Access to Essential Medicines & Health Supplies for

PREVENTION OF MATERNAL MORTALITY DUE TO UNSAFE ABORTIONS

A Situation Analysis

MAY 2016

HEPS FOR HEALTH RIGHTS

HEPS-UGANDA

HEPS-Uganda – Coalition for Health Promotion and Social Development – is a non-profit, health consumer organisation that advocates for the right to health, focusing on access to affordable essential medicines for the poor and vulnerable people.

ABBREVIATIONS AND ACRONYMS

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EXECUTIVE SUMMARY

Introduction

Uganda has in recent years made progress in promoting sexual and reproductive health. It has increased budgetary allocation to family planning; and put in place several policies and policy guidelines to improve provision and access family planning and other sexual and reproductive health services.

In spite of these efforts, the state of sexual and reproductive health remains poor. Only 20.4% of Ugandan women use a modern family planning method; the national contraceptive prevalence rate (CPR)[1] stands at 30%, while the 'unmet need'[2] for family planning has been estimated at 34% (UBOS 2011). The country's maternal mortality ratio (MMR) was estimated at 438 deaths per 100,000 live births 2011. It is further estimated that 54 out of every 1000 sexually active Ugandan women will procure an abortion – most of them unsafe – in their lifetime.

Study objective

The overall objective of this study was to conduct a situation analysis on essential medicines and commodities to prevent maternal mortality due to unsafe abortion and for post abortion care (PAC) in Uganda.

Methodology

The study used both quantitative and qualitative approaches, and also combined a field survey of EMHS for SRH and desk review of the policy and legal frameworks. The study was conducted in four regions of the country – East, West, Central and North for national representation of findings. A sample of 120 facilities, 30 from each sector (public, mission, private) was selected for the study as per recommendations by the WHO/HAI methodology.

The desk review analysed the national policy and legal frameworks.

Policy framework

Overall, the different policy documents highlight a set of undertakings on the part of the Government of Uganda, to generally ensure access to medicines and access to SRH services. In very limited provisions including under the 2015 Standards and Guidelines and the National Medicines Policy, the two areas are brought together and commitments are made to ensure access to medicines for SRH services.

Two key limitations are manifest in the assessment of the policy commitments and the outcome of the implementation of prior policy commitments by the government:

1 Contraceptive prevalence rate (CPR) is the proportion of married women of reproductive age (15-49 years) using at least one family planning method

2 "Unmet need" refers to the percentage of women who want to, but are not using contraception

1) First, is the chronic failure to realise the targets and outcomes of the policy commitments whose tenures have since lapsed.
2) The other major limitation of the policy commitments and action plans developed is the huge funding gap between the policy commitments and the implementation plans developed and the amount of funds projected to be available which implies that most of the plans that have been proposed may not be implemented by the end of their respective tenures.

Legal framework

Further to the policies, Uganda has number of laws that affect access to medicines for sexual and reproductive health. The laws are at different levels with the Constitution being the supreme law. **I**n addition to the Constitution, the government has worked on several parliamentary legislation to address several aspects on sexual and reproductive health.

The legal framework providing for access to medicines for SRH is largely indicative and has no real provision creating an obligation to the state to specifically ensure access to medicines for SRH services. However, the NODPOSP of the Constitution, buttressed by Article 8A create a very strong foundation for the state to build upon to mainstream access to medical services into its national legal framework.

The legal environment has not kept abreast with the policy developments of the policy arena. For example while the government has committed significant resources towards the management of PAC, the EMHS list does not provide for commodities that are essential for the management of PAC. It is therefore essential that a regulatory review be conducted to bring the regulatory framework for access to medicines in tandem with the government's policy commitments.

Availability of EMHS for reproductive health

- Most contraceptives were either out of stock or sparsely available across all sectors. The most available contraceptives were progestin-only injectable contraceptives (Depo Provera) and male condoms. Commodities that were least available include Progestin oral contraceptive pills, cycle beads for standard days method, emergency contraceptive pills and vasectomy kits.

- Mifepristone, the recommended medicine for safe termination of pregnancy, was available in only one public facility, one private facility and none of mission facilities.

- Oxytocin, used in the management of post-partum haemorrhage, was available in 94% of public facilities, 54% of private and 77% of mission facilities.

- Supportive commodities and sundries were more readily available in mission sector but availability of emergency related commodities – IV fluids and blood – was low.

- Hygiene and infection control at the facility level are a major concern as the availability of disinfectants was so low.

- Availability of HCG kits for pregnancy tests was high in mission sector (92%) but at least

two of five facilities (approx. 60%) in public and private sector facilities did not have these kits.

- At least two antibiotics for management of sexually transmitted infections (STIs) were more readily available. Doxycycline and Ciprofloxacin were respectively found in 82% and 78% of public health facilities; 84% and 95% of private facilities; and 88% and 92% of mission facilities. Beyond these two, however, the range of antibiotics in health facilities was limited.

Affordability of commodities

The field survey assessed prices of a basket of selected SRH commodities in private and private-not-for-profit facilities. Overall, the range of prices across facilities was high particularly in private sector. For example, prices of IUCDs in private sector ranged from being free to a cost of UGX 15,000 (median UGX 5,000). Misoprostol cost between UGX 2,500 - 8,000 per tablet.

Conclusion and recommendations

Availability of EMHS for prevention of unintended pregnancies, as well as for provision of safe abortions and management of complications from unsafe abortions is still a challenge in the public, mission and private sectors.

Aspects that need to be addressed are:

- There is need to review, update and clarify the law on termination of pregnancy
- The Essential Medicines List (EML) needs updating to include EMHS for SRH and family planning.
- Availability of family planning commodities need to be improved and the range of methods enhanced
- The availability of Mifepristone and Misoprostol need to be enhanced.
- Availability of IV fluids and blood needs to be improved to strengthen emergency preparedness
- There is need for service integration to ensure that as many of EMHS for reproductive health as are needed by clients are accessible

1. CONTEXT

1.1 Introduction

Uganda has in recent years made progress in promoting sexual and reproductive health. During the 2012 London Summit on Family Planning, it was one of the 20 countries that made commitments to address policy, financing, delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies. Uganda committed to increasing its annual budget allocation for family planning supplies to US $5 million per year, and to mobilise an additional US $5 million per year from development partners.

Starting Fiscal Year 2014/15, Government of Uganda (GOU) fulfilled this commitment by increasing its budgetary allocation to family planning supplies from US$3.3 million to US$6.9 million; and mobilised an additional US$5 million from UNFPA, USAID and UK DFID for reproductive health commodities.[1]

As part of the global "A Promise Renewed" campaign, Uganda developed "the sharpened plan"[2] in 2013, committing to end preventable maternal and child deaths, including averting an additional 120,000 child deaths and 6,100 maternal deaths, by 2017. Initially designed to address slow progress on Millennium Development Goals (MDGs) 4 and 5, the sharpened plan is relevant for the attainment of at least three targets of Sustainable Development Goal 3 (SDG 3): "Ensure healthy lives and promote well-being for all at all ages").[3] Access to contraceptives is critical to ensuring universal access to sexual and reproductive health services and rights as envisaged by SDG 3 and SDG 5.

In November 2014, Ministry of Health published an ambitious US$235 million Family Planning Costed Implementation Plan (2015-20), aiming to reduce Uganda's unmet need for family planning, increase the modern contraceptive prevalence rate (CPR) among married women, and increase the number of women in Uganda currently using modern contraception. The plan prioritises access to family planning by young people, addressing family planning myths, policy implementation, and improving commodity security.

In 2015, Ministry of Health launched Standards and Guidelines for Reduction of Maternal Mortality and Morbidity Due to Unsafe Abortion, to provide guidance to health providers regarding the equipment, skills and facilities necessary for provision of abortion-related services (including violence and STI prevention), gender and rights, supporting the provision of non-judgmental,

1 Uganda official FP2020 progress report. http://www.familyplanning2020.org/entities/80

2 The formal title is, "A promise renewed: Reproductive maternal, newborn and child health sharpened plan for Uganda" (November 2013)

3 **SDG Target 3.1**: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; **Target 3.7**: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; **Target 3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. https://sustainabledevelopment.un.org/sdg3

youth-friendly services, counselling and care. The guidance document also explains the laws and policies regulating provision of abortion-related services.

In spite of these efforts, the state of sexual and reproductive health remains poor. Only 20.4% of Ugandan women use a modern family planning method; the national contraceptive prevalence rate (CPR)[4] stands at 30%, while the 'unmet need'[5] for family planning has been estimated at 34% (UBOS 2011). Ugandan women on average produce 1.6 more children than they would want to; the total fertility rate is estimated at 6.1 (UBOS 2011). Teenage pregnancy is high – estimated at 25% – and contributes to the high prevalence of unsafe abortions and maternal mortality and morbidity.

Overall, the country's maternal mortality ratio (MMR) was estimated at 438 deaths per 100,000 live births 2011. This translates to at least 6,000 women dying every year – or 16 deaths per day – from pregnancy-related conditions alone (MOH 2015). Up to one quarter of these deaths (26%) are linked to unsafe abortions.

According to the latest Uganda Demographic and Health Survey (UDHS), an estimated 1.5 million pregnancies occur in Uganda per year (UBOS 2011). About 56% of this total are unintended. One third of the unintended pregnancies (30%) end up into induced abortions. In terms of numbers, 400,000 abortions are induced by all kinds of women but the vulnerable women, such as the rural poor and those with disabilities suffer more severe consequences because of their inability to secure safe abortion options.

