Natal and the North West indicated that this constraint, along with inadequate skilled pharmaceutical staff can also lead to unusable and expired stock. According to Lubinga et al. (2014), shortages of pharmacists and pharmacist assistants causes challenges for sustainable essential medicine supplies in the region. More recently, Zuma and Modipa (2020: 92) argue to improve availability of essential medicines it is important for the government to appoint Pharmacists and Pharmacist Assistants to facilities, rather than depend on other health professionals for management of medicine supplies.

Overall, these findings indicate poor planning, budgetary constraints, and incompatible information data systems, lack of training and inadequate human resources limit reproductive choices for women and girls in South Africa.

Conclusion & Recommendations

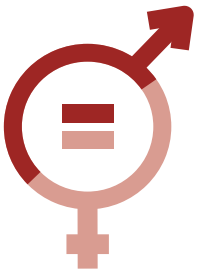
This study examined information on the availability of contraceptives, the supply chain and its impact on access to contraceptives. The results illustrate shortages and stockouts of, especially injectable contraceptives and external condoms, are ongoing.

Our evidence also reveals the recent and present causes of contraceptive stockouts in South Africa lie at the national and provincial levels. They are primarily poor national supply chain planning, and provincial budgetary limitations, incompatible electronic information systems, poor management of payment, ordering and stock systems, and inadequate human resources and storage. Importantly, the drivers of contraceptive stockouts, outlined here, are not unique, and also cause limited access to other medical supplies and medicines.



In order to secure a reliable contraceptive supply and meet the reproductive rights of women and girls in the country, we recommend the government:

1. Ensures accountability for the errors of poor national planning resulting in long-term contraceptive stockouts;
2. Prioritises gender equality, adolescent pregnancy, and reproductive rights with a defined and adequate budget for contraceptives, contraceptive delivery, and termination of pregnancy;
3. Addresses incompatible and manual data information systems for payment, stock and ordering within, and between provinces;
4. Appoints and increases adequate human resources, including through sharing of information and pharmaceutical training on procurement planning and stock management using a whole of society approach focused on relevant professionals.



While there is a clear constitutional right to access to healthcare services, including reproductive healthcare, without this prioritisation, and a clear plan of action, guidelines and monitoring these rights will remain unrealised, even 30 years into democracy.

References

Ambe, I., & Badenhorst-Weiss, J. (2012). Procurement challenges in the South African public sector. *Journal of Transport and Supply Chain Management,* 6(1), 242-261.

Baldwin-Ragaven, L., London, L., Dr Gruchy, J. (1999) An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa. University of Cape Town Press, Cape Town, South Africa.

Callahan RL, Cartwright AF, Beksinska M et al. (2023) Impact of the COVID-19 pandemic on women's contraceptive use: a mixed-methods study in South Africa and Zambia [version 1; peer review: awaiting peer review]. *Gates Open Res,* 7:61

Department of Health, Republic of South Africa. (2010) Challenges and Opportunities for Improvement of Medicines Procurement in South Africa's Public Sector. Accessed 3 July <http://ipasa.co.za/Downloads/Policy%20and%20Reports%20-%20Medicines/procurement/Medicines%20Procurement%20Task%20Team%20Report-%20Final%2029%2004%202010.pdf>

Evidence for Contraceptive Options and HIV Outcomes (ECHO) Trial Consortium, (2019). HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: A randomised, multicentre, open-label trial. *Lancet.* 394, pp. 303–313.

Enoos, B., (2023). Supply chain analysis: A case study of differentiated physical distribution for chronic medicines in the public health sector of South Africa. Unpublished MA Thesis, University of Stellenbosch.

Government of South Africa, (2012) National Contraception and Fertility Planning Policy and Service Delivery Guidelines. Pretoria, South Africa.

Government of South Africa, (2003) National Contraception Service Delivery Guidelines. Pretoria, South Africa.

Government of South Africa, (1996a). Constitution of the Republic of South Africa. Pretoria.

Government of South Africa, (1996b). The Bill of Rights of the Constitution of the Republic of South Africa, No. 108 of 1996. Pretoria, South Africa.

Lubinga, S.J., Larsen-Cooper, E., Crawford, J., Matemba, C., Stergachis, A. & Babigumira, J.B. (2014). Impact of Pharmacy Worker Training and Deployment on Access to Essential Medicines and Health Outcomes in Malawi: Protocol for A Cluster Quasi-Experimental Evaluation. Washington: *Biomed Central.* 1-9.

MacLeod C. (2016) Public reproductive health and 'unintended' pregnancies: introducing the construct 'supportability' *Journal of Public Health*, (38) 3, Pp e384–e391.

Magadzire B.P., Ward K, Leng H.M.J., Sanders D. (2017) Inefficient procurement processes undermine access to medicines in the Western Cape Province of South Africa. *S Afr Med J.* 107(7) pp. 581-584.

Modisakeng, et al. (2020) Medicine shortages and challenges with the procurement process among public sector hospitals in Gauteng: findings and implications. BMC Health Serv Res 20, 234.

Senderowicz, L., (2019) "I was obligated to accept": A qualitative exploration of contraceptive coercion. Soc. Sci. Med. 239, 112531. https://doi.org/10.1016/j.socscimed.2019.112531

SSP, Stop Stockouts Project, (2022) Access to Contraceptives in South African Public Health Clinics August.

Towriss, C.A., Phillips, T.K., Brittain, K., Zerbe, A., Abrams, E.J., Myer, L., (2019) The injection or the injection? Restricted contraceptive choices among women living with HIV. Sex. Reprod. Heal. Matters 27, 1628593. https://doi.org/10.1080/26410397.2019.1628593

Tsui, A.O., Brown, W., Li, Q., (2017) Contraceptive Practice in Sub-Saharan Africa. Popul. Dev. Rev. 43, 166–191. https://doi.org/10.1111/padr.12051

Zuma, S. (2022). Assessment of medicine stock-outs challenges in public health services. *Africa's Public Service Delivery & Performance Review, 10*(1),

Zuma, S. M. & Modiba, L. M. (2020). Framework for the provision of essential medicines for district health services in South Africa. *African Journal for Physical Activity and Health Sciences, 26(1), 81-98.*