



THE REPUBLIC OF UGANDA

Committing to  
**Maternal  
& Child  
Survival**



# A Promise Renewed

**REPRODUCTIVE MATERNAL, NEWBORN AND  
CHILD HEALTH SHARPENED PLAN FOR UGANDA**

**November 2013**



COMMITTING TO CHILD SURVIVAL

**A PROMISE RENEWED**





**THE REPUBLIC OF UGANDA**

# **REPRODUCTIVE MATERNAL, NEWBORN AND CHILD HEALTH SHARPENED PLAN FOR UGANDA**

**November 2013**



COMMITTING TO CHILD SURVIVAL

---

**A PROMISE RENEWED**



## FOREWORD

NEW  
VISION  
PLEASE  
INSERT  
PHOTO

Hon. Dr. Ruhakana Rugunda  
Minister of Health

Uganda has made important progress towards achieving the Millennium Development Goals (MDGs). The country has achieved MDG targets on reducing the percentage of population living below the poverty line, promoting gender equality, empowering women, increasing access to safe and clean water and creating avenues for information and communication technology.

Though the country is on track in regard to reaching the MDG 4 by reducing under five mortality level, there is still work to be done to achieve the MDG 5 on improving maternal health targets regarding the reduction of maternal mortality.

Government and development partners have made a commitment to reduce maternal and child mortality. Government, development partners and other stakeholders need to take stock of steps taken to reduce child and maternal deaths.

In this regard, Government, with its partners, has come up with the Sharpened Reproductive, Maternal, Neonatal and Child Health (RMNCH) Plan. The RNMCH plan is geared at advocacy, resource mobilisation and prioritisation of high impact interventions to accelerate progress towards achieving MDG 4 and 5 targets.

The plan has also defined five strategic shifts as positive business. It places a strong emphasis on strengthening accountability and monitoring mechanisms as well as partnerships for social mobilisation, funding and technical assistance. It is not meant to replace the existing Road Maps for reduction of maternal mortality and the Child Survival Strategy but to boost them.

The Ministry will rigorously monitor the implementation of the plan to ensure that the priority actions and interventions are quickly instituted in order to achieve the desired impact by 2015. I therefore call upon all stakeholders from Government ministries, civil society, development partners, parliamentarians, faith based organisations, the private sector, academia and professional bodies to join hands firmly with the Ministry of Health to fully execute this plan and prevent the unnecessary death of mothers and children across Uganda.

HON. DR. RUHAKANA RUGUNDA  
MINISTER OF HEALTH

## MESSAGE FROM THE MINISTRY OF HEALTH



**Hon Sarah Opendi**  
Minister Of State For Health,  
Primary Health Care

By working together, we can prevent death of Ugandan women and children from the leading killer diseases. Women and children have a right to quality health care and to survival. These are fundamental rights that should be respected and protected.

The objective is under the phrase that “Every pregnancy should be protected, every delivery should be safe and every newborn child should be healthy.” A well-coordinated and integrated approach can help realise this based on policy advocacy, availability of services and financial resources, action and accountability.

There is recognition that the RMNCH Sharpened plan cannot be adequately dealt with separately but only through integrated programmes. It addresses the critical need for coordinated and collaborative implementation across various sectors. With accelerated and coordinated implementation, there will be tremendous gains through the efficient and effective use of scarce resources.



**Hon. Dr Elioda Tumwesigye**  
Minister Of State Health,  
General Duties



**Dr. Asuman Lukwago**  
Permanent Secretary

“Today, child and maternal mortality are the slowest moving target of all the Millennium Development Goals. Together, let us make maternal and child health the priority it must be. In the twenty-first century, no woman should have to give her life to give life. No newborn or child should fall short of seeing his or her fifth birthday.” I call upon all our partners and stakeholders To Action – to renew our promise to our people and align all our efforts to the commitments we have made. Today, the slowest progress towards achieving the Millennium Development Goals relates to child and maternal mortality. Together, let us give maternal and child health the priority it deserves. In the 21st century, no woman should have to lose her life to give birth.

No child should fail to reach his or her fifth birthday. I call upon all our partners and stakeholders to take action and to renew our promise to our people and align all our efforts towards the commitments we have made

Preventing maternal and child deaths requires a new way of “doing business”. This plan looks at five strategic shifts or goals as the priority for a forward looking, compelling, integrated and sustainable RMNCH agenda with the MDGs in mind. These will form the focus for action and introduce a paradigm shift that will overcome obstacles so as to prevent avoidable death. They reflect a national commitment and also recognise the importance of leadership at local level and encourage districts, partners, civil society organisations and other players to implement them..



**Dr. Jane Ruth Aceng**  
Director General Health Services

## EXECUTIVE SUMMARY

Over the last twenty years, Uganda has experienced slow progress in reduction of child and maternal mortality rates.

We have the tools and knowledge to change that trend in a bid to bring an end to preventable deaths with greater participation of all partners and stakeholders, a change in focus, and commitment to hold ourselves accountable. Uganda has developed this evidence-based country plan to address the slow progress in relation to the MDG 4 target of reducing by two thirds the under-five mortality rate and the MDG 5 targets of reducing by three quarters the maternal mortality ratio and of achieving universal access to reproductive health by 2015.

The plan focuses on why the country is making slow progress in attaining the targets, reviews the maternal mortality, the situation of newly born children, child mortality and morbidity in Uganda, sets an agenda on how to accelerate progress, establishes deadlines for the acceleration of the MDG targets and proposes five strategic shifts in doing business differently.

The plan is aligned with Uganda's Vision 2040 and the National Development Plan (NDP) for 2010/11 – 2014/15.

The purpose of this plan is to push for collective action towards achieving equitable accelerated improvements in maternal, newborn and child mortality rates in Uganda. Our vision and our responsibility is to end preventable deaths in the context of attaining targets for MDGs and beyond by ensuring a strategic shift to doing business and universal coverage of high impact health interventions using all three delivery platforms - communities, the population and individual clinical services. The five strategic shifts are:



The Lives Saved Tool (LiST) identified and prioritised a handful of existing and achievable evidence-based and focused interventions that have the greatest impact on reducing mortality and improving health. These priority interventions are contained in existing strategies and plans of the Ministry of Health. They will be implemented alongside the on-going interventions, which are necessary to sustain the current gains. The key results and targets of this plan are outlined in the matrix below. The cost of the plan is US\$ 682 million and it will avert about 137,573 deaths.

## GOAL: TO END PREVENTABLE MATERNAL AND CHILD DEATHS IN UGANDA

### Impact

1. Reduced the Maternal Mortality Ratio from 438 per 1,000 live births to 211 per 100,000 live births by 2017
2. Reduced Under 5 Mortality Rate from 90 per 1,000 live births to 53 per 1,000 live births by 2017
3. Reduced the Infant Mortality Rate from 54 per 1,000 live births to 30 per 1,000 live births by 2017
4. Reduced the Neonatal Mortality Rate from 27 per 1,000 live births to 10 per 1,000 live births by 2017

## PURPOSE: TO REDIRECT AND REFOCUS EFFORTS TOWARDS ACCELERATING THE ATTAINMENT OF MDG 4&5 IN UGANDA

### Key result

1. Coherent, prioritised and funded country led integrated RMNCH plan
2. Commitments and mutual accountability for sustained collective action by government, development partners, private sector, and CSOs
3. Transparency and evidence based planning and reporting to accelerate progress and deliver results

## STRATEGIC OBJECTIVES

1.0 To accelerate greater coverage in high-burden districts and populations

2.0 To expand coverage of high impact interventions

3.0 To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths

4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths

### Key Result

- 1.1 Identification of High Priority Districts (HPDs) based on a 'composite health index' across districts
- 1.2 Differential planning for HPDs
- 1.3 Scaled up community- outreach based delivery platform formic packages to most burdened populations
- 1.4 Reduced coverage disparities between regions and within districts
- 1.5 Equity-sensitive monitoring data

- 2.1 Enhanced access to and use of life-saving RMNCH commodities and equipment
- 2.2 Scaled and sustained demand and supply of highest impact, evidence-based interventions
- 2.3 Appropriate lifesaving task-shifting regulations and policies implemented
- 2.4 Enhanced uptake of community level RMNCH interventions

- 3.1 RMNCH prevention targets and services integrated in non-health programs
- 3.2 Women are empowered to make RMNCH decisions
- 3.3 Environmental factors addressed e.g., sanitation and hygiene

- 4.1 Functioning transparency and mutual accountability mechanism
- 4.2 Unified MMC survival voice, shared targets, harmonized approaches and common metrics across levels and partnerships
- 4.3 Mutual assessments of progress in implementing agreed commitments
- 4.4 Increased visibility of RMNCH statistics

## Indicators and Targets

- Proportion of regions, districts or sub-districts with previously the highest mortality rates registering a 50% reduction in mortality: Target 60% by 2017
- Proportion of regions, districts or sub-districts with previously highest mortality rates reduced to current national average: Target 70% by 2017
- Proportion of regions, districts or sub-districts with previously highest mortality rates with increased budget allocations to high impact interventions: Target 90% by 2017
- Percentage narrowing in midwives staffing differences between regions, districts or sub-districts with previously highest mortality rates compared to those with lowest mortality: Target 20% by 2017
- Out-of-pocket expenditures for the poor reduced to <
- Proportion of facilities with no stock outs of lifesaving commodities raised to 80%
- Proportion of nurses, midwives, VHTs providing lifesaving interventions increased to >60%
- Increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (4+ ANC visits, EmONC, pre-term care, treatment of newborn and child infections)
- Proportion of planned quality RMNCH performance reports produced, debated and used to strengthen program management and resources allocation
- Proportion of commitments met on schedule by each partner
- Proportion of resources allocated and spent based on previously made commitments and goals
- Teenage pregnancy and motherhood reduced from 24% to <15%
- Girls married by age 18 reduced from 46% to <10%
- Unmet need for contraception reduced from 34.4% to <20%
- Stunting among children Under 5 years reduced from 33% to <25%
- Anaemia in non-pregnant women reduced to <20%
- Households with access to improved sanitation increased from 16% to >80%

# TABLE OF CONTENTS

Foreword .....	i
MESSAGE FROM THE MINISTRY OF HEALTH.....	ii
Executive Summary .....	iii
<b>1 OVERVIEW.....</b>	<b>1</b>
1.1 Background.....	1
1.2 The National Health Context .....	1
1.3 Process of Development of the Plan .....	2
1.4 The Time Period for the plan.....	3
1.5 Outline of the Plan .....	4
1.6 Overview of the Uganda RMNCH Commitments.....	4
<b>2 THE ROAD AHEAD .....</b>	<b>9</b>
2.1 Progress on MDG 4: Reducing Child Mortality by two thirds .....	9
2.2 Progress on MDG 5: Reducing maternal mortality ratio by three quarters.....	14
2.3 Progress on other contributing factors.....	18
2.4 Drivers of MDG 4 AND 5 achievement in Uganda .....	21
<b>3 ESTABLISHING A BASELINE: WHERE ARE WE .....</b>	<b>25</b>
3.1 Integrated delivery of RMNCH Interventions .....	25
3.2 Strengthening health system and the health work force .....	27
3.3 Community Ownership and Demand Generation .....	30
3.4 Innovative approaches to increasing efficiency and impact.....	30
3.5 Promoting Rights, Equality and Gender balance .....	33
3.6 Improving Monitoring and Accountability.....	34
<b>4 REACHING THE TARGETS-2015 AND BEYOND .....</b>	<b>35</b>
4.1 Introduction.....	35
4.2 Vision.....	35
4.3 The Five Strategic Shifts.....	35
4.4 Bending the Curve – Lives to be Saved.....	40
4.5 Coordination of the Multi-sectoral approach.....	50
4.6 Holding Ourselves Accountable.....	50
4.7 Advocacy and bridging the financial gap .....	54
<b>5 RENEWING THE PROMISE .....</b>	<b>55</b>
5.1 A call to action – we all have a role to play.....	55
5.2 Government and policy makers (National and district levels).....	55
5.3 United Nations and Other Multi Bi Lateral Organization .....	55
5.4 Forums in Parliament .....	55
5.5 Civil Society Organization .....	56
5.6 Cultural Institutions .....	56

5.7	Faith Based Institutions .....	56
5.8	Private Sector .....	57
5.9	Uganda Private Midwife Association .....	57
5.10	Health Care Workers and their Professional Associations .....	57
<b>6</b>	<b>APPENDICES .....</b>	<b>61</b>
	Appendix 1: M&E Framework for Priority Interventions .....	62
	Appendix 2: Mutual Accountability Matrix.....	65
	Appendix 3: Illustrative Intervention Planning Matrix.....	67
<b>7</b>	<b>BIBLIOGRAPHY.....</b>	<b>69</b>

## TABLE OF FIGURES

<b>Figure 1:</b> Plan Development Process .....	2
<b>Figure 2:</b> Trends in Mortality 1995-2011 .....	9
<b>Figure 3:</b> Geographical disparities in ARI prevalence among U5s .....	10
<b>Figure 4:</b> Causes of under-five mortality (2010) .....	11
<b>Figure 5:</b> Causes of Neonatal Mortality .....	12
<b>Figure 6:</b> HIV+ pregnant mothers on ARVs for PMTCT 2004 – 2015.....	12
<b>Figure 7:</b> Immunisation Coverage Trends - UDHS 1988 to 2011.....	13
<b>Figure 8:</b> Trends of Maternal Mortality Ratio .....	14
<b>Figure 9:</b> Direct Causes of Maternal Mortality .....	15
<b>Figure 10:</b> Proportion delivering in health facility .....	16
<b>Figure 11:</b> Un-met need for family planning .....	18
<b>Figure 12:</b> Disparities in U5MR and National Average.....	19
<b>Figure 13:</b> Funding Sources for RMNCH .....	20
<b>Figure 14:</b> Bottlenecks in ORS use .....	22
<b>Figure 15:</b> Bottlenecks in Implant use .....	23
<b>Figure 16:</b> Bottlenecks in BemONC .....	23
<b>Figure 17:</b> Strengthening RMNCH along the continuum of care. ....	26
<b>Figure 18:</b> Coverage of Interventions along the continuum of care.....	27
<b>Figure 19:</b> Staffing Disparities by Facility Level.....	29
<b>Figure 20:</b> Regions with excess Under-five Mortality .....	36
<b>Figure 21:</b> Population groups with excess Under-five Mortality .....	37
<b>Figure 22:</b> RMNCH Strategic Shifts .....	39
<b>Figure 23:</b> Highest Impact Interventions and Their Relative Importance in Reducing Maternal Mortality.....	41
<b>Figure 24:</b> Highest Impact Interventions and Their Relative Importance in Reducing Child Mortality .....	41
<b>Figure 25:</b> Projected increase in Coverage by Priority Interventions .....	42
<b>Figure 26:</b> Projected Under-Five Mortality Reduction by 2017 .....	44
<b>Figure 27:</b> Projected Infant and Neonatal Mortality Reduction by 2017.....	44
<b>Figure 28:</b> Projected Maternal Mortality Reduction by 2017.....	45
<b>Figure 29:</b> Intervention costs.....	47
<b>Figure 30:</b> Mutual Accountability Process .....	51
<b>Figure 31:</b> Illustrative of a Score Card.....	53

# TABLE OF TABLES

- Table 1:** Lives saved by Priority Interventions ..... 43
- Table 2:** Total costs of the Sharpened RMNCH Plan (x 1000 US \$) ..... 46
- Table 3:** Intervention costs breakdown (x 1000 US \$) ..... 46
- Table 4:** Programme costs breakdown (x 1000 US \$) ..... 47
- Table 5:** Illustrative Indicators for a District level Scorecard..... 53
- Table 6:** Strategic Framework ..... 58
- Table 7:** Summary Log-frame for the Sharpened RMNCH Plan ..... 60

## LIST OF ACRONYMS

ACS	Adreno-cortico-steroids
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
APR	A promise Renewed for Child Survival
ARVs	Anti-Retroviral Drugs
BEmONC	Basic Emergency Obstetric Care
BFHI	Baby Friendly Hospital Initiative
BNA	Bottle Neck Analysis
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CH	Child Health
CSO	Civil Society Organisations
DHO	District Health Office
DPT	Diphtheria Pertussis Tetanus Vaccine
EBF	Exclusive Breast Feeding
EID	Early Infant Diagnosis
EMDL	Essential Medical Devices List
EMHSLU	Essential Medicines and Health Supplies List of Uganda
EML	Essential Medicines List
EPI	Expanded Programme on Immunisation
ETAT	Emergency Triage and Treatment
FIGO	International Federation of Gynaecologists and Obstetricians
FP	Family Planning
GAPPD	Global Action Plan for Pneumonia and Diarrhoea
HBB	Helping Babies Breathe
HC	Health Centre
HCT	HIV Counselling and Testing
HIV/AIDS	Human Immuno Deficiency Virus
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HSD	Health Sub-District
HSSIP	Health Sector Strategic Investment Plan
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Child Birth
IMR	Infant Mortality Rate
IPT	Intermittent Presumptive Treatment

IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated Nets
JMS	Joint Medical Stores
LAM	Lactation Amenorrhea
LCs	Local Councils
LiST	Lives Saved Tool
LLIN	Long Life Insecticide Treated Nets
LMIS	Logistics Management Information System
LOGIC	Leadership in Obstetrics &Gynaecology for Impact & Change
LTFP	Long Term Family Planning
M&E	Monitoring and Evaluation
MCHTWG	Maternal Child Health Technical Working Group
MDG	Millennium Development Goal
MDPR	Maternal Death Perinatal Reviews
MMR	Maternal Mortality Ratio
NDA	National Drug Authority
NDP	National Development Plan
NMCP	National Malarial Control Programme
ORS	Oral Rehydration Salt
PAC	Post Abortion Care
PHP	Private Health Provider
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PNC	Post Natal Care
PNFP	Private Not For Profit
PPH	Post-Partum Haemorrhage
PPP	Private Public Partnerships
QPPU	Quantification and Procurement Planning Unit
RAIC	Rapid Assessment of Interventions and Commodities Tool
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RRH	Regional Referral Hospital
SBA	Skilled Birth Attendant
SMC	Social Marketing of Condoms
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
TT	Tetanus Toxoid
U5MR	Under -Five Mortality Rates
UDHS	Uganda Demographic Health Survey
UHSSP	Uganda Health Systems Strengthening Project
VHT	Village Health Team
WHO	World Health Organisation

# 01

## OVERVIEW

### 1.1 Background

Over the last twenty years, Uganda has experienced progress in reduction of child mortality rates. The progress has been inspiring, occurring in some of the poorest and disadvantaged populations. But it is not enough.

Uganda has also seen improvement in five out of the six maternal health indicators under Millennium Development Goal (MDG) 5.

However, this has not translated into significant change in maternal mortality ratios. Based on the rates of progress to date in MDG 4 related to reduction of child mortality and MDG 5, improving maternal health, Uganda is unlikely to achieve 2015 targets for these goals. There are glaring disparities between the rate of child and maternal death across wealth groups and geographical regions – disparities that will persist unless Uganda takes action.

Uganda has got the tools and knowledge to change that trend and bring an end to preventable deaths with greater participation of all partners and stakeholders. There is need for a change in focus and commitment to hold partners and stakeholders accountable.

In June 2012, the Child Survival Call to Action was launched in Washington DC, United States, with the objective of mobilising political leadership to end preventable child deaths.

The call encouraged governments to commit and renew promises to child and maternal survival, with evidence-based country plans, executed with transparency, mutual accountability by all partners, and the use of the media and other communication channels to sustain the momentum and gains well into the future.

In April 2013, Uganda embarked on the development of an evidence-based plan to address the slow progress relating to achieving MDGs 4 and 5 targets, hence this Reproductive, Maternal, Newborn and Child Health (RMNCH) Sharpened Plan.

### 1.2 The National Health Context

This plan is aligned with key national priorities. It is in line with Uganda's Vision 2040, the National Development Plan as well as the National Health Strategic plans, policies and related sectoral plans.

Uganda's Vision 2040 launched in 2013 states that, to improve the quality of the population

over the Vision’s period, Uganda will focus on creating a more sustainable age structure by reducing the high fertility rate through increased access to quality reproductive health services and focus on building an efficient health services delivery system which emphasises prevention over curative services.

The goals of the National Development Plan (NDP) 2010/11 – 2014/15 are similar to the MDGs, especially for women and children.

The NDP states that, although high mortality is a health outcome, it is not solely the responsibility of the health sector and activities geared towards reduced mortality are multi-sectoral.

In addition, the NDP indicates that high mortality is not due to lack of appropriate policies in Uganda but rather due to inadequate policy implementation.

The decentralisation policy stipulates efficiency and effectiveness of service delivery, guided by the Constitution of Uganda (1995) and the Local Government Act (1997).