It is estimated that 54 out of every 1000 sexually active Ugandan women will procure an abortion – most of them unsafe – in their lifetime, which is far above the East African average of 38.

Out of the estimated 400,000 induced abortions that take place in Uganda each year, at least 90,000 of them lead to severe health complications, of which an estimated 1,500 end up in death. Many more women suffer from abortion-related complications that are serious, debilitating or life-threatening (MOH 2015).

It is estimated that at least Ushs35 billion was spent on treating more than 100,000 cases of post-abortion cases in 2010, including costs related to medicines, labour, supplies, infrastructure, and other things (Guttmacher Institute 2014). The cost, to the health system, of treating complications from unsafe abortions is equivalent to 4.1% of total government spending on healthcare in Uganda (MOH 2015).

4 Contraceptive prevalence rate (CPR) is the proportion of married women of reproductive age (15-49 years) using at least one family planning method

5 "Unmet need" refers to the percentage of women who want to, but are not using contraception

1.2 Rationale

The Coalition to Stop Maternal Mortality Due to Unsafe Abortion (CSMMUA), a multidisciplinary Ugandan civil society coalition, has since 2012 engaged in advocacy, education, research and legal analysis to tackle preventable maternal deaths caused by unsafe abortion. One of the pillars of the Coalition's work is to increase access to safe services for prevention and management of unwanted pregnancy.[6] Advocacy over the last few years has emphasized clarifying the legal and policy framework and fighting stigma among health workers and within the community.

A tremendous advocacy opportunity has opened with the launch of the Ministry of Health Standards and Guidelines to Reduce Maternal Mortality Due to Unsafe Abortions in 2015. Section 3, Standard 5 of the Standards and Guidelines states that "*commodities and supplies appropriate to the level of service provision should be available at all times"* (MOH 2015).

This survey has been undertaken to build on the current policy gains, to inform advocacy for increased access to essential medicines and commodities to prevent maternal mortality due to unsafe abortions.

1.3 Study objectives

The overall objective of this study was to conduct a situation analysis on essential medicines and commodities to prevent maternal mortality due to unsafe abortion and for post abortion care (PAC) in Uganda.

The specific objectives were:

1) Assess the extent to which national policies and laws provide for access to medicines for SRH services
2) Determine availability and prices of a basket of EMHS for prevention of pregnancy and management of abortion at public and private health facilities within the public, private and mission sectors
3) Determine stock-out days for basket of EMHS for prevention of unintended pregnancies, provision of safe abortion and management of complications from unsafe abortions

6 CSMMUA Strategic plan

2. METHODOLOGY

2.1 Study Design

The study used both quantitative and qualitative approaches, and also combined a field survey of EMHS for SRH and desk review of the policy and legal frameworks. The quantitative approach utilised semi-structured questionnaire adapted from the standardized WHO/HAI Medicine Prices Monitoring Tool.[7] A list of key medicines and health supplies was selected for price and availability survey. The highest and lowest-priced medicines available on pharmacy shelves and in stores were considered for data collection from facilities accredited by MOH. Qualitative approaches were done using a key informant interview guide with health facility managers or in-charges of facilities.

2.2 Study areas, population, sample size, selection criteria

The study was conducted in four regions of the country – East, West, Central and North for national representation of findings. The official 2012 inventory of health facilities accredited by MOH was used to select facilities. Health facilities were randomly sampled from the list. A sample of 120 facilities, 30 from each sector (public, mission, private) was selected for the study as per recommendations by the WHO/HAI methodology.

The desk review analysed the following policies and laws. Policies include:

- Uganda Vision 2040
- The Second National Development Plan 2015/16 – 2019/20 (NDPII)
- The Second National Health Policy (2010/11-2019/20)
- The National Health Sector Development Plan (2015/16 - 2019/20)
- Uganda National Medicines Policy 2015
- National Pharmaceutical Sector Strategic Plan III 2015–2020
- National Adolescent Health Policy, 2004
- National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2012
- National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda, 2015
- National Youth Policy, 2001

The laws include:

- The Constitution of Uganda, 1995
- National Drug Policy and Authority Act
- National Medical Stores Act, 1993
- Local Government Act, Cap 243
- Public Procurement and Disposal of Public Assets Act, 2003
- Investment Code Act, Cap 92
- Industrial Properties Act, 2014

7 www.haiweb.org/medicineprices

2.3 Medicine and Supplies List

The following basket of EMHS were surveyed:

1) Combined oral contraceptives
2) Progestin only contraceptive pills
3) Progestin only inject able contraceptives
4) Male condoms
5) Female condoms
6) Intrauterine contraceptive devices (IUCD)
7) Implants
8) Cycle beads for standard days method
9) Emergency contraceptive pills
10) Vasectomy kits
11) Tuboligation kits

Medicines for management of abortion:

1) Mifepristone
2) Fefolate 60mg
3) Oxcytocin inj
4) Misoprostol
5) Antibiotics: Amoxicillin, Ceftriaxone, Gentamicin, inj. Metronidazole
6) Doxycycline
7) Ciprofloxacin
8) Pain management analgesics: Paracetamol, Ibuprofen, Diclofenac
9) Inj. Pethidine
10) Diazepam

Instruments and other sundries:

1) Manual vacuum aspiration kits (MVA)
2) Speculum
3) Cervical dilators
4) Curate
5) Sponge holding forceps
6) Ultra sound scan
7) HCG kits
8) Fetal scope
9) Evacuation bed
10) Sterilizer machines
11) Flowing water
12) Gauze
13) Cotton
14) Gloves, (sterile and disposable)
15) Drip stands
16) Syringes
17) Antiseptic, (chlorhexidine/Alcohol)
18) IV fluids
19) Blood

2.4 Sample Selection

Uganda has several levels of facilities, from hospitals down to health centres or dispensaries. Lower level facilities are often more widely dispersed than upper level ones. The MOH inventory of health facilities was stratified per level: Hospital, Health Centre IV, Health Centre III, and Health Centre II. Facilities were randomly selected from levels expected to offer reproductive health care (from HC III) as per table below.

Table 1: Sampling regions and facilities

	Sampling
Geographic areas	*Country split into 4 regional blocks with probability proportional to population size: central, northern, western and eastern*
Total facilities	120
Public health facilities with pharmacy / main dispensing units for outpatients	*1 public hospital (district or regional) per area; 5 randomly selected public facilities*
NGO/mission health facilities	*Randomly selected NGO/Mission health facility that would both be expected to provide reproductive and maternal health services*
Private for profit facilities	*1 randomly selected licensed private health facility per public facility*

Public health facilities were used to anchor the sample, with other types of facilities (by ownership, i.e. non-government (NGO) or mission, and private) chosen by their proximity to these facilities from a list of all public health facilities in each survey area that are roughly within a three-hour drive[8] of the main government health facility in the relevant district. This was meant to reduce survey costs such that if no NGO/Mission or private facility was available within three-hours' drive of the anchor public facility, then no data was collected from such facilities.

NGO/mission and private facilities within three-hours' drive of an anchor public health facility were selected randomly until a sample of 30 facilities was reached per region.

2.5 Survey Team

The study involved the following personnel:

- Project Coordinator/ Principal investigator,
- Survey Manager
- Eight associate researchers familiar with medicine surveys, and based in the four regions (6 pharmacists and 2 social scientists) working in pairs
- Two data entry clerks

8 WHO/HAI standard methodology

2.6 Survey Process

2.6.1 Selection of data collectors

HEPS-Uganda has a network of research associates across the country. Selection of survey data collectors was dependent on regions/districts where the data collectors were based/ resided, their competencies for the survey as well as their availability during the survey period. These data collectors were responsible for collecting quantitative and qualitative data at health facilities.

2.6.2 Establishment of an advisory committee for process management

HEPS-Uganda conducted this survey with guidance from an advisory committee composed of experts in the field of reproductive health. The committee provided overall guidance to the survey; reviewed data collection tools; made quality assurance visits; and reviewed draft reports. Members of the committee were drawn from CSMMUA, Ministry of Health, and Uganda Family Planning Consortium.

Data collection procedures, instruments and quality assurance

2.7.1 Data collection

Prior to data collection, all data collectors were involved in three days' training and field test. Data collectors worked in teams of two coordinated by the Survey Manager. For each medicine included on the data collection form, availability, stock out duration as well as the price (if applicable) was noted. The data was recorded by interviewing the attendant in the outlet; the data collectors asked to see the items as well. Also using stock cards of the various commodities at the different stores, data collectors noted stock outs experienced in previous six months before the survey and for various stocked out medicines the number of days of stock out was recorded.

2.7.2 Quality assurance

The Survey Manager was responsible for dealing with queries and communicating with data collectors to ensure that any issues that arose during data collection were managed. A quality assurance team travelled to selected areas to ensure data quality.

Multiple quality assurance processes were used. The advisory team provided overall quality assurance to review the survey process, tools and reports. The developed survey tools were pretested before survey and prior to data collection, all survey personnel participated in training and field test.

Each regional/district team together with their supervisor on a daily basis cross-checked all data collected for completeness, legibility and consistency and communicated with field coordinator. The field coordinator was also validated data collection in 10% of the sampled outlets. This was done by visiting or calling the outlets on the same day that the data collectors visited.

