INACCESS

MONITORING ACCESS TO MATERNAL HEALTH COMMODITIES IN UGANDA

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MONITORING ACCESS TO MATERNAL HEALTH COMMODITIES IN UGANDA

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CEHURD

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EXECUTIVE SUMMARY

The Uganda government is implementing interventions in the areas of emergency obstetric care (EmOC), skilled attendance at birth, family planning, and antenatal care (ANC) to meet its international and national obligations on maternal health, such as the United Nations Millennium Development Goals (MDGs). However, progress on these priority interventions remains slow and therefore the country is, at the current pace, unlikely to achieve the set targets of reducing the maternal mortality ratio (MMR) to 131 deaths per 100,000 live births.

At 435 deaths per 100,000 live births, an estimated 6,000 women die from giving birth in Uganda every year (Ministry of Finance, 2011). Government acknowledges that insufficient supplies and commodities is one of the key challenges facing effective delivery and utilisation of effective maternal health services.

This report summarises trends in availability of key maternal health commodities at selected public health facilities; explores issues related to affordability of essential medicines, supplies and services for maternal and newborn health; notes the individual and community perceptions that affect access to essential medicines, supplies and services for maternal health. It is a result of a process reviewed data sourced from MoH/WHO/HAI (HEPS) Monitoring Medicine Prices Database covering the period 2006-10, supplemented by interviews at three government facilities in Pallisa district as case studies.

Availability of at least one type of contraceptive at government health facilities was found to be 100% in Lira district in 2009, compared to only 33.3% in non-government health facilities (Kibira, D. et. al, 2009). However, the range of contraceptives varied widely, with the most available contraception options being male condoms, pills and injectables. Condoms were available at most health facilities for free. Long-term options were particularly not available in the government facilities. This limits choice, and leaves out women who fill that the short-term oral and injectable hormonal options have higher side-effect profiles.

There was no consistency in availability of key ANC commodities. The period between July 2008 and July 2009 showed a general decline of almost all the commodities studied which indicated serious supply chain problems at the time. However, since July 2009, there has been a gradual increase in the availability of commodities even as figures show that universal access is still a far cry.

Availability of HIV test kits has been a major concern for the implementation of prevention of mother-to-child HIV transmission (PMTCT). Availability of Nevirapine in both tablet and suspension formulations has been generally poor at health facilities providing PMTCT services. This suggests that many women who need this medicine during labour, and their infants in the first week of life, are unable to access it. This contributes to the high levels of HIV infection in children, yet the way to prevent such infection is known.

Commodities for emergency obstetric and neonatal care (EmONC) have also not reached the desired levels to assure universal access. There are unpredictable fluctuations in availability of all supplies, yet medicines are generally unaffordable for ordinary mothers in the private and mission/NGO facilities. The analysis shows that it would require the lowest paid government worker 2.9 days to afford post-partum treatment commodities in the private sector and 2.3 days in the mission sector. Note that this excludes the cost of delivery bed, intravenous fluids, and a mama kit used in delivery.

To improve access to maternal health commodities, Ministry of Health and development partners should undertake an audit of the different treaties, conventions, laws and policies both at national and international levels as part of a grand plan to scale up investments using a costed plan of action to meet the different government obligations on maternal health. The procurement and distribution system still needs improvement, and the Ministry of Health should speed up the roll out of the most effective PMTCT medications. Ministry of Health, National Medical Stores, United Nations Population Fund and other development partners should work closely to expand and make available a wider range of family planning options and invest in their promotion and social marketing.

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
C-Section	Caesarean section
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
HAI	Health Action International
HB	Haemoglobin
HEPS	Coalition for Health Promotion and Social Development
HSSP	Health Sector Strategic Plan
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ITN	Insecticide treated mosquito net
IUD	Intrauterine device
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MoH	Ministry of Health
MPS	Making Pregnancy Safer (programme)
MVA	Manual Vacuum Aspirator
PMTCT	Prevention of mother-to-child (HIV) transmission
RHCS	Reproductive Health Commodity Security
STI	Sexually transmitted infection
UDHS	Uganda Demographic and Health Survey
Ushs	Uganda shillings
UN	United Nations
WHO	World Health Organisation

1. BACKGROUND

1.1 Introduction

Women's rights to life, health, and non-discrimination entitle them to the services and care they need to go through pregnancy and childbirth safely (Center for Reproductive Rights, 2008). The 1994 International Conference on Population and Development (ICPD) made reproductive and sexual rights a priority at both the national and international levels, and adopted a programme of action intended to make universally available quality reproductive health services.

At the national level, the Ministry of Health, through the "*National strategy to improve reproductive health in Uganda 2005-10*", aimed to increase institutional deliveries and emergency obstetric care, strengthen family planning provision, and to implement goal-oriented antenatal care. In addition, Uganda and other United Nations member states have pledged to reduce by two thirds – between 1990 and 2015 – the death rate among children under-five years of age (United Nations Millennium Development Goal, MDG 4), and to reduce by three quarters the maternal mortality ratio (MMR) over the same period (MDG 5).

In relation to maternal health, the Uganda government has prioritised four key interventions: 1) Emergency obstetric care (EmOC), which addresses the major direct causes of maternal death; 2) Skilled attendance at birth, which helps to detect and manage complications, or give appropriate referral for their further management; 3) Family planning, which prevents pregnancies that are unintended as well as those that are too early, too late or too frequent; and 4) Effective antenatal care (ANC), which prevents, detects and treats conditions associated with pregnancy.

However, the latest MDG national progress report shows that performance on these priority interventions that address MDG 5 on maternal health is poor and therefore that the country is, at the current pace, unlikely to achieve the set targets of reducing the MMR by three-quarters; and expanding access to reproductive health to universal levels (Ministry of Finance, 2011). The World Health Organisation (WHO) estimates indicate that 15% of all pregnant women will develop obstetric complications which, if left untreated, can lead to death or severe disability.

Every day, an estimated 16 women die from giving birth in Uganda (Ministry of Finance, 2011). On average, that is one death every hour and a half, and nearly 6,000 every year. The major direct causes of maternal death – responsible for up to 80% of maternal deaths in Uganda – are haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour, while the major indirect caused of maternal deaths are malaria, anaemia and HIV/AIDS (Ministry of Finance, 2011).

