

Topic: Reproductive Health Commodity Security in post-conflict situations, a case of northern Uganda.

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1.0 Background

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, universal access to reproductive health care by the year 2015 was emphasized. Elaborating on the goal of achieving universal access to reproductive health care, the ICPD+5 document, *Key Actions for the further implementation of the Program of Action*, states:

‘Governments should strive to ensure that by 2015, all Primary Health care and Family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective Family planning and contraceptive methods; essential Obstetric Care, Prevention and management of reproductive tract infections including sexually transmitted diseases; and barrier methods such as male and female Condoms and microbicides if available, to prevent infection. By 2005, 60 percent of such facilities should be able to offer this range of services, and by 2010, 80 percent of them should be able to offer such services’ (Paragraph 53)

The need to achieve universal access to reproductive health was consolidated and augmented by the World summit in 2005 which made universal access to reproductive health by 2015 a target under MDG5. A subsequent political declaration on HIV and AIDS set a target of universal access to comprehensive HIV prevention by 2010. A series of prior United Nations conferences also emphasized the need for universal access¹. Not only did these meetings secure international commitment to address universal access in general, they also acknowledged and endorsed the importance of Reproductive health commodity security in particular. More specifically, attaining the goals of universal access was seen as premised on individuals (especially women) having the right commodities, in the right place and at the right time. Critically, Commodity security can be seen as pivotal to achieving at least three of the MDGs: that is, reducing child mortality (Goal 4); improving maternal health (Goal 5); and combating HIV/AIDS (Goal 6). Access to reproductive health commodities- including contraceptives for Family planning, condoms for prevention of sexually transmitted infections and HIV and other reproductive health commodities is thus an integral part of the efforts to achieve the MDGs

¹ These include: ICPD plus 5 and ICPD at 10

1.01 Problem statement

Uganda faces challenges in ensuring RHCS² resulting from interplay of technical, logistical, economic and socio-cultural variables. According to the MOH Annual Health Sector performance report 2005/06, 73 percent of health units had a monthly store room stock-out of one or more HSSP3-indicator⁴ commodities and availability had actually deteriorated. All levels of care were affected by poor availability, and the supply of these key commodities fell far short of demand. The report also noted inadequate buffer stocks at facility level. The deterioration of this situation was in part attributable to delays in National Medical Stores' (NMS) delivery to the districts. An analysis of lead times showed that the average time taken for NMS to process and deliver orders at district level was about 60 days compared with the benchmark of 30 days. With regard to ordering practices, it was acknowledged that poor estimation of requirements and lack of prioritization at the facility level also contributed to stock-outs.

According to the Ugandan Annual Health Sector Performance Report 2005/06, 73% of health units had a monthly store-room stock-out of one or more Health Sector Strategic Plan (HSSP)II indicator commodities and availability had deteriorated over the last two years. Major factors contributing to this included poor commodity management at health facility level, poor records management, suboptimal expenditure of cash budgets for medicines, inadequate stocks at the national level and poor distribution of available stock. Furthermore, an analysis of lead times for sixty seven orders for commodities showed that the average time taken for the Uganda National Medical Stores (NMS) to process and deliver commodities at the district level was about 60 days (3 months) compared to the benchmark of 30 days. This is compounded by the poor ordering practices in terms of poor forecasting and lack of prioritization at the health facility level leading to grave stock-outs of indicator commodities.

In northern Uganda given the effects of the 20-year insurgency the situation is even worse. The 20 years protracted war led to the breakdown of political, social-economic and cultural systems and people were displaced into camps. This resulted into low political commitment, breakdown of coordination structures, inadequate human resources, limited financing for social services like health, poor availability of health services and products. Given the above situation, this region has the poorest reproductive health indicators compared to other regions in the country. According to the Demographic Health Survey (DHS 2006) the northern region has the highest total fertility rate (8.6) compared to the national rate of 6.7; highest teenage pregnancy and lower levels of contraceptive use.

Recognizing the above challenges, the Ugandan Ministry of Health (MOH) Joint Review Mission for the year 2007 among its undertakings is to ensure no stock-outs of family planning commodities in at least 80% of health facilities at all levels of health care. In this regard it is critical that commodity security planning and budgeting, monitoring the supply chain at the different levels and on-job facilitative

² Reproductive Health Commodity Security

³ Health Sector Strategic Plan II

⁴ HSSP-Indicator commodities include Depo provera, COATEM (an anti malarial drug), Oral Rehydration Salts, measles Vaccine, and Cotrimoxazole (Septrin)

training on logistics management at health facility level are done. It is also absolutely critical to monitor trends in demand for and supply of reproductive health commodities in order to prevent problems that would have grave consequences on women and their families.

Cognizant of the fact that the Ministry of Health cannot achieve universal access to reproductive alone and the need for a secure supply of reproductive health products, the Ministry of Health, the Program for Accessible Health, Communication and Education (PACE) in Partnership with the United Nations Population Fund (UNFPA) in April 2008 launched a pilot public-private partnership project to ensure reproductive health commodity security in two districts of Pader and Kitgum in northern Uganda that ended in June 2009.

