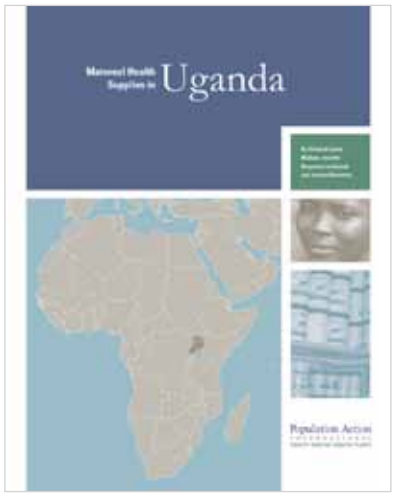
Population Action
INTERNATIONAL
HEALTHY FAMILIES HEALTHY PLANET

EXECUTIVE SUMMARY

Maternal Health Supplies in Uganda and Bangladesh

For women living in many developing countries, having a child can be dangerous. Lack of financing, poor infrastructure, and broken supply chains mean that women are often unable to get basic supplies that ensure a healthy pregnancy and safe delivery—despite widespread agreement on how to treat maternal killers like postpartum hemorrhage, eclampsia, and infection.



As the 2015 deadline to achieve the Millenium Development Goals creeps closer, maternal health is the most off-track of all the MDGs. Bangladesh and Uganda, the focus of two new reports on access to maternal health supplies, are two of the countries with the highest number of maternal deaths in the world.

Family planning is the first step in maternal health, by allowing women to avoid unintended pregnancies. Population Action International, which has long promoted access to family planning, recently partnered with Maternal Health Task Force (MHTF) and the Partnership for Maternal, Newborn and Child Health (PMNCH) to explore how policies, funding, and other health system challenges affect the availability of maternal health supplies in Uganda and Bangladesh. This research is intended to provide an evidence base for future advocacy to ensure access to reproductive, maternal, newborn and child health.

Findings show that in both countries, few women give birth at health care facilities. In Bangladesh, just 15 percent of women give birth at facilities, and skilled attendants assist at only 18 percent of births—major challenges for improving maternal health. In Uganda, only 41 percent of women give birth at facilities, despite the fact that 90 percent of pregnant women receive some antenatal care.

The report tracks four maternal health supplies—oxytocin, misoprostol, magnesium sulfate and manual vacuum aspirators (MVAs)—that address three of the most common direct causes of maternal mortality in Asia and Africa. Of the four, PAI found oxytocin and misoprostol—both used to treat postpartum hemorrhage—to be the most widely available in both countries. Health workers, down to the community level, have been trained to inject oxytocin, and miso-

Population Action International uses research and advocacy to improve access to family planning and reproductive health care across the world so women and families can prosper and live in balance with the earth. By ensuring couples are able to determine the size of their families, poverty and the depletion of natural resources are reduced, improving the lives of millions across the world.

prostol, a tablet, is becoming increasingly widespread since being approved by Uganda's government and added to Bangladesh's Essential Drug List in 2008.

Magnesium sulfate, an injection or intravenous treatment for severe pre-eclampsia and eclampsia, is more difficult to find. In Uganda, few providers in lower-level facilities have been trained in its use. In Bangladesh, while public facilities are capable of administering the injection, they often do not have it in stock. MVAs, used to treat early or incomplete abortions, are also often unavailable in both countries. Even when available at facilities, many MVA kits in Uganda and Bangladesh remain unused because providers have not been trained.

The governments of both Bangladesh and Uganda are widely viewed as supportive of maternal health, and both have enacted policies related to strengthening maternal and newborn health. However, the policies are not implemented or financed fully, resulting in diminished impact on the ground. None of the policies reviewed by PAI researchers include quantified targets to measure improvements in access to the four maternal health supplies.

Maternal health supplies are also often grouped with other reproductive health supplies in countries' budgets, and are therefore difficult to track. In neither Bangladesh nor Uganda is the government meeting the goal of spending 15 percent of its budget on health, and despite supply shortages, the money allocated in budgets for supplies frequently goes unspent.

Facilities in both countries reported stockouts of essential supplies due to supply chain problems across the health system. Procuring supplies not manufactured locally can be time-consuming and problematic; requests for supplies from the local levels are not always accurate, or go unfilled at higher levels of the health system; and supplies often do not make it to districts on time, creating shortages.

Civil society is already playing an important role in improving maternal health in these countries. Professional associations have provided technical advice to governments on the introduction of misoprostol, but advocacy on maternal health supplies is also needed. Key advocacy entry points include: raising awareness at the community level, monitoring national budgets, holding the government accountable for policies already in place, using donor resources effectively, and strengthening the supply chain.

Maternal health supplies today are where contraceptives were ten years ago. Unlike contraceptives and condoms, there is little dedicated donor funding for these critical supplies. Health and development partners (such as UNICEF, UNFPA, the World Bank and WHO) and civil society organizations must work together now and take action to overcome maternal health supply challenges.

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1300 19th Street NW, Second Floor ■ Washington, DC 20036 USA ■ (202) 557-3400
e-mail: pai@popact.org ■ www.populationaction.org
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