Government acknowledges that insufficient supplies and commodities is one of the key challenges – together with infrastructural shortages, referral inefficiencies and negative cultural norms and social influences, among others – facing effective delivery and utilisation of effective maternal health services. Access to good quality antenatal, perinatal and postpartum care has been widely recognised – by both the international health community and human rights bodies – as being essential to ensuring a healthy pregnancy and a healthy start to life for newborns. Essential components of this care have been elaborated by WHO and other partners, and have been shown to dramatically reduce maternal and perinatal mortality. However, adequate services, provided by qualified personnel and sufficiently supplied with essential medicines and equipment are not always available and accessible to the population (WHO, 2006).

1.2 Maternal health as a component of the right to health

The right to reproductive health has been recognised by several international and national human rights instruments and laws, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the African Charter on Human and Peoples Rights on the Rights of Women in Africa as well as the Uganda Constitution (1995). In 2009, the United Nations Human Rights Council adopted a resolution titled, “Preventable Maternal and Morbidity and Human Rights” which recognises preventable maternal mortality and morbidity as a health, development and human rights challenge.

According to the WHO Constitution, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion and political belief, economic or social condition. The recognition and protection of the right to health is broadly, among others, made on the basis that women and men are equal, with equal entitlement to protection of their rights. However, it is important to

recognise the fact that although women should be treated on the same basis as men, they have unique needs related to their gender and their role in reproduction that can only be fulfilled by specific health services.

The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (Article 14) commits signatory states to ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: the right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception; the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; and the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections (STIs), such as HIV/AIDS.

At the national level, the Uganda Constitution of 1995 guarantees the rights of women, stating in Article 33, "The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society."

The right to health, like all other human rights, imposes on the State Party three types of obligations: 1) Respect, which means simply not to interfere with the enjoyment of the right to health; 2) Protect, which means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health; and 3) Fulfil, which means taking positive steps to realise the right to health, including maternal health.

1.3 State of maternal health in Uganda

Publicly available figures are not up to date on the key indicators of maternal health in Uganda. The latest comprehensive monitoring survey, the 2006 Uganda Demographic Health Survey (UDHS), is more than five years old. This survey showed that the maternal mortality ratio (MMR) had reduced from 505 to 435 per 100,000 live births between 2001 and 2006, and was still much higher than the MDG target of 131.

The 2006 UDHS figure of 435 deaths per 100,000 live births translates to about 6,000 women dying every year – or 16 per day or one per every one and a half hours – due to pregnancy-related causes. And for every woman who dies, six survive with chronic and debilitating ill health, while about 29% of all infant deaths occur in the neonatal period, i.e. within the first month (Ministry of Health, 2008a).

The UDHS also showed that the proportion of births attended by skilled health personnel increased only marginally, from 38% to 42% over the same period, far lower than the MDG target of 100%. The situation is worse in rural areas, where up to 63% of women give birth at home, compared to 20% in urban areas. Contraceptive prevalence rate stood at 24%; and unmet need for family planning at 41%. Teenage birth rate (number of births by women aged 15-19 per 1,000 women in that age group) at 159, while the overall proportion teenage pregnancies was estimated at 25% of all pregnancies – is one of the highest in Africa and a major contributor to the high MMR. ANC attendance among women aged 15-49 who have a live birth was recorded at a relatively high level of 94% , but those making the required for visit was estimated to be much lower at 47%.

Women generally have a higher HIV prevalence, estimated at 7.5%, than men – and above the national average of 6.4% (National Planning Authority, 2010). This phenomenon contributes to a high level of HIV infection in newborns through mother-to-child transmission, which accounts to one fifth of all infections in the country. The proportion of HIV-positive pregnant women who received antiretroviral treatment (ART) to reduce the risk of mother-to-child HI transmission stood at only 52% in June 2009, yet most of them were receiving the least effective medication. Of those who received prevention of mother-to-child HIV transmission (PMTCT) medication, only 25% received the most effective medication of a combination of drugs; 17% were already on ART for their own health, which also works effectively for PMTCT; but up to 58% were receiving single-dose Nevirapine (Sd NVP), which at best is only 40% effective.

1.4 Rationale of the study

Every Ugandan of reproductive age has the right to choose, obtain, and use quality, essential reproductive health medicines and supplies, including those required for safe child birth and newborn care, whenever they need them. This concept, known as “reproductive health commodity security” (RHCS), requires government to ensure and maintain access to and availability of reproductive health commodities. This includes commodities for family planning, antenatal care (ANC), and emergency obstetric and newborn care (EmONC).

RHCS is one of the core elements of a functional health system and its functionality is a measure of the degree of investment in women’s empowerment in the health, education and

productive sectors, including active participation in the labour market (MOH, 2009). RHCS is also essential to meeting the target of universal access to reproductive health by 2015, as called for by the International Conference on Population and Development (ICPD), and reiterated at the 2005 World Summit (MOH, 2008).

1.5 Survey objectives

The overall objective was to assess access to essential medicines, supplies and services for maternal and newborn health at government health facilities in Uganda.

The specific objectives were:

1) To review trends in availability of key maternal health commodities at selected public health facilities;
2) To assess prices and affordability of essential medicines, supplies and services for maternal and newborn health at selected government and non-government health facilities; and
3) To identify individual and community perceptions that affect access to essential medicines, supplies and services for maternal and newborn health.

1.6 Methods

The survey process combined quantitative and qualitative approaches, and used both secondary and primary data. Secondary data was sourced from MoH/WHO/HAI (HEPS) Monitoring Medicine Prices Database covering the period 2006-10. The survey team reviewed two key MoH (2008a, 2008b) resources: *Access to and use of medicines by households in Uganda*; and *Pharmaceutical situation assessment*; as well as other existing government and independent evidence, including internet resources. Also reviewed were the specific national and international human rights instruments, including covenants and treaties, that Uganda is party to and which layout the framework for the right to health, including sexual and reproductive health rights.

Sources of primary data consisted of health service providers and clients at three government health facilities (a hospital, health centre IV and a health centre III) in Pallisa district that serve as cases in this survey. Interviews with respondents were conducted using prepared interview guides.

Data collection and analysis took place in September 2011. Quantitative data was analysed using MS Excel computer application, while qualitative data was collated and synthesized by theme to complement quantitative data.

This survey assessed trends in access to essential reproductive health commodities at public health facilities in Uganda for the five-year period (2006-2010). This survey assessed the following reproductive health commodities that are listed as essential for reproductive health commodity security by MoH (2009): Fansidar, Niverapine, deworming tablets, Combivir (Zidovudine/Lamivudine); and emergency obstetric and newborn care (EMONC) commodities – Methylergometrine, Metronidazole tablets, Amoxicillin capsules, Gentamycin injection, tetracycline eye ointment.