1.02 Project Goal and objectives:

The overall goal of the pilot project was to contribute to the improvement in the reproductive health commodity security especially contraceptives and condoms at district and lower level health structures in Uganda. The pilot project was intended to contribute to an environment that enables the populations of Pader and Kitgum districts enjoy constant and reliable availability of reproductive health commodities to meet their reproductive health needs. The specific objectives of the project were;

- ❖ To ensure the availability of reproductive health commodities at all levels in the supply chain.
- ❖ To build the capacity of key personnel at UNFPA and MOH in reproductive health commodity security
- ❖ To build the capacity of districts, health and districts (HSDs) and health facilities at all levels in logistics management.
- ❖ To create client demand for utilization of reproductive health commodities at the community level.

1.0.3 Key project strategies:

The implementation of the project was based on the following strategies both at the national level and district;

National level

- Developing a comprehensive sexual and reproductive health commodity strategy.
- Building the capacity of key personnel at MOH, the districts and UNFPA in reproductive health commodity security.
- Procurement of reproductive health commodities (contraceptives, female and male condoms).

District level

- Training central and district teams in logistics management information system (including a pipeline database for commodity management)
- Conducting on-job training for health facilities in logistics management at all levels.
- Supporting coordination structures for reproductive health commodity security (central reproductive health commodity security committee, district reproductive health commodity security committees in districts of operations.
- Supporting the distribution of reproductive health commodities from one level to another.
- Creating demand for reproductive health commodities at community level.

1.0.4 Nature of the partnership

The pilot project was a partnership project that was comprised of a core group of partners at the national, district, health sub district, health facility and community levels each with specific roles. Core partners included Ministry of Health-Reproductive Health Division, National Medical Stores (NMS), UNFPA, PACE, district health teams, Medicine and Therapeutic Committees, health workers and Village Health Teams (VHTS). It was designed to increase collaboration between the public and private sectors and maximizing the impact of the project by utilizing the complementary strengths and strategic advantages of the partnering agencies in making RH logistics available in the districts. The table below shows the partners and their specific roles.

Level	Partner	Roles
National	Ministry of Health	<ul style="list-style-type: none">✓ Providing a forum for over coordination of planning, monitoring and evaluation✓ Providing a forum for knowledge and information sharing where successes, challenges and lessons from the project are addressed and decisions made.✓ Guide the strategy development and ensure overall coordination of activities
National	PACE	<ul style="list-style-type: none">✓ Lead private partner and implementer of the district pilot project✓ Expected to undertake capacity

		building, support logistics distribution, demand creation, data management and documentation of best practices at district level.
National	National Medical stores	<ul style="list-style-type: none"> ✓ Mandated to for procurement, warehousing and distribution of commodities and supplies. ✓ Work with the filed implementer (PACE) to ensure availability of quality commodities at all levels of the logistic chain
National	UNFPA	<ul style="list-style-type: none"> ✓ Procure RH commodities, avail them to NMS and ensure a reliable supply. ✓ Managing disbursement of funds to partners. ✓ Coordinating report writing and ensuring accountability.
District	The district health teams Medicine and Therapeutic Committees	<ul style="list-style-type: none"> ✓ Overall supervision at the district level. ✓ Plan, monitor and evaluate commodity supply chain at the district level. ✓ Ensure proper management of logistics and records
District	District health sub districts (HSD)	<ul style="list-style-type: none"> ✓ Support to lower level health units in operationalizing the supply chain
District	Health facilities	<ul style="list-style-type: none"> ✓ Quantify and request for RH commodities ✓ Manage commodities and account for them ✓ Regular reporting through the health

		management information systems ✓ Provide RH services (especially family planning)
Community	Village Health Teams (VHTs)	✓ Dissemination of information on RH services ✓ Provision of some services at community level

2.0 Achievements, challenges, recommendations and best practices:

An end of project evaluation was carried out in June 2009 by an independent consultant and the main objectives of the evaluation were;

- To assess the quantitative and qualitative effects and outcomes of the project
- To assess the key processes involved in project implementation with a view to documenting best practices and challenges.
- To establish the extent to which planned activities were implemented as laid out in the project proposal.

2.0.1 Achievements:

During the end of project evaluation both quantitative and qualitative methods were used to collect information from the two districts of operation and national level stakeholders and the findings thereof show significant achievements made by the pilot project. These include the following below;

Development of a country Reproductive Health Commodity Security Strategy:

A country situation analysis on Reproductive Health Commodity Security (RHCS) was undertaken by consultants working with the RHCS committee of the Ministry of Health to provide baseline information that informed the development of the reproductive health commodity strategy. Both the situational analysis and the development of the RHCS strategy for the country were done through a series of consultative activities involving all stakeholders led by MOH and the activities included consultative meetings, RHCS committee meetings, consensus building and dissemination workshops. Through the concerted efforts of various stakeholders, a five year RHCS strategy that runs from---- was developed for Uganda for the first time.

