

MARCH 2016



The human face
of contraceptive
stockouts

A qualitative study in Uganda



Reproductive Health
SUPPLIES COALITION



Background

Ensuring access to contraception is one of the most critical and cost-effective means of improving women and children’s health and reducing maternal mortality. All too often, however, contraceptive methods are not on the shelf in the clinics and pharmacies that people depend on. A contraceptive stockout is a time when one or more contraceptive options are unavailable at a health facility that routinely provides that method, or that based on policy should be providing that method. Despite the widespread occurrence of contraceptive stockouts, little is known about the impacts they have—on women and their families, healthcare providers, and the critical services that clinics provide.

STUDY DESCRIPTION

Ibis Reproductive Health and researchers from the Mbarara University of Science and Technology conducted a qualitative study to better understand these issues in two districts of Uganda (Kamuli and Mbarara). The objectives were to assess the perceived magnitude, scope, and causes of contraceptive stockouts; identify how women and providers cope with them; and describe the consequences they have. To answer these questions, the study team conducted eight focus groups with a total of 50 women aged 18 to 45; 24 individual in-depth interviews with family planning service providers and health facility managers; and 11 in-depth interviews with district-level policymakers and decision-makers. A number of key findings emerged from these interviews and focus group discussions, which are outlined in the next pages.



Key findings

Contraceptive stockouts are common and pervasive—particularly for the pill and long-acting methods

Women and providers reported that contraceptive stockouts occurred frequently, but that they varied by facility and method type. Private facilities were less likely to report experiencing contraceptive stockouts compared to public facilities. In terms of methods, providers reported that progestin-only pills had been out of stock for years in most facilities, and that combined oral contraceptive pills were chronically out of stock at public facilities. Long-acting methods (implants and intrauterine devices) were also reported to be frequently unavailable. However, stockouts did not impact all methods. Condoms were readily available and only one provider reported a stockout of depot medroxyprogesterone acetate (“Depo” or DMPA). The perception from women and providers was that DMPA was always available.

“*Nowadays we giving only Depo and condoms, we don’t have the other types of family planning.... Since I came here in 2013, I have never seen Implanons [implants].... It is those pills and Implanons which are most frequently out of stock.... We have never got out of stock of Depo.... Depo is there in plenty.*” (Provider, public health facility, Kamuli)

“*The IUDs and the implants mostly [are out of stock].... We have Depo, but we normally get stockouts of COCs [combined oral contraceptive pills].*” (Provider, public health facility, Mbarara)