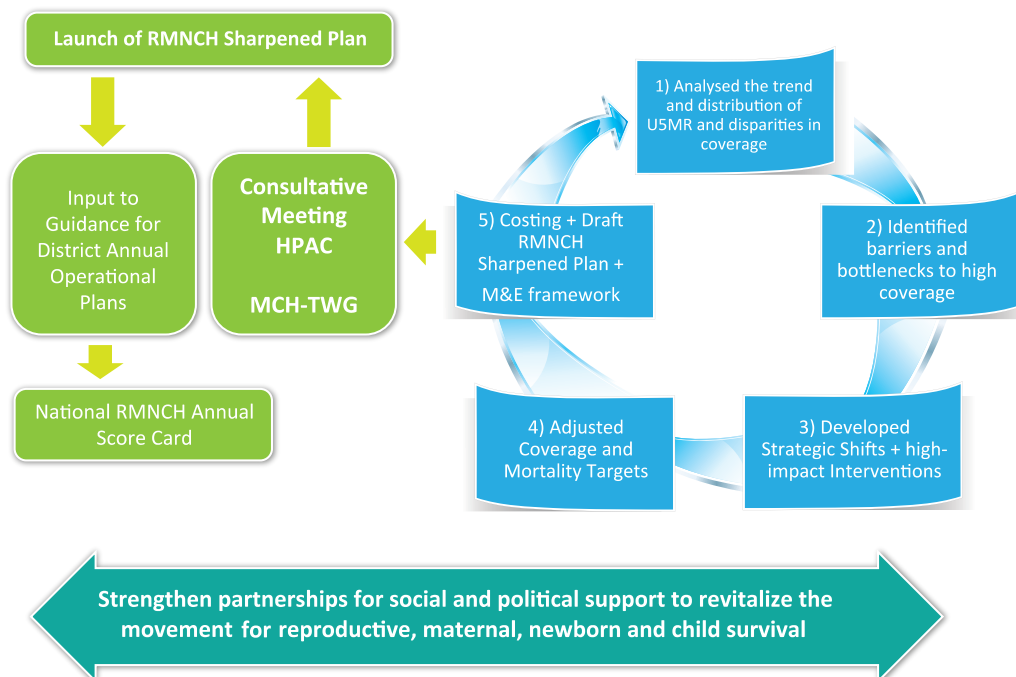
The second National Health Policy (2010/11–2019/20) and the Health Sector Strategic and Investment Plan (HSSIP) 2010/11–2014/15 defines Maternal, Child and Newborn mortality reduction as the 3 outcomes of the health sector.

The Roadmap for the Reduction of Maternal and Newborn Mortality, National Child Survival Strategy and other strategies and related frameworks have prioritised high impact interventions, which are appropriate for vulnerable population, including the less advantaged. The biggest challenge this plan aims at addressing, is the prioritisation among the wider array of RMNCH interventions within the context of limited funding and resources.

This plan is centred on strengthening health services and empowering districts and lower levels to make decisions to ensure equitable access to services.

### 1.3 Process of Development of the Plan

Figure 1: Plan Development Process



The planning process followed the “Framework and Guidance for Landscape Analysis of Life-Saving Reproductive, Maternal, Newborn and Child Health Interventions and Commodities”. The planning process was country-led with multi-stakeholder involvement in each step over a period of five months, starting in May 2013. Figure 1: summarises the key activities and main outputs associated with each action in the plan’s development process. Four major analysis tools were used:

#### Step 1: Analysing the trends:

The Rapid Assessment of Interventions and Commodities Tool (RAIC) was used to collect information on the country, programme and RMNCH commodity specific profiles. In addition, an equity analysis was done using data from the Uganda Demographic Health Survey (UDHS) to reveal patterns of disparities related to geographic locations (regions), wealth groups, gender, urban-rural divides, ethnic groups, educational levels, etc.

#### Step 2: Identifying Barriers and Bottlenecks:

The Bottleneck Analysis (BNA)<sup>1</sup> was used to determine and prioritise factors which limit the attainment of adequate coverage and the highest impact on RMNCH. Using tracer indicators, the bottleneck analysis considered the three platforms of service delivery (the population level, the community and the individual or clinic platforms) and identified the bottlenecks therein.

#### Step 3: Developing strategic shifts, and high impact interventions:

Through consultative and interactive processes which included workshops, meetings of technical working groups and meetings with the academia, professional bodies, etc, new ways of doing business were arrived at (i.e. the strategic shifts) and a compendium of high impact interventions that will accelerate progress towards reaching the MDG 4 and 5 targets were identified. These interventions were then subjected to the Lives Saved Tool and the One Health Costing Tool in Steps 4 and 5 (below). Global evidence and practice informed the process.

#### Step 4: Adjusted coverage:

The **Lives Saved Tool (LiST)** is an evidence-based tool to assess the burden of disease and to identify high-impact package of interventions for maternal, neonatal and child health based on changes to the coverage levels of interventions. The LiST was used to project the amount of mortality reduction that could be achieved in the country if coverage levels of specific high impact interventions were increased based on the initial coverage, demographic characteristics and planned coverage targets.

#### Step 5: Costing and drafting:

The **OneHealth Costing Tool (OHT)** provided funding projections of the RMNCH Sharpened plan. Using the identified and agreed high impact interventions, estimates for the various inputs such as medicines, equipment and associated programmatic costs were derived.

### 1.4 The Time Period for the plan

Developed with participation of national and district stakeholders, the plan is a shared effort towards sharpened, collaborative and focused prioritised actions, with clearly defined roles for different stakeholders. Thus the plan will guide maternal and child mortality reduction towards:

2015 when the country will assess its performance against MDG targets 4 and 5.

1 The BNA approach was derived from the Tanahashi Model (1979)

2017 when the midterm review of the next five-year Health Sector Strategic Investment Plan (HSSIP) will take place.

2020 when the next five-year HSSIP ends and when the next Uganda Demographic Health Survey will take place

## 1.5 Outline of the Plan

Chapter 1 sets the background to the plan and the local context within which the plan is designed, time period covered by the plan, and how the plan was developed. It ends by highlighting commitments made by the Government of Uganda to reduce maternal, newborn and child mortality.

Chapter 2 describes the progress made towards the achievement of MDGs 4 and 5, as well as the other related MDGs and their drivers. It also discusses the disparities therein. Using a “bottleneck” analysis, the chapter highlights key root cause that underpins these disparities.

Chapter 3 examines the coverage and extent of integration of interventions and health systems for delivery, including innovative approaches. It further discusses the cross-cutting issues of equality, rights and gender.

Chapter 4 provides a roadmap to address this situation. It begins by forecasting estimates of lives to be saved through scale up of selected cost effective interventions. It defines the goal, strategic shifts and objectives of the plan, including the cost.

Chapter 5 consolidates the new commitments of the different stakeholders regarding the reduction of maternal, newborn and child deaths.

## 1.6 Overview of the Uganda RMNCH Commitments

Uganda is a signatory to global commitments that aim at accelerating progress towards reduction of child and maternal mortality. This plan presents the key commitments to reinforce the obligation of the country to improve maternal, newborn and child health, and to ensure that RMNCH stays high on the agenda.

### 1.6.1 UN Secretary General’s Global Health Strategy (GSWC) Pledge

In September 2011, the Government of Uganda made a commitment towards the GSWC in the following respect:

To ensure that comprehensive Emergency Obstetric and Newborn Care (EmONC) services in hospitals increase from 70% to 100% and in health centres from 17% to 50%.

To ensure that basic EmONC services are available in all health centres.

To ensure that skilled health service providers are available in hard-to-reach and hard-to-serve areas.

To reduce the unmet need for family planning from 40% to 20%.

To increase attendance of focused antenatal care from 42% to 75% with special emphasis on Preventing Mother-to-Child Transmission (PMTCT) and treatment of HIV.

To ensure at least 80% of children under 5 years with diarrhoea, pneumonia or malaria have

access to treatment, oral rehydration salts and zinc within 24 hours of contracting the problem.

To improve immunisation coverage to 85%.

To introduce pneumococcal and Human Papilloma Virus (HPV) vaccines.

These commitments cover the whole continuum of care, with a special emphasis on the human resources for health component of the health system.

### **1.6.2 Scaling up Nutrition (SUN) Movement Pledge**

In March 2011, Uganda signalled its commitment to join the SUN Movement meant to bring organisations together, across sectors, to support a national plan to scale up nutrition by helping to ensure that financial and technical resources are accessible, coordinated, predictable and be improved upon.

Uganda committed to this approach with a focus on five cross sectoral objectives set out in the Uganda Nutrition Action Plan Framework (UNAP). They are: improving maternal, infants and young child feeding; enhancing diet diversity; protecting households from the impacts shocks; strengthening policy, legal and institutional frameworks; and increasing national awareness in regards to nutrition.

### **1.6.3 Global Vaccine Action Plan (GVAP) Pledge**

Global Action Plan for Vaccines (GVAP) was endorsed in May 2012. It is geared at providing equitable access to existing vaccines for people in all communities, polio eradication as well as new and improved vaccines until 2020.

The government committed to increase and sustain coverage of all vaccines to a level above 80% and introduce new vaccines, namely, pneumococcal, human papilloma and rotavirus by 2015.

### **1.6.4 Family Planning 2020 (FP2020) Pledge**

Family Planning 2020 (FP2020) was launched at a London Summit in 2012.

Its main focus is to provide every woman with modern family planning choices and access by 2020. Uganda did commit to ensure an enabling policy to allow women to exercise their family planning choices by specifically meeting the financial requirement to reach the target through increasing yearly government allocation for family planning supplies from \$3.3m (sh7.8b) to \$5m (sh12b) for the next five years. There is also an effort to mobilise an additional \$5m (sh12b) per year from donors.

Uganda also committed to sustain the momentum from the London Summit and ensure all partners work to guarantee commodity security, voluntary planning and concrete measure to prevent coercion and discrimination and ensure respect for home rights.

Data is available to support all the above initiatives through a score card, national health sub account and publication of an annual report to update all stakeholders on the progress and challenges. Uganda has since attained and even surpassed this financial target and subsequently donor aid as a proportion of total health care aid reduced from 8.2% to 2.6% between 2000 and 2009.

### **1.6.5 Global Action Plan for Pneumonia & Diarrhoea (GAPPD) Pledge**

The World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) launched the GAPPD programme for the prevention and control of pneumonia and diarrhoea. It proposes a cohesive approach to end preventable child deaths from these diseases by 2025.

It brings together critical services and interventions to create healthy environments, promote practices known to protect children from disease and ensure that every child has access to proven and appropriate preventive and treatment measures.

The goal is to reduce deaths from pneumonia to fewer than 3 children per 1000 live births and from diarrhoea to less than 1 in 1000 by 2025.

In July 2012 during the visit of former US President Bill Clinton to Uganda, attention was drawn to recommitting the public sector, civil society, private sector to diarrhoea and pneumonia treatment and advocate for the implementation of the National Prevention, Protection and Treatment (PPT) of diarrhoea and pneumonia strategy.

The strategy is about a holistic and more coordinated approach to these two neglected diseases and addresses all age groups.

His Excellency the President of Uganda Yoweri Museveni announced the introduction of rotavirus and pneumococcal vaccines.

### **1.6.6 Information and Accountability for Women's & Children's Health Pledge**

The Global Strategy for Women's and Children's Health called for the process to ensure global reporting, oversight and accountability.

In response, the Commission on Information and Accountability for Women and Children Health (CoIA) was convened and delivered its report in 2011.

Under "Keeping Promises, Measuring Results", 10 recommendations were put forth to fast-track results for women's and children's health in the 75 countries that account for 95% of maternal and child deaths in the world.

The Commission also identified 11 core indicators to enable stakeholders to track progress in improving coverage of interventions needed to ensure the health of women and children across the continuum of care. The indicators cover: maternal mortality ratio, the under-five mortality category, stunting prevalence, demand for family planning issues, antenatal care, anti-retroviral treatment for HIV positive pregnant women, skilled attendants at birth, postnatal care for mothers and babies within two days of birth and exclusive breastfeeding. There is also the issue of three doses of DPT-HiB coverage and antibiotic treatment for childhood pneumonia.

Uganda is one of the pathfinder countries committed to developing an accountability framework and to follow up on the recommendations.

### **1.6.7 Life Saving Commodities (LSCo) for Women and Children's Health Pledge**

The United Nations Commission on Life-Saving Commodities was created by the UN Secretary General Ban Ki-moon under the auspices of the Every Woman Every Child Movement. It seeks to amplify efforts to save and improve the lives of 16 million women and children.

This Commission is tasked with promoting affordable and effective medicines and health supplies that currently do not reach women and children who mostly need them by providing a platform to help overcome the major bottlenecks.

Uganda is among the pathfinder countries identified to implement the 10 UN Commission recommendations.

In October 2012, ministers of health from the pathfinder countries signed a ministerial communiqué committing to this effect and agreed to undertake a review of the status of the 13 life-saving commodities, identify opportunities and gaps based on the recommendations and develop plans for implementation.

### **1.6.8 Preventing Premature Births & Deaths - “Born Too Soon” (BTS) Pledge**

World Prematurity Day is observed every 17th of November. In a bid to accelerate reduction of under-five mortality targets, the government committed towards a new goal to reduce deaths due to complication of pre-term birth by 50% between 2010 and 2025. This was done to specifically incorporate targets for pre-term care into the national policies and plans, increase the pace of scaling up high impact interventions to reduce deaths due to prematurity, especially the management of women in pre-term labour, using antenatal corticosteroids and Kangaroo Mother Care services.

There was also need to working with Village Health Teams (VHTs) and their district counterparts to strengthen linkages between communities and health facilities through early identification, referral and care of small babies.

Uganda will commemorate every World Prematurity Day to create awareness and start the pathway to new commitments as progress is made.

### **1.6.9 The Call to Child Survival- A Promise Renewed (APR) Pledge**

In June 2012, under the leadership of participating governments and in support of the UN Secretary Generals Every Woman Every Child Strategy, A Promise Renewed was launched, to commit to accelerating the decline in under-five mortality.

A modelling exercise presented at the high level forum demonstrated that the world can accelerate progress by scaling up the full continuum of care for woman and children and all countries can lower child mortality to 20 or fewer deaths per 1000 live births by 2035 as an important mile stone towards the ultimate goal of ending preventable child death.

Uganda was among 176 governments that signed a pledge, renewing their commitment to save a greater number of children from dying of preventable causes.

Uganda also committed to translating its commitments into practical actions through a sharpened plan, setting measurable benchmarks and strengthening national accountability for child survival.

### **1.6.10 Global Newborn Action Plan (GNAP) – Every Newborn Pledge**

The ‘Global Action Plan for Newborns – Every Newborn Pledge’ is set to be launched in May 2014 in conjunction with the World Health Assembly. The idea is to start implementing the

plan in 2014 and beyond by all stakeholders.

This pledge will contribute to the global strategy for 'Every Woman, Every Child' and provide a road map and joint action platform for the reduction of preventable newborn mortality.

It will also define the role and responsibility of stakeholders, setting out a vision, targets and objectives with the recommended key actions to implement based on proven strategies for change and latest evidence on effectiveness, costs and expected impact of interventions.

The 'Every Newborn' commitment is being developed through a series of consultative meetings throughout 2013, facilitated by the core group chaired by UNICEF and WHO. Twenty countries have been identified to start analysing their situation in preparation for more detailed planning. Uganda went through this process in May 2013.

#### **1.6.11 Elimination of Mother to Child HIV Transmission (eMTCT) Pledge**

In line with a new campaign towards the elimination of transmission and HIV free survival for children, Uganda's plan sets two ambitious targets for 2015, both from a 2009 baseline to reduce the number of children newly infected with HIV by 90%.

It also sets out to reduce the number of HIV associated deaths among women during pregnancy, childbirth and the six weeks that follow by 50%.

The initiative championed by the First Lady Janet Museveni is focusing on programmatic innovations for identifying HIV infected children and retaining them on ART care and treatment, community mobilisation and support for HIV positive women and their children and better integration of Prevention of Mother to Child Transmission (PMTCT) services into stronger systems of maternal, newborn and child health care.

#### **1.6.12 Universal Insecticide Treated Mosquito Net (ITN) Distribution Pledge**

Another milestone is implementation of Universal ITN coverage planned to commence in 2013.

It aims at providing a net to every individual in a household by 2015.

In 2013 alone, more than 21 million nets were supposed to be distributed through a mass campaign.

At least, two people in every household will own one insecticide treated mosquito net. The approach will be a major improvement over the low availability rate in 2000.

The proportion of children under five that sleep under ITNs rose from 2% in 2000 to 38% in 2011, with some regions attaining levels of over 60%.

This intervention complements other malaria control interventions in the country and has great potential to reduce malaria deaths among pregnant mothers and children.

# 02

## THE ROAD AHEAD

Uganda has already met two of its seventeen MDG targets, reducing by half the number of people living in absolute poverty and achieving debt sustainability. The country is on track to achieve more eight targets.

There are areas where progress remains slow, has stagnated or experienced a reversal. Trends in maternal mortality and HIV-AIDS are particularly worrying, given their direct impact on the lives of so many Ugandans.

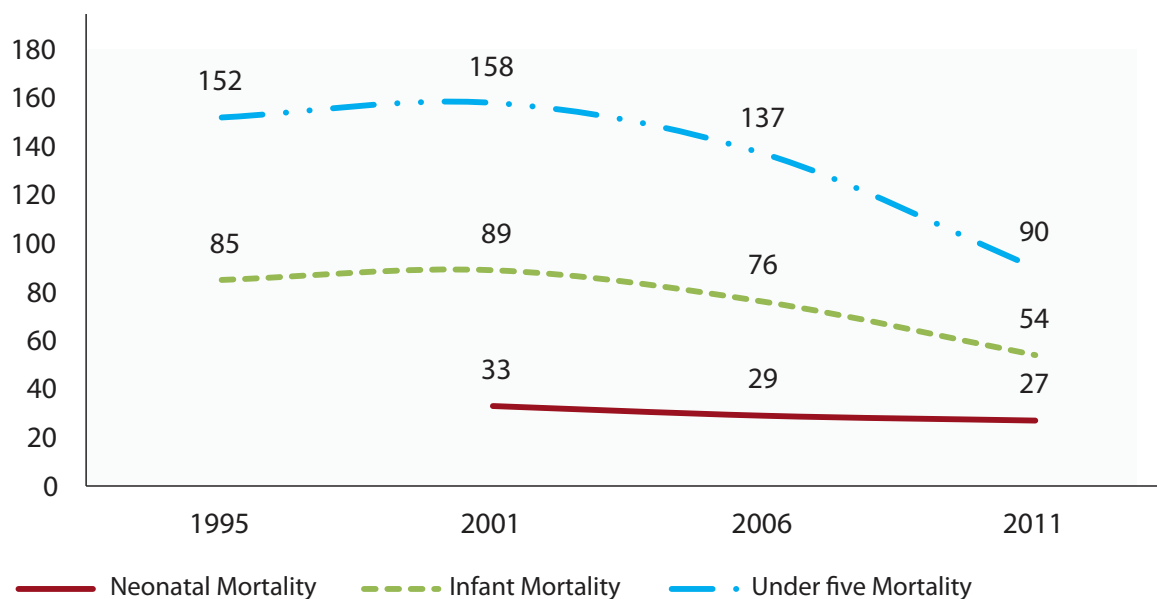
On the other hand, child mortality trends remain on course.

### 2.1 Progress on MDG 4: Reducing Child Mortality by two thirds

#### 2.1.1 Under-five mortality rate

*The number of Under-five deaths has fallen from 167 per 1,000 births in 1990 to 90 in 2011 equivalent to a 6.3% reduction per year. This means one in every 19 babies born in Uganda does not live to the first birthday and one in 11 children will die before their fifth birthday. The pace needed to achieve MDG target of 56 under-five deaths per 1000 births by 2015 (Figure 2) is 10% reduction per year.*

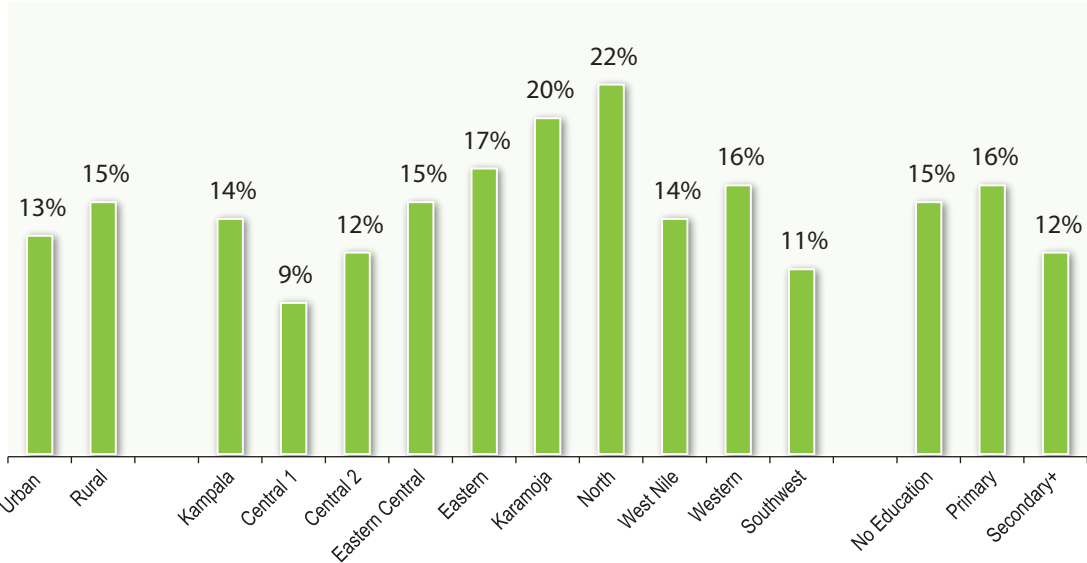
Figure 2: Trends in Mortality 1995-2011



Child mortality is not evenly distributed across the country. The chances of survival for Ugandan children depend upon where the baby’s family lives; how wealthy the family is and the education level attained by the mother. For example, only 15 districts account for 36% of child deaths in the country. All regions still have high mortality above the MDG target of 56/1000 live births but Kampala and the central regions have comparatively lower mortality rates.