Improved logistics management practices

Prior to the actual district level implementation of the project, PACE conducted a mapping exercise of service delivery points in the target districts. Through the mapping exercise a number of capacity gaps were identified at facility levels which included among others; lack of skills in logistics management by

health providers. Consequently, a total of 80 health workers were trained in logistics management (40 in Kitgum and 40 in Pader). All functional health units had at least one staff trained in logistics management. After the training, the trained health workers were also followed up once by the trainers, to guide them on implementation of the skills learned. As a result of the training in logistics management of the health providers, there have been improvements in the capacity of health units to order for their commodities. All health centres are now able to prepare their credit line orders. Prior to the project health units used not to order for RH commodities as part of the Credit Line orders. RH logistics were perceived as not part of the regular requirements and health units expected the district to provide them through a push system. The project has trained health units to initiate their own quantification and orders for RH commodities. There has been a general improvement in the use of stock-cards and logistics management in general in the health units. The quotation below from one of key district officials during the end of project evaluation shows the extent to which the pilot project helped in building capacity at operational levels.

“Previously, in most of the health facilities, there were no stock cards and most health workers did not know how to fill the stock cards and did not appreciate the importance of filling stock cards. With the onset of the project, there has been general improvement in logistic management including reproductive health commodities,” District Reproductive Health Focal Person, Kitgum district.

The project ensured that the Health Management Information System (HMIS) forms are available at all health facilities in the district. Capacity was also built at HSD and facility level to enable the providers to understand the forms and use them for commodity supply orders and control. Records of orders and deliveries to facilities in the two districts are kept and so are delivery notes and FP registers at different levels of the logistics chain. Although Stock cards are available at the majority of health facilities they are not properly used when making inventory control decisions. The filling of these forms is still challenged by inadequate appropriately qualified personnel at the health facilities. The quality of Monthly Reports being sent out by health facilities to higher levels is often incomplete especially with regards to family planning commodity consumption data

Revitalization of coordination structures

Furthermore, the Medicine and Therapeutic Committees (MTCs) that were previously not present in the districts were formed both at the district and HSD levels. They were formed following guidelines from the Ministry of Health on composition of these committees. The composition of the committees included representatives of the political leadership of the district, the Chief Administrative Officers, the Chief Finance Officers as well as a technical team from the Health Office that included the District Assistant Drug Inspectors (DADI). After the committees were established, they were trained in logistics management as well as the coordination and monitoring of drugs and pharmaceuticals in the districts. After training, MTCs developed work plans for strengthening logistics management and the project facilitated them to conduct quarterly monitoring visits to the health facilities using a monitoring tool (the Facility Assessment Checklist for Indicators of Medicine Management) that was developed jointly by the MTCs and PACE.

Reduction in the lead times for deliveries of RH commodities to Operational Levels

Lead times for contraceptives generally reduced in the two districts from over 60 days to an average of 3-4 weeks. Prior to project implementation, there was a notable deterioration in delivery of commodities to health facilities in part attributable to delays in National Medical Stores (NMS) delivery to the districts. The average time taken for NMS to process and deliver orders at district level was about 60 days compared with the benchmark of 30 days. The improvement in lead times is partly attributable to general improvement in the management of the National Medical Stores but also to the fact that PACE undertook distribution of commodities, regularly handpicked commodities destined to the two districts. It is notable that lead times did not reduce for other essential drugs. The fact that lead times for other essential drugs have not reduced implies that there are still capacity gaps at the National Medical Stores that need to be addressed to create sustainable reduction in lead-times. The quotation below from one district RH Focal persons alludes to the fact of reduction in lead times.

“Since the start of the project, there has been improvement in ordering practices for reproductive health commodities. Previously the lead times would take 3 months but now; it takes 1 to 2 weeks,” District Reproductive Health Focal Person, Kitgum district.

Reduced stock –outs for RH commodities

The MOH target is to ensure that at least 80 percent of health facilities at all levels have Zero- stock out for FP commodities. The strategy for ensuring that this target is met consisted of monitoring the commodity supply chain within the two districts and building the capacity of the districts, health sub districts and health facilities in logistics management. Store room stock status at health facilities improved, with the two districts recording 100 percent of the health facilities at HC III and above stocked for index commodities in the three months preceding this report. The quotation below from one of the key informant interviews during the end of project evaluation bears witness to this fact.

“Since the project was started, there has been timely delivery of reproductive health commodities and therefore the district has not experienced stock outs at all,” District Reproductive Health Focal person, Kitgum district.