This survey also adopted the ICESCR's General Comment on the Right to Health as the working definition for access to healthcare in the context of the right to health. According to the General Comment, the realisation of the right to health contains four elements:

1) *Availability*: Functioning public health and health care facilities, goods and services, as well as programmes in sufficient quantity.
2) *Accessibility*: Health facilities, goods and services accessible to everyone within the jurisdiction of the State Party. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability); information accessibility.
3) *Acceptability*: All health facilities goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.
4) *Quality*: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

The survey's key limitation was that it relied on secondary evidence available in a database that is updated up to 2010. Therefore, it may not represent the latest status of access. The general trends and other documented evidence however, provide a sufficient picture to advocate for improvements in aspects of access that have persistently underperformed.

2. FAMILY PLANNING

Family planning is recognised as one of the high-impact interventions in reducing maternal deaths, through prevention of pregnancies that are unintended as well as those that are too early, too late or too frequent (Ministry of Finance, 2011). It is estimated that the use of family planning alone could reduce maternal mortality by 30%, while family planning combined with improved EmOC can reduce maternal mortality by more than 75% (Reproductive Health Uganda, website).

Women who can plan the number and timing of the birth of their children enjoy improved health, experience fewer unplanned pregnancies and births, and are less likely to have an abortion (California Department of Family Planning, 2006). Available evidence also suggests that the proportion of infants born with a health disadvantage is significantly lower if the pregnancy was intended than if it was mistimed or not wanted, and an unwanted pregnancy increases the likelihood that the infant's health will be compromised (Kost K, et al, 1998).

The key Ministry of Health-listed commodities used in planning the number and timing of pregnancies are: male and female condoms, injectables, implants, IUDs, pills, and surgical contraception equipment. Availability of at least one type of contraceptive at government health facilities was found to be 100% in Lira district in 2009, compared to only 33.3% in non-government health facilities (Kibira D, et al, 2009).

However, availability of the different contraceptives varied widely, with the most available contraception options being male condoms, pills and injectables. Condoms were available at most health facilities for free. Long-term options were particularly not available in the public sector, but tend to be available in the private sector, where they are accessed at varying fees. This limits choice, and leaves out women who fill that the short-term oral and injectable hormonal options have higher side-effect profiles.

Health workers interviewed at government health facilities in Pallisa district were generally dissatisfied with the level of demand and uptake of family planning services, which they attributed to limited options being available and men's negative attitudes to family planning.

> *"At the moment we have only pills; we do not have any other options in stock and yet some women prefer the injection. We have condoms but even HIV-positive mothers who have been counselled to use them are not interested. The biggest problem is that men are against family planning and even the women fear the side-effects."* – **Health worker at Kamuge Health Centre III**

Clients of maternal health services were more concerned about the side-effects of family planning commodities. In one case, a client carrying her eighth pregnancy reported she was interested in stopping producing children but family planning was not an option.

> *"I was using the injection until about three years ago before I conceived this pregnancy, but they treated be so badly and I had to give them up. There are problems in using those things (*family planning commodities*); I nearly died. I was badly affected; I am not going to use them again. I would have wished to stop here but God may choose to give me another baby… I only have one girl."* – **ANC client at Butebo Health Centre IV**

According to the 2009/10 Annual Health Sector Performance Review Report, 30% of health facilities had monthly stock-outs of Depo Provera, up from 5% the previous year. According to the 2010 stock status reports by Securing Ugandan's Right for Essential Medicines (SURE), a USAID-funded programme, the supply was "relatively good" for most of the contraceptives supplies in question but reports of overstocks of contraceptives, especially of emergency contraceptives, IUDs, and Microgynon were common. Overstocking is associated with commodity expiries at the affected facilities.

This status has been attributed in part, to the different contraceptives distribution policies introduced by National Medical Stores (NMS) during the year 2009. These policies include among others, rationing of contraceptive supplies to non-government health facilities; introducing the "push distribution system" in place of the demand-driven "pull system"; and withdrawing Depo Provera and emergency contraceptives from the supplies kit to level-two health centres (HC IIs).

There is also evidence that contraceptives supplies are distributed to places where users do not easily obtain them. For example, though 40% of users obtain their supplies from the private medical sector, the NMS distributes contraceptives largely through the public health system infrastructure (Reproductive Health Uganda, website).

3. ANTENATAL CARE

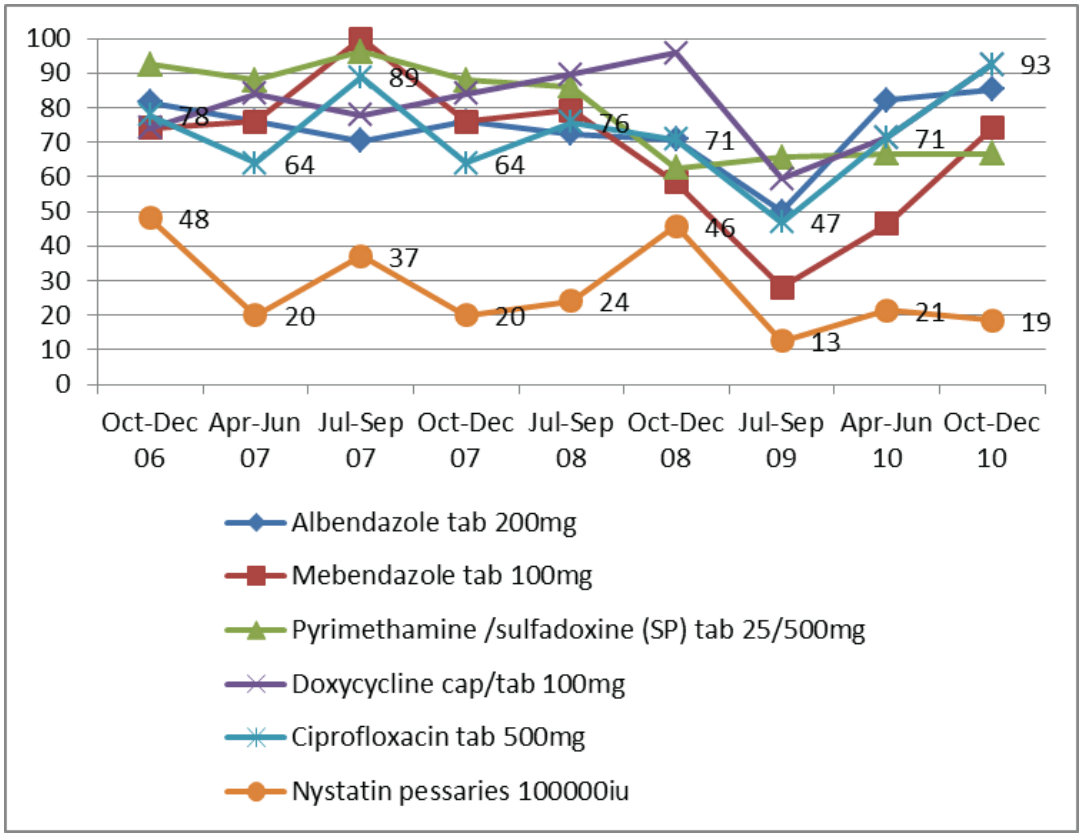
3.1 Access to commodities for general antenatal care