The highest mortality is in Karamoja, Southwest, West Nile and the western regions. Death is also more likely among children born in rural areas and in households with the lowest wealth levels. Children born to better-educated mothers have a greater chance of survival. It was also noted that - education is critical for reducing the incidence of diarrhoea.

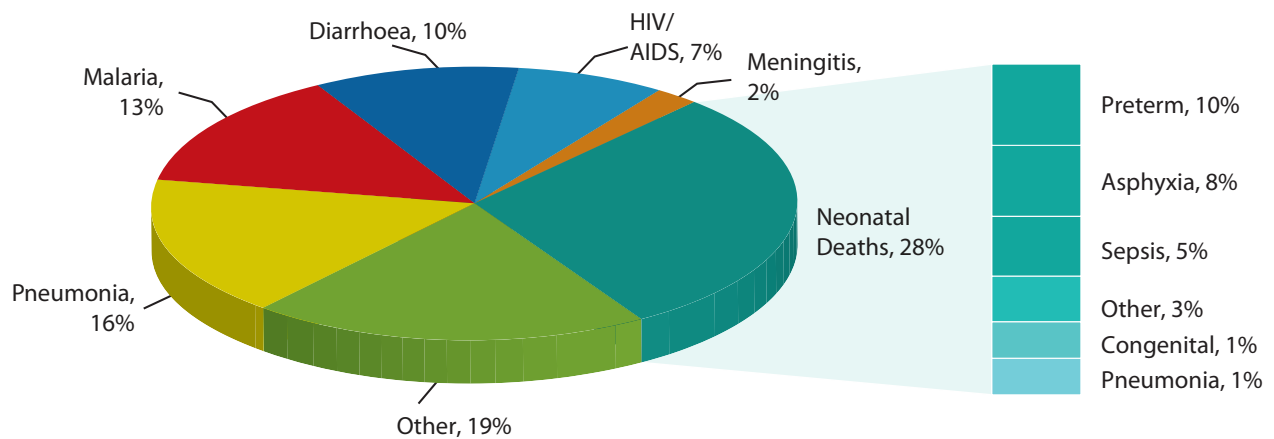
**Figure 3: Geographical disparities in ARI prevalence among U5s**



The 3 main killers of children below five years are pneumonia, malaria, diarrhoea and other infections like HIV. Together, these problems account for more than 70% of the deaths. (Figure 4).

Compared to other leading causes of mortality, less progress has been made in tackling pneumonia and other respiratory infections. Important factors influencing acute respiratory infections in Uganda include breastfeeding practices and housing conditions as well as wealth status. The median period of exclusive breastfeeding has increased slightly from 3.1 months in 2006 to 3.4 months in 2011. But the figures still fall short of that of 6 months recommended by the WHO.

**Figure 4: Causes of under-five mortality (2010)**



These are easily preventable through simple improvements in basic health services and proven interventions such as oral rehydration therapy, insecticide treated mosquito nets and vaccination. Inadequate micronutrient intake and severe malaria is the common cause of anaemia. Following a drive to expand malaria prevention and control measures, the heavy burden imposed by the disease has begun to be rolled back.

Less improvement was noted in coverage of other interventions.

For example, only 31% of children with suspected pneumonia receive antibiotics, 35% with diarrhoea receive ORS and 2% zinc tablets compared to the set target of at least 80% of under 5 children. These are children with diarrhoea, pneumonia or malaria and do not have access to treatment.

### 2.1.2 Infant mortality rate

*The number of infants under 12 months has fallen from 86 per 1,000 births in 1995 to 54 in 2011, implying that one in every 19 babies born in Uganda does not live to their first birthday. Thirty seven percent of infant deaths occur in the first 28 days of life forming the single largest category of death.*

Reducing newborn deaths will be essential for further progress in infant mortality reduction in Uganda.

The first 24 hours after labour, childbirth and the first week is the most risky period of life. It also provides a window of opportunity to prevent and manage newborn complications.

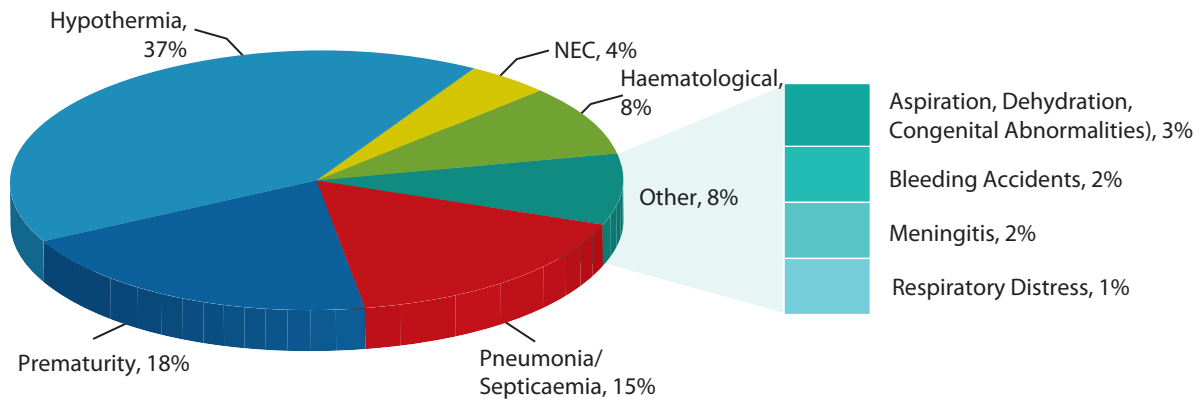
Newborn babies die mostly from three complications. These are premature birth (born before 37 weeks of gestation), birth asphyxia and infection as illustrated in Figure 5.

Yet only a half (54%) of the babies are born in the hands of skilled providers and only 34% receive post-natal check-up within 7 days after birth.

Improved access to treatment has reduced the numbers of deaths associated with HIV/AIDS, but the prevalence in people of the 15 to 24 age group has increased. Improved treated has indirectly contributed to a drop in the number of new infections by ensuring greater longevity for those living with HIV.

Coverage of HIV positive pregnant mothers accessing the package of **Elimination of Mother to Child HIV Transmission (eMTCT)** services stands at 57%.

**Figure 5: Causes of Neonatal Mortality**

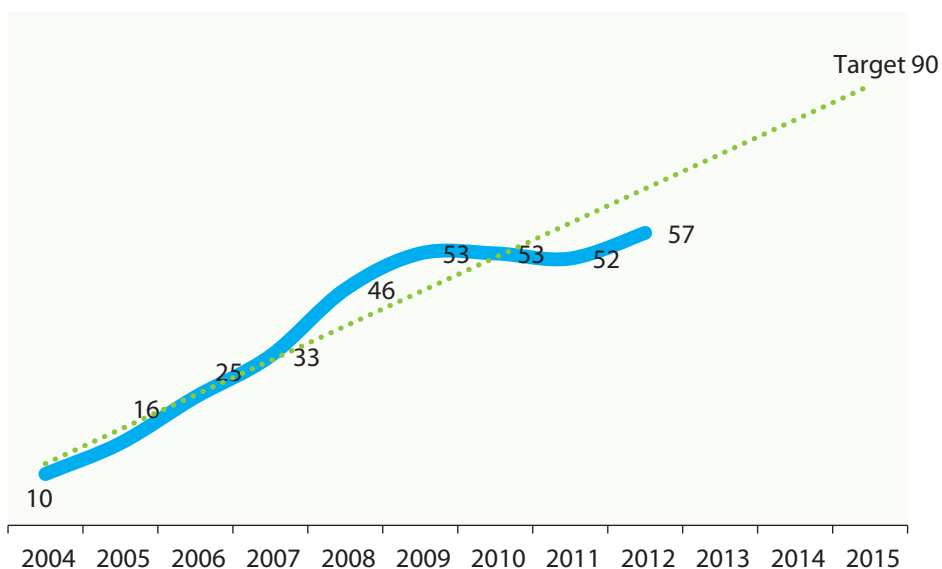


To reverse the spread of HIV/AIDS, Government is revitalising the prevention strategies that accounted from the significant decline in the new infection during the 1990s.

It is estimated that 18% of the new infections are due to mother to child transmission. Government is rapidly rolling out revised WHO guidelines to ensure HIV infected mothers and their infants receive triple ARV prophylaxis during labour and through breastfeeding period.

This means reducing new paediatric HIV infections from 25,000 to 2,000 by 2015. This intervention will directly contribute to universal ART access for women and girls as shown in Figure 6.

**Figure 6: HIV+ pregnant mothers on ARVs for PMTCT 2004 – 2015**



### 2.1.3 Proportion of 1 year old children immunised against measles

*The proportion of one-year old children immunised against measles has risen from 60% in 1995 to 76% in 2011. But the figure is still significantly below the 85% national target that is required to stop the transmission. Measles deaths have reduced by more than two-thirds since 1990 surpassing the initial target to halve deaths due to measles by 2005.*

In 2011, coverage with full childhood immunisation was highest in Karamoja (62%), Southwest (62%), and Western (60%). These are the same regions where the under-five mortality was highest. This underscores the need to understand and address the multiple factors that have a bearing on different parameters of health. Vaccination is known to be effective in preventing infant and child deaths.

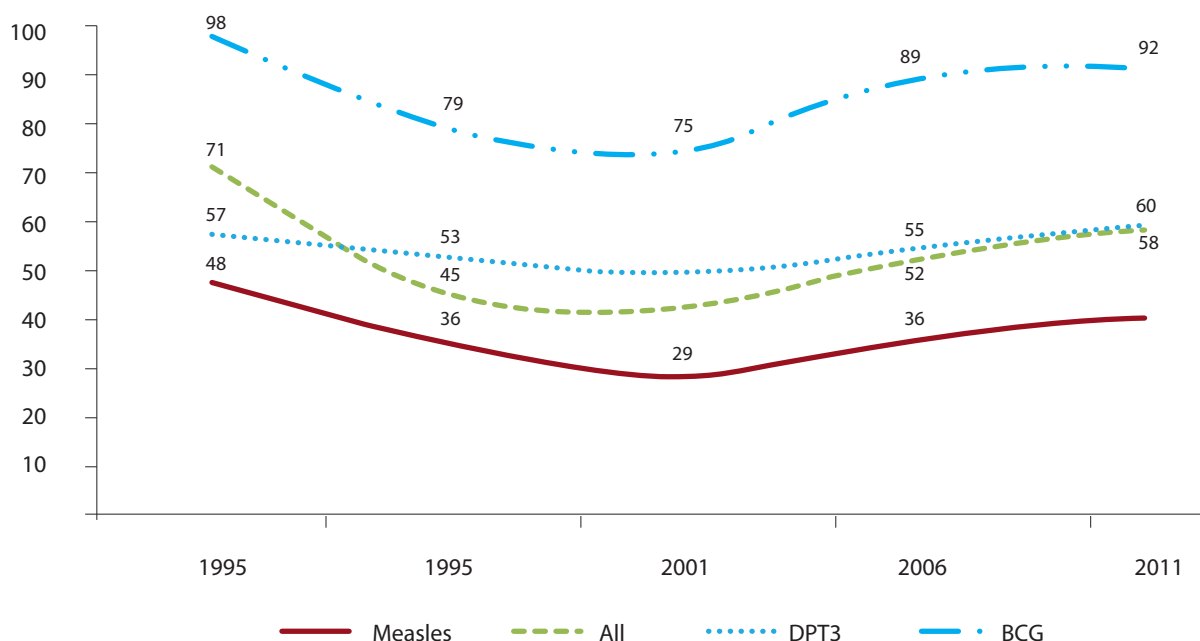
District level DPT vaccination rates display a highly significant effect in bringing down infant mortality rates in Uganda. The slow progress in reducing mortality in the late 1990s and early 2000s is partly explained by a reversal in vaccination rates.

This was addressed by Government through the implementation of the 2001-2005 immunisation revitalisation strategic plan which has seen a full immunisation.

BCG, measles and three doses each of DPT, polio, hepatitis and heamophilus vaccine coverage increased to 41% (Figure 7) although substantial room for improvement remains.

The pneumonia vaccine has been introduced and plans are underway to introduce rotavirus and human papilloma virus (HPV) vaccines.

**Figure 7: Immunisation Coverage Trends - UDHS 1988 to 2011**



## 2.2 Progress on MDG 5: Reducing maternal mortality ratio by three quarters

The link between child mortality and maternal mortality is indelible. Infants whose mothers die within the first 6 weeks of their lives are more likely to die before reaching age 2 than infants whose mothers survive.

### 2.2.1 Maternal mortality ratio

*Maternal mortality in Uganda has declined from 527 deaths per 100,000 live births in 1995, to 438 deaths per 100,000 live births in 2011 away from the MDG target of 131 deaths per 100,000 live births by 2015. This translates into an annual decline rate of 5.1% and an average of 18 women dying every day. Maternal mortality is highest in Western and Karamoja regions and lowest in Central region 1.*

Figure 8: Trends of Maternal Mortality Ratio



The most important direct causes of maternal mortality is haemorrhage accounting for 42% of deaths, obstructed or prolonged labour 22% and complications from abortion 11%.

Important indirect causes include malaria, a factor in 36% of maternal deaths recorded, anaemia at 11% and HIV/AIDS at 7%.

High total fertility rate (TFR), high teenage pregnancy rate and high unmet need for family planning increase exposure to the risk of pregnancy and hence pregnancy related deaths for both women and newborns.

Government is concerned that in spite of the progress as reflected in many maternal health indicators, there is no significant reduction in the maternal mortality ratio and Uganda is unlikely to meet the MDG 5 target of reducing maternal mortality by three quarters.

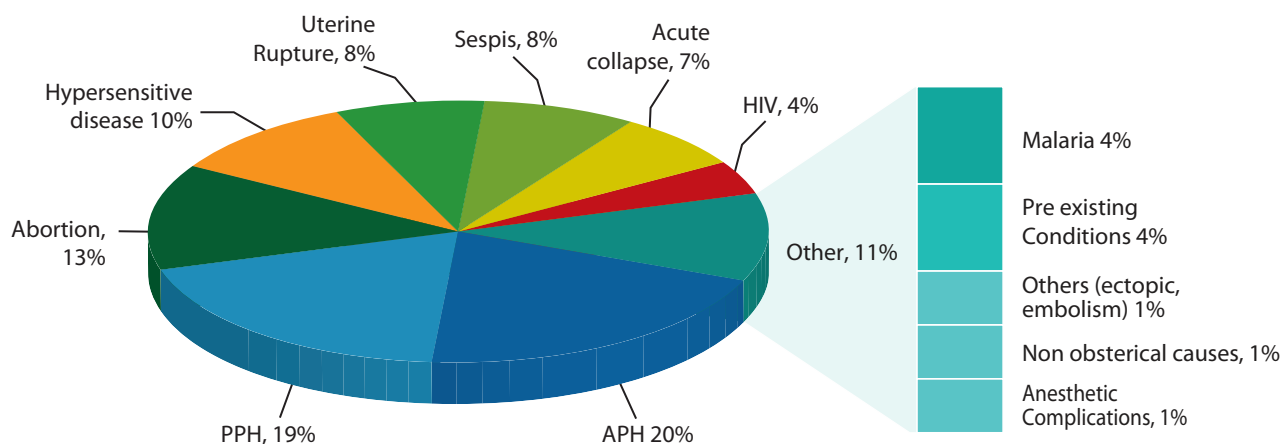
This is partly due to the use and quality of services along the continuum of care - from pregnancy, to childbirth and to the post childbirth period.

Evidence from international experts suggests that good prenatal care can prevent up to a quarter of maternal deaths by increasing a woman's awareness of potential complication and the danger signs during pregnancy.

In addition, many mothers do not receive any post natal check-up yet and over 60% of maternal deaths occur 23-48 hours after delivery, mostly due to haemorrhage and hypertensive disorders or after 48 hours because of sepsis.

Government investments in skilled birth attendants, geographical access and rural transportation infrastructure are critical for improving access to emergency obstetric care to prevent these deaths.

**Figure 9: Direct Causes of Maternal Mortality**



Compared to 2000, the number of health facilities expected to offer emergency obstetric care has improved from 3% to almost a half in 2011. They provide obstetric care or having at least one staff member trained in managing complications in pregnancy and child births. This is compared to the country commitment of 100%.

As tracer indicators for comprehensive emergency obstetric care (CEmOC), the percentage of health centre IVs and hospitals that offer caesarean section increased from 45% in 2006 to 77% in 2011. At the same time, blood transfusion services stands at 46%.

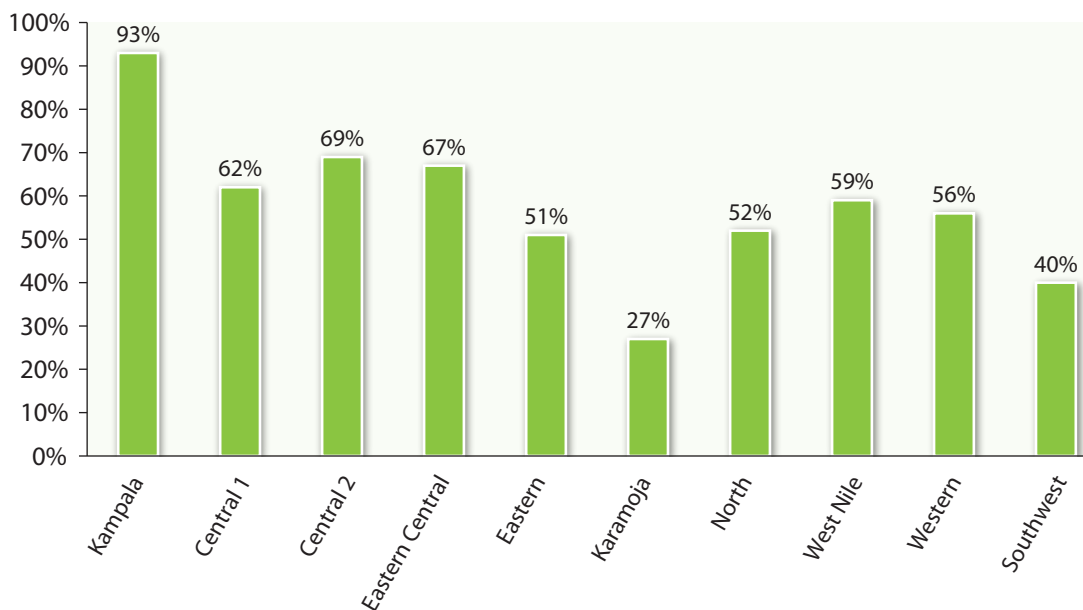
### 2.2.2 Proportion of births attended by a skilled health personnel

*The proportion of births supervised by a skilled health worker has risen from 38% in 1995 to 58% in 2011. Between 2006 and 2011, there was a large increase from 42% to 58% across all regions of the country.*

A skilled birth attendant assists 53% of births in rural areas compared to almost 90% of all births in urban areas. Karamoja (31%) and the South-Western (42%) regions post the lowest coverage of births supervised by a skilled provider.

Institutional deliveries are currently at an average of 60% nationwide and the proportion of births at health facilities follows a similar disparity trend as illustrated in Figure 10.

**Figure 10: Proportion delivering in health facility**



### 2.2.3 Contraceptive prevalence rate

*Contraceptive prevalence rate among all married women or those with a partner (age 15-49 years) has doubled from 15% in 1995 to 30% in 2011. This has probably lessened maternal and infant health risks by preventing unintended or closely spaced pregnancies and has helped to reduce the adolescent birth rates.*

Uganda has one of the highest population growth rates in the world at 3.2% per year and a high fertility rate of 6.7%.

This trend has remained the same over a long period of time. Regional disparities exist with Karamoja region having the lowest at 30% followed by western region.

### 2.2.4 Adolescent birth rate

*Although declining, Uganda has one of the highest rates of adolescent pregnancy in Sub-Saharan Africa. Overall teenage birth rate or the proportion of birth per 1000 women aged 15-19 has decreased from 204 to 135 between 1995 and 2011 with 24% giving birth to their first child before turning 19.*

The region recording the highest rate of teenage pregnancy in the country is mid-western region with Kasese district recording the worst rate (31%), followed by Eastern region at 26% from 43%. This was in the period in 2006 to 2011.

Early motherhood not only increases the risk of dying in childbirth, it also jeopardises the wellbeing of surviving mothers and their children.

Still births and child deaths are 50% more likely for babies born to mothers younger than 20 compared to those aged 20-29.

The percentage of teenage pregnancies among those with secondary education is 16% compared to 45% for those with no education. The drop in adolescent births is slow considering the intricate linkage of adolescent pregnancies to unsafe abortions and the resultant need for Post Abortion Care (PAC) services.

Abortion and pregnancy related sepsis account for one in five maternal deaths (20%) with about 60% of the abortion cases categorised as induced abortions.

Uganda is however scaling up training for health workers to provide Post Abortion Care (PAC), including access to counselling services. Scaling up life-saving commodities and equipment including misoprostol and emergency contraceptives as well as other emergency obstetric care (EmOC) services are being implemented and key to increasing PAC coverage.