Increased client load for family planning services:

A multi-media approach was used for demand creation among the population to increase uptake of family planning services. The strategy involved building the capacity of VHT to mobilize communities to demand and use services and to provide selected services to the community. It also involved production and adaptation of IEC materials and conducting radio talk shows. The key message was to increase uptake of family planning services. A mixture of popular tradition, community sensitization through VHTs, radio and print media were used to create awareness among the general public. The VHTs were involved in mobilizing communities and making them aware of the need for family planning and the availability of services as well as distribution of condoms and oral contraceptives.

The project produced some IEC materials for use in sensitization of communities. These materials focused on uptake of Family Planning. The materials were also translated into the local language. They include posters, and family planning flip charts. The FP Flip Charts had a pictorial message without

wordings and could easily be used by the VHTs. The VHTs were also given T-Shirts with logos, as a means of identification within the communities. The T-Shirts were widely appreciated by both the Ministry of Health and the VHTs themselves. The project also supported the district health teams to undertake talk-shows on Family planning. As a result of the above demand creation activities in the two districts, there was increased uptake of family planning services and a doubling of Couple Years of Protection. There is evidence that client satisfaction for FP services improved and client load increased especially in Kitgum district (See Figure 1 & 2).

Figure 1: Client load trend –Kitgum district (2007 and 2008)

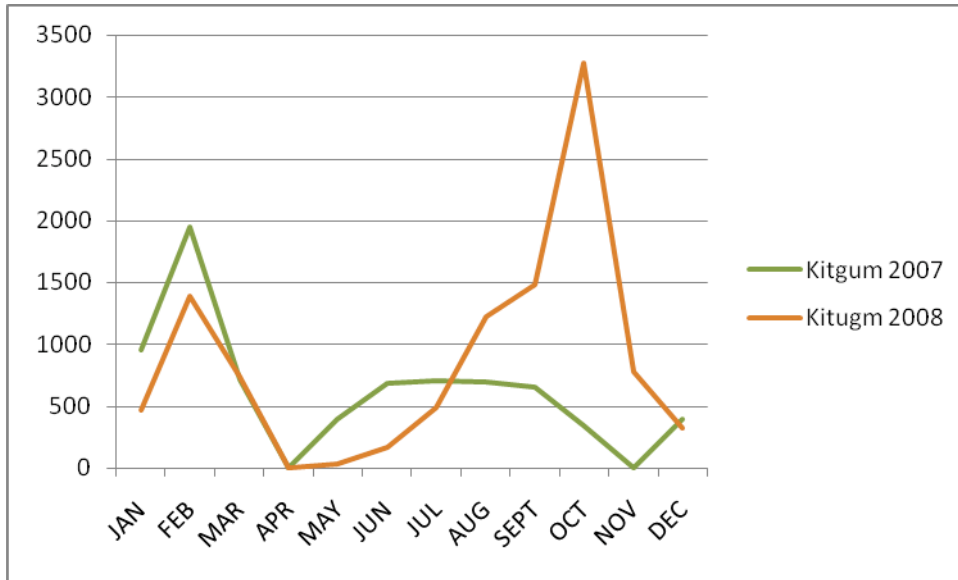


Figure 2: FP client load for Kitgum for 2007 and 2008

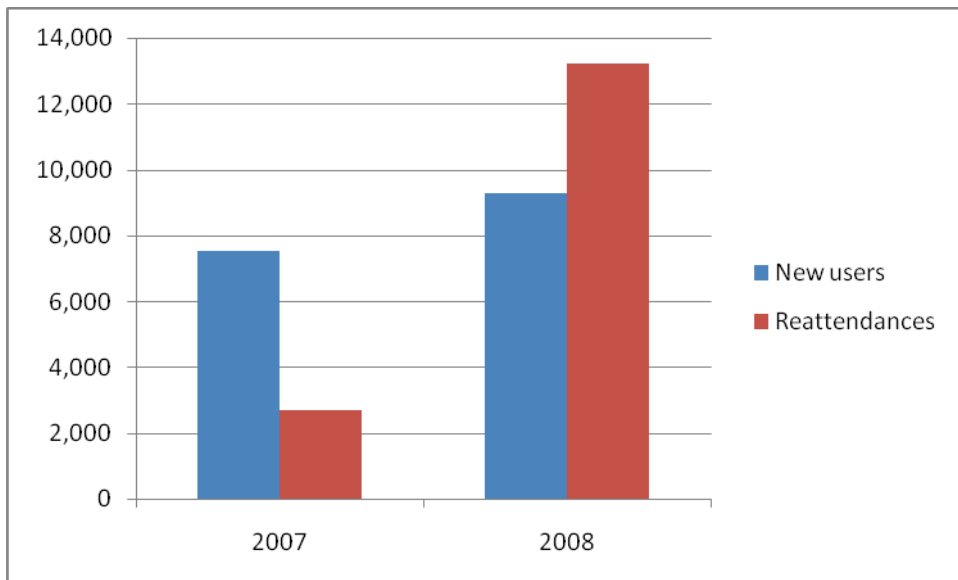


Figure 3: Client Load trend-Pader (2007 and 2008)