The field coordinator checked all the relayed data for completeness and consistency. Random selection was conducted of some relayed data and verified by telephone and field visits to ensure accuracy of the data.

2.8 Data management and analysis

At the end of data collection, the data collectors sent filled forms to the HEPS Secretariat where data was processed and analysed for final report. The statisticians worked with field coordinator to ensure data quality. Double entry for data was used to flag out errors and the workbook and software underwent preliminary tests to ensure the system was free of bugs. The workbook was made in such a way to easily identify outliers and anomalies in the data and have them corrected.

Qualitative data from paper and audio recorders was subjected to content analysis according to questions in the survey. Themes were generated from data and the information was used to enrich quantitative data in report. Also some direct quotes were extracted for report but names of respondents were concealed.

The availability of individual medicines was calculated as the percentage of sampled medicine outlets where the medicine was found. Data were reported in aggregate as public, private or mission sector medicine outlets. Overall availability per sector was calculated as median of medicines surveyed.

For stock data, facilities that had not stocked a particular medicine for six months prior to survey were expressed as a percentage of total number of facilities. For those that reported to have had the medicine in the previous six months, a monthly average of stock-out days was calculated. The median, minimum and maximum unit prices of medicines and commodities were recorded in Uganda Shillings.

Medicine prices obtained during the survey were expressed as ratios relative to a standard set of international reference prices (Management Sciences for Health, 2014).

$$Medicine.\ Price.\ Ratio..(MPR) = .\frac{median.local.unit.price}{international.reference.unit.price}$$

Medicine price ratios were calculated only for medicines with price data from at least four medicine outlets. The exchange rate used to calculate MPRs was 1$ = UGX3667.9. This was the mid-rate (average of purchase and sale rate) taken from Bank Uganda website on the first day of data collection.

The 2014 Management Sciences of Health (MSH) reference prices were used, taken from the International Drug Price Indicator Guide (Management Sciences for Health, 2014). These reference prices are the medians of recent procurement prices offered for generic products by for-profit and not-for-profit suppliers to international not-for-profit agencies.

Affordability of commodities

Affordability was calculated based on the number of days it requires to pay for standard treatment or dose of treatment. Affordability was determined based the daily income of the lowest-paid unskilled government employee. The daily wage of the lowest paid government worker (attendants) is approximately UGX 6255 (USD 1.78) as per Uganda Ministry of Public Service salary structure[1]. Treatments that require more than one day's wages to purchase are considered unaffordable.

2.9 Ethical Considerations

2.9.1 Obtaining informed consent

- Introduction letters from Ministry of Health endorsed by District Health Officers were used to introduce the data collectors to the respondents.
- Institutional approval was received from Joint Clinical Research Centre (JCRC) Institutional review Board.
- Interviewers visited the selected facilities, identified in-charges to explain the study and identify other potential interviewees for example stores and dispensing personnel, if potential participants were not interested, the facility was replaced with nearest facility of the same level.
- Once an eligible respondent was available, the interviewer carefully reviewed the whole study outline so that the participant fully understood what was being requested, this was to ensure honesty of respondents. Participants were also informed that they could exit the study at any point in time without any consequences.

2.9.2 Special populations and vulnerable groups

The study did not include community members and therefore no interviews were held with any special and vulnerable groups.

2.9.3 Foreseeable risks

The study involved no more than minimal risks to the participants. Participants were asked to spend no more than one hour of their time to complete a survey. Participant names and other identifying information were kept confidential and linked to a unique participant identification code. Once data collection was complete, and the data was entered into paper and electronic database, participant names and other identifying information were removed.

3. UGANDA'S POLICY FRAMEWORK ON ACCESS TO MEDICINES

3.1 Uganda Vision 2040

The Uganda Vision 2040 is centred on transforming Ugandan society from a peasant to a modern and prosperous country within 30 years. The Vision explains aspirations for national development including access to affordable quality health and education services. There are no specific targets set for access to medicines and the only reproductive health specific target set is reducing maternal mortality to 15 deaths for every 100,000 live births.

To transform the health sector, the Vision aims at among others transforming health care delivery from the present facility based system to a household based health delivery system by empowering households to take better preventive control of their health, undertaking public-private partnerships to improve access to highly specialized services and developing a universal health insurance system. Even then, one can infer from the policy that industrialisation on pharmaceutical manufacturing is one of the long term goals of the government.

This would contribute towards commodity security as the country would run away from relying on importations of essential medicines including those for sexual reproductive health rights. Even then, the absence of some short and medium term targets on access to medicines is a big setback for access to medicines of sexual reproductive health.

3.2 The Second National Development Plan 2015/16 – 2019/20 (NDPII)

The National Development Plan (NDP) is the normative framework that seeks to operationalize the realisation of the objectives and targets of Vision 2040 by stream-lining development between the year 2015 and 2020 (The Republic of Uganda, June 2015). The Second National Development Plan (NDP II) is the second in the National Development frameworks for Uganda and is designed to build on the achievement of the NDP I. It undertakes to serve as a point of reference in all government planning with the objective of eliminating parallel planning that was a key challenge to NDP I. As far as access to medicines is concerned, the NDP II reports that the proportion of facilities without stoke-outs increased from 43% to 53% with most products and technologies being imported because of a low and immature local manufacturing capacity.

The NDP II recognises the players in the promoting health in addition to the government including non-governmental organisations (NGOs), indigenous traditional and complimentary health practitioners and communities and households. The NDP does not make any specific undertaking to increase access to medicines for SRHRs but this undertaking can be read into several commitments that are aimed towards improving health care delivery.

In order to contribute to the production of a healthy human capital through provision of equitable safe and sustainable health services, the NDP purposes to procure, distribute appropriate medical equipment at all levels and build capacity to operate and maintain medical equipment. It also undertakes to provide quality and affordable services that are consistent with the Uganda National Minimum Health Care Package and establish National Referral System from community, national and foreign levels of health care.

While no express mention of access to sexual reproductive health commodities is made under the policy, the importation of a commitment on ensuring quality and affordable services within Uganda's minimum health care package without a doubt introduces a strong pointer for engaging the government on access to the basic sexual reproductive health commodities which are already spelt out under documents such as the essential medicines list.

3.3 The Second National Health Policy (2010/11-2019/20)

The National Health Policy is informed by the National Development Plan and was designed to streamline the government policy as far as the health sector is concerned. The National Health Policy II (NHP II) focuses mainly on health promotion, disease prevention, early diagnosis and treatment of diseases (Ministry of Health, 2010). It was designed to prioritise effective health care delivery with a focus on early diagnosis and treatment of diseases, efficient utilisation of resources, strengthening of public and private partnerships for health and strengthening the health system. In that regard, the NHP II prioritises the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP) which is proposed by the second Health Sector Strategic Investment Plan (HSSP II).

The NHP II underlines the organisational set up of health care delivery of Uganda and recognises Ministry of Health as the key policy formulating, resource mobilising, budgeting and strategic planning institution in the government. It also recognises the other agencies that play a major role in health care delivery including the National Medical Stores and the National Drug Authority that play key functions in ensuring access to medicines in Uganda.

Reporting on the state of supply of medicines, the NHP II noted that by 2008 only 28% of all health facilities in Uganda had a constant supply of medicines and health supplies throughout the year. This it stated was because of the inadequate financial and human resources, capital investment and management issues that persisted in the supply chain for medicines in Uganda. Also it was reported that as a result of the low levels of pharmaceutical production in Uganda, up to 90% of all medicine supplies in Uganda are imported with 95% being generic products.

Acknowledging the shortage of medicines and health supplies as a key bottleneck for service delivery, the NHP II undertook to ensure that all essential medicines and health supplies are available and rationally used in health facilities at all times. To this end, the Policy undertakes to among others ensure adequate financing for essential medicines and health supplies, promote regional cooperation on medicine regulation and bulk purchasing, encourage local pharmaceutical production and ensure compliance with Standards of good manufacturing practices, promote support and sustain interventions that ensure efficient medicines and health supplies management, prescribing, dispensing and use.

This policy further points to the importance of scaling up supply of medicines including through encouraging local pharmaceutical production. It also indicates the key actors in the medicines sector such as the national drug authority and the national medical stores. Following from the policy, it is therefore important to ensure that these national actors are engaged on their roles in ensuring access to sexual reproductive health medicines. For instance, the NDA would be engaged on its roles of ensuring the efficacy and safety of medicines relating to family planning.

Similarly, the NDA needs to be engaged to play its central of ensuring that medicines that are used in comprehensive abortion care are cleared and brought to the Ugandan market. Similarly, the engagement of the National Medical Stores (NMS) on efficient and timely delivery of SRH related medicines in critical.

3.3 The National Health Sector Development Plan (2015/16 - 2019/20)

The National Health Sector Development Plan (HSDP) flows from the policy framework proposed by the NDP II and the NHP II to provide a mid-term planning framework for the health sector. It focuses on business and investment plans and the budgeting process for the health sector (Ministry of Health, 2015). The business and investment plans provide health service programmes, system areas like human resources, parastatals and districts with sector targets and priority intervention areas. The sector budgeting process on the other hand provides the financing direction for the sector by providing for the key health sector investments that require funding and the outcomes that may result from such funding.