Poor access to antenatal care (ANC) services has been identified as an impediment to good maternal health, leading to poor birth outcomes, particularly premature births, small babies and caesarean sections. A higher proportion of women who make less than three ANC visits and those that make the first ANC visit late tend to have premature births; while undernourished women are more likely to produce babies that are small-for-age (Magadi, et al, 2001).

Commodities that are required for quality ANC include Fefolate, Fansidar, mama kit, Niverapine, deworming tablets, Combivir (Zidovudine/Lamivudine), STI kits, haemoglobin (HB) estimation kits, Uristix, and insecticide-treated bed-nets (ITNs). Figure 1 shows trends in availability of some common essential commodities, including medicines, required during pregnancy.

> A Mama Kit consists of 2 pairs of gloves to prevent bacterial infections and HIV; 2 new razor blades to cut the umbilical cord; 1 bar of soap; 2 gauze pads for cleaning the eyes of the newborn; 8 sanitary towels for the mother; 0.25kg (a quarter kilo roll) of cotton wool; and 1 polyethylene sheet on which the mother gives birth.

Figure 1: Trends in availability of ANC commodities 2006-2010



Source: MoH/WHO/HAI (HEPS), 2006-2010. Monitoring Medicine Prices Database

Overall, Figure 1 shows that there was no consistency in the availability of key ANC commodities. The period between July 2008 and July 2009 showed a general decline of almost all the commodities studied which could be indicate serious supply chain problems at the time. However, since July 2009, there has been a gradual increase of the commodities although the figures show that universal access is still a far cry.

Pregnant women are particularly susceptible to malaria, which is associated with higher levels of miscarriage. Availability of Sulfadoxine/Pyrimethamine, used for prophylaxis of malaria in pregnancy, has declined since 2006. Availability of sulfadoxine/ pyridoxine for malaria prophylaxis has oscillated between 90-60% of facilities in the past five years, with the trend tending downwards. Availability of Nystatin pessaries to treat vaginal fungal infections has been low throughout the period. Availability of other commodities has also been fluctuating.

Health workers interviewed at government health facilities in Pallisa district reported inconsistent and insufficient supplies as one of the biggest challenges in the provision of maternal and newborn services. The other challenge that featured prominently in the responses was shortage of qualified staff. Pallisa Hospital reported having only three medical officers; Butebo HC IV had none (and yet it is a referral facility); while Kamuge HC III and Butebo HC IV each had only one midwife in spite of the many deliveries they handle.

> "*The majority of the women, including some of those that attend ANC do not come to deliver in the hospital, yet we are overwhelmed by the few who come to deliver here because we are so few. And remember we are telling the women to come and deliver hospital, what will we do if they all decided to come? The supplies are not enough and yet there are people you really can see that they cannot afford them. Many times we also can't help because I cannot pick from my own pocket to provide commodities*." – **Health worker at Pallisa Hospital**

The shortage of health workers is leading to long-waiting hours and heavy workloads and in the process compromising the quality of services, client interest and health worker motivation and attitudes.

> "*The care here wouldn't be bad but there are some things that I think they (health workers) need to be helped with. For example we came three women and we were all pushing at the same time but there was only one woman working. So it was very difficult for her to attend to us all at the same time*." – **Client at Butebo HC IV**

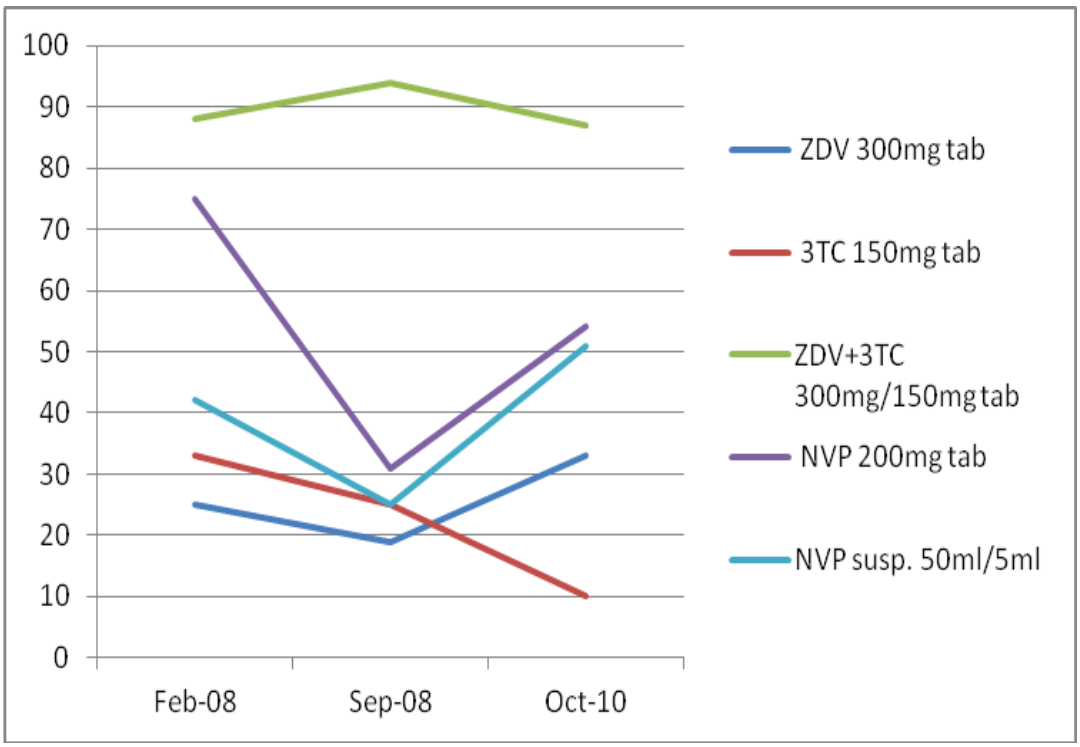
> "*The biggest problem here is privacy because the (labour) beds are only two. When I came both of them were being used by other women. I was put in the examination room where there are no curtains in the window and men were walking behind there. Women the women who had come for antenatal were all over there congesting the front and all over this ward where I was brought after I delivered and I was still very weak*" – **Client at Butebo HC IV**