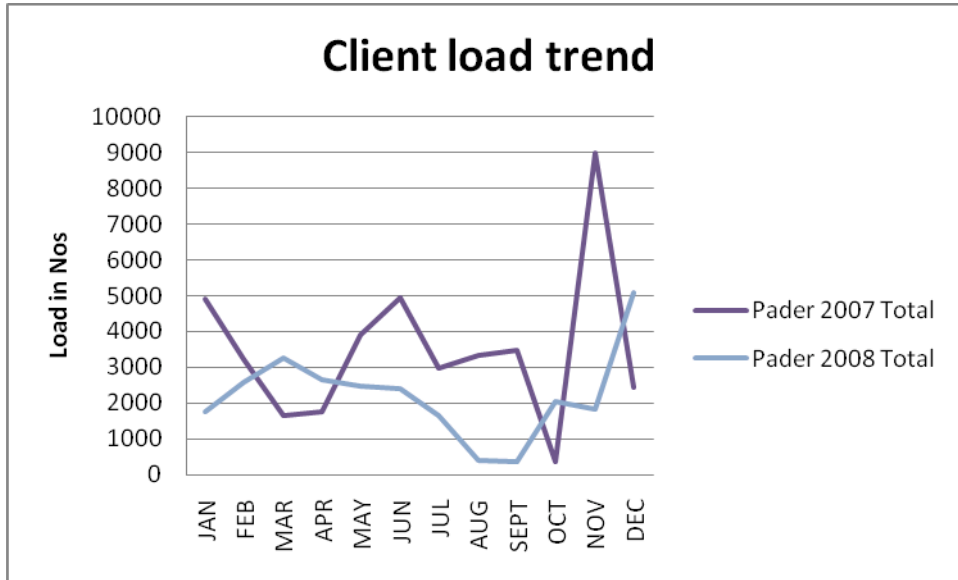


Figure 4: FP Client Load for Pader district for 2008 and 2009

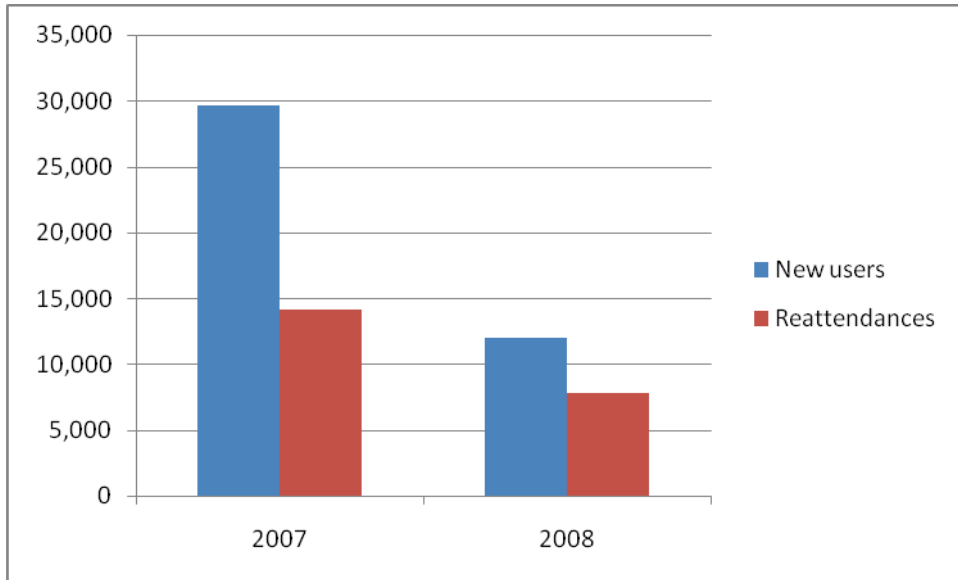


Figure 2 shows a general increase in total FP client load for Kitgum district in 2008. Kitgum district recorded a total client load of 15,965 in 2008 compared to 10,200 clients in 2007 (56% increase). The FP client load steadily increased from April 2008 up to October 2008 when it sharply dropped (Figure 1). This drop is attributed to a re-direction of district human resources towards fighting the Hepatitis E epidemic which affected the two districts in the third and fourth quarter of 2008. Pader district recorded a 46 percent decline in total client load from 43,708 in 2007 to 23,650 in 2008 (See figure 4). This drop is attributable to movement of the populations from organized camps to distant villages following the

advent of relative peace. Figure 3 however shows a steady but relatively slower rise in total FP client load for Pader district which starts from around September 2008. This increase corresponds with the start of VHT activities in the district.

Overall, there was a doubling of Couple Years of Protection in both districts. This is mainly attributed to an increase in uptake of the longer term methods of Family Planning. It should be noted however that these improvements are not attributed to the RHCS project alone. There has been a mix of other interventions that include FP training for health workers (including the long-term methods), FP outreaches by other agencies like Marie-Stopes International, (especially for long-term methods) and training of VHTs by other agencies. However, evidence that the project had a significant contribution stems from the fact that at times, people would miss insertions of implants by the Marie-Stopes teams because they would run out of stock in the health units. This was reported in both Kitgum and Pader. It therefore demonstrates that commodity security indeed has an impact on FP outputs.