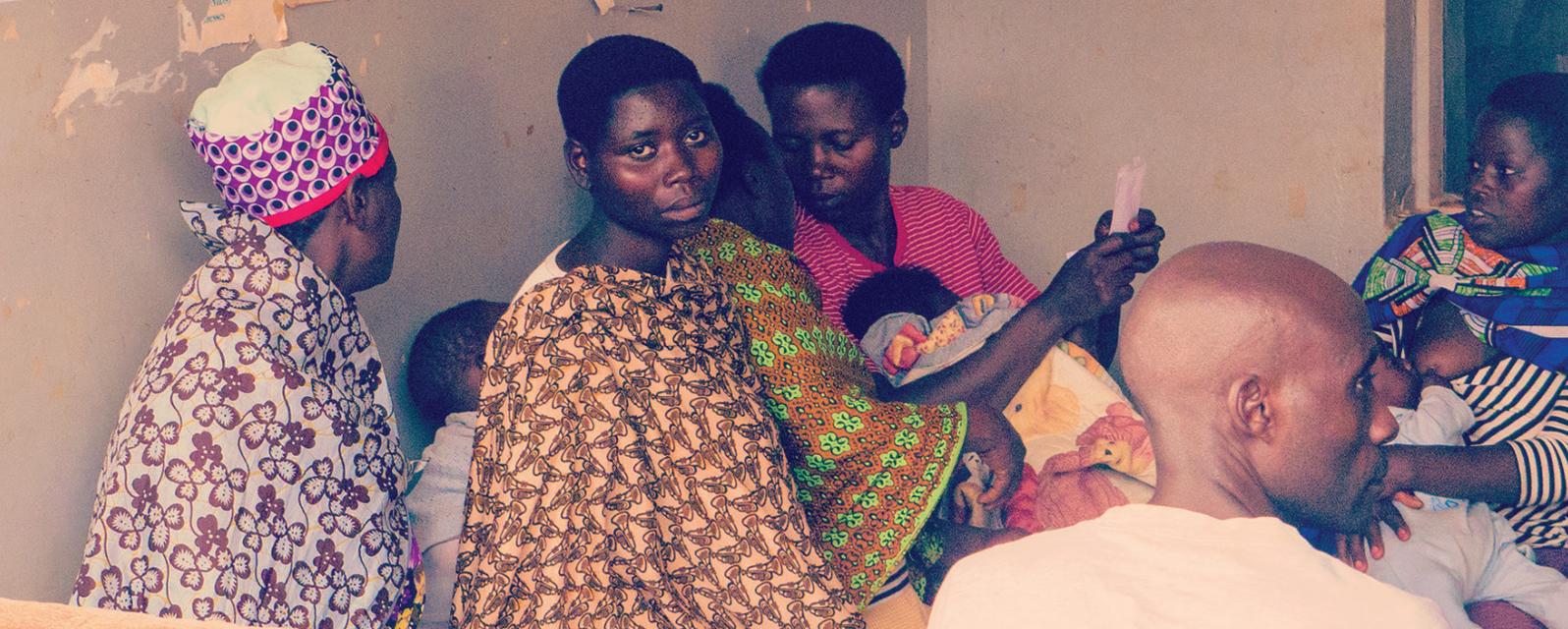
Women are accustomed to stockouts and develop methods to cope

When faced with a stockout, women most frequently reported going to another facility or pharmacy to procure their preferred method. Often providers would help facilitate the process by referring women to other facilities or calling to check stock. Because they proactively sought methods from multiple places, many women did not perceive stockouts as a major contributor to method discontinuation. In fact, most women’s initial reaction when asked about their opinions of contraceptive stockouts was that they were normal. If women could not obtain their preferred method, they reported occasionally changing to an alternate method, assisted by provider counseling. However, this tended to result in a shift to less effective alternatives like condoms or the withdrawal method. Many women or their partners did not want to use alternate methods, and in those cases women reported waiting for supplies while abstaining from sexual activity. However, abstinence could be difficult for some women to negotiate with their partners.

“*Women come often for family planning and when it is out of stock... we have to convince them to take condoms, but they complain saying their men might not allow [them] to use them.*” (Provider, public health facility, Mbarara)

“*[When faced with a stockout], I refuse [to have sex]. At least I can [pretend to] fall sick, as I am planning to go to the clinic to get the family planning method I want.*” (Woman aged 26–45, middle-high SES, Kamuli)

“*Since I do not want to produce more children I try by all means to see that I get it [the stocked out method] from pharmacies and clinics. You can think hard if it means borrowing 1,000 [Ugandan Shillings] from a friend or you can sell maize to get the money.*” (Woman aged 18–25, low SES, Kamuli)



Stockouts lead to numerous negative consequences for women, including unplanned and unwanted pregnancy, stress, domestic conflict, and increased costs

The impacts of stockouts on women varied by age, socioeconomic status, and spousal support for family planning. The most common consequence cited by participants was unplanned and unwanted pregnancies. Women also faced stress when they were unable to get their preferred method. In some cases, a woman's attempt to abstain from sex or to request her partner use a condom led to conflict and domestic violence. An unintended pregnancy resulting from a stockout could also lead to abandonment and rejection of the child by the partner. Providers reported that adherence was often affected when women had to switch to a new method, as they had a heightened awareness of side effects. Women who had to search for a method from multiple sources emphasized that travel costs and the time spent waiting at multiple facilities were their biggest challenges in accessing methods. This was particularly true for rural women who had to travel farther to reach facilities. In a country where one-third of the population lives on less than US\$2 per day,¹ expenses for travel to clinics were substantial, ranging from US\$0.60 to \$5.00. Women also reported that time spent seeking contraceptives ranged from 30 minutes to a full day. If public facilities did not have the method, some women would go to private facilities resulting in further out-of-pocket expenses. Women reported that adolescents reported additional challenges, including greater difficulty travelling to a different clinic when faced with a stockout. Adolescents also faced confidentiality concerns of going to a new facility with providers they did not know when a stockout occurred at the facility where they normally obtained contraceptives.