But gathering data about PAC coverage, ensuring quality and utilisation still remain a challenge.

### 2.2.5 Antenatal care coverage

*The proportion of pregnant women who made the WHO recommended minimum of four antenatal visits has remained low. It was 47.6% in 2011 compared to 47.2% in 1995 against the national target of 75% by 2015. While 95% of women received antenatal care from a skilled provider at least once during pregnancy in 2011, the median duration of pregnancy for the first antenatal visit is 5.1 months.*

Central region has the lowest (88%) antenatal care attendance, translating to at least one visit. The national focus is “A goal oriented ANC”, an approach that emphasises evidence-based goal oriented actions to a woman from a time when a pregnancy is diagnosed up the time of delivery, including eMTCT.

Knowledge of mother to child transmission of HIV among women 15-49 years was 71% in 2011. The low antenatal care coverage affects use of these services.

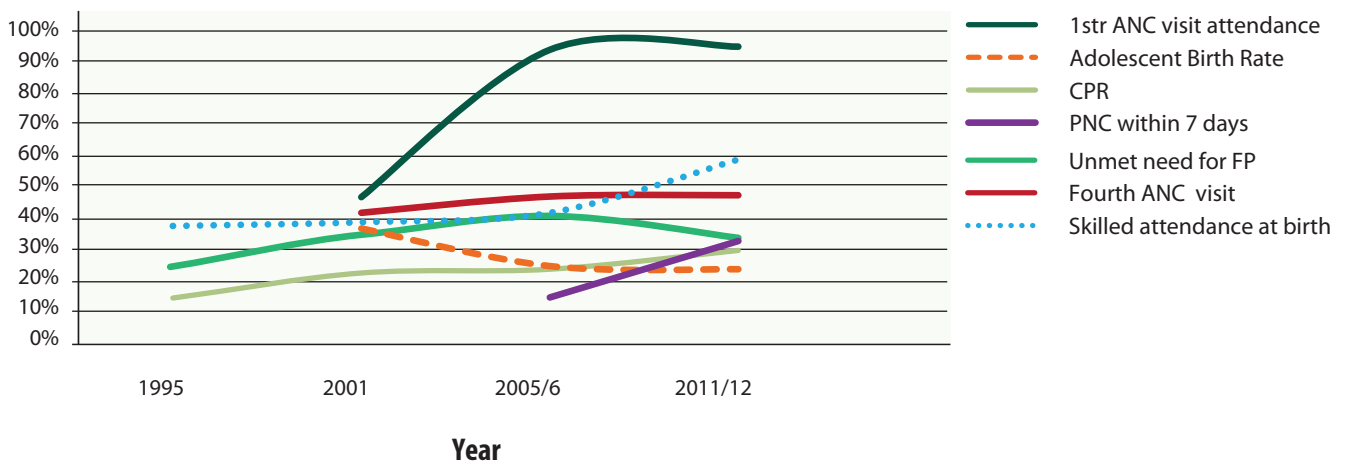
### 2.2.6 Unmet need for family planning

*The proportion of all married women or those with a partner (age 15-49 years) who wished to delay or avoid pregnancy but did not use any contraceptive has increased from 22% in 1995 to 34.3% in 2011 compared to the target of 20%..*

Unmet need of family planning is highest in West Nile and northern Uganda at a rate of 43% and lowest in Kampala at 17% and Karamoja region at 21%.

Regional variations are a result of inaccessibility to family planning services. The total demand for family planning in Uganda is at 64.3% (unmet need + met need for family planning). This gives 36.7% of those who do not currently have any need for family planning. These are groups that still have negative perceptions about family planning coupled with cultural beliefs in preference for large families, fear of side effects and level of education for mothers.

**Figure 11: Un-met need for family planning**



## 2.3 Progress on other contributing factors

The specific targets in the MDGs and the synergies therein offer opportunities for linking across various MDGs and sectors. RMNCH has deep links with hunger, poverty and under-nutrition (MDG 1), education (MDG 2), gender (MDG 3), safe drinking water and sanitation (MDG 7).

### 2.3.1 Nutrition and Hunger

*There has been an essential reduction in hunger and under nutrition since 1995. The problem of underweight children has reduced by half from 25.5% in 1995 to 13.8% in 2011. Because of chronic under-nutrition, a third of the children under five are stunted (have low height for their age). Malnutrition reflects a 55% figure of infant and child deaths.*

Mothers who are under-nourished are more likely to deliver low birth weight babies. Preventing child deaths of this nature and improving maternal health outcomes requires addressing underlying risks of poor nutrition. Effective regulatory frameworks and guidelines on issues like the international code on marketing breast milk substitutes and maternal protection for working women, are among the priorities for Government.

### 2.3.2 HIV/AIDS

*HIV prevalence has risen from 6.4% in 2005 to 7.3% in 2011. On the other hand, the proportion of the population with advanced HIV infection with access to anti-retroviral drugs increased from 44% in 2008 to 62% in 2012.*

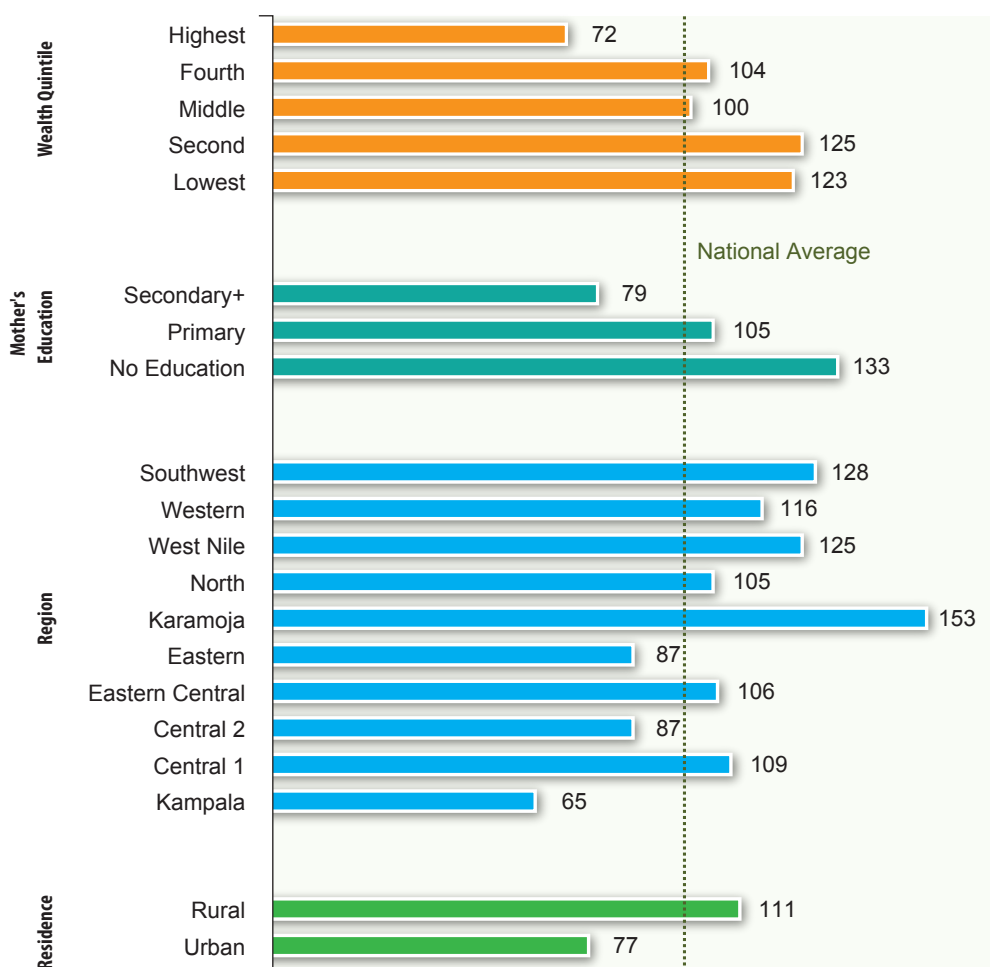
Even with the expansion in the eligible population, Uganda is on course to achieve the national target of providing anti-retroviral drugs to 80% of those in need by 2015. Improved access to treatment has improved the number of deaths associated with HIV/AIDS but the prevalence rate among the 15 – 24 age groups has increased. This may partly be due to improved treatment that has indirectly contributed to the raise in numbers of new infections by ensuring greater longevity for those living with HIV/AIDS.

### 2.3.3 Education

*Universal primary education has dramatically increased primary school enrolment and reduced inequalities in access to education relating to gender, income and location. It has also increased the probability that children start school at the right age. Dropout rates and grade repetition remains high.*

There have been substantial efforts to improve education levels but disparities still exist with Karamoja region registering the lowest school enrolment with fewer girls completing primary education and enrolling in secondary education compared to boys. Figure 12 below shows the disparities in education, poverty, region and residence in relation to child mortality.

**Figure 12: Disparities in U5MR and National Average**



### 2.3.4 Water and Sanitation

*The proportion of population using improved drinking water sources and sanitation facilities has improved from 52% to 70% and 52% to 75% between 2001 and 2011 respectively.*

Open defecation is still practiced by an estimated 3.3 million people, mainly in rural areas. Elimination of this practice is an essential step towards reducing child mortality from associated diseases.

Large disparities in access to both improved drinking water sources and improved sanitation exist across the country, between urban and rural populations. Better knowledge of proper sanitation among better-educated mothers is a key driver for diarrhoea mortality.

### 2.3.5 RMNCH Financing

*Expenditure on reproductive and child health was US\$0.22b each compared to US\$0.48b (US dollar) required for rolling out the child survival strategy. Health expenditure per child under five years is \$40 US dollars and 52 US dollars per capita for reproductive health.*

Government allocation to districts is based on health facility level rather than population need.

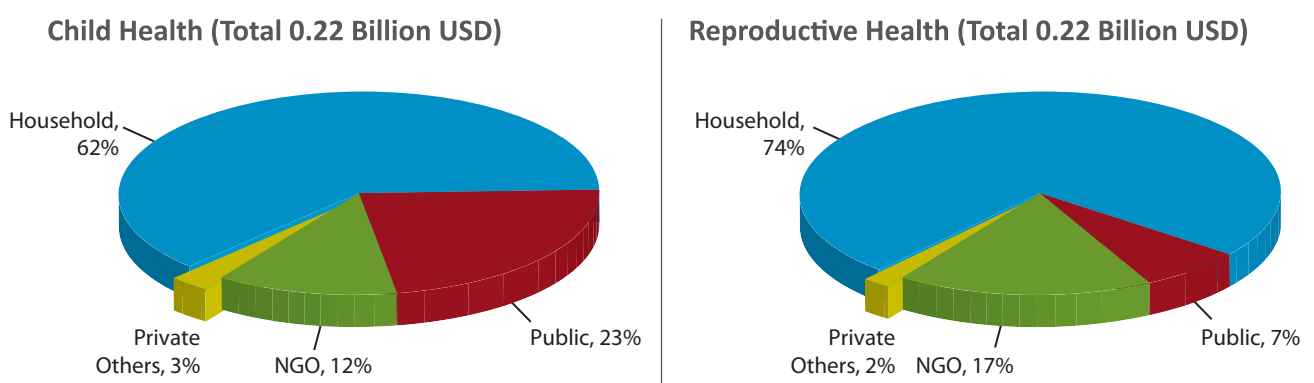
Annual health total expenditure has increased from US\$1.5 billion to 3.2 billion (US dollar) between Financial Year 2008/9 and Financial Year 2009/10 which is equal to 8% of the total government expenditure compared to the 15% Abuja target.

Out of pocket payment remains the largest form of payment within the Uganda health sector despite the large flow of donor funds into the country. Government funding of services within public health facilities and subsidies of health services at Private Not For Profits (PNFPs) Health Facilities. Household manage around 40% of the total health expenditure with 62% for child health and 74% for reproductive health.

Achieving positive outcomes for women and children with high impact interventions will require sufficient funding.

This will further require “more health for the money” by ensuring that resources for RMNCH are used effectively, equitably, and efficiently. It also requires “more money for the health” by mobilizing additional resources for RMNCH.

**Figure 13: Funding Sources for RMNCH**



## 2.4 Drivers of MDG 4 AND 5 achievement in Uganda

### 2.4.1 Bottlenecks to scaling up

Both supply side and demand side bottlenecks are affecting scaling up of RMNCH interventions.

A Bottleneck Analysis (BNA) – a structured analysis of the determinants of coverage to key RMNCH interventions was applied.

Derived from Tanahashi model (1979), this was used to define particular elements that limit the whole system capacity to improve the health outcomes of the population. The focus of the BNA was on the relationship between six determinants of coverage.

This has a great added value when compared to the analysis of the determinants taken individually since it allows for an in depth understanding of the process that leads to the successful provision and utilization of services and it provides an easy way to prioritise the bottlenecks with the highest impact on coverage.

Five critical tracer interventions of interest were selected for analysis to serve as proxies for all interventions in a given service delivery platform. The health system was examined against array of supply (availability of commodities, human resources and geographical access), demand (initial and continuous utilisation) and quality of services (effective coverage) factors that determine the extent to which targeted populations benefit from the health services.

It also offered an opportunity to review the bottlenecks along the three service delivery platforms (the community/households, population/outreach and individual/clinical level platforms).

The BNA was followed by a causal analysis which identified the root causes of bottlenecks using the “5 WHYS” approach.

#### 2.4.1.1 House Hold and Community Platform

**Supply side bottleneck:** The tracer intervention selected for this platform was pneumonia treatment at community level.

Figure 14 shows six bars of analysis, three on the supply side (left side) and three on the demand side (right side).

The main supply side bottleneck is lack of human resource capacity for integrated Community Case Management (iCCM), defined as inadequate number of Village Health Teams (VHTs) trained to provide services. The root cause of this bottleneck is the high cost of training. The factors contributing to this high turnover of VHTs necessitate repeated training.

One reason is low motivation caused by irregular supervision and lack of incentives hence high attrition rates.

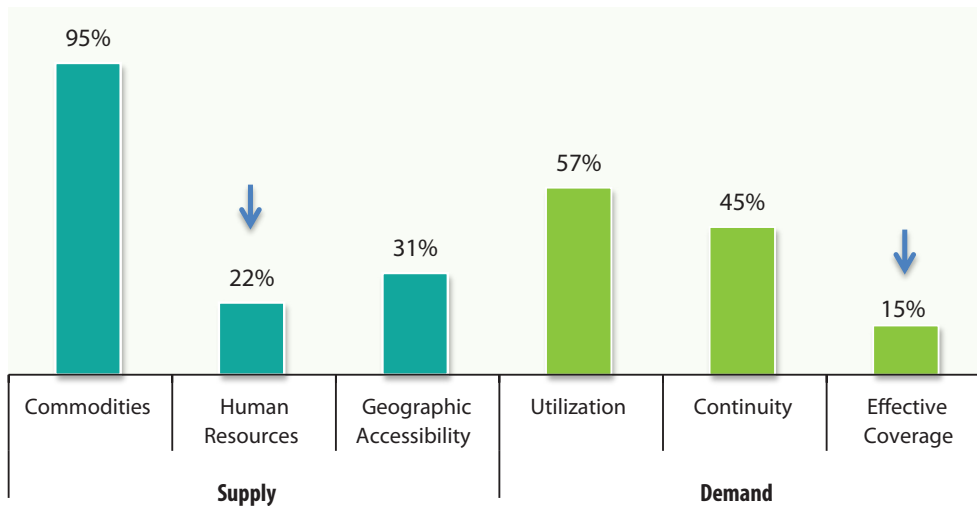
Private drug shop operators offer alternative services to manage children with diarrhoea and could reduce on VHT work but most do not have the necessary skills. Yet most of them lack opportunities for training.

**Demand side bottleneck:** The main bottleneck is non-care giver compliance to use of Oral Rehydration Salts (ORS)

The root causes for this are the strong cultural traditional beliefs on causes and treatment of diarrhoea compounded by low perception of ORS efficacy. VHTs can play a significant role in improving caregiver knowledge and demand for ORS.

Lack of clean water for mixing ORS however hampers uptake.

**Figure 14: Bottlenecks in ORS use**



#### 2.4.1.2 Population wide scheduled services

**Supply side bottleneck:** The tracer intervention selected for this platform was Long Term Family Planning (LTFP) as illustrated in Figure 15. The main supply side bottleneck is lack of commodities for LTFP.

However, even when commodities are made available, inadequate human resource capacity defined as “skilled health workers trained to insert and remove implants” is a more critical bottleneck which will hinder availability of these commodities to the client.

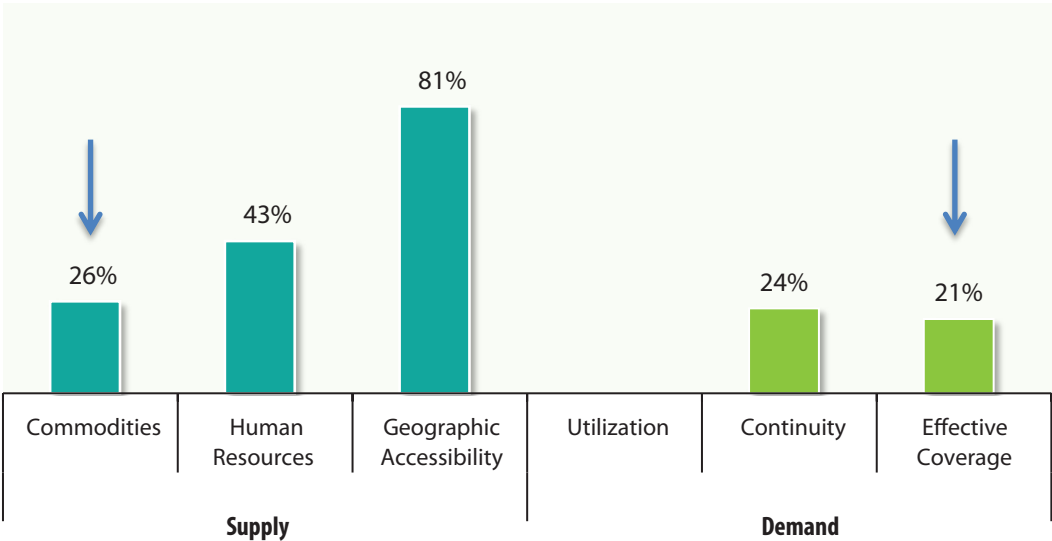
A task shifting policy allowing trained paramedical workers to insert and remove implants exists but is not being implemented.

The factors contributing to this include provider non-compliance due to fear to insert implants, limited knowledge and skills to manage side effects.

**Demand side bottleneck:** The main bottleneck is discontinuation of use of long terms methods despite the high rate of insertion. The root causes for this are multiple side effects such as bleeding, plus cultural and religious influence which discourage contraceptive use.

This is further complicated by the lack of male involvement, limited knowledge and value of implants.

**Figure 15: Bottlenecks in Implant use**



**2.4.1.3 Clinical/Individual Level Platform**

**Supply side bottleneck:** The tracer intervention selected for this platform was basic emergence obstetric and newborn care (BEmONC) at the health facility (Figure 16).

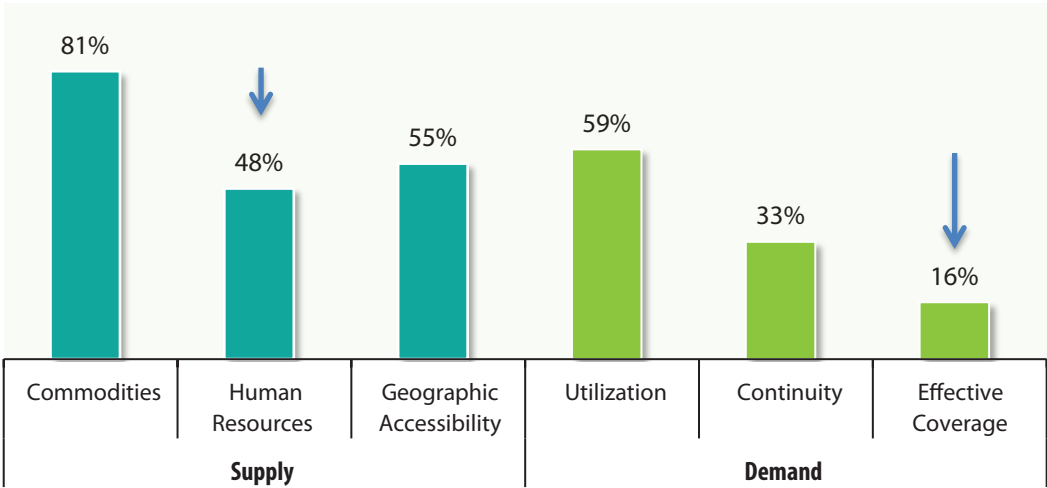
The main bottleneck is unavailability of skilled human resources to deal with complications arising during pregnancy and labour.

The root cause of this bottleneck is the low production, recruitment and retention especially in hard to reach areas. Pre-service training could offer a sustainable solution but BEmONC is not fully integrated in training needs especially competence based training.

**Demand side bottleneck:** The key bottleneck here is the failure of mothers who have delivered to seek postnatal care at 6 weeks. This lack of continuum of care is attributable to the low awareness of mothers about the importance of postnatal care checks.

This is further compounded by poor geographical access, lack of male involvement, financial barriers and the long waiting time at the clinics.