The commonest complications reported among women delivering at health centres include postpartum haemorrhage, obstructed labour and placenta previa. Commodities for the management of these complications were limited. At the time of this survey, Pallisa Hospital, which delivers an average of four women daily, had only one ampoule of Oxytocin (for the management of postpartum haemorrhage), while Kamuge HC III had none, yet it reported delivering an average of five women daily.

3.2 Access to PMTCT commodities

Whereas mother-to-child transmission accounts for upto one fifth of all new HIV infections in Uganda, medicines for PMTCT are not accessible at public health facilities. The commodities used for PMTCT include HIV test kits, Nevirapine, Combivir (Zidovudine and Lamivudive), and other retroviral medicines used for the general health of the mother.

Figure 2: Trends in availability of medicines for PMTCT



Source: HEPS 2011. Essential HIV/AIDS and TB medicines and diagnostics in Uganda: An Assessment of Accessibility and Management

A key challenge in the management of HIV in women and their infants is low uptake of testing and other services for PMTCT, including low institutional deliveries. National figures indicate that only about 13% of women know their HIV status; less than half of facilities that provide ANC and delivery services have integrated PMTCT services; and that only 42% of women deliver under professional supervision in health facilities (Uganda Bureau of Statistics, 2006).

Availability of HIV test kits has been a major concern. NMS is supposed to supply test kits once every two months, but by mid-February 2011 Lira district had last received a delivery in November 2010 – and it was the last from UNICEF. Supplies of test kits have in the past been supplemented by UNICEF, AIDS Information Centre (AIC), and Northern Uganda Malaria, AIDS and TB (NUMAT) programme. UNICEF has ceased its support, and NUMAT was scheduled to wind up before the end of 2011.

At Kawempe Health Centre IV, supplies from Infectious Disease Institute (IDI) had alleviated the situation, which had deteriorated when Protecting Families Against HIV/AIDS (FREFA), a health NGO, withdrew. At Ogur Health Centre IV in Lira, ANC clients were being counselled and requested to return when test kits are available. The shortage of HIV test kits has affected access to PMTCT services.

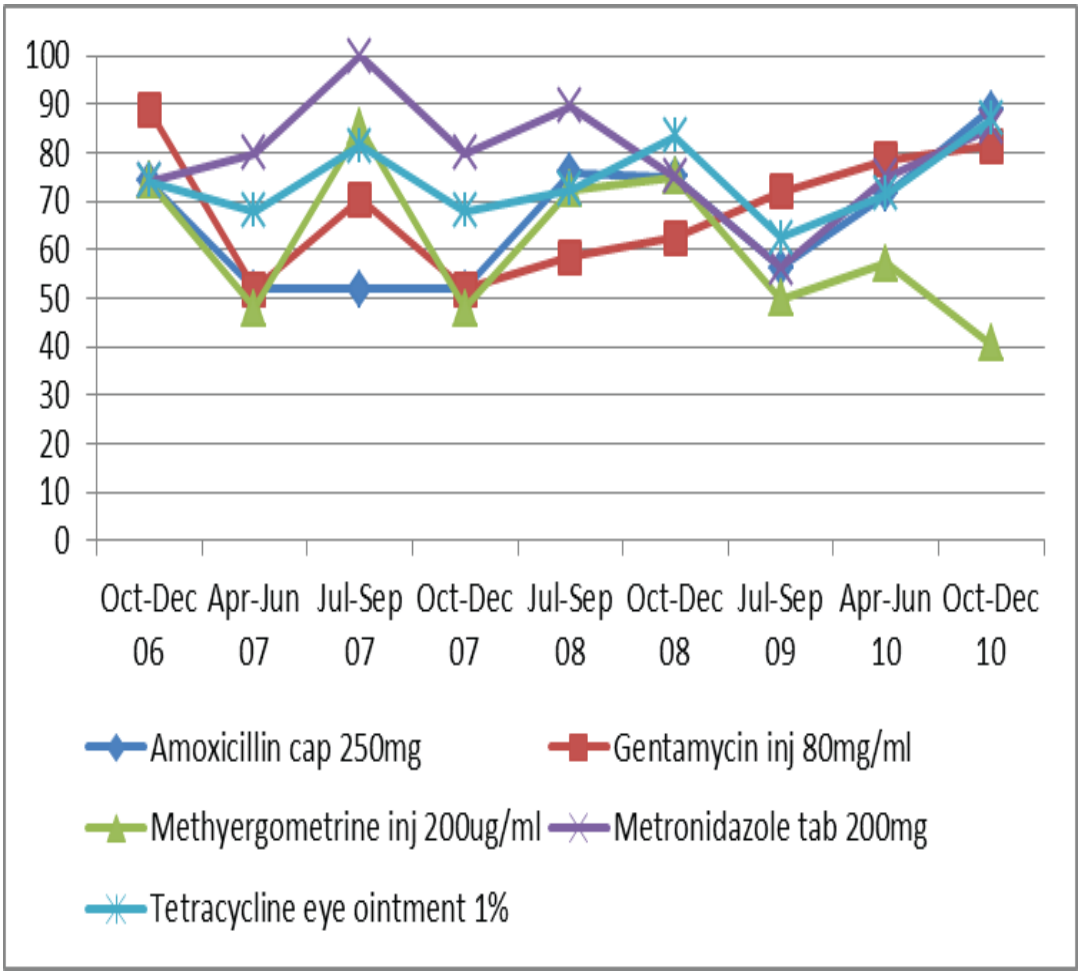
Availability of Nevirapine in both tablet and suspension formulations has been generally poor at health facilities providing PMTCT services. This suggests that many women who need this medicine during labour, and their infants in the first week of life, are unable to access it. This contributes to the high levels of HIV infection in children, yet the way to prevent such infection is known.