¹ World Bank. World development indicators: Uganda. 2015. Accessed 12/21/2015. Accessed from: <http://databank.worldbank.org/data/reports.aspx?source=2&country=UGA&series=&period=>

“The effects are too many by the way. Because you find my clients sometimes they come and they are like, ‘You know the other time I came and asked you to give me an injection and it was not there, now it seems I am pregnant.’” (Provider, public health facility, Mbarara)

“It happened to me once when I went to the dispensary and didn't find microgynon, I went to the clinics and also failed to get [it], so that night I slept on tension and worried that I could get pregnant.” (Woman aged 26–45, low SES, Mbarara)

“A woman will go without a method [after encountering a stockout], and if they have sex with their husbands, that could bring unwanted pregnancies. Even any attempt by a woman to deny the husband sex could lead to violence in the home.... They fight and some may even chase you out of their homes. For women who are on family planning secretly, it becomes hard because they may think that you have other men.” (Woman aged 18–25, low SES, Mbarara)

“Some of them even end up divorcing because some men are like ‘Me I told you I don't want any more kids and now you are pregnant again!’ So the man rejects the kid.” (Provider, public health facility, Mbarara)

Providers face emotional distress, demoralization, blame, declining skills, and decreased demand

Providers expressed empathy for the women they served and spoke of the emotional burden of not being able to help women when there was a method stockout. Providers felt demoralized and expressed how difficult it was for them to provide only counseling when a stockout occurred. It was also common for them to report that women who were faced with a stockout and those with resulting unintended pregnancies blamed them for the situation. In addition, stockouts contributed to decline in provider skills, particularly for placing long-term methods, when providers were unable to practice. Finally, women lost trust in facilities that had frequent or persistent stockouts. Information on stockouts was quickly shared throughout the community. When women perceived that a facility was chronically out of stock of family planning methods, the overall number of women seeking services was reduced.

“Sometimes I feel demoralized because these mothers keep coming and we push them away not because I don’t know what to do, but because I don’t have what [I need] to use.” (Provider, public health facility, Mbarara)

“If a client becomes pregnant she can blame you, the provider, like ‘You didn’t bring this drug now [I] am pregnant.’ They complain to me.” (Provider, public health facility, Kamuli)

“This can affect the whole facility because if one client comes and you tell her that implants are out of stock, she will go out spreading rumors that the facility doesn’t have family planning methods, that is what they normally say, yet there is only one method that is out of stock.” (Provider, public health facility, Kamuli)

Perception of the causes of stockouts varies across women, providers, and policymakers

Women were unsure of the cause of stockouts but frequently attributed the situation to providers. They felt they were not provided the method because of an intentional choice to withhold it or a lack of time to serve them. Similarly, most of the policymakers and decision-makers interviewed guessed at the causes or placed blame on others along the supply chain. Among providers, a range of causes for stockouts were cited, including:

SUBOPTIMAL SUPPLY CHAIN PLANNING AND REQUISITION PROCESSES

- › Providers at higher-level public facilities reported using preset order forms for requesting family planning supplies from National Medical Stores, the governmental organization that distributes medical supplies. However, long-term methods such as IUDs were not included on the preset order form and required additional paperwork. The bifurcation in the ordering process was a hurdle to accessing these methods.
- › Providers at lower level public facilities reported receiving supplies through a ‘push system’ as opposed to the

requisition system used at higher level facilities. Each lower level facility received a standard medicine kit, the contents of which were decided annually at the district level. The quantity and contents of the standard kits were the same regardless of facility-specific differences such as patient load or prescribing patterns. Providers felt that their lack of involvement in kit development led to stockouts at lower level facilities.

- › Providers from private facilities suggested that a lack of stable suppliers contributed to stockouts at their facilities.