**Figure 16: Bottlenecks in BemONC**



## 2.4.2 Commodity specific bottlenecks

Thirteen lifesaving commodities have been first tracked by the UN commission to ensure that they are available to all women and children in need. These cover a range of items for reproductive, maternal, child and newborn health. Constraints were analysed for each item for the following areas.

Insufficient supply of high quality health commodities, inability to effectively regulate the quality of these commodities, lack of community access and awareness of how, why and when to use them and provider issues in utilising commodities such as lack of awareness on the use of the commodities, lack of equipment, lack of training on their use and provider biases that promote preferential use of a product they are used to.

The Lifesaving Commodities are grouped as:

- a) **Reproductive Health Commodities** comprising female condoms, contraceptive implants and emergency contraceptive pills;
- b) **Maternal Health Commodities** comprising misoprostol for prevention and treatment of Post-Partum Haemorrhage (PPH) magnesium sulphate for prevention, treatment of severe pre-eclampsia and eclampsia, oxytocin injection for prevention and treatment of PPH;
- c) **Newborn Health Commodities** comprising antenatal corticosteroids for management of pre-term labour, injectable antibiotics for neonatal sepsis, newborn resuscitation devices and chlorohexidine for cord care and,
- d) **Child Health Commodities** comprising oral rehydration salts and zinc treatment for diarrhoea, amoxicillin tablets for treatment of pneumonia in children

# 03

## ESTABLISHING A BASELINE: WHERE ARE WE

Uganda has witnessed progress during the last 20 years in improving the chances of children and women surviving. Progress has been made against a number of causes of mortality. This progress is a result of a number of initiatives or efforts including Government and its partners. These actions are reflected below.

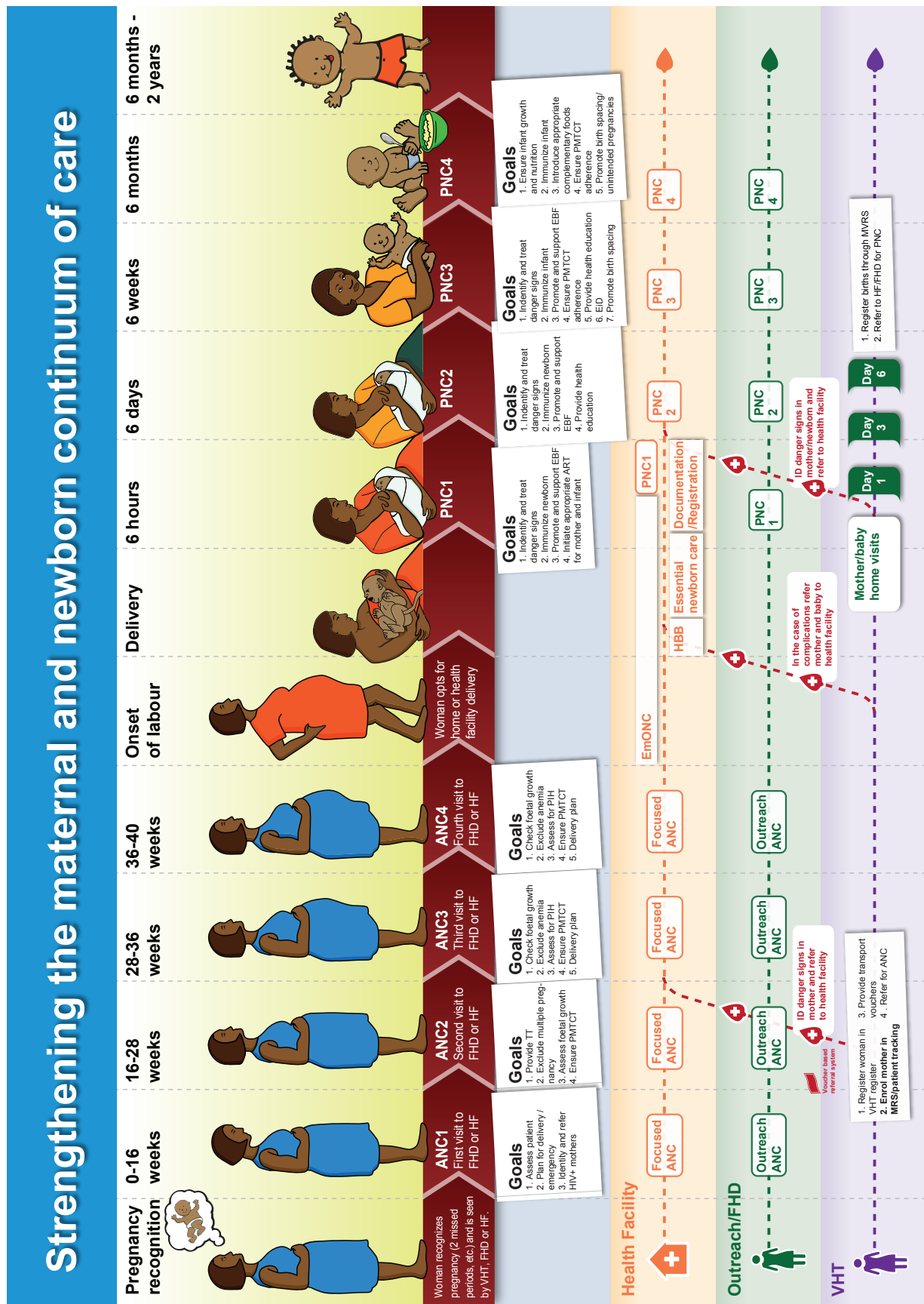
### 3.1 Integrated delivery of RMNCH Interventions

Continuous care across life stages and from home to hospital is crucial for health for complete physical mental and social wellbeing.

In the context of RMNCH, this takes on a greater significance because a child's health is closely linked to the mother's from conception through to birth and beyond.

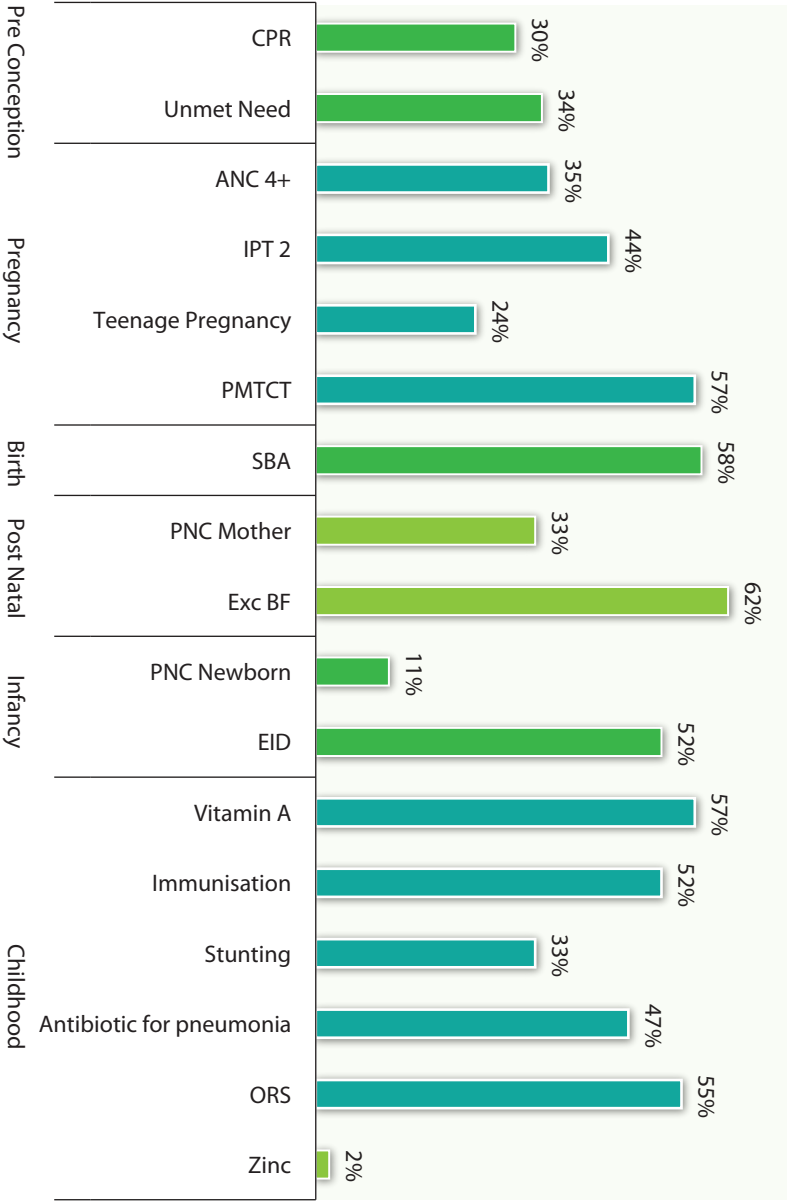
Progress towards MDGs 4 and 5 is therefore intricately linked. An effective continuum of care for RMNCH includes integrated service delivery for mothers and children from pre-pregnancy to delivery and the immediate postnatal period and childhood. Such care is provided by families and communities through outpatient services, clinics and other health facilities.

Figure 17: Strengthening RMNCH along the continuum of care.



The country is implementing most of the existing evidence-based interventions. Figure 18 shows the varying degree of coverage of interventions in the continuum of care further reflecting the missed opportunities for integration. For example, teenage pregnancy, zinc for diarrhoea management, post natal care (PNC) for newborn and mothers are remarkably low in coverage 2% to 24%, compared to exclusive breastfeeding which is at a rate of 62%.

**Figure 18: Coverage of Interventions along the continuum of care**



### 3.2 Strengthening health system and the health work force

#### 3.2.1 Health system strengthening

The government plans to revise the monitoring, supervision and quality improvement strategy for the health sector.

Currently, lack of an institutionalised quality assurance/improvement system and the missed opportunities in educating and follow up of mothers and newborns created by a lack of clarity on how integrated RMNCH services should be organised is an issue of concern.

Poor adherence to national standard treatment guidelines and/or clinical protocols in public and private sector is common and needs attention.

Referral systems are not readily available to send women from one facility to next, leaving the burden to often very poor families. These challenges will need to be rapidly addressed if the country is to witness rapid scale up to the MDGs.

With the establishment of the National eHealth Programme (NEP) in 2012, the Government has significantly enhanced their capacity to guide and coordinate this emerging field. With a draft eHealth Strategy and Technology Framework in place, Government now has a clear vision for the national Health Information System (HIS). However, there remains human resource, capacity, infrastructure and funding gaps at the national and sub-national levels to fully manage a countrywide HIS.

Health Management Information System (HMIS) registers adequately captures most aggregate planning data. Uganda has strengthened HMIS with two electronic platforms – a web based District Health Information System (DHIS2) and a Health Facility based SMS reporting tool called m-Trac – which have now been rolled out nationwide. However, while there are significant improvements to the prior paper based system, reporting rates, data quality and information utilisation continue to be a challenge. Patient level data is currently rarely available at the District and National levels, and as such not used for quantification, forecasting, allocation and distribution of resources let alone for making planning decisions at relevant levels. However, the recently launched National Health Records Programme (NHRP) is an attempt to address this.

In addition, weak or absent reporting from Private Health Providers (PHP) which make up approximately 50% of the Health Facilities nationwide, and the absence of routine reporting on RMNCH indicators need urgent attention.

Finally, there continues to be a lack of demand for information by users and stakeholders especially at the district levels.

### **3.2.2 Health work force**

The shortage of midwives is compounded by inequitable and inefficient distribution. Uganda has made progress in improving the health work force in particular in the years between 2006 -2011. Lately, there has been an enhanced staff recruitment drive and provision of staff retention incentives for rural facility health workers, but the capacity to recruit qualified health workers varies from district to district and between urban and rural settings with over 80% of doctors and 60% of nurses located in hospitals, which largely serve urban populations.

Many of the newly created districts find it difficult to attract, recruit and retain critical health workers.

Some cadres in particular have suffered severe shortages including midwives and anesthetics. According to the current staffing norms, Health Centre IIIs and IVs are provided 2 and 3 midwives respectively.

However, this number is inadequate besides many of the established positions for mid-wives remain unfilled.

WHO recommends one skilled birth attendant for every 175 pregnant women but Uganda has only one midwife per 7000 births.

The health sector human resources information system, a competence based training programme including scholarships by government have been established to improve the shortage of midwives in the country.

Skills of in-service providers to handle maternal and newborn care will still need to be developed and alternative ways to scaling up capacity building are being considered.

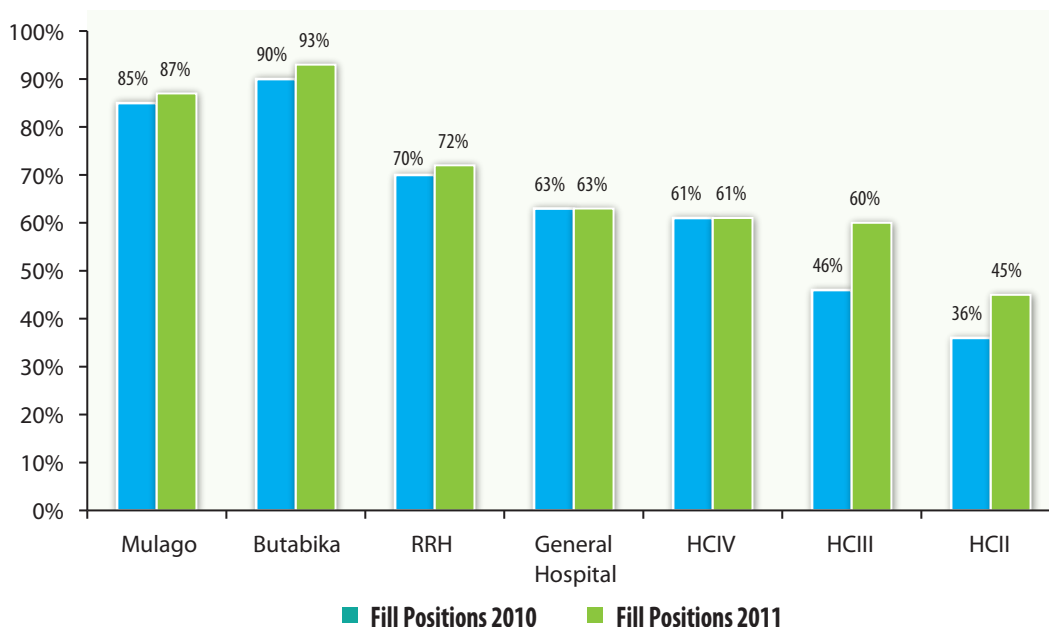
Given the heavy workload that health facilities experience and the lack of clear job descriptions, lack of support supervision coupled with lack of the necessary tools with which to work, staff morale has gone low characterised by high rates of absenteeism.

The rapid increase in the number of Ugandan districts (from 34 in 1990 to, 112 in 2012) has further exacerbated these disparities.

Some new districts lack physical infrastructure and the critical personnel and resources to effectively perform as a “functional district health system.” Critical RMNCH personnel who should provide leadership, quality services and to manage the health system in general is lacking.

Only less than one quarter of all districts in Uganda have an Assistant District Health Officers in-charge of Maternal Child Health who can provide leadership and manage RMNCH performance.

**Figure 19: Staffing Disparities by Facility Level**



### 3.3 Community Ownership and Demand Generation

Uptake of many lifesaving health services remains low especially in communities with the highest mortality burden. Government has pursued a unified approach on Village Health Team (VHTs) strategy with partners.

However, the community component has not gone to scale. This has led to low continuity in use of RMNCH services (VHTs are either inactive or absent, or communities do not use the service due to the perceived poor quality of services they provide).

At community and household levels, lack of awareness on danger signs and the poor or weak male involvement in RMNCH programmes has undermined use of services and encourages poor compliance to follow up.

VHTs are not yet empowered to identify, register, refer and follow patients as well as to provide pre-referral lifesaving care.

Several Information Education and Communication/Behavioural Change Communication (IEC/BBC) strategies exist but they are standalone documents focusing on individual interventions and weakly implemented.

Consequently, communities are not appropriately involved in prioritising relevant RMNCH problems and in planning, implementing, monitoring, and providing feedback. Community engagement is necessary for gains in equity and sustainability.

### 3.4 Innovative approaches to increasing efficiency and impact

#### 3.4.1 Reproductive Health Voucher scheme

World Bank has supported the following interventions; the Voucher-and-Accreditation Interventions to improve Reproductive Health Service Delivery Business Models, Focused ANC; Making Pregnancy Safer Initiative through Integrated Management of Pregnancy and Child Birth (IMPAC); Intermittent Preventive Treatment (IPT) for malaria, Insecticide Treated Nets (ITNs), Prevention of Mothers to Child HIV Transmission (PMTCT) Option B+ Kangaroo Mother Care and provision of Maama Kit.

Other initiatives include; the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA); The Red Ribbon Alliance; Breaking Silent Suffering (2010); Saving Mothers Giving Life; Saving One Million Lives; Maternal Child days and the Born Too Soon campaign.

#### 3.4.2 Saving Mothers Giving Life Initiative

Since June 2012, Saving Mothers Giving Life, supported by the US government agencies and Ministry of Health have bolstered maternal health programmes and reduced maternal mortality.

Together they have worked in 4 districts of western Uganda to train health workers, upgrade health facilities and encourage more women to give birth in safe functional facilities. Excellent progress has been made in the short period of time.

Extensive monitoring and evaluation was integrated into all programme activities as a result, the number of pregnant women delivering in facilities has increased in all districts from 2,585 to 4,707 deliveries over 12 months (82% increase).

Maternal deaths and newborn deaths have reduced by 30% after only one year.

The Evaluation findings are informing the scaling up and expansion to new districts.

### **3.4.3 Help Life Initiative of Karamoja**

The Help Life Initiative programme of Karamoja under UNICEF consists of various innovations, namely, the help life birth cushion for women who opt to deliver in a modified squatting position; help life partogram for monitoring progress in labour and early referral on mothers with complications during labour; solar kit for improved lighting in the maternity wards; and mobi station for training, health education and medical consultations. These innovations are being rolled out to increase uptake of MNH services.

### **3.4.4 The Mother Child Health Passport – Handheld Records**

The strengthening of health systems has got to centre stage of global health since the TOYAKO Framework of 2008 and is supported by many global health initiatives.

The case for Mother Child Health passport implementation, in the context of attaining MDG 4 and MDG 5 makes it the leading wedge to health systems in a bid to strengthen RMNCH.

These hand held records provide great priority to the community health strategy since it is in the communities that the mothers are found.

Launched in May 2012, the Government is gradually rolling out the mother passport with the aim of providing continuity in health care records from pregnancy through to early childhood in order to improve the quality of care and caregiver knowledge in regard to demand for services. The priority given to Maternal Child Health (MCH) improvement is clearly underlined in the MCH passport implementation strategy.

### **3.4.5 Training health workers on Helping Babies Breath Plus (HBB+) using simulated models**

Helping Babies Breathe (HBB) is an evidence-based curriculum in neonatal resuscitation for use in resource limited areas to train birth attendants who are responsible for the care of both the woman and the newborn infant at delivery, who may not have assistance from lower levels of trained helpers. It was designed to be easily incorporated along with other ongoing maternal and newborn care initiatives and strategies. In Uganda HBB has been integrated with IMNCI (essential newborn care) and has been utilised in a variety of settings.

### **3.4.6 Computerised learning for IMCI (ICATT)**

In hopes of reducing the time and cost of the traditional training method while maintaining or improving the knowledge transfer, a computerised learning tool intended to provide electronic training for health workers is being introduced in Uganda.

Whereas the standard course involves lectures, the computer-based training tool provides the same content in about six days with about four facilitators available to provide assistance.

Like the standard lectures, the computer based course content requires clinical practice and preceptor-ship.

#### **3.4.7 Maternal and Perinatal Death Audits (MPDR)**

A programme to reduce maternal and perinatal deaths has been put in place for death notification and death audits.

The aim is to review all deaths to identify avoidable factors for quality improvement coupled with confidential death inquiry by independent assessors. All deaths are taken note of through the ministry of health surveillance system and reported in a weekly bulletin.

#### **3.4.8 Integrated Community Case Management including Antenatal Community Registrations**

It is an initiative to bring closer to home the treatment for common childhood illnesses through use of lay Village Health Workers (VHTs) to distribute medicines.

Working with partners including WHO, UNICEF, Malaria Consortium, Healthy Child Uganda, Government has managed to reduce the treatment gap for malaria, pneumonia and diarrhoea in children under 5 in very remote areas including Karamoja.

To improve the continuum of care, VHTs are now able to conduct postnatal care visits during the first week of life including registering and referral of pregnant women. This initiative has been rolled out in 34 districts. Following an evaluation, the Government will be scaling up this initiative to include main medicines supply chain system.

#### **3.4.9 Women Parliamentarians Advocacy for reduction of maternal and child mortality (AWUMP)**

The parliament has been critical to maternal and child health as they represent the people and their concerns. Not only have they made political announcement that support the global health strategy and child and maternal survival including the Kampala Resolution on the Role of Parliaments in Women's and Children's Health in 2012. They have been instrumental in advocating for the increase of the national RMNCH budget including mobilizing funding from a World Bank loan for reproductive health.

Recently they developed their own advocacy plan for reducing maternal newborn and infant mortality which was adopted by the Speaker of Parliament.