4. EMERGENCY OBSTETRIC AND NEONATAL CARE

4.1 Availability of EmONC commodities

Emergency obstetric and neonatal care (EmONC) is the attention/treatment women and their newborns receive during labour, delivery and six weeks after to ensure their safe recovery and good health.

Figure 3: Trends in availability of EmONC commodities



Source: MoH/WHO/HAI (HEPS), 2006-2010. Monitoring Medicine Prices Database

Commodities for EmONC have also not reached the desired levels to assure universal access. As noted for commodities for ANC, there are unpredictable fluctuations in availability of all supplies. Over, the period, metronidazole used in common obsteric infections was the most available commodity over the study period Methylergometrine used in labour was found to be declining since 2006 reaching 40% in in the survey October-December 2010.

4.2 Affordability of commodities for EmONC

Affordability of treatment is estimated as the number of days' wages the lowest-paid unskilled government worker needs to purchase medicines prescribed at a standard dose (www.haiweb.org). For acute conditions, treatment duration is defined as a full course of therapy, and a 30-days' supply of medicines for chronic diseases. The daily wage for the lowest-paid unskilled government worker in Uganda, which is Ushs 3,000, is used in the analysis. It should be noted however, that the lowest-paid government worker is not the poorest person in Uganda, where nearly one third of the population survives on the equivalent of less than one US dollar a day. So for this section of the population, the affordability situation is even worse that implied in the picture painted in this analysis.

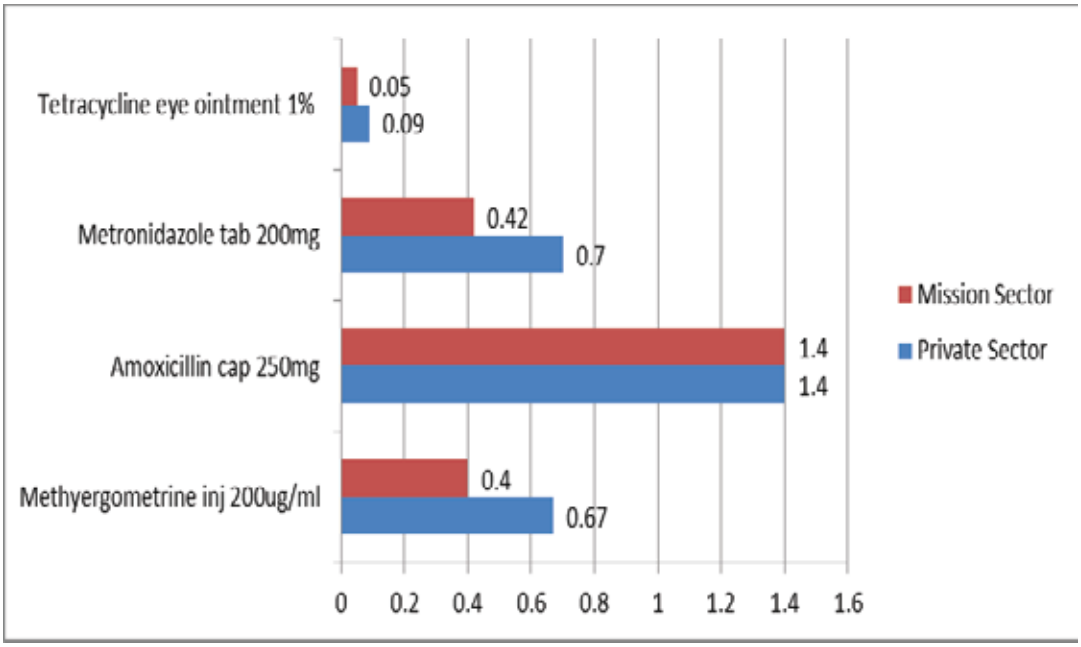
Table 1: Prices of commodities in private and mission sector (October-Dec 2010)

MEDICINE	TREATMENT SCHEDULE	PRIVATE SECTOR		MISSION/NGO SECTOR	
		UNIT COST	TOTAL COST	UNIT COST	TOTAL COST
Albendazole tab 200mg	2tab x1x1day	1000	2000	400	800
Amoxicillin cap 250mg	2capX3 x 7days	100	4200	100	4200
Ciprofloxacin tab 500mg	1tabx2x7days	230	3220	150	2100
Cotrimoxazole tab 400+80 mg	2tabx2x7days	50	1400	50	1400
Gentamycin inj 80mg/ml	1x3x7days	500	10,500	500	10500
Mebendazole tab 100mg	1x5x1day	50	250	30	150
Methylergometrine inj 200ug/ml	2x1x1day	1000	2000	600	1200
Metronidazole tab 200mg	2x3x7days	50	2100	30	1260
Nystatin pessaries 100000iu	1x10days	200	2000	150	1500
Pyrimethamine /sulfadoxine (SP) tab 25/500mg	3tabsx1x1day	450	1350	200	600
Tetracycline eye ointment 1%	1	286	286	143	143

Source: MoH/WHO/HAI (HEPS), 2006-2010. Monitoring Medicine Prices Database

Table 1 shows some of the expenses an expectant mother has to meet in both private and mission/NGO facilities when they are unable to obtain maternal health commodities in government health facilities. In addition to the once daily iron and folic acid tablets which may cost anywhere from Ushs 3,000 per monthly dose, a mother who requires a dose a albendazole for deworming (done once in both second and thrid trimester); a dose of pyrimethamine and sulfadoxine for malaria prophylaxis (done once in both 2nd and 3rd trimester) and is battling with vaginal candidiasis (requiring nystatin pessaries) would have to part with Ushs 8,350 in the private sector and Ushs 5,900 in the mission/NGO facilities.

Figure 4: Affordability of treatment for safe delivery



From the costs in Table 1, Figure 4 describes comparison of medicine costs between private and mission sector for a mother who has a safe delivery at a private health facility. The figure shows that just for the commodities above received after a safe delivery, it would require the lowest paid government worker 2.9 days to afford the treatment in the private sector and 2.3 days in the mission sector. It should be noted that this cost excludes cost of delivery bed, intravenous fluids, and mama kit used in delivery. This therefore indicates that the cost of delivery is unaffordable to majority of Ugandans but much less for the big numbers that live in poverty.