The HSDP sets its goal as the acceleration of universal health coverage. The objectives that have been identified include contributing to a healthy human capital through provision of equitable, safe and sustainable health services, increasing financial risk protection of households from health expenditures, addressing key determinants of health through strengthening inter-sectoral collaboration and enhancing the regional and global competitiveness of the health sector.

The HSDP proposes a cross-section of strategic interventions to realise the above objectives and also sets targets that should be achieved during the term of the HSDP. The targets set in relation to sexual reproductive health include:

- Reducing the maternal mortality ratio to 320 deaths per 100,000 live births
- Reducing the adolescent pregnancy rate from 24% to 14%
- Increasing ART coverage from 42% to 80%
- Increasing the number of HIV+ women receiving ARVs for PMTCT during pregnancy and delivery from 72% to 95%
- Increasing contraceptive prevalence rate from 30% to 50%

To generally improve the availability of and access to medicines, the HSDP purposes to overcome supply bottlenecks that are existent in the health sector today and to increase the stock of the health medicines and supplies procured by the government. The HSDP identifies areas that need intervention to include regulation and quality assurance, local production of pharmaceuticals, procurement, warehousing and distribution of health medicines and supplies and the rational use of essential medicines and health supplies . To this end, the HSDP proposes to strengthen the policy and regulatory framework for quality assurance and to strengthen post-marketing surveillance and pharmacovigilance of essential medicines.

The HSDP also proposes to promote local production of pharmaceuticals and strengthen the capacity of facility staff to quantify and forecast medicines and supplies needs in addition to procuring sufficient amount of medicines and health supplies. However, lacking from these strategies is a specific attempt to redress inequities pertaining to access to medicines in Uganda today particularly for sensitive needs like access to contraceptives for youth and adolescents and supply bottlenecks that frustrate supply of medicines to hard-to-reach areas across the country.

The HSDP proposes various mechanisms for its financing however its key limitation is that the government commits very minimal resources to support its implementation with the bulk of the financing needs being placed on the international development partners and individual out of pocket financing. This raises concerns of both sustainability of health sector financing but also creates favourable conditions for household catastrophic expenditure which may frustrate the proposed intervention to reduce household impoverishment through sustainable health services.

That notwithstanding, the HSDP also predicts incremental financing gaps starting from its first year of implementation and increasing up to its final year of implementation. This implies that some of the propositions made in the plan will definitely not be realised as sacrifices will have to be made in light of the clearly manifest funding gaps.

One of the key strengths of the HSDP is that it outlines the management and implementation framework responsible for realisation of its objectives. The structure that has been explained and illustrated is however, merely descriptive and explains the generic roles of each of the authorities and agencies in the health sector but does not clearly indicate how they will be responsible for implementing the specific strategies of the HSDP. A clear indication of specific roles in relation to the commitments of the HSDP in addition to the stages of intervention would have been necessary in terms of ensuring accountability but also facilitating monitoring and evaluation of the implementation of the HSDP.

Despite these weaknesses in the plan, there are clear indications which advocacy on access to medicines for SRH can follow up including the dealing with challenges within the supply chain and investments in local production of medicines. The policy also emphasises the regulation and quality assurance of medicines which is critical for SRH health related medicines.

3.4 Uganda National Medicines Policy 2015

The Uganda National Medicines Policy (NMP) builds on the developments of the National Drug Policy of 1993 and 2002 to streamline mechanisms to ensure access to medicines in Uganda (The Ministry of Heath, July 2015). The goal of the NMP is stated as the progressive realisation of the highest attainable standard of health by Ugandans, by ensuring access to medicines. The NMP hinges its objectives on facilitating the progressive realisation of UHC by making available medicines needed for comprehensive essential services, making available a range of EMHS to all people based on their needs and ensuring efficient use of available limited resources for EMHS, and increasing the effectiveness of service delivery and improve patient safety through investments in quality of care.

The NMP proposes investment in a cross section of focus areas aimed at ultimately facilitating the financing, procurement, supply and use of medicines in Uganda. These areas include utilisation of available funds, improvement of medicines use, improving the flow of pharmaceutical information within the health system, increasing the public financing for the EMHS, private sector involvement in policy implementation, establishment of the district pharmacists, strengthening the independence and autonomy of the National Medicines Authority and strengthening the supervision and regulation of pharmacists practice.

The key stakeholders who have a role in ensuring access to medicines include:

- Ministry of Health whose Pharmacy Division is responsible for sectoral coordination and quantifying national pharmaceutical requirements and harmonising the supply chain management,
- NDA which is responsible for quality assurance of all medical products in Uganda,
- National Medical Stores (NMS) that is responsible for procuring, warehousing and distributing pharmaceutical products to public health facilities,
- Joint Medical Store (JMS) that is responsible for procuring, warehousing and distributing pharmaceutical products to Private-Not-for-Profit (PNFP) health facilities
- Medical Access Uganda Limited (MAUL) which that distribute HIV related medicines
- Uganda Health Marketing Group (UHMG) which reproductive products

The NMP sets a number of policy objectives and strategies aimed at improving the local production, local procurement and supply, the distribution and use and the management of EMHS in Uganda. The NMP for example undertakes to create standards for selection, quantification and procurement of medicines while at the same time seeking to improve inventory management by setting maximum and minimum stocks for pharmaceutical products and improving local manufacturing by providing incentives to local pharmaceutical manufacturing companies and minimising importation of quality EMHS that can be produced locally.

Just like the sectoral policies, the NMP does not specifically provide for EMHS for SRH services but proposes measures to generally improve access to quality and affordable medicines within the health system in Uganda. The policy however indicates that extra funds are needed to cater for the growing population, and the increasing need for family planning. It also cites the NDP which emphasises the importance of universal access to family planning services.

If most of the policy objectives and their strategies can be translated into a clear operational plan, it can be expected that some of the benefits that will be derived by implementing the NMP across the health sector will also be reflected in the delivery of SRH services and yet it is important that such a plan should also appreciate the uniqueness of the needs for the EMHS pertaining to SRH services. The policy in a unique way expands the stakeholders in the medicines sector to include a number of non state actors. This points to governments commitments towards public-private partnerships in ensuring the citizens access essential medicines. It therefore means that strategic efforts on access to SRH medicines need to be opened up to other non state actors in the country.

3.5 National Pharmaceutical Sector Strategic Plan III 2015–2020

The National Pharmaceutical Sector Strategic Plan III (NPSSP III) provides a roadmap for investments and interventions to improve access to essential medicines and pharmaceutical services in Uganda. It outlines the priority issues to be addressed in the areas of regulation and legislation, supply chain, medicines use, medicines financing and pricing, taking account of the health sector and overall national development agenda (Ministry of Health, 2015).

The Plan highlights key indicators that reflect the health situation in Uganda and notes that communicable diseases are responsible for the highest number of life years lost in Uganda. It however, also notes that non-communicable diseases are increasingly presenting a major burden. It also highlights the major stakeholders in health care delivery in Uganda and for the first time underlines the role of traditional and complementary medicine practitioners in addition to private not for profit and private for profit under the private sector.

The Plan reports that while the NDA has expanded its regulatory efforts to include both private and public sector actors and the quality of pharmaceutical imports has since improved, there has been an increase in adverse reactions to drug use and pharmacovigilance is still not well implemented.

Funding for medicines by the government remains extremely poor considering only 6.9% of the total budget for the year 2015/16 was allocated to the health sector with UGX219 billion being allocated towards the annual medicines needs of Uganda in 2014 which is an overall per capita expenditure of about US$2.4 way below requirement of US$12.4. The pharmaceutical sector is also particularly exposed being funded up to 70% by donors and a high out of pockets expenditures.

The Plan identified several challenges facing the pharmaceutical sector including lack of clarity in definition of roles of medicines regulators, poor quality and inadequate storage facilities for medicines and health supplies, poor dispensing and prescribing practices for medicines, insufficient number of pharmacy professionals who are also poorly motivated and overworked and the lack of a central agency to conduct pharmaceutical research.

To overcome these challenges, the Plan undertakes to address factors that may impede effective utilisation of pharmaceutical services to ensure that the services provided are responsive to the legitimate needs of the clients. The Plan undertakes to define the essential package of EMHS that will ensure all essential services can be provided country wide and provide a basis for reimbursement for social health insurance schemes, optimise the referral system including defining the nature of pharmaceutical care to be provided at each level and the attendant skills and competencies required to deliver the service, increase investments in specialised pharmacy services to ensure a higher quality of care and promote the use of appropriate technology to improve service delivery among others.

While the Plan makes very commitments and undertakings for the removal of barriers to accessing medicines in the pharmaceutical sector generally, no effort has been made to prioritise providing access for sexual reproductive health which is a key area of concern in the health sector. While there is no doubt that all of these measures if implemented will have an impact on the ability of people to access medicines, it is important that deliberate effort be implemented in the context of sexual reproductive health to ensure access to medicines.

3.6 National Adolescent Health Policy, 2004

The National Adolescent Health Policy (NAHP) recognises the integral role of adolescents in national development and seeks to protect and enhance their health and wellbeing (Ministry of Health, 2004). The policy is designed for individuals between 10 and 24 years with the adolescents being the people between 10 and 19 years and the youth being the people between 20 and 24 years. Justifying the need for the NAHP, the policy notes the large contribution that unwanted pregnancies makes to the high number of maternal deaths in Uganda and also underlines the increasing incidence and prevalence rates of HIV/AIDS in Uganda.