#### **3.4.10 Mobile Vital Registration:**

The country launched the Mobile Vital Registration System (Mobile VRS) using mobile phone technology for registration of births and for issuing of birth certificates which is under the mandate of the Uganda Registration Services Bureau (URSB). UNICEF is currently developing the capacity of URSB, sub-county chiefs and hospitals to integrate the Mobile VRS into their routine work by providing equipment, training and supervision. This will rapidly increase the number of registered children to over 50%.

However, challenges remain – Mobile VRS still needs to be integrated into the NHRP strategy and databases such as DHIS2, and legally only hospitals – not the vast majority of Health Facilities – are authorised to register births.

### 3.4.11 U-reporting

In collaboration with the Scouts and other youth organisations nationwide, U-report uses SMS messages and communication channels like radio, TV and website to provide a platform for strengthening dialogue and conversation around core development issues and advocacy at the national level.

Over 250,000 young Ugandans are now signed up as U-reporters with this number growing daily.

U-reporters serve as “social monitors” and agents of change at the community level. .

They are sent weekly polls gathering quantitative and qualitative data on community services and youth issues and receive feedback including poll results information about services as well as useful facts for action and advocacy.

The most critical U-report issues are featured weekly on TV and radio shows and also in newspapers.

## 3.5 Promoting Rights, Equality and Gender balance

Discrimination against women and girls including gender-based violence, economic exclusion, and the lack of appropriate and affordable reproductive health services are common problems.

Unequal access to and inadequate healthcare services between women and men largely stem from unequal power relation which influences decision making for health in the household.

The Uganda Demographic Health Survey (UDHS) 2011, shows that about 55% of the women mainly decide by themselves how their earnings are to be spent, 32% report that they make the decision jointly with their husband/partner while 13% report that the decision is mainly made by their husband/partner.

There are variations in the proportion of women who make independent decisions about their earnings ranging from 24% in Eastern region to 79% in Kampala.

This shows that women in urban areas are more likely to make independent decisions compared to those in rural areas.

The Ministry of Health is making efforts to create an enabling environment for promoting RMNCH include capacity building and development of training guidelines on how to integrate Human Rights Base Approach in health programming.

The principles in this approach promote respect for the choices by women including companionship during maternity care and ensuring that every woman has the right to privacy and confidentiality and is treated with dignity and respect.

It also promotes equality, freedom from discrimination, equitable care and recognises the right to health care for every woman and child.

### 3.6 Improving Monitoring and Accountability

Uganda is implementing a plan for RMNCH information and accountability which has been developed in line with the 10 UN recommendations.

Actions being strengthened include vital events, incorporation of the core indicators to monitor maternal and child health, innovation on integrating information technologies, resource tracking, country compacts, national health sub accounts and sub national MDG countdown.

Strong political and senior-level ministerial leadership on RMNCH exists with the Maternal Child Health technical working group that provide strong input into the broader health policy and strategies.

Strategic plans, policy documents, national standard treatment guidelines and clinical protocols have been formulated including Client's Charter which spells out the rights and responsibilities of patients. However, leadership for RMNCH at the district level and below is weak and almost lacking in most districts

# 04

## REACHING THE TARGETS - 2015 AND BEYOND

### 4.1 Introduction

Uganda's options for accelerating progress towards the reduction of child and maternal mortality up to 2035 will have far reaching implications for the country's agenda and period when targets are reached.

Given the progress, it would be a mistake to start a new RMNCH agenda from scratch.

There is much unfinished business from the MDGs. Some targets have been achieved to a great extent, but others, especially maternal mortality ratio and neonatal mortality achieved much less.

Government realised that the next development agenda must build on the real experiences, ideas and solutions of people at grassroots.

However, health service provision may not always be the policy instrument best placed to reduce deaths but there is also the need to look outside the health sector.

Government commitment to accountability for results and resources has also been a relatively weak driver of past progress towards the MDGs.

This RMNCH Sharpened plan for Uganda provides an overview of where the country plans to move in terms of preventing these avoidable deaths, with emphasis on developments towards reaching the MDGs in 2015 and beyond.

The purpose of this plan is to activate collective action towards achieving equitable accelerated improvements in maternal, newborn and child mortality in Uganda. This is a movement to child and maternal survival where partners and civil society organisations will work together to assure the promise renewed.

### 4.2 Vision

Our vision and our responsibility is to end preventable deaths in the context of attaining targets for MDGs and beyond by ensuring a strategic shift to doing business and universal coverage of high impact health interventions using all three delivery platforms (communities, population-scheduled and individual clinical services).

### 4.3 The Five Strategic Shifts

This plan proposes five strategic shifts; as the priority for a forward-looking, compelling and integrated

sustainable RMNCH agenda for keeping the promise of the MDGs and remain beyond 2015. The five shifts will form the focus for action and introduce a paradigm shift that will overcome the obstacles to prevent avoidable death. They reflect a national commitment and also recognise the importance of leadership at a local level and encourage districts, partners, CSOs and other players to implement them. The five strategic shifts are:

**Shift 1: Focusing Geographically:**

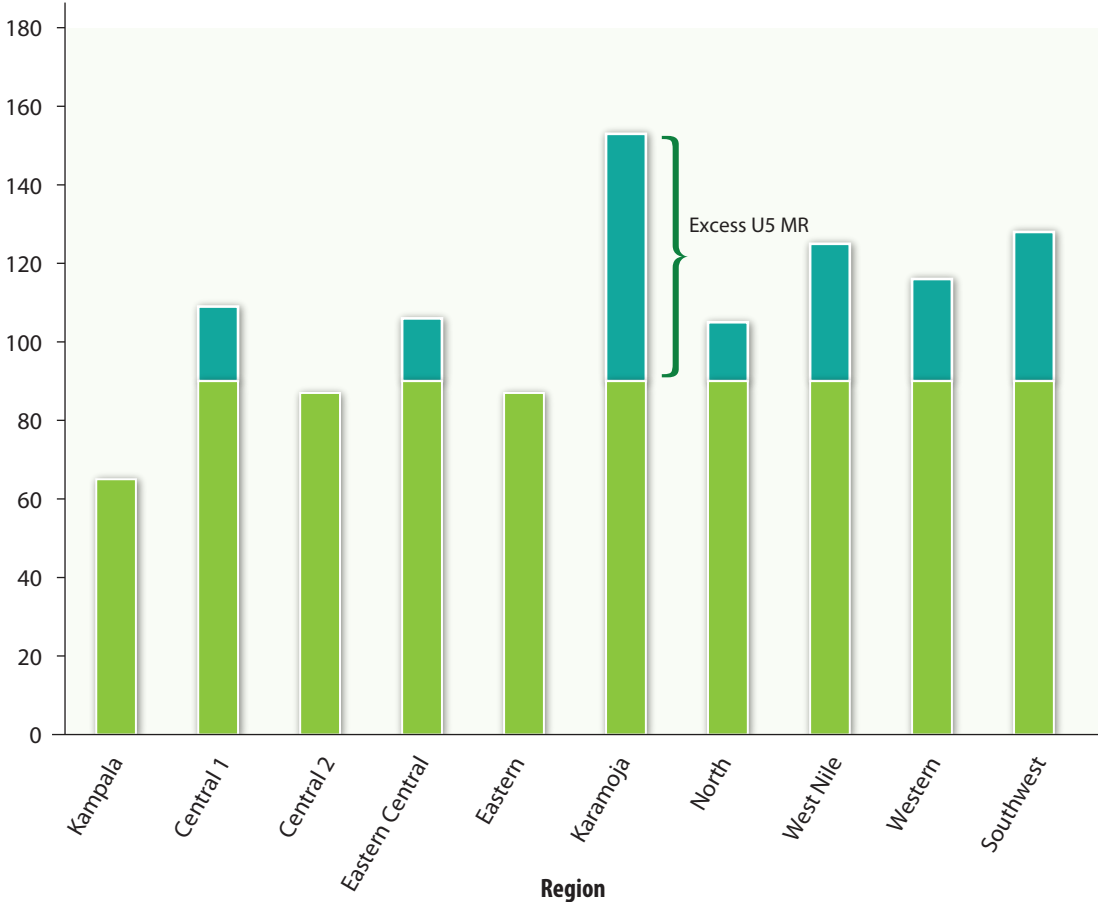
*Increase effort in geographical places; regions, districts and villages with the highest number of deaths (especially where a half of deaths occur), prioritising resources and refocusing health systems to expand access to these underserved, most burdened places including hard to reach remote areas.*

This shift must tackle the causes of geographical inequity in child and maternal death and increase efforts, budgets and commitment to these regions, districts and sub districts with most deaths.

This will require a shift from a mainstream approach that targets easy-to-reach populations and apply equity-focused delivery and use of RMNCH services among the regions and districts.

Local data will be required to inform this process of prioritisation and participation from all stakeholders.

**Figure 20: Regions with excess Under-five Mortality**

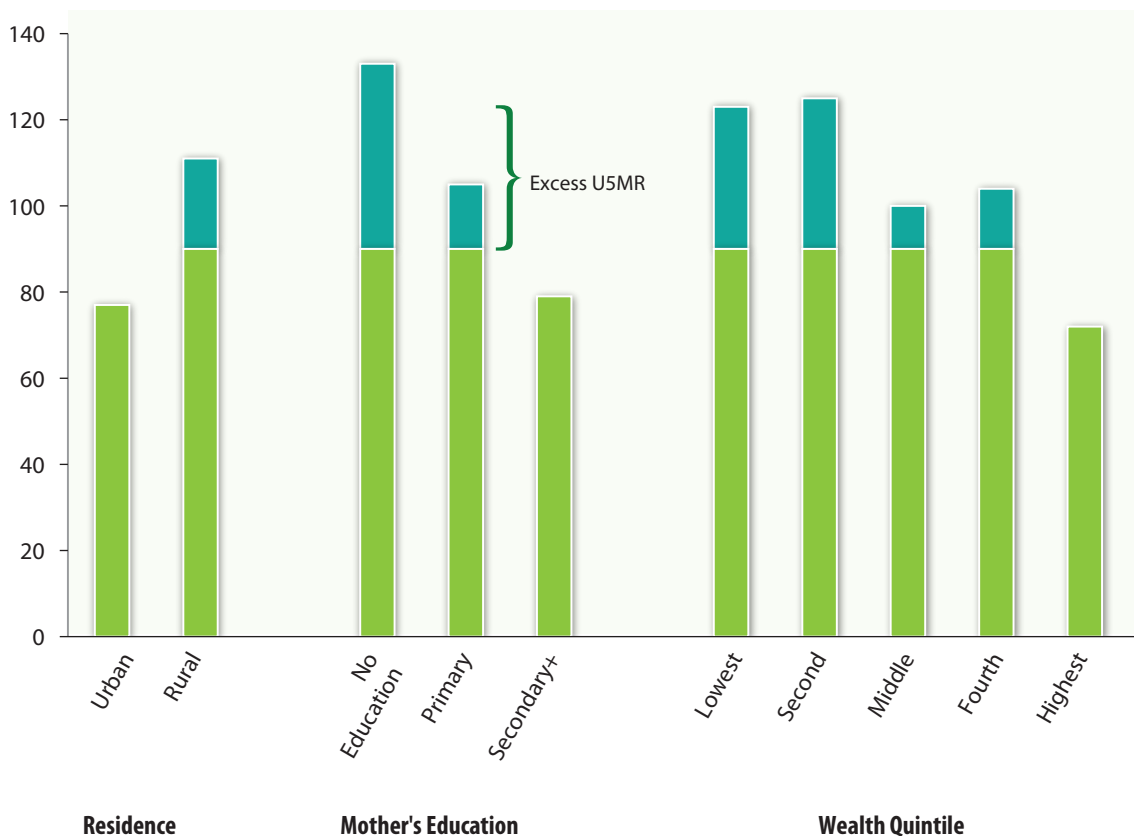


### Shift 2: Increasing access for high-burden populations:

*Identify and increase effort among population groups with the highest disease burden and number of deaths prioritising resources and refocusing health system to expand access to the under-served and the hard-to-reach remote areas.*

Special and innovative strategies will be employed to reach population groups that are not accessing services due to geographical, economic and social cultural barriers. For example, the rural and less educated poor, access to post-abortion care for in school and out of school adolescents.

**Figure 21: Population groups with excess Under-five Mortality**



### Shift 3: Emphasise evidence based high impact interventions:

*Target and expand coverage of interventions of the biggest opportunity for impact on lives saved e.g. neonatal care and skilled attendance at birth. Scale up and sustain demand and supply of high impact solutions as well as investment in innovations to accelerate results.*

This shift will target the greatest opportunities for impacting on maternal, newborn and child mortality, the most risky period of life around child birth and the first days of life, the most neglected but easily preventable child killer- pneumonia, diarrhoea and malaria. There is also the issue of new vaccines, access to and use of essential life-saving commodities as well as investing in neonatal and maternal health care and nutrition.

Uganda stands to reap the benefits of radical reductions in mortality rates through closer attention and investing in these solutions.

All Partners and Government will work to support districts in decision-making; implementation of processes by ensuring districts have the capacity, information, data, policy standards and systems they need and support the roll out process.

Scaling up core lifesaving interventions will require guidance that highlights new strategic choices backed by local evidence, non-fragmentation of the health system, institutional capacity building for a variety of technical and managerial skills, financial inputs as well as better coordination of interventions.

Special attention will be paid to the removal of financial barriers to accessing RMNCH services, thus enhancing realisation of universal access.

Without the people and equipment to deliver services, prevention of deaths will not be sustainable over the long term.

#### **Shift 4: Addressing the broader context - education, empowerment, economy and environment:**

*Adopt a multi-sectoral approach to harness the structural and social determinants of health, including water, sanitation, and hygiene, income, gender considerations and education that enable survival of women and children. This will be achieved through strengthening multi-level linkages, collaboration and coordination among partners in the public and private sectors.*

This will involve greater collaboration and coordination with policies and programmes that impact on social determinants of health including girls' education, women's empowerment, inclusive economic growth and the physical environment such as access to clean water and sanitation.

#### **Shift 5: Strengthening mutual accountability for ending preventable deaths:**

*Develop and sustain collective action and mutual accountability to drive transparency and responsibility relating to resources and results, monitoring and evaluating results to be able to sustain commitments and results.*

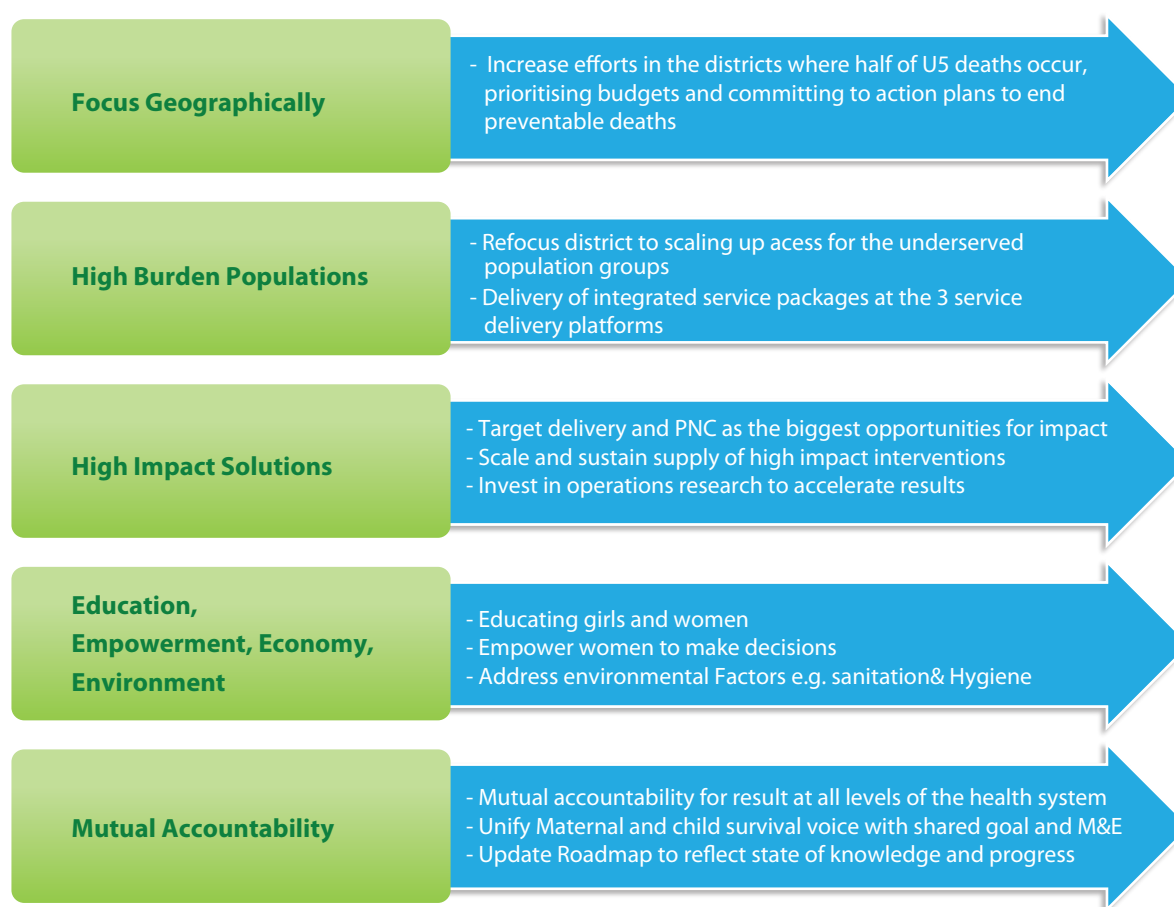
This shift focuses on three thematic areas- accountability for results and resources, result-based financing and innovation.

Accountability will encompass political accountability to commitments, performance accountability to meet targets; economic accountability for reporting financial information and importantly accountability to provide quality care to patients.

This shift calls for an effective, sound public system that is responsive to people's needs, supports information sharing, permit scrutiny so that citizens can see exactly where their resources are spent. Political, managerial and social accountability will encourage implementation of commitments to RMNCH.

For example, maternal death reviews will help the Ministry of Health to ensure a chain of accountability.

Figure 22: RMNCH Strategic Shifts



#### 4.3.1 Strategic Objectives

1. To accelerate greater coverage in high-burden districts and populations.
2. To expand coverage of high impact interventions that directly reduce maternal, newborn and child mortality.
3. To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths.
4. To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths.

#### 4.3.2 Guiding Principles

The implementation of this plan will be guided by the following principles:

- **Time bound nature:** Set boundaries initially then make a decision for continuation based on assessment of effectiveness and continued need to address coverage gaps.
- **Leveraging:** Build on and catalyse actions by a broad range of partners committed to the sharpened plan efforts and strengthening partnerships to maximize resources and avoid duplications.

- **Harmonization:** Adapt/use tools and processes developed by previous initiatives or plans to support RMNCH plans including joint assessment and improved aid effectiveness. Avoid re-inventing the wheel by using existing programmes to overcome service delivery bottlenecks.
- **Separation of Functions:** Avoid conflicts of interests by clearly separating functions of the health sector, districts and other sectors and levels
- **Inclusiveness:** Both public and private sector actors are active in major initiative across the RMNCH continuum and recognize that adolescents, mothers, newborns, and children are inseparably linked in life and in health care needs.
- **Country leadership and ownership:** harness the diversified systems, capacities and financing arrangements and promote shared responsibility and mutual accountability.

#### 4.4 Bending the Curve – Lives to be Saved

A Lives Saved Tool (LiST) an evidenced tool used to assess the burden of the disease and identify high impact packages of interventions for RMNCH based on changes to the coverage levels of interventions was used.

LiST projects the amount of mortality reduction that could be achieved if the coverage levels of specific interventions were increased based on the initial coverage, demographic characteristics and planned coverage targets.

The LiST tool was used to evaluate the impact of scaling up all of the RMNCH interventions and the amount of under-five and maternal lives saved under various scenarios between 2014 and 2017. Coverage data from the UDHS 2011 was used as a baseline and targets were derived from various strategic documents and consultative meetings.

A key assumption taken into consideration in setting the targets for the LiST tool was that implementing partners would scale up their current interventions and system strengthening will continue to deliver the interventions.

##### 4.4.1 Priority interventions

Proven interventions that can reduce maternal and child mortality and morbidity rates are well known and the majority of deaths in children and pregnant women in Uganda are due to a small number of common, preventable and treatable conditions.