Expectant mothers attending ANC services are given a list of requirements to bring along when they come for delivery. One client at Butebo HC IV, a government facility, reported she was requested to bring gloves, a thread, razor blade, cotton wool, syringe, polythene, detergent and jik.

> "*I was able to bring them because she told me early so I was buying slowly by slowly. We used them today but she provided the ones she had. Not all of are able to buy whatever they ask, because some women do not have supportive husbands*" – **Client at Butebo HC IV**

Delivery services remain above the means of the poorest women and households. Mama kits were not available at all health facilities visited; mothers are expected to bring them as they come to deliver. At some facilities, the mama kits were available for sale at up to Ushs 20,000. Non-government facilities charge women for delivery, while government health facilities officially offer it free of charge but women pay all sorts of informal charges.

5. CONCLUSIONS AND RECOMMENDATIONS

- WOMEN in Uganda are yet to achieve the required universal access to adequate, affordable, quality and readily accessible maternal health services, supplies and commodities. Government should increase investment in maternal health commodities as well as improve efficiency of the national medicine distribution systems

- THE Uganda government has obligations under various international and national instruments it must live up to ensure women realise their reproductive health rights, but it has not lived up to its obligations. Among the many failures it has not ensured adequate supply of medicines, logistics and supplies, and other requisite commodities. The Ministry of Health should undertake an audit of the different treaties, conventions, laws and policies both at national and international levels and layout a costed plan of action to meet the government's maternal health obligations

- MOST mothers accessing PMTCT services are using the least effective medicines, when there are more effective options. Ministry of Heath should speed up the roll-out of the WHO-recommended Option B and Option B-plus regimens to not only improve the quality of life of the HIV-positive mothers but also to minimise mother-to-child HIV transmission

- THE Ministry of Health, NMS, and the United Nations Population Fund should review and improve the distribution concept and mix for the different family planning commodities – including both short-term and long-term options – as well as female condoms to ensure they are accessible at points that are convenient to women

- THE Ministry of Health should scale up health promotion activities to improve community attitudes toward family planning and other reproductive health services

ANNEX I: DESCRIPTION OF REPRODUCTIVE HEALTH COMMODITIES

Family planning commodities

COMMODITY	USE
Condoms	Used consistently and correctly, the male latex condom protects against unwanted pregnancy and HIV. The female condom provides an alternative for women who are unable to insist on condom use by the partner.
Injectables	Given every one, two or three months, injectable contraceptives are highly effective and reversible. They account for 10% of modern contraceptive use
Implants	Implants are small flexible rods or capsules that are placed just under the skin of the arm to provide long-term (3-7 years) pregnancy protection and are immediately reversible
Intrauterine devices (IUDs)	Copper-bearing device inserted into the uterus to last 3-12 years. One of the safest, best tolerated methods available for long-term contraception
Pills	Taken daily, pills are an effective method of reversible fertility control. Progestin-only pills are safe for breastfeeding women and their babies, as they do not affect milk production. Emergency contraceptive pills help prevent pregnancy when taken up to 5 days after unprotected sex.
Surgical contraception Equipment	Used in sterilization of men (vasectomy) and women who do not wish to have any more children.

Emergency obstetric and neonatal care

Oxytocin	Prevents postpartum haemorrhage, the most important cause of maternal death worldwide and to induce or augment labour
Magnesium Sulphate	Prevents seizures in women with pregnancy-induced hypertension, which is estimated to complicate 2%-8% of pregnancies
Gentamicin injection	Treats severe/serious bacterial infections
Amoxicillin injection	For common bacterial infections
Metronidazole injection	Treatment of gynecologic bacterial infections, which almost always happen in delivery

Tetracycline eye ointment	Treats infections of the eye especially for babies
Manual Vacuum Aspirator (MVA) kits	Used to terminate early/advanced pregnancies: to help a woman who has had a miscarriage or abortion that was not complete; to regulate monthly bleeding; or to end an unwanted pregnancy
Gynaecological gloves	Used by medical personnel for examine pregnancies, handle delivery, surgery, afterbirth, and wherever there is need for sanitation and to prevent cross-infection
Caesarean section kits	Used to handle C-Section deliveries in cases where a woman cannot have a normal, vaginal delivery. C-section is also considered safer for the baby in case the mother is HIV-positive (PMTCT
Misoprostol	Used in medical abortion, which is recommended if the mother has no ability to carry a pregnancy or in other life-threatening situations as determined by medical personnel

Antenatal care (ANC) and prevention of mother-to-child transmission of HIV (PMTCT)

Fefolate	Iron supplement to prevent anaemia, which is a major problem among pregnant and breastfeeding women and babies
Fansidar	Prophylaxis for malaria in pregnancy. Malaria is a major cause of miscarriages
Mama kit	Consists of several items that medical personnel use to safely handle deliveries
Nevirapine, Zidovudine/lamivudine	For prevention of mother-to-child transmission of HIV during labour and delivery
Deworming tablets	Given to pregnant women and babies to control worm infestation, which are sometimes responsible for anaemia
STI kits	For testing for STIs
Cervical cancer screening kits	Used to screen women for cancer of the cervix

ANNEX II: AVAILABILITY OF MATERNAL HEALTH COMMODITIES

Period October 2006

SECTORS	PUBLIC	PRIVATE	MISSION
Medicine		**Availability %**	
Albendazole tab 200mg	81.5	77.8	65.2
Amoxicillin cap/tab 250mg	74.1	92.6	100.0
Ciprofloxacin tab 500mg	77.8	85.2	95.7
Doxycycline cap/tab 100mg	74.1	77.8	95.7
Gentamycin inj 80mg/ml	88.9	81.5	82.6
Mebendazole tab 100mg	74.1	81.5	104.3
Methyergometrine inj 200ug/ml	74.1	63.0	87.0
Metronidazole tab 200mg	74.1	92.6	95.7
Nystatin pessaries 100000iu	48.1	59.3	82.6
Paracetamol tab 500mg	74.1	103.7	104.3
Pyrimethamine /sulfadoxide (SP) tab 25/500mg	92.6	92.6	100.0
Tetracycline eye ointment 1%	74.1	81.5	87.0