Development of a pipeline data base.

The project also had a positive effect of improving the evidence base mainly through the measurement of outputs from health units. Through the regular monitoring visits conducted by both the PACE Field Officer and MTCs, PACE was able set up an electronic data-base that tracked the monthly outputs generated from the field reports. The regular stock-taking activities which provided the information that ended up in a monthly data base on key outputs by district was a major step in building an evidence base for monitoring and performance appraisal of health facilities and the districts as whole.

Sustainability of initiatives

It is evident that working through the structures and systems of MOH and the districts the project established some level of sustainability. At the national level, a RHCS strategy to guide the country on reproductive health commodity security issues for the next five years was developed. At operational levels, the capacity of districts was built through the creation of MTCs that were previously non-existent and the training of health workers in logistics management where almost all health units had a staff trained in logistics management. As already indicated above, at the community level a pool of VHTs were trained in communication skills on RH services to educate and mobilize communities for RH services and through them communities were linked to nearby health facilities resulting into establishment of a community referral mechanism. Therefore, the establishment of relevant structures at the operational level as well as the training of operational level health workers and VHTs at the community level was a key strategy for sustainability.

2.0.2 Challenges

Although the project resulted in significant achievements, there were and or are still a number of challenges both at the national and district levels that either jeopardized or may jeopardize the gains made by the pilot project and future projects. These include the following;

The MOH provided a forum for planning, monitoring and Evaluation of the project. It was also the forum for knowledge and experience sharing and where successes, challenges and lessons could be addressed and decisions made. In line with its designated role MOH guided the RHCS strategy development and ensured overall coordination of activities. The partnership forum could have done more in knowledge sharing and decision making. This however was not always the case as participatory approaches were often frustrated by weak coordination at the central level. In this regard collective decision making and

harnessing the complimentary roles of the different players were not always realized. At the district level coordination of commodity security through Medicine and Therapeutic Committees was also sometimes frustrated by the busy schedules of District Health Officers who were supposed to chair the MTC. These committees at both the district and health facility level were mandated to plan, monitor and evaluate Commodity supply chain at these levels. They also ensured proper management of Logistics management records.

The relative sizes of the partners posed a bit of a challenge in the partnership. Whereas in a small private organization like PACE decision making and action can be made faster this is not the case with a big public partner like MOH because of bureaucratic procedures involved in almost every undertaking. In this partnership for instance the development of the RHCS strategy was delayed by four months due to bureaucratic challenges related to the procurement process in the Ministry of Health, especially the recruitment of the consultant who undertook the strategy development process. Due to the delays in the development of the RHCS strategy, the implementation of project activities at the district level had to start since the funding was time bound (by December 2008)therefore an opportunity was lost to utilize the RHSC strategy in the implementation of the interventions at the district levels.

The two districts of Pader and Kitgum were affected by a Hepatitis E outbreak which curtailed project activities as district authorities had to re-direct their resources (including personnel, material and time) to stem the epidemic. Training of Medicine and Therapeutic Committees and demand creation activities in Pader and Kitgum districts, for example, had to be postponed because resources were redirected to fighting the Hepatitis epidemic

Transportation of commodities at the district and health sub-district levels remains a key challenge. HSDs do not have adequate means to coordinate the distribution of logistics and the district stores also rely on partners to deliver logistics to health units. HSDs do not have formalized drug distribution schedules. Sometimes they deliver the drugs to the health units while on some occasions, the health unit in-charges have to travel long distances to collect the drugs and they have to carry boxes of drugs using public means or bicycles. The support given by project in transportation of logistics was a supplemental commitment and therefore not sustainable in the longer term. In addition, storage facilities at the district, HSD and health facility levels are still inadequate and in a sorrowful state.

The MTC at district level is difficult to operationalize. The district Medicine and Therapeutic Committee mirrors the coordination interventions of the RHCS committee at the National level. The Committee functions as a coordination body in each of the Districts. It conducts specific meetings to ensure the efficiency and effectiveness of the supply chain and distributes RH commodities to the health facilities. The District Health Office is the Secretariat for this Committee. The membership of the MTC is however limiting. With its membership composed of high level district officials, getting the MTC structure to function is always a challenge. The MTC members are always busy with other priority activities of the districts and even when they are available to do reproductive health commodity security activities, they are curtailed by limited resources in the districts.

The Village Health Team Strategy is effective in as far as reproductive health commodity security is concerned, but is facing challenges. The Village Health Team is a health system structure that serves as a

first link between the community and the formal health providers. In this project the VHT facilitated community mobilization and provided limited services to the community. Each village however has a VHT composed of 9-10 people and there are numerous villages in any particular district. The vastness of the VHT makes the VHT strategy unsustainable. Where the VHT members were trained and supported however, they were able to identify community health needs, mobilize communities for health programs, and oversee the activities of Community Health workers.