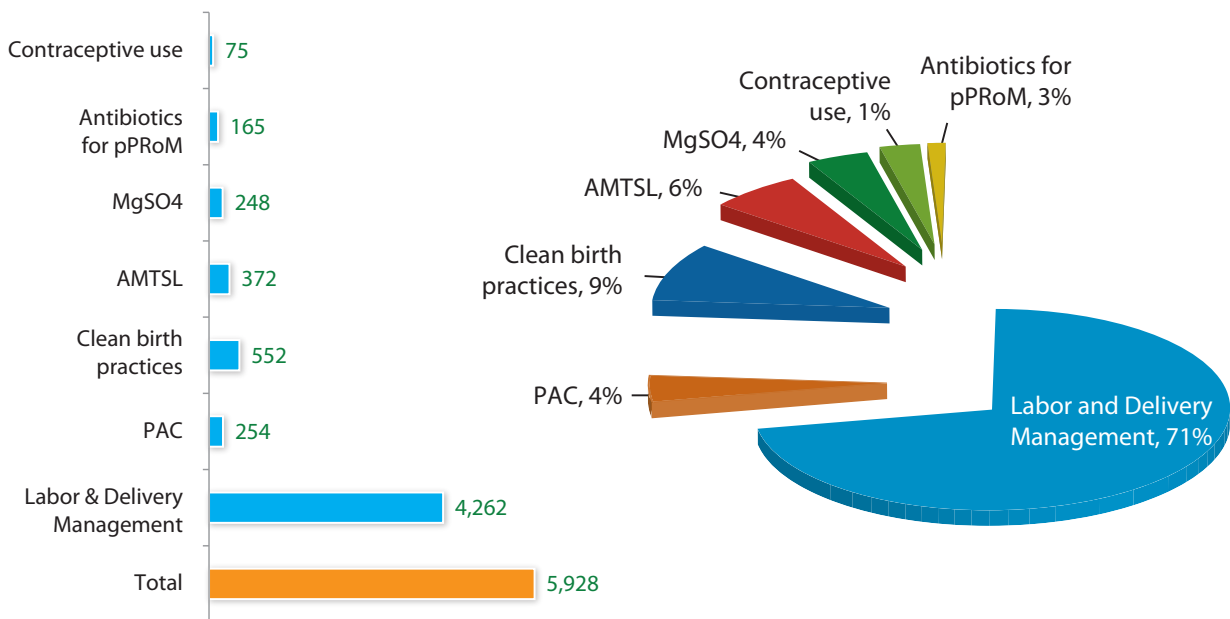
The Lives Saved Tool (LiST) was used to identify and prioritise a handful of existing and achievable evidence-based and focused interventions that have the greatest impact on reducing mortality and improving health.

Based on existing coverage levels and epidemiologic patterns in Uganda, priority high impact interventions that need rapid scale up to yield the desired immediate benefits towards acceleration have been identified.

These priority interventions are anchored in existing strategies and the Ministry of Health plans. They will be implemented alongside the ongoing interventions which are necessary to sustain the current gains.

The priority interventions, which deliver the highest impact in averting mortality in both mothers and children, are clustered around labour and delivery management. Highest impact interventions on maternal and child mortality are shown below (Figure 23 and 24). This strategy will focus on these.

**Figure 23: Highest Impact Interventions and Their Relative Importance in Reducing Maternal Mortality**



**Figure 24: Highest Impact Interventions and Their Relative Importance in Reducing Child Mortality**

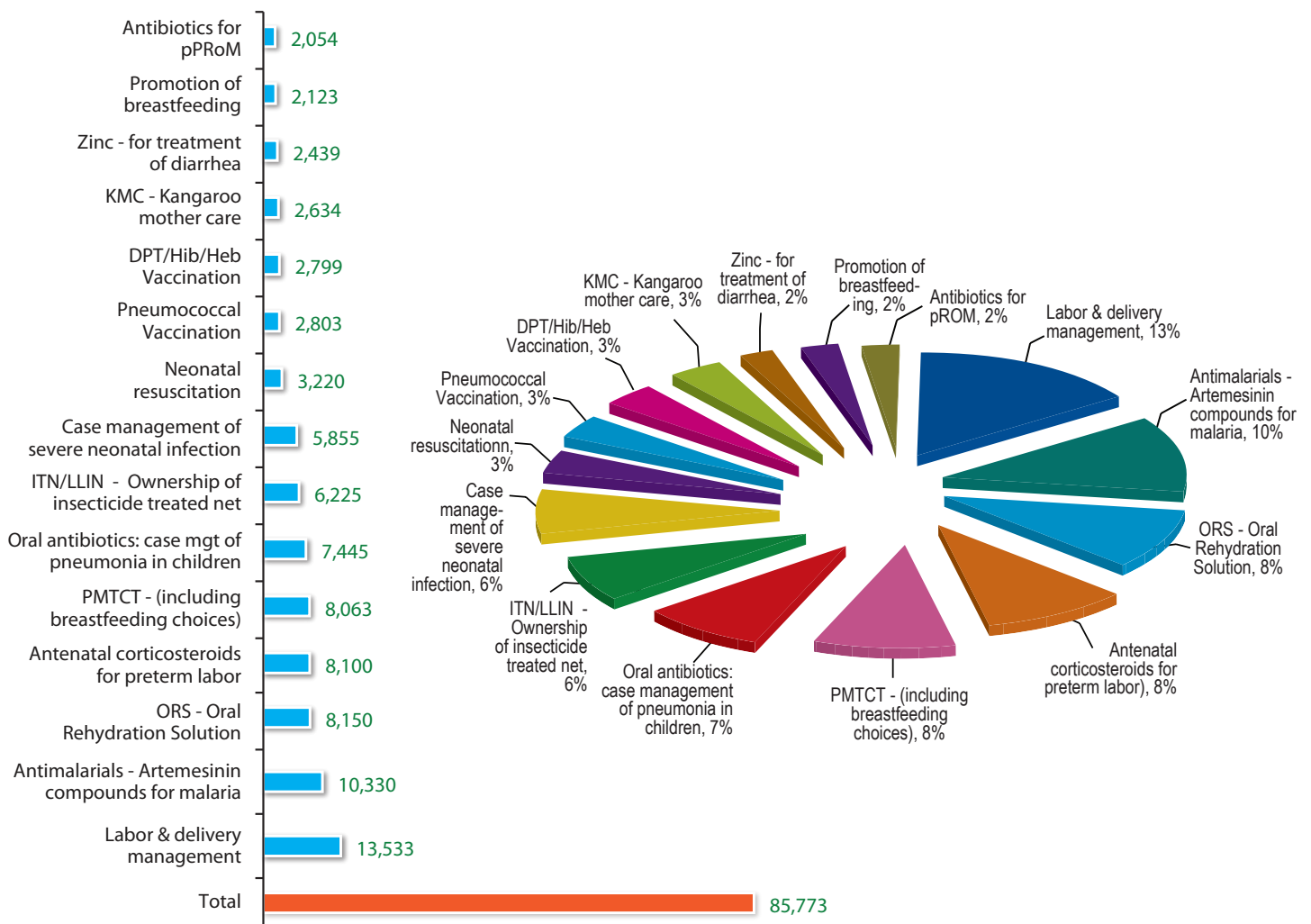
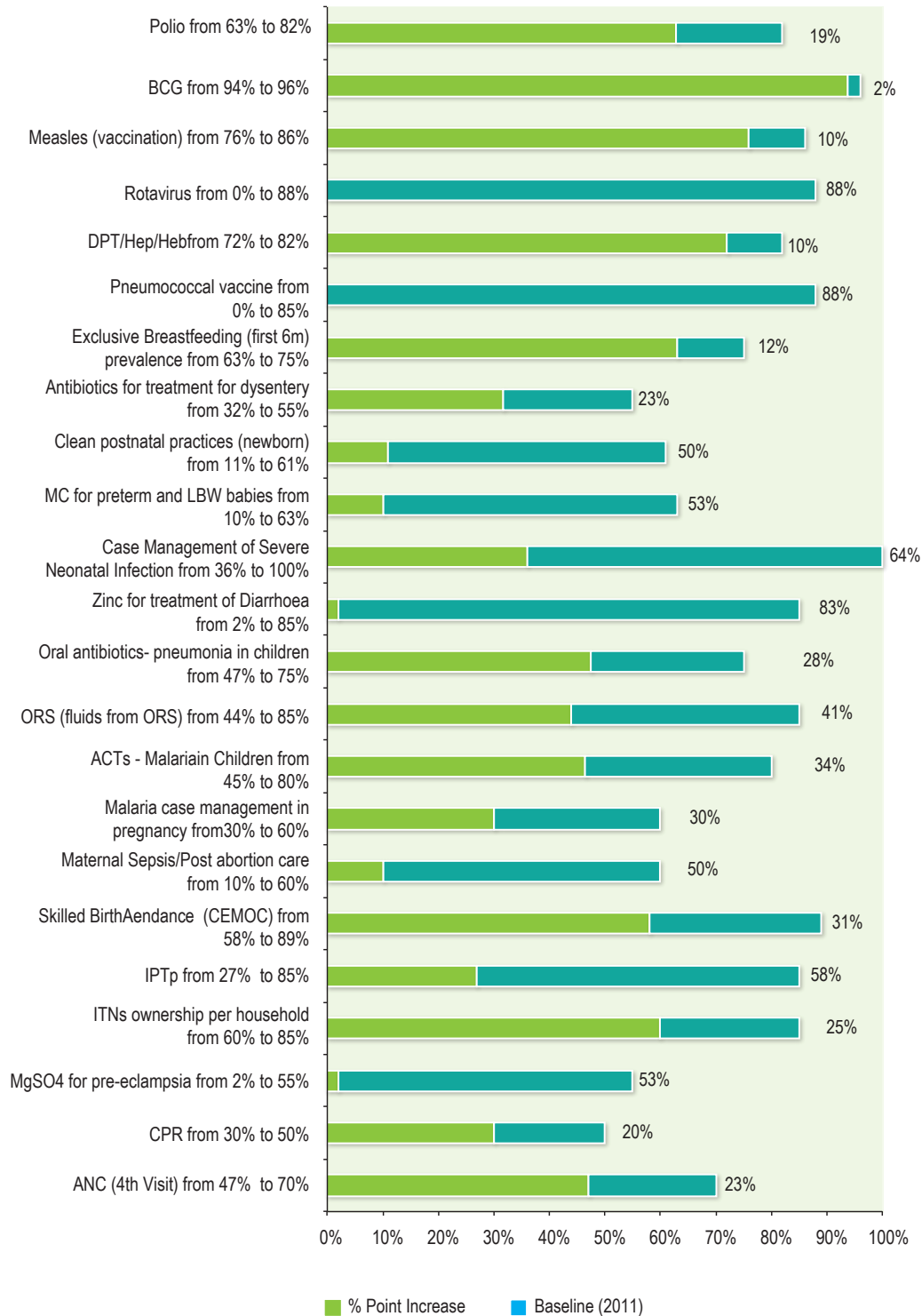


Figure 25 below shows the prioritised high impact interventions that have been selected along the continuum of care.

**Figure 25: Projected increase in Coverage by Priority Interventions**



It is estimated that an additional 120,000 child and 6,100 maternal deaths will be averted over the 4 year period through scaling up the above priority interventions. This will translate into a 40% and 26% annual reduction in child and maternal mortality respectively.

These interventions therefore represent areas of high impact investment for accelerating improvement of maternal and child health indices in the country.

It is clear from this tool that to achieve dramatic reduction in maternal mortality, the health system and other drivers need to be addressed.

Structural economic transformation and sustainable high rates of economic growth as targeted in the Vision 2040 must occur.

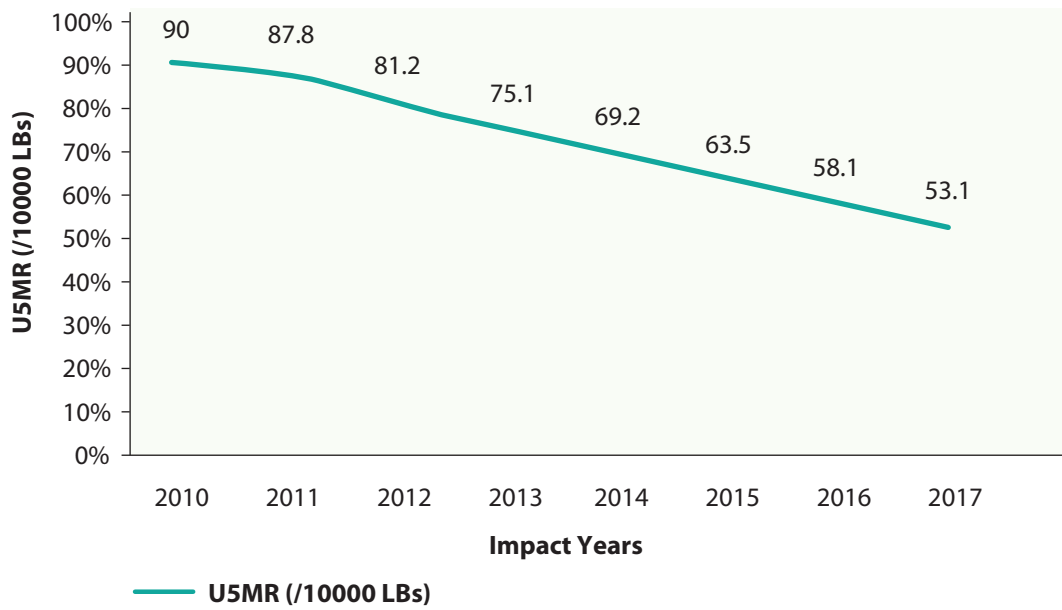
Government must implement infrastructure development effectively together with economic productivity, look at new technologies, reduce income poverty and improve public investment and efficiency.

**Table 1: Lives saved by Priority Interventions**

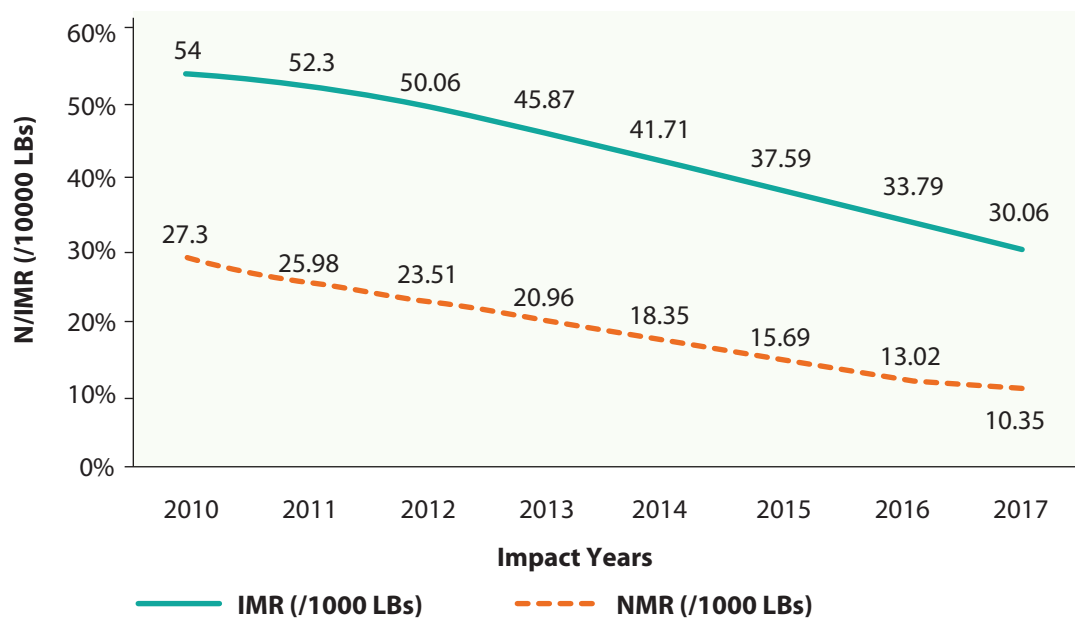
	Interventions	2014	2015	2016	2017	Total	%
Child and newborn	Labour and delivery management	1,836	3,887	6,114	8,463	20,300	15.8
	Antimalarials – ACTs	1,697	3,249	4,655	5,895	15,496	12.0
	ORS - oral rehydration solution	1,407	2,625	3,666	4,527	12,225	9.5
	Corticosteroids for pre-term labour	1,096	2,324	3,659	5,072	12,151	9.4
	PMTCT - (including breastfeeding choices)	1,455	2,849	3,675	4,116	12,095	9.4
	Oral antibiotics for pneumonia in children	1,221	2,339	3,353	4,256	11,169	8.7
	ITN/LLIN ownership	947	1,881	2,805	3,705	9,338	7.3
	Management of severe neonatal infection	1,046	1,931	2,642	3,165	8,784	6.8
	Neonatal resuscitation	449	936	1,454	1,992	4,831	3.8
	Pneumococcal Vaccination	431	852	1,263	1,659	4,205	3.3
	DPT/Hib/Heb Vaccination	429	851	1,262	1,658	4,200	3.3
	KMC - Kangaroo mother care	647	1,050	1,191	1,064	3,952	3.1
	Zinc - for treatment of diarrhoea	425	789	1,097	1,349	3,660	2.8
	Promotion of breastfeeding	332	651	957	1,245	3,185	2.5
	Antibiotics for pPRoM	275	585	927	1,295	3,082	2.4
Maternal	Labour and delivery management	579	1,223	1,923	2,669	6,394	71.8
	Post abortion case management	42	81	116	143	382	4.3
	Clean birth practices	75	158	249	347	829	9.3
	AMTSL--active management of the third stage of labour	50	107	168	234	559	6.3
	MgSO4 management of eclampsia	35	72	113	153	373	4.2
	Antibiotics for pPRoM	23	47	75	104	249	2.8
	Contraceptive use	8	20	35	51	114	1.3

The above lives saved will translate into the maternal and child mortality reduction trends over the four years period as illustrated in the figures 26, 27 and 28.

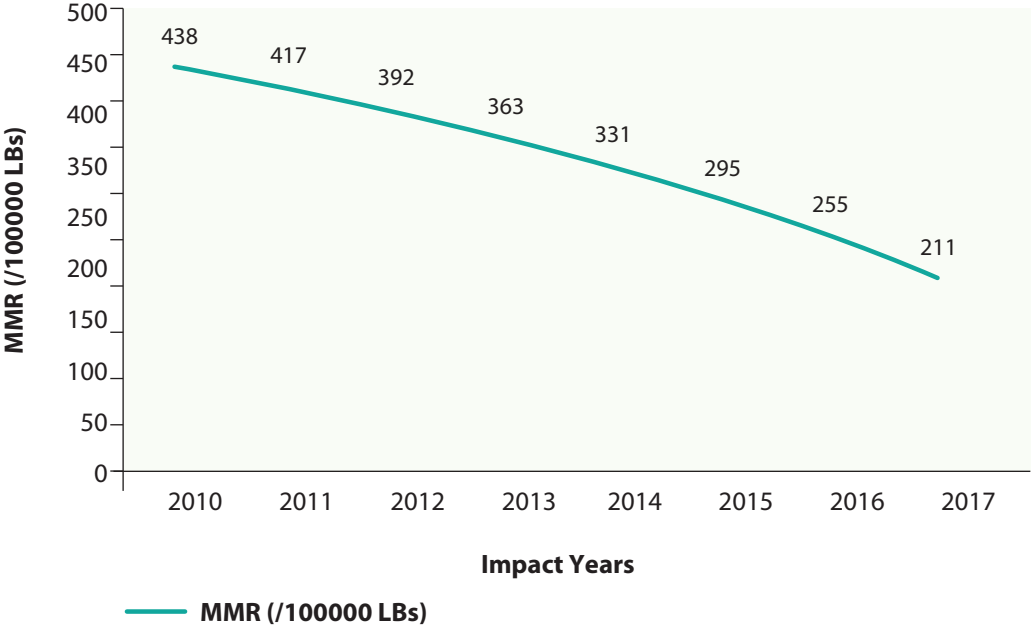
**Figure 26: Projected Under-Five Mortality Reduction by 2017**



**Figure 27: Projected Infant and Neonatal Mortality Reduction by 2017**



**Figure 28: Projected Maternal Mortality Reduction by 2017**



**4.4.2 Costing**

Financial projections required to address the identified priorities and implement planned activities was done following the principles of UN OneHealth Costing Tool, in light of economic conditions, medium term expenditure and fiscal space constraints in the country.

The plan for financing is consistent with the health sector financing strategy and projections for the sector as a whole.

The tool allowed for calculations of revenue collections including different funding scenarios, identification of what can be funded under each scenario (e.g. how the target level of coverage or which element of the essential package will change if there is less funding available for RMNCH), prioritisation of the critical interventions and actions to strengthen systems in ways that address the highest priority issues (including improving equity) and when resources are tight (done using the LiST tool described earlier).

The stakeholders ensured a well-defined process for agreeing on expenditure priorities in line with programme priorities once the level of funding was known.

However, the cost provided here does not include health systems costs which are catered for elsewhere.

The projections in this section will be the main basis for development of the resource mobilization plan and its implementation.

**Table 2: Total costs of the Sharpened RMNCH Plan (x 1000 US \$)**

Cost category	2013	2014	2015	2016	2017	Total	%
Intervention costs	99,955	112,220	124,508	136,559	148,628	621,871	91.2%
Programme costs	9,658	13,263	13,114	12,050	11,886	59,972	8.8%
<b>Total</b>	<b>109,614</b>	<b>125,483</b>	<b>137,622</b>	<b>148,609</b>	<b>160,514</b>	<b>681,844</b>	<b>100%</b>

**Table 3: Intervention costs breakdown (x 1000 US \$)**

Intervention	2013	2014	2015	2016	2017	Total	%
Malaria Control	44,517	47,949	51,209	54,322	57,276	255,275	41.0%
Immunization	21,290	26,510	31,868	37,334	42,889	159,894	25.7%
Diarrhoea management	6,309	7,664	9,023	10,388	11,756	45,141	7.3%
PMTCT	7,492	7,745	7,997	7,997	7,997	39,229	6.3%
Family Planning	6,061	6,541	7,042	7,570	8,169	35,385	5.7%
Facility births	5,966	6,279	6,596	6,912	7,227	32,982	5.3%
ANC	3,380	3,763	4,155	4,554	4,957	20,812	3.3%
Post-natal care	2,821	2,982	3,145	3,308	3,471	15,729	2.5%
Other	2,115	2,782	3,468	4,169	4,883	17,420	2.8%
<b>Total</b>	<b>99,955</b>	<b>112,220</b>	<b>124,508</b>	<b>136,559</b>	<b>148,628</b>	<b>621,871</b>	<b>100%</b>

The total drug and supplies costs (intervention costs) required amount to \$ 681.844 million (Table 2).