Availability of Maternal health commodities 2007

Period	Apr- Jun 2007			July - September 2007			October - December 2007		
Sectors	Public	Private	Mission	Public	Private	Mission	Public	Private	Mission
Medicine	Availability %			Availability %			Availability %		
Albendazole tab 200mg	76%	93%	75%	70%	70%	63%	76.0%	92.6%	75.0%
Amoxicillin cap/tab 250mg	52%	96%	80%	52%	89%	100%	52.0%	96.3%	80.0%
Ciprofloxacin tab 500mg	64%	89%	90%	89%	93%	95%	64.0%	88.9%	90.0%
Dextrose 5% inj	68%	74%	75%	78%	67%	95%	68.0%	74.1%	75.0%
Doxycycline cap/tab 100mg	84%	89%	95%	78%	81%	95%	84.0%	88.9%	95.0%
Gentamycin inj 80mg/ml	52%	67%	85%	70%	59%	74%	52.0%	66.7%	85.0%
Mebendazole tab 100mg	76%	96%	90%	100%	96%	100%	76.0%	96.3%	90.0%
Methyergometrine inj 200ug/ml	48%	48%	80%	85%	59%	89%	48.0%	48.1%	80.0%
Metronidazole tab 200mg	80%	93%	100%	85%	100%	100%	80.0%	92.6%	100.0%
Nystatin pessaries 100000iu	20%	63%	55%	37%	56%	68%	20.0%	63.0%	55.0%
Pyrimethamine / sulfadoxide (SP) tab 25/500mg	88%	100%	80%	96%	96%	95%	88.0%	100.0%	80.0%
Tetracycline eye ointment 1%	68%	96%	80%	81%	78%	89%	68.0%	96.3%	80.0%

Availability of Maternal health commodities 2008

Period	July - September 2008			October - December 2008		
Sectors	**Public**	**Private**	**Mission**	**Public**	**Private**	**Mission**
Medicine	**Availability %**			**Availability %**		
Albendazole tab 200mg	72%	71%	50%	70.8%	75.9%	50.0%
Amoxicillin cap/tab 250mg	76%	91%	100%	75.0%	93.1%	92.9%
Ciprofloxacin tab 500mg	76%	91%	100%	70.8%	93.1%	96.4%
Dextrose 5% inj	66%	69%	96%	83.3%	82.8%	82.1%
Doxycycline cap/tab 100mg	90%	89%	88%	95.8%	93.1%	85.7%
Gentamycin inj 80mg/ml	59%	54%	88%	62.5%	82.8%	82.1%
Mebendazole tab 100mg	79%	86%	85%	58.3%	89.7%	89.3%
Methyergometrine inj 200ug/ml	72%	46%	69%	75.0%	44.8%	71.4%
Metronidazole tab 200mg	90%	89%	100%	75.0%	86.2%	96.4%
Nystatin pessaries 100000iu	24%	57%	69%	45.8%	65.5%	71.4%
Pyrimethamine /sulfadoxide (SP) tab 25/500mg	86%	97%	96%	62.5%	86.2%	85.7%
Tetracycline eye ointment 1%	72%	83%	88%	83.3%	86.2%	89.3%

Availability of Maternal health commodities 2009

Period	Aug - October 2009		
Sectors	**Public**	**Private**	**Mission**
Medicine	**Availability %**		
Albendazole tab 200mg	50%	58%	50%
Amoxicillin cap/tab 250mg	56%	91%	93%
Ciprofloxacin tab 500mg	47%	88%	93%
Dextrose 5% inj	78%	67%	89%
Doxycycline cap/tab 100mg	59%	85%	86%
Gentamycin inj 80mg/ml	72%	76%	79%
Mebendazole tab 100mg	28%	85%	89%
Methyergometrine inj 200ug/ml	50%	39%	68%
Metronidazole tab 200mg	56%	94%	96%
Nystatin pessaries 100000iu	13%	76%	71%
Pyrimethamine /sulfadoxide (SP) tab 25/500mg	66%	64%	57%
Tetracycline eye ointment 1%	63%	85%	82%

Availability of Maternal health commodities 2010

Period	Apr - June 2010			October - December 2010		
Sectors	**Public**	**Private**	**Mission**	**Public**	**Private**	**Mission**
Medicine	**Availability %**			**Availability %**		
Albendazole tab 200mg	82%	72%	50%	85.2%	76.7%	78.3%
Amoxicillin cap 250mg	71%	84%	94%	88.9%	90.0%	91.3%
Ciprofloxacin tab 500mg	71%	91%	100%	92.6%	96.7%	91.3%
Dextrose 5% inj	82%	75%	94%	92.6%	76.7%	91.3%
Doxycycline cap/tab 100mg	71%	81%	100%	92.6%	96.7%	82.6%
Gentamycin inj 80mg/ml	79%	78%	100%	81.5%	80.0%	100.0%
Mebendazole tab 100mg	46%	91%	78%	74.1%	86.7%	78.3%
Methyergometrine inj 200ug/ml	57%	38%	67%	40.7%	50.0%	43.5%
Metronidazole tab 200mg	75%	94%	100%	85.2%	96.7%	91.3%

ANNEX III: TRENDS OF PRICES OF MATERNAL HEALTH COMMODITIES IN PRIVATE AND MISSION SECTORS 2007-2010

	Apr 2007		Oct 2007		Jul 2008		Oct 2008		9-Aug		10-Apr		10-Oct	
Medicine	Private	Mission	Private	Mission	Private	Mission	Private	Mission	Private	Mission	Private	Mission	Private	Mission
Albendazole tab 200mg	500	400	500	250	500	125	500	200	1000	200	500	200	1000	400
Amoxicillin cap/tab 250mg	50	50	50	85	100	70	100	80	100	100	100	80	100	100
Ciprofloxacin tab 500mg	200	150	200	150	200	135	200	150	200	200	250	175	230	150
Co-trimoxazole tab 400+80 mg	37	30	50	50	30	30	40	45	50	50	50	50	50	50
Gentamycin inj 80mg/ml	500	500	450	500	500	500	300	550	500	700	500	500	500	500
Mebendazole tab 100mg	33	30	29	30	25	30	25	30	23	30	30	30	50	30
Methyergometrine inj 200ug/ml	850	500	700	600	600	500	600	500	1000	500	1000	500	1000	600
Metronidazole tab 200mg	25	30	30	30	25	30	50	30	33	30	50	30	50	30
Nystatin pessaries 100000iu	179	100	200	100	167	100	179	100	200	125	200	125	200	150
Pyrimethamine / sulfadoxide (SP) tab 25/500mg	300	167	300	300	200	200	200	183	330	200	500	300	450	200
Tetracycline eye ointment 1%	143	143	143	143	143	143	143	143	200	286	286	286	286	143

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