INACCURATE DEMAND FORECASTING

- › Providers perceived that inaccurate demand forecasting at higher-level public facilities also led to stockouts. Most facilities used the number of methods previously dispensed as opposed to demand to generate forecasts.

LIMITED PROVIDER INPUT AND FEEDBACK

- › Providers reported that they were expected to report supply discrepancies to the District Health Office or the National Medical Stores. However, providers stated that

the reports had little to no impact on fixing the discrepancy. Instead, they waited for the next scheduled supply distribution.

- › District-level politicians and decision-makers generally were not aware of stockouts, further suggesting that feedback mechanisms were inadequate.

LACK OF A BUDGET LINE ITEM FOR CONTRACEPTION

- › Providers and policymakers reported that national funds were deposited at National Medical Stores to purchase essential drugs, including family planning commodities, for every facility, and that purchasing of family planning commodities did not count against a clinic's credit line. Without a dedicated budget for family planning, public facilities reported they were unable to obtain supplies from other sources when the National Medical Stores failed to provide adequate supplies of methods. Occasionally facilities were able to obtain supplies from another health center through a Ministry of Health sanctioned transfer of supplies.

FAILURE TO INCLUDE FAMILY PLANNING AVAILABILITY MEASURES IN ASSESSMENT OF FACILITY AND SYSTEM PERFORMANCE

- › Family planning was perceived by providers as not being prioritized. Stakeholders explained that contraception-related indicators were not included as core measures for assessing facility performance by the Ministry of Health. Furthermore, DMPA was reported to be the only method that was used as a tracer drug to assess supply chain performance.

Discussion

Contraceptive stockouts were common, particularly for long-term methods and oral contraceptives. Women's coping mechanisms lessened some of the impacts; however, there were numerous negative consequences. These included stress, increased costs, domestic conflict, and unwanted or unplanned pregnancies. Providers were also affected, experiencing emotional distress, demoralization, blame, deterioration of skills, and lower demand for their services as a result of stockouts.

Providers attributed stockouts to underlying supply chain issues and a lack of prioritization of contraception at the national level. Addressing these issues will require improvements to health information systems to capture family planning demand data; streamlining the financing and logistics management for family planning methods; and raising political support for family planning services. Addressing the effects of stockouts will also require additional efforts to raise community awareness on family planning and to engage with men. A driving factor across many of the negative consequences women experienced was a lack of partner receptiveness to the use of contraception. Furthermore, partner receptiveness also impacted women's abilities to cope with stockouts. For example, it was much easier for women to spend time away from their families to search for methods at multiple facilities or to abstain from sex when doing so did not require deception or avoidance. As a result of the critical role that men play, solutions to lessen the impact of stockouts should include active engagement of men. Group education, community outreach, and clinic-based interventions have been shown to be effective globally in getting men involved in family planning. Similar programmatic efforts should be implemented and customized to local settings.

A stockout is more than the pill not being on the shelf—it is also a woman who spends a full day travelling to another clinic; a family who faces an unintended pregnancy; and a provider who is unable to fulfill his or her commitment to providing the health services that clients seek. Going beyond the numbers and seeing this human face of stockouts reinforces the critical need to both reduce stockout occurrence, as well as mitigate the negative consequences that they have.

The Reproductive Health Supplies Coalition

The Coalition is a global partnership of public, private, and non-governmental organizations dedicated to ensuring that everyone in low- and middle-income countries can access and use affordable, high-quality supplies for their better reproductive health. It brings together agencies and groups with critical roles in providing contraceptives and other reproductive health supplies. These include multilateral and bilateral organizations, private foundations, governments, civil society, and private sector representatives.

Ibis Reproductive Health

Ibis Reproductive Health is an international nonprofit organization with a mission to improve women's reproductive autonomy, choices, and health worldwide through clinical and social sciences research.

Citation

Grindlay K, Turyakira E, Kyamwanga IT, Nickerson A, Blanchard K. The experience and impact of contraceptive stockouts among women, providers and policymakers in two districts of Uganda. *International Perspectives on Sexual and Reproductive Health*. 2016;42(3):141-50.