There was a general problem of staffing norms at operational levels which in a way undermined capacity building activities. Many of the health centres were manned by Nursing Assistants, as result some of the health centres levels 111 are not able to offer long term family planning methods. Although Stock cards are available at the majority of health facilities they are not properly used when making inventory control decisions. The filling of these forms is still challenged by inadequate appropriately qualified personnel at the health facilities. The quality of Monthly Reports being sent out by health facilities to higher levels is often incomplete especially with regards to family planning commodity consumption data.

Much as there was increased client load for family planning services male resistance to family planning services was still high in the intervention districts. Women often had to seek approval from their spouses, many of whom were not supportive. This explains why the women preferred the longer term methods of family planning. Despite the presumed privacy offered by the implants, men had also learnt of their existence and some of them knew how to examine their wives to see if they had the implant. Below is a quotation from a health work during the end of project interviews to show lack of support by men for family planning services.

“Mothers have been coming back to the health facilities after a few months to remove Jadel after their husbands have realised that they are on family planning,” Acting In-charge, Kitgum Matidi Health Centre III.

2.0.3 Lessons learned and best practices

A number of key lessons were learnt from the pilot project as well as best practices. Below is a summary of the key lessons and best practices.

It is clear from the pilot project when the public and private sectors work together, bringing in their strategic advantages, experiences and competencies through concerted efforts and collaboration with other actors; reproductive health commodity security can be greatly improved through increased client load for uptake of family planning services, reduction in the lead times for delivery of commodities to districts, reduced stock outs of RH commodities , revitalization of coordination structures as well as improvement in logistic management practices at health facility levels. This can indeed go along way in helping to achieve the MDDs earlier on mentioned in this paper and consequently universal access to reproductive health services.

Partnerships are classrooms if well harnessed they promote learning. When partners come together for a shared objective, each with strategic advantages, experiences and expertise; an opportunity for each learning from the other is created. This results in acquisition of new technologies and techniques of doing things leading to improvements in reproductive health services.

In partnerships especially public-private ones the success or failure of interventions depends on the systems already inbuilt by the public sector. As the saying goes “**No chain is stronger than its weakest point**”. Whereas the private agency like PACE in this partnership played an important role in building the capacity of operational levels(districts) by revitalizing the coordination structures and ensuring improvements in logistics management practices at health facility levels, the poor staffing norms at the districts undermined these efforts..

Flexibility in planning and implementation approaches is crucial in the event of unanticipated obstacles. In this case the Hepatitis E outbreak required the implementing partners to quickly adjust to the situation and work with district leadership and communities to avert a crisis before project activities could continue. An Outbreak like Hepatitis E can however also be turned into an opportunity to advance project objectives. In the case of Kitgum and Pader, the districts invested resources in the training of Village Health Teams (VHT) to disseminate information on the epidemic. PACE took advantage of the critical mass of Village health team created to integrate family planning messages into the work of the VHT.

The Village Health Team Strategy is effective but is facing challenges. The Village Health Team is a health system structure that serves as a first link between the community and the formal health providers. In this project the VHT facilitated community mobilization and provided limited services to the community. Each village however has a VHT composed of 9-10 people and there are numerous villages in any particular district. The vastness of the VHT makes the VHT strategy unsustainable. Where the VHT members were trained and supported however, they were able to identify community health needs, mobilize communities for health programs, and oversee the activities of Community Health workers.

Capacity building activities at operational levels can have tremendous positive effects in service delivery and improving logistics management in general. Through capacity building the six components of the reproductive health commodity security namely; the right product, to the right place, at the right time, in right quantity and in the right condition are realized. Above all, needed products must be on hand when clients come for them. Therefore capacity building in a number of critical functions is of paramount importance in ensuring clients’ ability to choose, obtain, and use reproductive health products.

3.0 Conclusion:

The public-private partnership model if well harnessed can greatly improve the reproductive health commodity security in post –conflict situations and even in non conflict areas. Working towards a shared objective, utilizing the complementary strengths, experiences and expertise of constituent partners as well as collaborating with other actors, public-private partnership can help a lot in addressing the

bottlenecks in the supply chain of RH commodities and if well embraced by all relevant stakeholders can have a multiplier effect on other commodities.

The achievements made by this project prove that the private sector can have visible impacts on capacity building activities for operational levels in the public sector and it can leverage resources for these activities. It is also possible for the public health system to work with the private sector to address gaps in service delivery. Capacity building through training is the backbone of any commodity security strategy. As a result, the six components of the reproductive health commodity security namely; the right product, to the right place, at the right time, in right quantity and in the right condition are achieved. This in turn helps in ensuring clients' ability to choose, obtain, and use reproductive health products. All districts and health units should however have a critical number of staff that are trainable and capable of managing procurement and use of drugs and logistics.