The policy aims at mainstreaming adolescent health concerns in the national development process with the focus on highlighting adolescent health concerns to policy makers, legal and socio-cultural development, capacity development of health service providers and health facilities and advocating for resource allocation among others.

The NAHP presents a cross-section of thematic objectives including:

- increasing contraceptive use, increasing the practice of dual protection,
- integrating post abortion care into health centres up to HC1 level
- increasing percentage of mothers receiving tetanus toxoid during pregnancy
- increasing proportion of adolescents accessing ARVs treatment
- integration of emergency contraceptives among others.

These objectives were designed to be achieved through increased advocacy, communicating behavioural change mechanisms for youth and adolescents, training of health workers and social workers to handle adolescent health issues, resource mobilisation to support adolescent health, increase in research, development adolescent friendly services and improving sectoral coordination and monitoring and evaluation among others.

The institutional framework for the implementation of the policy is pivoted on a proposed National Steering Committee on Adolescent Health to be established by Ministry of Health and which consists of a cross section of stakeholders working in areas related to adolescent health. The policy also recognises other ministries like the Ministry of Finance, Ministry of Education and Sport and the local governments among others and the roles they play in the promotion of adolescent health in Uganda.

3.7 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2012

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2012 are the third in a series of policy guidelines and service standards developed by Ministry of Health for the purpose of setting standards and providing guidance for reproductive health services in Uganda (Ministry of Health, 2012). The policy guidelines prescribe the rules and regulations governing reproductive health services, what the services should contain and target priority groups for reproductive health service provision among others. The service standards on the other hand prescribe the minimum acceptable level of performance and expectations for the components of reproductive health services and the attendant roles of the service providers across the levels of health service delivery.

The guidelines and service standards are meant to be used to guide planning and implementation of reproductive health services, identify types of services to be provided at the various levels across the health service delivery points and to give guidelines on targets and priorities for training and delivery of reproductive health services. To that end the guidelines and service standards aim to improve sexual and reproductive health by guiding the planning, implementation and monitoring of reproductive health services, standardising reproductive health services, ensuring the optimum and efficient use of resources for the sustainability of reproductive health services and promoting sexual and reproductive health rights.

The roles of various stakeholders in the implementation of the guidelines and services standards are defined including the Reproductive Health Division at the Ministry of Health which is responsible for among others policy initiation and formulation, resource mobilisation and capacity building. The health facilities including the regional and national referral hospitals, Health Centres IV, III, II, and I are mandated to deliver a cross-section of reproductive health services at their respective levels including provision of integrated reproductive health services, emergency obstetric care, community mobilisation and distribution of SRH commodities among others.

The Guidelines and Service standards propose a number of measures for delivery of medicines and commodities for reproductive health. NMS, JMS and district local governments are obliged to ensure the availability of standard commodities and supplies of optimum quality and quantity at all times. The policy prescribes standards for procurement of SRH supplies and commodities, their storage at the national level but NMS, JMS and at the district levels by the district/Sub-District Medical Stores and at the facility level in approved storerooms, and their distribution in accordance with the agreement between the Ministry, district authorities and central warehouses.

The guidelines and service standards cover a number of thematic areas for reproductive health care services including family planning and contraception use under which the use of a number of commodities for family planning and contraception is proposed including both artificial and natural contraception methods, safe motherhood including both maternal and newborn health care, treatment of obstetric fistula, provision of adolescent sexual and reproductive health services, integration of STI/HIV treatment and sexual reproductive health services and treatment of infertility among others.

3.8 National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda, 2015

The National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (2015 Standards and Guidelines) recognise the contribution of unsafe abortion to the high rates of maternal mortality and proposes measures through which the latter can be reduced by reducing the former (Ministry of Health, 2015). Launched in 2015, the Standards and Guidelines include measures for primary prevention of unsafe abortion, the management of unintended and risky pregnancies, provision of post abortion care and monitoring and evaluation of abortion.

Standards and Guidelines for the primary prevention of unsafe abortion include empowerment of youth with information on SRH services especially access to contraceptive services, ensuring the availability, accessibility of quality reproductive health programmes and services for youth, integration of family planning and contraceptive services in the health sector at all levels and development of appropriate health systems for provision of family planning and contraceptive services through appropriate staffing and ensuring accessibility family planning services among others. The Standards and Guidelines provide for the needs of survivors of sexual and gender based violence, through provision of emergency contraception at facility and community based health care providers.

On the management of unintended and risky pregnancies, Standards and Guidelines permit trained health professionals, in good faith and with reasonable skill and care, to provide safe abortion services to preserve the life or health of the pregnant woman or girl taking into consideration the circumstances of the case. Women and girls undergoing termination of pregnancy should be counselled for the contraception and offered a full range of methods available to make their freely informed choice. The 2015 Standards and Guidelines also require that termination of a pregnancy within the first 12 weeks of gestation should be conducted only with misoprostol or in combination with mifepristone. Among the quality care guidelines for the termination of a pregnancy, patients should be given prophylactic antibiotics before surgical uterine evacuation where possible.

Post abortion care (PAC) can only be provided by trained, qualified, registered and skilled professionals including medical doctors, clinical officers, nurses and midwives in a registered health facility with appropriate equipment and health supplies. PAC services can be provided through surgical operations and medical evacuation using misoprostol. Facilities providing PAC services are required to provide a mix of contraceptive services according to their level of care and skill of providers and where a patient's preferred method of contraception is not available they should be immediately referred to a facility with the preferred method while at the same time being provided with an interim method of contraception.

The 2015 Standards and Guidelines are essentially a paradigm shift in the prevention and management of termination of pregnancies in Uganda. They provide the principles, prescribe standards and establish guidelines for health service providers through which the measures can be undertaken to prevent unwanted and risky pregnancies and where they occur to propose safe methods of termination of such pregnancies and where unsafe terminations have been conducted to manage the complications arising from such unsafe terminations.

3.9 National Youth Policy, 2001

The National Youth Policy (NYP) is the policy statement of the government on its approach to fulfilling the potential of the youth, being people between 12 and 30, as they transition into the most productive age group of the country (The Ministry of Gender, Labour and Social Development, 2001). The NYP is not meant to replace any sectoral policies with components applicable to the protection of the youth but is meant to provide inter-sectoral links to promote the development of the youth through the clearly identified government priorities.

The policy outlines the principles upon which its implementation is to be based including equity and accessibility of programmes, services and resources, gender inclusiveness especially for disadvantaged and marginalised youth, participation of youth in democratic process and youth empowerment through creating conducive socio-cultural and economic environments among others. The NYP takes a rights approach to recognise the rights the youth are entitled to including the right to life, right to better health, protection from sexual exploitation and abuse and participation in decision making that affects their lives among others.

To realise health among the youth, the policy undertakes to advocate for the improvement, provision and expansion of access to services, equipping the youth with appropriate life skills and creating a safe and supportive environment for youth development, advocating for innovative ways of resource mobilisation for the youth, protecting women and men from all sorts of violence and exploitation, building partnerships among stakeholders involved in youth health and development and adopting and implementing the adolescent health policy.

The NYP was developed to be implemented by Ministry of Gender and Social Development through a multi-sectoral committee consisting of a cross section of stakeholders working with youth including line ministries, development partners, civil society organisations among others all of whose roles have been highlighted in the policy.

Overall, the different policy documents highlight a set of undertakings on the part of the Government of Uganda, to generally ensure access to medicines and access to SRH services. In very limited provisions including under the 2015 Standards and Guidelines and the National Medicines Policy, the two areas are brought together and commitments are made to ensure access to medicines for SRH services.

Two key limitations are manifest in the assessment of the policy commitments and the outcome of the implementation of prior policy commitments by the government:

1) First, is the chronic failure to realise the targets and outcomes of the policy commitments whose tenures have since lapsed. The newer policies identified are in that regard introducing components of monitoring and evaluation to ensure that they realise the targets and outputs proposed in the policy commitments and dedicating clear institutional frameworks to take lead on their implementation.

2) The other major limitation of the policy commitments and action plans developed is the huge funding gap between the policy commitments and the implementation plans developed and the amount of funds projected to be available which implies that most of the plans that have been proposed may not be implemented by the end of their respective tenures. There is a need for a deliberate effort to identify sustainable sources of funding to ensure that the plans that have been developed have sufficient funds available to them to be implemented.

As Government and particularly Ministry of Health, enter a new phase of policy and development plan implementation, it is critical to learn from past failures in implementation of development plans to ensure that policy commitments by the government to ensure access to medicines for SRH services results in access to quality medicines that fulfil the SRH needs of the people of Uganda.

4. LEGAL FRAMEWORK FOR SRH MEDICINES

Further to the policies, Uganda has number of laws that affect access to medicines for sexual and reproductive health. The laws are at different levels with the Constitution being the supreme law. **I**n addition to the Constitution, the government has worked on several parliamentary legislation to address several aspects on sexual and reproductive health.

4.1 The Constitution of Uganda, 1995

The legal framework on access to medicines for SRHR is guided by the spirit of the 1995 Constitution of Uganda. Although the Constitution of Uganda, 1995 lacks a substantive provision on the right to health, it makes mention of the right under the National Objectives and Directive Principles of State Policy (Mulumba, 2010). The Constitution however interestingly has a strong provision on women rights that could be construed as creating obligations of the state to uphold the reproductive rights of women and girls in Uganda which includes ensuring access to SRHR commodities.

