Challenges and Entry Points for Improving Access to Maternal Health Supplies

Woodrow Wilson International Center for Scholars
November 30, 2010

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Population Action International
Research Approach and Outline

- Building on successes of decade+ reproductive health supplies movement
- “No product, no program?”
- Case studies of Bangladesh and Uganda: policies, financing, logistics, health system
- Evidence base for future advocacy and policy change
- Supported by Maternal Health Task Force and Partnership for Maternal, Newborn & Child Health
Which Maternal Health Supplies?

• Four “tracer” supplies selected:
  - Oxytocin for PPH
  - Misoprostol for PPH
  - Magnesium sulfate for pre/eclampsia
  - Manual vacuum aspirators (MVA) for early and incomplete abortion

• Prevention and treatment of three leading direct causes of maternal mortality

• Many other supplies needed for good maternal health: antibiotics, painkillers, antimalarials, blood, gloves, gauze...
Supplies within the Health System

• Maternal health outcomes inextricably tied to health system strength/weakness
• Low rates of facility-based deliveries
  o 15% Bangladesh
  41% Uganda
• Expectation that supplies may be out of stock in facilities
  o “It doesn’t encourage [women] to come to facilities when you ask them to buy drugs”

Private sector hospital, Bangladesh
Financing of Maternal Health Supplies

- Little dedicated donor funding for maternal health supplies, unlike contraceptives and condoms
- Maternal health supplies aggregated with others and difficult to track
- Significant underspending of budget allocations despite frequent supply shortages
- Widespread unofficial user fees
  - Inability to afford treatment is the most common reason for not delivering in a facility (Uganda DHS)
### Availability of Tracer Supplies: Oxytocin

<table>
<thead>
<tr>
<th></th>
<th>Bangladesh</th>
<th>Uganda</th>
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</thead>
<tbody>
<tr>
<td><strong>National policies/guidelines</strong></td>
<td>Use in all deliveries as part of AMTSL</td>
<td>Included in AMTSL training but slow transition from ergometrine</td>
</tr>
<tr>
<td><strong>Facility availability</strong></td>
<td>Through upazila (sub-district)</td>
<td>Should be available through Health Center III (sub-county)</td>
</tr>
<tr>
<td><strong>Health worker protocols</strong></td>
<td>Community attendants trained to administer</td>
<td>Midwives, clinical officers and doctors can administer</td>
</tr>
<tr>
<td><strong>Supply chain issues</strong></td>
<td>55% of district hospitals and 38% upazila health centers had in stock</td>
<td>74% of Health Centers III and 97% of hospitals had in stock</td>
</tr>
<tr>
<td></td>
<td>Khan 2009, World Bank</td>
<td>Mbonye et al. 2007, IJGO</td>
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## Availability of Tracer Supplies: Misoprostol

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<tbody>
<tr>
<td><strong>National policies/guidelines</strong></td>
<td>Approved for PPH 2008 and part of EDL; being scaled-up from pilots</td>
<td>Approved for PPH 2008; not on EDL; piloted in 20 districts and large hospitals</td>
</tr>
<tr>
<td><strong>Facility availability</strong></td>
<td>Should be available throughout health system</td>
<td>Should be available throughout health system when scaled-up</td>
</tr>
<tr>
<td><strong>Health worker protocols</strong></td>
<td>Community workers reportedly allowed to administer; some NGOs distributing to pregnant women</td>
<td>Nearly all health workers, including Village Health Teams, allowed to administer Ministry of Health 2008 Clinical Guidelines</td>
</tr>
<tr>
<td><strong>Supply chain issues</strong></td>
<td>Government had not procured as of early 2010</td>
<td>Government had not procured as of early 2010</td>
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### Availability of Tracer Supplies: Magnesium Sulfate

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<tbody>
<tr>
<td><strong>National policies/guidelines</strong></td>
<td>Included on Essential Drug List</td>
<td>Included on Essential Drugs List</td>
</tr>
<tr>
<td><strong>Facility availability</strong></td>
<td>Should be available through union level</td>
<td>Should be available through Health Center III</td>
</tr>
<tr>
<td><strong>Health worker protocols</strong></td>
<td>Not provided to government community workers; NGO pilots at community level</td>
<td>Conflicting reports on whether midwives are allowed to administer</td>
</tr>
<tr>
<td><strong>Supply chain issues</strong></td>
<td>42% of district hospitals and 23% upazila health centers had in stock</td>
<td>Not widely available; low level of training; use of alternative diazepam</td>
</tr>
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</table>

Khan 2009, World Bank
## Availability of Tracer Supplies: MVAs

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<tbody>
<tr>
<td><strong>National policies/guidelines</strong></td>
<td>Permissible for menstrual regulation; husband/guardian consent required</td>
<td>Permissible for evacuation/treatment of incomplete abortion</td>
</tr>
<tr>
<td><strong>Facility availability</strong></td>
<td>Through upazila (sub-district) or lower level NGO outlets</td>
<td>Should be available through Health Center III, unlikely below Health Center IV</td>
</tr>
<tr>
<td><strong>Health worker protocols</strong></td>
<td>Paramedics up to 8 weeks, Doctors/midwives up to 10 weeks</td>
<td>Doctors, clinical officers and midwives (per training)</td>
</tr>
<tr>
<td><strong>Supply chain issues</strong></td>
<td>Trained providers reportedly often unavailable</td>
<td>Many remain unused due to untrained providers</td>
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Supplies in the Private Sector

- 51% of facility deliveries in Bangladesh, 29% Uganda
- Perceived reliability for supplies and quality of care
- Strong public-private partnerships
  - Private sector reliance on government for supplies
- Pharmacies as source of supply (and information)
Forecasting, Procurement and Logistics

• Lower likelihood of annual forecasting relative to family planning
• Importation challenges and higher costs if no local manufacturing
• Limited procurement cycles
• Oxytocin cold chain
• Quantity mismatch between orders and delivery
• “Informal markets in labor wards are well established due to chronic shortage of supplies”

Joint Medical Store, Uganda
Training and Community Distribution

• Training frequency: “If a midwife doesn’t have an update for 10 years, at the end of the day she becomes a traditional birth attendant”
• Lack of clarity surrounding protocols for administration of drugs by different cadres of health worker
• CSBAs in Bangladesh, VHTs in Uganda
• How to re-supply community-based workers?

Public sector facility, Bangladesh
Entry Points: Supply Chain

- Maintain accurate quantification and forecasting
- Deliveries must adapt to facilities’ growing demands
- Ensure supplies on agenda of government/donor cooperation
- Expand training and availability of miso per national guidelines

Private sector hospital, Bangladesh
Additional Entry Points

• Implement and fund policies already in place
• Raise awareness and scale up community-based approaches
  o Uganda: 40% of women say husbands make decisions about their health care
• Prioritize family planning
  o Uganda: unmet need 41%, reproductive-age female population grew 20% in 5 years
• Monitor the national budget for maternal health
• Human resources training, remuneration and workload

Moulvi Bazar, Bangladesh