The project also provided evidence that through concerted interventions and with collaboration from other actors, uptake of Family Planning services can indeed improve. In the two districts of intervention, there was a doubling or near doubling of Couple Years of Protection, even when one district had a dramatic fall in the number of clients served. There is also evidence that improving commodity security can have an impact on RH services. There were some instances where partners involved in long-term FP methods did not provide them to all the clients that needed them because they run out of stock during the outreaches.

Notwithstanding the achievements of the private-public partnership, viable strategies for addressing the challenges indicated above need to be put in place. In order for the partnership to be more effective, harnessing partnership synergy at national level and creating sustainable commodity security mechanisms needs to be re-enforced. The MOH needs to work further with partners to create viable public-partnership collaboration specifically by convening regular partnership meetings so as to nurture the partnership. Without regular meetings, such partnerships can decay, and while the lead implementer may remain active, other partners become passive. The MOH should finalize the public-private partnership policy to guide future partnerships.

4.0 Recommendations:

In a bid to address the above challenges, the recommendations below are being advanced;

In order to strengthen the Public-Private partnership on RH commodity security MOH should review, update and implement relevant policies and guidelines to prioritize RHCS. One of the key policy documents that need to be reviewed is the Public-Private Partnership for Health policy. Supervision guidelines should also be reviewed to incorporate RHCS issues.

Government should take lead in resource mobilization to ensure commodity security. Resource mobilization will have to be inclusive both of government own resources and of donors' support. In this regard the MOH should engage both government and donor in mobilizing resources for commodity security.

Since the Reproductive Health Commodity strategy is in place, it should be operationalized and the government should take lead in this. In operationalizing it, the best practices and lessons learnt from the pilot project should be a priority focus. Furthermore, the strategies utilized in the implementation of the pilot project that have yielded good and sustainable results should be adopted in the operationalization of the RHSC strategy. This will go along way in helping to address the challenges in the supply chain not only of RH commodities but also all other commodities.

The current improvements in practices related to logistics management in health units should be enhanced and sustained through regular and closer supportive supervision. Apart from the periodic monitoring activities by the MTCs, systems for routine support supervision should be strengthened, with the HSDs taking the lead. The monitoring visits should be used as an opportunity to identify skills gaps and conduct on-job skills enhancement for health workers in lower health units. In addition, in order to promote a mentoring approach to cascade the learning experiences, health units that excel after the in-service training should be used to mentor staff in other health centres.

At district level the Medicine and Therapeutic committee membership should be reviewed. Currently the MTC is composed of high level district personnel whose busy schedules compromise its functionality. It is recommended that the MTC is composed of technical staff who report directly to the District Council (the political wing of the district)

Sustainable mechanisms for reduction of lead times for all essential drugs should be taken as a priority when operationalising the new commodity security strategy. If as demonstrated in the pilot project the availability of FP logistics improved, then it is possible for the availability of other essential supplies to improve, including EmOC drugs. Therefore, the public-private partnership model as demonstrated in the pilot project should be encouraged and maintained in order to address the challenges in the supply chain of all commodities that lead to the long lead times in the deliveries to districts.

Government will have to do more to make NMS a viable player in commodity security. The mission of NMS is to ensure that the Ugandan population is efficiently provided with affordable good quality pharmaceuticals. NMS however still has to grapple with a number of capacity gaps before it is able to fulfill its mandate to procure, warehouse, distribute and supply medicines and supplies for the public sector. The NMS will have to establish and maintain systems to ensure the effective delivery of quality goods to health facilities, in addition to more accurate estimation of current and future needs as a basis for procurement planning and budgeting. Inter-linkages between MOH and NMS should be clearly defined and coordination among the two entities has to be strengthened.

There is need to develop a sustainable strategy for transportation and distribution of logistics to the sub-district and operational levels. In future projects of this kind, HSDs should also be mentored to develop formal distribution schedules for commodities at the HSD level. In a bid to improve logistics management in the districts, drug storage capacity at the HSDs and health facilities should also be

improved. The HSDs and health facilities should be supported to procure pallets, cupboards and make some renovations to create storage space.

The increased client load for Family planning services should be maintained and built on, so that they are sustainable. This should be done through creating adequate diffusion of information in the communities by maintaining the VHT approach, training adequate numbers of VHTs so that all the villages are covered especially now that people are returning from the IDP camps back to their villages; use of a multi-media approach in demand creation should be maintained but also more of interpersonal communication activities (IPC) like drama shows, peer education and counseling to allow more of one-to-one communication especially with men. The multi-pronged approach will go along way to address the lack of support by men for family planning services, misconceptions on family planning and eventually result in increased uptake of family planning services.

Government will have to invest more in establishing the Village Health Team if the VHT strategy is to function. There is still need to discuss and agree on the critical number of VHTs that need to be trained and facilitated, so as to create adequate capacity for community mobilization in districts.

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