The National Objectives and Directive Principles of State Policy (NODPOSP) require the state to endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and in particular among others to ensure that all Ugandans enjoy rights and opportunities and access to health services (Objective XIV). Furthermore, the State is required to take all practical measures to ensure the provision of basic medical services to the population (Objective XX).

These provisions ought to be read together with Article 8A that requires that Uganda shall be governed based on the principles of national interest and common good enshrined in the national objectives and directive principles of state policy. In that regard, national legal frame work should be modeled alongside these provisions of the Constitution and any divergence there from can be treated as a diversion from the constitution itself.

The Constitution also has good provisions on wider aspects that could affect access to medicines. For instance, it contains other general provisions that speak to the right to information (Article 41), Right to privacy (Article 27), freedom from non-discrimination (Article 21), Freedom from in-human, cruel and degrading treatment (Article 24) and obligations of the government and private actors to recognize and protect to human rights enshrined in the Constitution (Article 20(2). These general provisions provide the foundation on which other laws that impact on access to medicines for SRHR in Uganda.

The Constitution under Article 33 provides for the Rights of Women, and specifically Clause 1 requires that women should be accorded full and equal dignity of the person with men which means that health services and commodities that are specific to woman should be readily available, accessible, adequate and of good quality.

Clause 3 on the other hand imposes an obligation on the state to protect women and their rights, taking into account their unique status and natural maternal functions in society. These two clauses read together reinforce the obligation upon the state to ensure that the standard for meeting the health needs especially the reproductive health needs of women in order to uphold the dignity of women should be at par with that of men.

This is a classic provision that is inspired by the provisions of the constitution on non-discrimination, freedom from in-human and degrading treatment and most importantly the overall provision that espouses the obligations of governments especially to respect the rights of women. The Constitution clearly provides the impetus for access to medicines on sexual reproductive health as a matter of rights for women in Uganda. The state would therefore be expected to take practical steps to ensure that women access medicines for their sexual and reproductive health.

4.2 National Drug Policy and Authority Act

The National Drug Policy and Authority Act of 1993 establishes a National Drug Authority as the body charged with the implementation of the national drug policy and, in particular, dealing with the development and regulation of the pharmacies and drugs in Uganda. The Authority is mandated with ensuring the availability, at all times, of essential, efficacious and cost-effective drugs to the entire population of Uganda, as a means of providing satisfactory health care and safeguarding the appropriate use of drugs. Under Section 2 of the Act, the national drug policy shall be to ensure that essential, safe, efficacious and cost-effective drugs are made available to the entire population of Uganda to provide satisfactory health care

The National Drug Authority functions are spelt out under Section 5, to include among others approving the national list of essential drugs and supervising the revision of the list in a manner provided by the Minister; estimating drug needs to ensure that the needs are met as economically as possible; controlling the importation, exportation and sale of pharmaceuticals and controlling the quality of drugs. Section 8 of the Act mandates the Authority to compile a national list of essential drugs that can be revised from time to time.

The most recent compilation of the Essential Medicines and Health Supplies (EMHS) list has a list of medicines, commodities that are used in either curative or preventive basis for different reproductive indications. Important to note is that most contraceptives contained are hormonal varieties and the list does not seem to indicate the non-hormonal methods like IUDs. It also seems to completely leave out drugs that are used for the termination of pregnancy. Also in a country where contraceptive failure is still a major barrier to prevention of un-intended pregnancies and rape, incest and defilement are rife, it would seem important to have the emergency contraceptives included on the essential medicines and health supplies list.

By implication therefore there is no initiative for public health facilities to make available to the public non-hormonal contraception methods and medicines for safe termination of pregnancies since the regulatory authority has not included them on the list. It is therefore essential that the next version of the EMHS list provide for non-hormonal contraceptives and medicines for termination of pregnancies.

4.3 National Medical Stores Act, 1993

This Act establishes the National Medical Stores (NMS) and provides for its composition, powers, object, functions and its administration. The Act provides for the mandate of the medical stores as ensuring the efficient and economical procurement of medicines and of certain other medical supplies of good quality primarily to the public health services. Other functions of the medical stores include to ensure the secure safe and efficient storage, administration, distribution and supply of the medicines, having regard to national needs and to the special nature of the medicines and products in question in accordance with the national drug policy and the national drug authority,

From the foregoing, it is noteworthy that the mandate to procure the required SRHR medicines and commodities to meet the need of the women and girls in Uganda, including to ensure access to commodities required for the termination of pregnancy within the legal frame work lies with NMS. NMS would therefore be required to bridge the current gap of access to sexual reproductive health medicines and commodities. For instance, the medical stores would be engaged on the a persistent unmet need for family planning commodities that currently stands at 34% according to the Uganda Demographic Health Survey of 2012.

This figure is contrary to NMS' mandate of ensuring a secure, safe and efficient storage, administration, distribution and supply of the goods, having regard to national needs and to the special nature of the goods in question. This role is complemented by other institutions like the Joint medical Stores which is registered under the Trustees Incorporation Act. However, even with these institutions in place, stock outs of SRHR commodities continue.
It would therefore be important to engage the Medical stores on its roles in ensuring that medicines and products for sexual reproductive health are available in line with the needs of the population.

4.4 Local Government Act, Cap 243

In 1986, government embarked on a decentralisation process that saw the establishment of Resistance Councils which were a form of locally elected governments that later got renamed as Local Councils. These Councils were the first direct experience of many Ugandans with democracy after many decades of varying levels of authoritarianism. These would later be legitimised as a government policy for effective service delivery in the 1995 Constitution.

Later in 1997 a full legislation on Local Government was enacted to put into effect the provisions of the constitution and it substantially devolved powers previously exercised by the central government to the district local authorities. Following decentralisation, the health care delivery system was also designed along the same system with a corresponding health unit level for each level of local government or administrative unit.

The Local Government Act (1997) mandates the Local Governments (LGs) to plan, budget and implement health policies and health sector plans. The LGs have the responsibility for recruitment, deployment, development and management of human resource for district health services, development and passing of health related by-laws and monitoring of overall health sector performance. LGs manage public general hospitals and lower Health Centers and also supervise and monitor all health activities (including those in the private sector) in their respective areas of responsibility. The other critical level is the Health Sub-District (HSDs).

The HSDs are mandated with planning, organisation, budgeting and management of the health services at this and lower health centre levels. HSDs carry an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities.

The decentralised nature of Uganda's health system means that authority for provision of SRH services is shared between the Ministry of Health that is responsible for policy formulation and administration of referral level hospitals and the local government that is responsible for administration of health services provision at district level and health facilities from the level of Health Center I to IV (The Local Government Act, Cap. 243). By vital of the powers granted to the local governments under the Local Government Act, they have an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities including those carried out by the PNFP, and PFP service providers in the health sub district .As such health care at the district level is provided in Health Centers I, II, and III and a network of VHTs has been established in Uganda which is facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health services.

Despite the increment in grants to Local Governments from UGX 721.5 billion in the 2003/04 to over UGX 2.3trillion in the 2014/15, local governments are still inadequately financed and this has affected to procurement of medicines for SRH services at the district level (National Planning Authority, 2015).

One of the major implications of this law was to decentralize the provision of health services without following this up with provisions on funding the local governments. This means that while the local governments have the powers to deal with medicines at the local government level, they have to depend on the central government's allocation of financial resources to provide these medicines.

4.5 Public Procurement and Disposal of Public Assets Act, 2003

This law establishes the Public Procurement and Disposal of Public Assets Authority and makes provision for policies and practices in respect of public procurement and disposal activities. While the Act addresses a broad array of procurements for the public sector, it has provisions specific on procurement of medicines for public health facilities.

The law under Section 40A provides for accreditation for alternative systems. Under this provision, the law states that a procuring and disposing entity which is not able to comply with a particular procurement or disposal procedure required under this Act, may apply to the Authority for accreditation of an alternative system.

Under the law, the Public Procurement and Disposal Authority (PPDA) can permit accreditation of an alternative system in a number of circumstances including:

- where exceptional requirements make it impossible, impractical or uneconomical to comply with the law
- where market conditions or behaviour do not allow effective application of this Act; and
- for specialised or particular requirements that are regulated or governed by harmonised international standards or practices.

The law provides for an alternative system for the procurement of medicines and other medical supplies through regulations which provide for a number of things including: the special nature of procurement of medicines and medical supplies; the specific attributes of medical supplies define the medical supplies and take into consideration developments, if any, in the procurement, storage and distribution of medicines and medical supplies.

The Procurement of Medicines and Medical Supplies Regulations, 2014 were developed to cater for the issues of medicines procurements. The regulations make a number of provisions which include provisions on direct procurement of medicines. The regulations guide that the entity shall use the direct procurement method where a provider is a single provider or a sole source provider. It is also possible to use a single provider where there is a limited number of providers who are able to provide the required medicines or medical supplies, such as in an emergency situation.

The regulations also permit the use of a sole source provider where only one provider is able to provide the medicines or medical supplies, or where there is need for continuity in the delivery of the medicines or medical supplies. The regulations list sundries and medical consumables to include items such as the: safe delivery kits, theatre supplies, medical equipment, and Test kits which are critical for sexual reproductive health.

Regulations of medicines procurement is very important because the prices that public sector agencies and health facilities pay to procure medicines are a key determinant of their ability to afford the medicines they need and in some systems of the prices charged to patients. Procuring medicines requires specialised technical skills that may not be present in all settings especially in decentralised health systems. Transparent procurement processes, effective negotiation and pooled procurement may decrease public procurement prices.

Transparent procurement data enables public sector policy makers and system managers to benchmark bid prices, track prices overtime, estimate budget requirements and assess the overall efficiency of the procurement process. This makes a good procurement law critical in ensuring access to medicines. At the same time, a procurement law could derail the procurement of urgently needed medicines when it introduces the lengthy procurement procedures. It is thus critical that in the case of Uganda the procurement law is subjected to passing these tests.

4.6 Investment Code Act, Cap 92

This Act regulates local and foreign investments in Uganda and establishes the Uganda Investment Authority, whose functions include:

- to promote, facilitate and supervise investments in Uganda
- receiving all applications for investment licences, to secure all licences, authorisations, approvals and permits required to enable any approval granted by the authority to have full effect
- to recommend to the Government national policies and programmes designed to promote investment in Uganda
- to assist potential investors in identifying and establishing investment projects in Uganda.

The Act also creates incentives for investors importing any plant, machinery, equipment, vehicles or construction materials for an investment project in form of concessional rates of import duty and other taxes as may be specified in the Finance Acts from time to time. And where the investment involves two or more phases, all those phases shall be treated as forming part of the new investment. (Section 21) This therefore that all plant and machinery involved in the setting up of a pharmaceutical plant are entitled to concessions on import duty among others until the plant is fully set up regardless of the number of phases it will take.

An investor commencing operation after coming into force of the act also qualifies for an incentive if their business enterprise contributes to ; the generation of new earnings or savings of foreign exchange through exports, resource-based import substitution or service activities; the utilisation of local materials, supplies and services; the creation of employment opportunities in Uganda; the introduction of advanced technology or upgrading of indigenous technology; the contribution to locally or regionally balanced socioeconomic development; and any other objectives that the authority may consider relevant for achieving the objects of this Code.

4.7 Industrial Properties Act, 2014

This is an Act that was enacted to provide for inventive and innovation activities and facilitate the acquisition of technology through the grant and regulation of patents. Patents are the legal protection that is given to an inventor of a technology that may include a pharmaceutical product. However, for a patent to be granted, the invention has to have met three characteristics that include: an inventive step, industrial application and be novel, this is as laid down under Section 9 of the Industrial properties Act.

Section 8 (3) (f) provided for inventions that should be excluded from patent registration, including pharmaceutical products. Through this provision the Industrial Properties Act has included the multilateral Agreement on Trade-Related Intellectual Property Rights (TRIPs) and related flexibilities into the Ugandan legal system. However, the implementation of these flexibilities has not been very rigorous.

One of the challenges sighted for this is the lack of the enforcement, is the lack of capacity by the Uganda Registration Services Bureau (URSB) to exercise its mandate under Section 4 (1) (a) on the powers of the registrar to receive, consider and grant applications for the Act, as such the patents must be sent to Aripo for examination. This raises the question as to whether the patents have not been registered in contravention of this section further impeding access to medicines for SRH.

Conclusion

In conclusion, the legal framework providing for access to medicines for SRH is largely indicative and has no real provision creating an obligation to the state to specifically ensure access to medicines for SRH services. However, the NODPOSP of the Constitution, buttressed by Article 8A create a very strong foundation for the state to build upon to mainstream access to medical services into its national legal framework. The failure of a woman to access medicines or any other health supplies required for the fulfillment of their reproductive health can therefore be construed as a violation of not only her reproductive health rights but also her constitutional rights.

Ensuring adequate access to quality medicines for SRH services requires the strengthening of the institutional framework that is existent for the regulation and administration of EMHS. Primarily, there should be a wide range of options for contraception available to the public. It is essential that non-hormonal commodities and medicines for termination of pregnancy be added to EML.

Strengthening sanctions to the bottlenecks that stifle the supply chain for medicines and health commodities is also essential to overcome the problems relating to stock outs that arise from among others poor management of health stocks and poor mechanisms for procurement and distribution of medicines. Public entities should be held to account for instances where health commodities get expired while in storage or instances where health facility administrators inadequately procure medicines compared to the need for medicines or instances where medicines that have been requisitioned are not promptly supplied.

The legal environment has not kept abreast with the policy developments of the country. For example while the government has committed significant resources towards the management of PAC, the EMHS list does not provide for commodities that are essential for the management of PAC. It is therefore essential that a regulatory review be conducted to bring the regulatory framework for access to medicines in tandem with the government's policy commitments.

5. AVAILABILITY OF EMHS FOR REPRODUCTIVE HEALTH

5.1 Availability of commodities to prevent unwanted pregnancies

The field survey assessed the availability of a range of commodities for prevention of unwanted pregnancies: Combined Oral Contraceptives (COC), Progestin oral contraceptive pills, Progestin-only injectable contraceptives, male and female condoms, intrauterine contraceptive devices (IUCD), Implants, cycle beads for standard days method, emergency contraceptive pills, vasectomy kits, and tuboligation kits.

Table 2: Percentage availability of commodities to prevent unwanted pregnancies

Medicine	Public sector			Private sector			Mission sector		
	Overall	Urban	Rural	Overall	Urban	Rural	Overall	Urban	Rural
Combined Oral Contraceptives	47%	52%	41%	46%	52%	25%	27%	31%	23%
Progestin Oral Contraceptive Pills	4%	7%	0%	8%	10%	0%	12%	15%	8%
Progestin only injectables	84%	78%	91%	54%	52%	63%	35%	46%	23%
Male condoms	80%	89%	68%	65%	69%	50%	38%	38%	38%
Female condoms	27%	19%	36%	8%	7%	13%	12%	8%	15%
Intrauterine contraceptive devices	49%	52%	45%	30%	31%	25%	27%	38%	15%
Implants	65%	78%	50%	49%	55%	25%	31%	38%	23%
Cycle beads for standard days	4%	4%	5%	3%	0%	13%	12%	15%	8%
Emergency contraceptive pills	8%	11%	5%	22%	24%	13%	4%	8%	0%
Vasectomy kits	18%	19%	18%	3%	3%	0%	15%	8%	23%
Tuboligation kits	20%	22%	18%	5%	7%	0%	19%	8%	31%

Most contraceptives were either out of stock or sparsely available across all sectors. The most available contraceptives were progestin-only injectable contraceptives (Depo Provera) and male condoms. Progestin-only injectable contraceptives were found in 84% of public facilities, 54% of private facilities and 35% of mission facilities. Male condoms were available in 80% of public, 65% of private and 38% of mission facilities. Hence, no single contraceptive was available in all facilities in any single sector, let alone across all sectors.

Commodities that were least available include Progestin oral contraceptive pills, cycle beads for standard days method, emergency contraceptive pills and vasectomy kits. In the public health facilities, Progestin oral contraceptives were available in just 4%; cycle beads in 4% facilities; emergency contraceptives in 8% facilities; vasectomy kits in 18% facilities; tuboligation kits in 20% facilities; female condoms in 27% facilities; and Combined Oral Contraceptives in 47% facilities.

5.2 Availability of commodities for safe termination of pregnancy

The commodities for safe termination of pregnancy assessed in the field survey include Mifepristone, Fefolate, Oxytocin, Misoprostol, Metronidazole, Gentamicin, Ceftriaxone, Ampicillin, Pethidine, and Diazepam.

Table 3: Percentage availability of commodities for safe termination of pregnancy

Medicine	Public sector			Private sector			Mission sector		
	Overall	Urban	Rural	Overall	Urban	Rural	Overall	Urban	Rural
Mifepristone 10mg or 25mg	2%	0%	5%	3%	3%	0%	0%	0%	0%
Fefolate 60mg	41%	37%	45%	38%	38%	38%	38%	31%	46%
Oxytocin 10IU, 1ml inj	94%	96%	91%	54%	52%	63%	77%	62%	92%
Misoprostol 200ug tab	43%	33%	55%	43%	52%	13%	77%	77%	77%
Metronidazole 200mg tab	90%	93%	86%	97%	100%	88%	100%	100%	100%
Gentamicin 40mg or 80mg inj	59%	56%	64%	97%	97%	100%	88%	92%	85%
Ceftriaxone Inj. 250mg, 500mg or 1g vial	55%	63%	45%	100%	100%	100%	100%	100%	100%
Ampicillin inj 500mg	2%	4%	5%	3%	3%	13%	4%	8%	8%
Pethidine injection 50mg or 100mg	57%	67%	45%	19%	21%	13%	54%	46%	62%
Diazepam 5mg tab	76%	78%	73%	84%	83%	88%	73%	69%	77%

Mifepristone, the recommended medicine for safe termination of pregnancy, was available in only one public facility, one private facility and none of mission facilities. Misoprostol was most available in the mission sector (77% of facilities). It was available in 43% of public and private facilities.

Oxytocin, used in the management of post-partum haemorrhage, was available in 94% of public facilities, 54% of private and 77% of mission facilities.

5.4 Availability of supportive commodities and sundries

The supportive medicines and other items covered in the survey were: Doxycycline, Ciprofloxacin, Paracetamol, Ibuprofen, Diclofenac, intravenous fluids, blood, HCG kits, flowing water, gauze, cotton, gloves (sterile and disposable), syringes, Antiseptic Chlorhexidine / alcohol.

Table 4: Availability of other supportive commodities and sundries

Medicine	Public sector			Private sector			Mission sector		
	Overall	Urban	Rural	Overall	Urban	Rural	Overall	Urban	Rural
Doxycycline 100mg	82%	85%	77%	84%	93%	50%	88%	77%	100%
Ciprofloxacin 250mg or 500mg	78%	85%	68%	95%	100%	75%	92%	85%	100%
Paracetamol 500mg	84%	96%	68%	97%	97%	100%	85%	77%	92%
Ibuprofen 200mg tablets	2%	4%	0%	30%	38%	0%	12%	8%	15%
Diclofenac 50mg tablets	12%	11%	14%	22%	28%	0%	12%	8%	15%
Intravenous fluids	2%	4%	5%	3%	3%	13%	4%	8%	8%
Blood	2%	4%	5%	3%	3%	13%	4%	8%	8%
HCG kits	59%	63%	55%	62%	66%	50%	92%	85%	100%
Flowing water	84%	93%	73%	68%	72%	50%	92%	100%	85%
Gauze	88%	93%	82%	76%	76%	75%	92%	100%	85%
Cotton	92%	93%	91%	76%	76%	75%	96%	92%	100%
Gloves (sterile and disposable)	86%	89%	82%	81%	79%	88%	100%	100%	100%
Syringes	73%	74%	73%	70%	72%	63%	85%	92%	77%
Antiseptic Chlorhexidine / Alcohol	39%	56%	18%	11%	14%	0%	46%	38%	54%

Supportive commodities and sundries were more readily available in mission sector but availability of emergency related commodities – IV fluids and blood – was low.

Hygiene and infection control at the facility level are a major concern as the availability of disinfectants was so low. Antiseptics for instance, were available in less than half of public and mission facilities, and in barely one eighth of private facilities. Overall, flowing water was less available in rural facilities compared to urban facilities; it was least available in private sector rural facilities (50%).

Availability of HCG kits for pregnancy tests was high in mission sector (92%) but at least two of five facilities (approx. 60%) in public and private sector facilities did not have these kits.

At least two antibiotics for management of sexually transmitted infections (STIs) were more readily available. Doxycycline and Ciprofloxacin were respectively found in 82% and 78% of public health facilities; 84% and 95% of private facilities; and 88% and 92% of mission facilities. Beyond these two, however, the range of antibiotics in health facilities was limited.

5.5 Availability of instruments

The instruments assessed in the field survey include manual vacuum aspiration kits (MVA), speculum, cervical dilators, curate, sponge holding forceps, ultra sound scan, evacuation bed, sterilizer machines, and drip stands.

Table 5: Availability of instruments

Medicine	Public sector			Private sector			Mission sector		
	Overall	Urban	Rural	Overall	Urban	Rural	Overall	Urban	Rural
Manual vacuum aspiration kits (MVA)	57%	59%	55%	24%	28%	13%	46%	54%	38%
Speculum	86%	81%	91%	62%	62%	63%	100%	100%	100%
Cervical dilators	78%	81%	73%	43%	55%	0%	73%	62%	85%
Curate	59%	74%	41%	30%	31%	25%	92%	92%	92%
Sponge holding forceps	88%	89%	86%	54%	59%	38%	100%	100%	100%
Ultra sound scan	55%	63%	45%	38%	45%	13%	69%	69%	69%
Fetal scope	96%	93%	100%	54%	52%	63%	100%	100%	100%
Evacuation bed	63%	63%	64%	46%	48%	38%	85%	85%	85%
Sterilizer machines	84%	85%	82%	57%	59%	50%	92%	92%	92%
Drip Stands	88%	93%	82%	84%	83%	88%	96%	92%	100%

Availability of instruments was highest in mission sector; with only the manual vacuum aspiration (MVA) kits being available in less than 50% of facilities. MVA kits for safe termination of pregnancy were the least available instruments found in 57% of public, 46% of mission and 24% of private facilities. Ultra sound scan machines were the next least available: in 69% of mission, 55% of public, and 38% of private facilities

6. AFFORDABILITY OF COMMODITIES

The field survey assessed prices of a basket of selected SRH commodities in private and private-not-for-profit facilities.

Table 6: Selected Private and Mission Sector prices of commodities

Medicine	Private sector (Median Unit Prices)			Mission sector (Median Unit Prices)		
	Overall	Urban	Rural	Overall	Urban	Rural
Progestin only contraceptives injection	1500		2000	0	0	0
Male condoms	317	250	400	0	0	0
Intrauterine contraceptive devices (IUCD)	5000			0	0	
Implants	5000			0	0	0
Emergency contraceptive pills	5000					
Fefolate 60mg	100	150		50	150	20
Oxytocin injection 10IU,1ml	1250	1500	1000	1000	2600	1000
Misoprostol 200,ug tablet	2500	2000		2329	2900	1230
Manual vacuum aspiration kits (MVA)	30000	0		0	0	0

Overall, the range of prices (difference between maximum and minimum prices observed) across facilities was high particularly in private sector. For example, prices of IUCDs in private sector ranged from being free to a cost of UGX 15,000 (median UGX 5,000). Misoprostol cost between UGX 2,500 - 8,000 per tablet. Mifepristone was priced at UGX 42,000 at the only private facility in which it was found. MVA services ranged from being free to UGX 450,000 in private sector whereas maximum service fee in mission sector was UGX 30,000.

Affordability was calculated based on the number of days it requires to pay for standard treatment or dose of treatment. Affordability was determined based the daily income of the lowest-paid unskilled government employee. The daily wage of the lowest paid government worker (attendants) is approximately UGX 6255 (USD 1.78) as per Uganda Ministry of Public Service salary structure[2]. Treatments that require more than one day's wages to purchase are considered unaffordable.

Table 7: Affordability in private sector

Medicine	Treatment units	Median Unit price	Treatment price	Affordability
Progestin only contraceptives injection	1	1,500	1,500	0.24
Implants	1	5,000	5,000	0.80
Emergency contraceptive pills	1	5,000	5,000	0.80
Mifepristone	1	42,000	42,000	6.71
Misoprostol 200 ug tablet	1	2,500	2,500	0.40
Manual vacuum aspiration kits (MVA)	1	30,000	30,000	4.80

Implants and Emergency contraceptives cost slightly under a day's wages in the private sector. Mifepristone would cost 6.71 days' wages whereas MVA services would cost 4.8 days' wages and up to 72 days wages in some instances.

7. LOGISTICS MANAGEMENT OF FAMILY PLANNING EMHS

Results from this work show that one in three health workers considered unfulfilled requests of EMHS to be the biggest challenge to access to essential medicines and health commodities for family planning. Only about 16% of the respondents considered lack of demand to be an issue, while capacity gaps among health workers for quantification and requisition of EMHS were a concern among 16% of respondents.

On the issue of access to EMHS for unsafe abortion, result show that the biggest challenge to access was limited awareness of the abortion law (36%). Other reasons were harassment of health workers by law enforcers (9%), lack of demand (9%) and skill gaps among health workers (3%). Up to 73% of health care managers interviewed felt that there was stigma related to abortion at their facility.

To improve access to EMHS for prevention and management of complications from unsafe abortions, respondents suggested sensitisation, training of health workers and sustained supplies of commodities and equipment.

8. CONCLUSION AND RECOMMENDATIONS

Availability of EMHS for prevention of unintended pregnancies, as well as for provision of safe abortions and management of complications from unsafe abortions is still a challenge in the public, mission and private sectors. As far as family planning commodities are concerned, the range of commodities is very limited, with only the injectable contraceptives and male condoms being fairly available. Emergency preparedness needs to be strengthened. The public sector showed more readiness for safe termination of pregnancy than the private and mission sectors.

Aspects that need to be addressed are:

- In spite of the fact that there are acceptable grounds for termination of pregnancy in Uganda's legal framework, there exists a misconception that termination of pregnancy is completely illegal in Uganda. The policy framework is apparently more expansive, particularly the Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda of 2015. However, the law is vague and poorly understood by law enforcers and health workers alike. Hence, there is need to review, update and clarify the law on termination of pregnancy
- The Essential Medicines List (EML) needs updating to include EMHS for SRH and family planning. Having these commodities included on the EML will prompt NMS to include them in their procurements and distribution.
- Availability of family planning commodities need to be improved and the range of methods enhances across all sectors, but more so in the mission and private sectors.
- Medicines for the safe termination of pregnancy are virtually unavailable, suggesting that this service cannot be provided to the women who need it. The availability of Mifepristone and Misoprostol need to be enhanced.
- To strengthen emergency preparedness, the availability of IV fluids and blood needs to be improved and the referral system streamlined to attach facilities that have capacity to stock blood attached to those that do not have the capacity.
- There is need for service integration to ensure that as many of EMHS for reproductive health as are needed by clients are accessible at the facility they seek services from.
- Facilities in rural areas need special attention as far as availability of EMHS for reproductive health are concerned and government (MOH) should explore the possibility of attracting private providers to rural location and to make EMHS affordable to rural communities.

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(Endnotes)

1 **Ministry of Public Service New Salary Scales for Public servants for FY 201415**
2 Ministry of Public Service New Salary Scales for Public servants for FY 2014/15

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