Out of the total cost, \$621.871 million (representing 91%) is accounted for by medicines and medical supplies for the different interventions in the plan while \$ 59.972million (9%) is for programme support costs.

The total costs ranges from \$109.614 million in 2013 to \$160.514 million in 2017 (Table 2).

Malaria treatment, immunization, diarrhoea management, child birth care, PMTCT and family planning account for 91.3% of the total intervention costs.

The “other” costs not specified under intervention costs include costs of pneumonia treatment, management of abortion complications and measles treatment.

**Figure 29: Intervention costs**

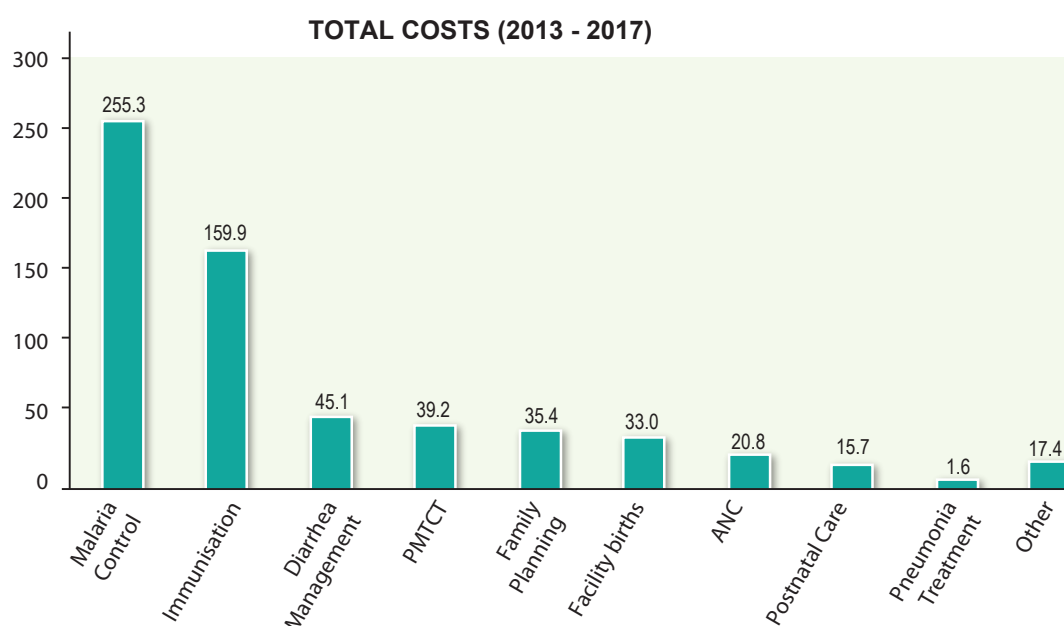


Figure 29 above shows the graphical distribution of intervention costs. As seen from the graph, malaria treatment, immunization and diarrhoea management stand out as most cost demanding intervention for reducing child deaths.

Child birth care follows on cost intensity for reducing both maternal and child deaths.

**Table 4: Programme costs breakdown (x 1000 US \$)**

Programme Category	2013	2014	2015	2016	2017	Total	%
Communication, Media & Outreach	2,579	2,624	2,544	2,564	2,544	12,854	42%
Training (in-service)	1,175	3,382	2,999	2,515	2,502	12,573	25%
Programme-Specific Human Resources	2,422	2,197	2,197	2,197	2,197	11,211	8%
Supervision	1,860	1,860	1,860	1,860	1,860	9,300	8%
Transport	99	1,582	1,594	1,505	1,107	5,887	6%
Infrastructure and Equipment	1,308	800	1,100	680	932	4,820	6%
Advocacy	0	571	571	571	571	2,284	3%
Monitoring and Evaluation	160	200	180	110	110	760	2%
General Programme Management	55	48	69	49	63	284	0.5%
<b>Total</b>	<b>9,659</b>	<b>13,263</b>	<b>13,114</b>	<b>12,050</b>	<b>11,886</b>	<b>59,972</b>	<b>100%</b>

Comparing resources with results, the accelerated RMNCH plan will cost additional \$681.915million and prevent a total of additional 126,100 deaths.

This costing needs to be fitted into the overall health sector budget. The above costs are over and above cross cutting health system investments for it to deliver the programmatic RMNCH interventions. Key system interventions include infrastructure, equipment and human resource.

It is important to note, guide and follow up investments in other sectors whose actions directly influence health outcome for example education, agriculture, water, community development, roads, information technology.

### 4.4.3 Management interventions

Scaling up technical interventions requires strong and efficient health system including management support. The following management interventions were selected and prioritised through a consultative process involving all concerned programs and stakeholders.

#### Strengthen RMNCH leadership at national, district and facility level:

- Dissemination of policy guidelines for district RMNCH management.
- Planning and monitoring, holding special technical working group meetings for rapid clearance of evidence based lifesaving best practices in RMNCH so as to hasten implementation of new cost effective interventions.
- Integrating, printing and disseminating RMNCH standard operating procedures so as to improve standards based case management.
- Providing missing key guidelines such as materials for in-service training, and new tools will be developed and incorporated.
- At district levels and as a priority, appointing or recruiting Assistant District Health Officer (MCH) and supporting their functions especially in High Priority Districts.

#### Reduce out of pocket expenditure for poor

- Scale up Reproductive Health voucher systems
- Social marketing of subsidised lifesaving commodities
- Negotiate free examination for pregnant women and newborn for the very poor in private sector

#### Increase access and use of lifesaving commodities for RMNCH

- Develop national RMNCH lifesaving commodities plan and integrate it in annual Ministry of Health procurement plan.
- Develop formularies and syringes for sick newborn treatment and integrate them in Essential Drug Management List for all levels.
- Establish private sector commodities supply system for RMNCH lifesaving commodities.
- Review guidelines to allow for re-distribution of RMNCH commodities between facilities and districts.
- Initiate a start-up push system to stimulate institutionalisation of RMNCH lifesaving commodities.
- Harmonise the clinical guidelines for supply of commodities to mandated facilities.
- Developing RMNCH kits for facilities.
- Update policies to enable nurses, midwives and VHTs provide lifesaving RMNCH commodities.
- Include lifesaving and equipment in National Essential Equipment List.
- Integrate forecasting and quantification within routine facility, district and quantification and procurement Unit) activities

#### Address Human Resource constraints

- Develop, review and update policies that enable nurses and midwives to apply skills to the delivery of lifesaving RMNCH commodities.
- Recruitment of midwives for the difficult to reach districts.
- Review the mandatory retirement of midwives in the difficult to reach districts.

- Link training schools with lower level facilities as practicum sites.
- Establish competence based interpersonal communication in pre-service training.
- Revise the job descriptions of nurses and midwives in line with RMNCH requirements.
- Revise staffing norms for midwives at health centres based on actual facility coverage.
- Training and mentoring midwives and nurses to use emergency lifesaving parenteral commodities.
- Scale up in service mentoring of health workers in interpersonal communication.
- Strengthen emergency obstetric and newborn care supervision.
- Procure clinical teaching materials and models to support competence based training at regional hospitals.
- Mandatory rotation of pre-service training in critical RMNCH areas.
- Training VHTs to help carry out counselling on essential maternal and newborn care birth preparedness, breastfeeding, clean delivery, cord care, and hypothermia prevention.

### Service delivery

- Institutionalise Quality Assurance/Quality Improvement systems in private and public facilities including standards based case management.
- Establish case management protocols on mobile phones.
- Provide essential case monitoring forms e.g. partograms in RMNCH kits.
- Provide integrated routine outreaches that cover all key maternal and newborn survival services.
- Use of transport voucher system to tap public-private partnerships for emergency ambulance services.
- Establish functional emergency maternal and newborn corners in all facilities.
- Provide and maintain basic amenities especially water and lighting in all facilities offering delivery services.
- Regular facility team meetings to discuss on-going readiness of facilities.
- Internal monitoring of facility emergency obstetric and newborn readiness.

### Strengthen monitoring and evaluation

- Train district and hospital based staff in use of scorecard.
- Support supervision in monitoring and evaluation to improve compliance with increased RMNCH requirements.
- Training and facilitation of Maternal Perinatal Death Review (MPDR) committees and Professional Councils to act on review findings and to undertake independent audits/verifications.
- Support monitoring and evaluation unit to develop RMNCH programme specific reports.
- Produce and effectively disseminate annual RMNCH programme report.
- Carry out a RMNCH programme review
- Develop VHT reporting on birth and death, testing new approaches, e.g. cell phones.
- Carry out RMNCH service availability mapping.
- Review supervision mechanisms and tools and include MPDR

## Community level engagement and demand creation

- Train VHTs especially in low performing districts and Health Sub Districts.
- Disseminate guidelines on male involvement in RMNCH.
- Social marketing so as to increase demand for lifesaving commodities especially in the private sector.
- Identify and strengthen VHTs for community based reporting (feedback) of MPDR (including verbal autopsies).
- Strengthen linkages to the community by working through the Health Centre Management Committee (HCMC) to establish community transport schemes.

## 4.5 Coordination of the Multi-sectoral approach

The Inter-Ministerial committee is mandated to work on crossing cutting issues including water and sanitation and nutrition. This committee will prioritise the RMNCH sharpened plan to ensure that commitments across sectors are realised for the attainment of MDG 4 and 5

The task force for the reduction of infant and maternal mortality will be revitalized. The Health Policy Advisory Committee (HPAC) is the donor/ stakeholder coordination mechanism that coordinates health policy.

The HPAC will ensure that the national policies and programmes are supportive to RMNCH principles and responsive the local health needs. The Maternal Child Health Technical Working Group and (sub) committees will provide technical coordination for the RMNCH plan.

Regional level networks and teams supported by the Referral Hospitals (RRH) and other relevant structures will complement the national level coordination.

The District RMNCH stakeholder's forum including the private sector partners will be strengthened under the leadership of the Assistant District Health Officer in-charge of maternal and child health (DHO-MCH) to coordinate this forum.

A standard planning and reporting format, tools and processes shall be provided to all districts, to guide their respective RMNCH stakeholders' forum.

A clear mechanism will be established for linking this structure and reporting including performance monitoring. At the lower level, community linkages with the health facility will be strengthened through the health unit management committees including representation of the village health teams and other sectors.

## 4.6 Holding Ourselves Accountable

### 4.6.1 Information and Mutual Accountability

This sharpened RMNCH plan calls for increased commitments from all levels of government, development partners, civil society actors, the cultural institutions, the faith based organisations, the private sector and the community at large.

Delivering on the commitments and motivating partners and stakeholders to implement their pledges is critical to the achievement of the objectives of this plan.

The objective of the accountability framework is to guide the national and sub national accountability mechanisms and practices towards fostering agreement on RMNCH objectives and targets to be achieved and the activities to achieve these objectives, to mobilise and link investments with RMNCH results and enable common monitoring of RMNCH commitments at all levels.

This is consistent with the Commission on Information & Accountability (Cobia).

Additionally, this plan provides Uganda with the opportunity to revitalize existing structures like the a) task force for reducing infant and maternal death chaired by ministry of finance, b) Health Sector Quality Improvement Framework and c) complement existing performance tools and oversight review processes at national, district, and sub-district levels (HMIS, MPDR profiles, and scorecards).

At the global level, the UN Commission on Information and Accountability (COIA) has established an accountability framework which: (1) makes strong linkages between country level and global mechanisms and holds donors accountable and, (2) places accountability firmly at national level with active engagement of government, parliament, civil society and the community.

The institutional mechanism to review and monitor the progress of implementation of the RMNCH will be built within the sector compact and annual reviews.

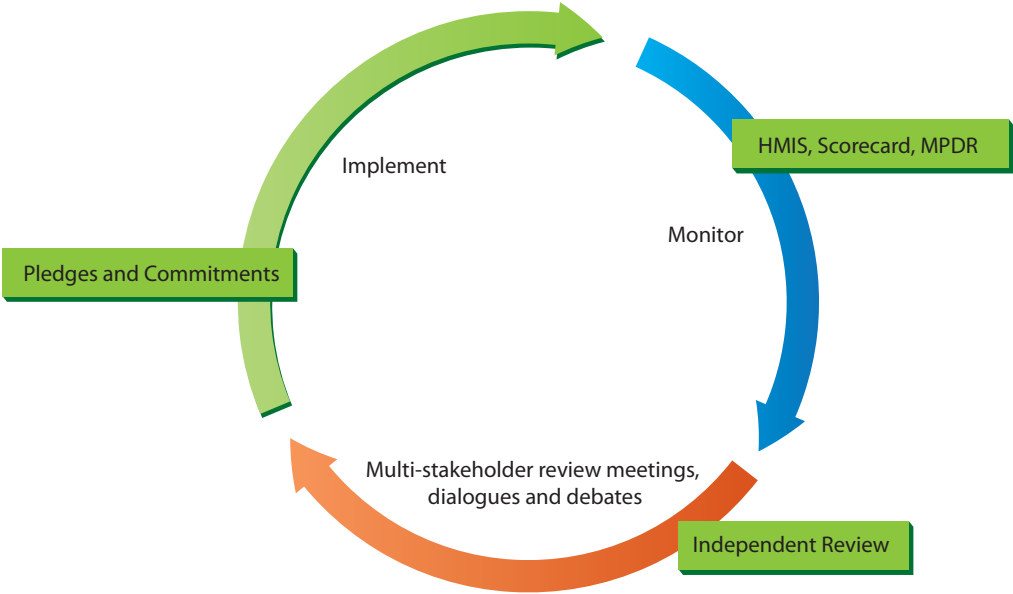
Monitoring and dialogue will enable decisions to accommodate changing realities and optimise resources to meet government’s RMNCH priorities.

Government and partners will strengthen RMNCH monitoring and coordination mechanisms through regular Maternal Child Health –Technical Working Group (MCH-TWG) meetings.

Civil Society Organisations are already part of the monitoring and dialogue processes. At the national level, the MCH-TWG will review progress of implementation against a set of a manageable number of indicators to be established in the national level scorecard.

Accountability mechanism will be a cyclical process of monitoring, reviewing and taking remedial actions (Figure 30).

**Figure 30: Mutual Accountability Process**



## 4.6.2 Score card

The principle of developing and implementing scorecards are in line with global initiatives including APR, CD, COIA, and Unclose

Uganda will institutionalize a national and sub national RMNCH score card system based on routine Health Management Information System (HMIS) data.

A quarterly dash board monitoring system at national level will be compiled in the first month of the next quarter. Districts will undertake similar exercises for their Health Sub Districts to better understand internal district disparities.

The scorecard will also allow facilities to review their performance within the quality improvement framework. The Uganda RMNCH scorecard (illustrated in Figure 31 and Table 5) is based on the five strategic shifts identified in plan.

The five domains are (1- Geographical focus, (2- Increase access to high-burden populations, (3- Measuring coverage of high-impact interventions, (4- Health System performance including, finance, human resource and policy and (5- Cross-cutting areas and mutual accountability.

Some of these shifts are embedded within the sharpened plan and highlighted in the scorecard (such as the emphasis on high impact interventions or “Lifesaving Commodities”).

Other shifts (such as identifying geographic focus, targeting high burden populations, or accountability) are better captured through the process, which will use scorecards or dashboards.

**Benchmarking, Quality Improvement and Performance Management:** RMNCH score card allows sub-national benchmarking.

This is helpful in identifying low performing areas and developing action plans. The scorecard tables are color-coded for easier reading.

The upper benchmark (in green) for each indicator is set at levels that have been agreed as targets for 2017.

The lower benchmark (in red) is set for below the national average for Uganda.

All results between the lower and upper benchmark are shown in yellow cells, showing a middle level of performance.

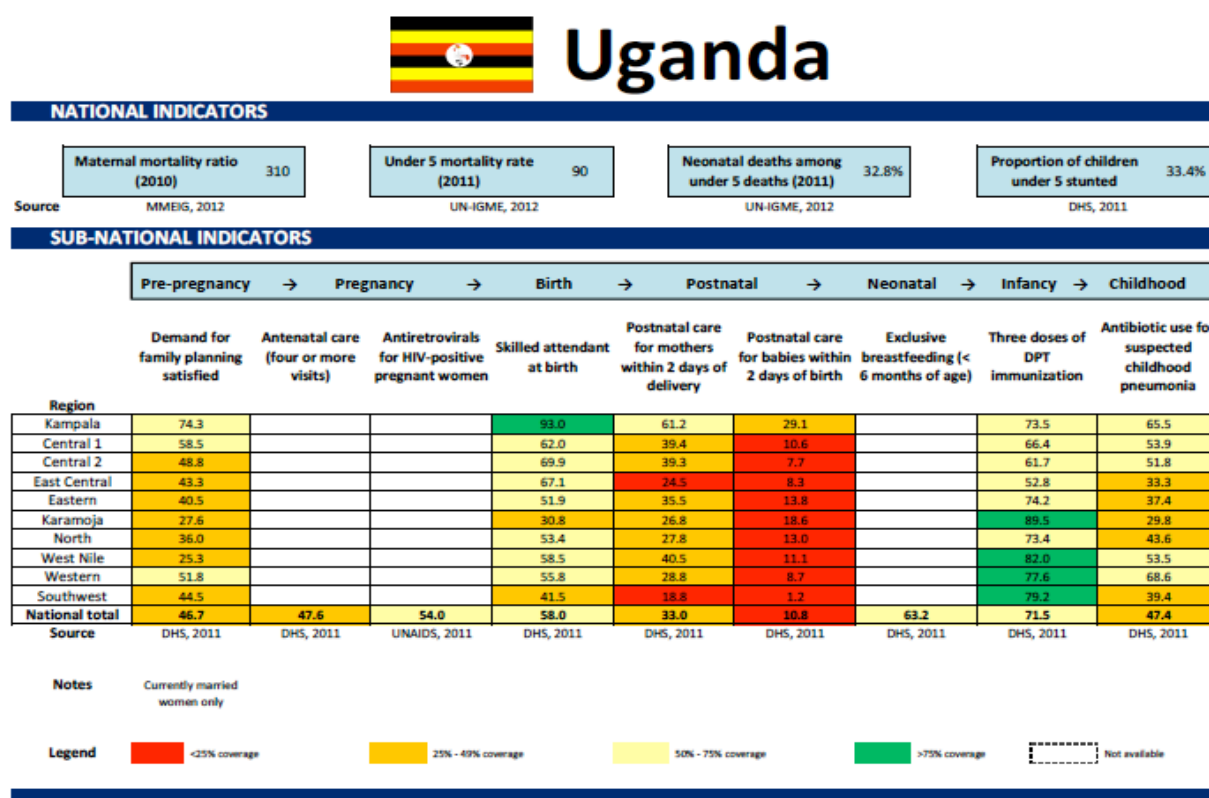
The last indicator “% of lower benchmarks” is a composite measure of performance.

It gives an overall ranking of regions/districts and demonstrates how regions/districts are doing in meeting the lower benchmark across the first 23 indicators.

This can be helpful in identifying low performing regions/districts and prioritise them.

The national score card may utilize heat maps that capture critical outcome variation in for example under-five or maternal deaths by district.

Figure 31: Illustrative of a Score Card



**Selection of Indicators:** The score card approach espouses the use of information systems to track a limited number of measures that are closely aligned with strategic objectives and the Five Strategic Shifts.

Uganda’s RMNCH score card is a management tool based on a prioritised set of RMNCH indicators. The tool aims to strengthen accountability; improve transparency; and drive action.

It has 23 indicators tracked for each region. Indicators are selected based on priority of intervention. The indicators are identified to measure quality and content of service delivery and provide robust metrics for identifying low performing areas guide improvement.

Table 5: Illustrative Indicators for a District level Scorecard

	Indicator (%)	Source
<b>Pre-pregnancy &amp; Adolescence</b>	Couples accepting a contraceptive method postpartum	HMIS
<b>Pregnancy</b>	Pregnant women receiving IFA	HMIS
	Pregnant women taking 2 or more doses of IPT	HMIS
	Sera-positive pregnant women treated with ARVs	HMIS
<b>Delivery</b>	Women provided with a uterotonic immediately after delivery	HMIS
	Women identified for pre-eclampsia and provided MgSO4	HMIS
<b>EmOC/Newborn care</b>	Women in P/Term labour receive at least 1 dose of dexamethasone	HMIS
	Newborns treated for puerperal sepsis	HMIS
	Newborn provided KMC among LBW	HMIS
	Sero-positive infants treated with ARVs	HMIS

	Indicator (%)	Source
<b>Postnatal period</b>	Newborn infection cases treated with parental antibiotics	HMIS
<b>Childhood</b>	DPT 3 coverage and dropout rate	HMIS
	U5 diarrhoea cases provided ORS and Zinc	HMIS
	U5 pneumonia cases provided with antibiotics	HMIS
<b>Outcomes</b>	Stillbirths; Neonatal, Child and Maternal Deaths	HMIS
<b>Health Systems</b>	Health facilities with stock-outs of Lifesaving Commodities	HMIS
	VHTs stock-outs of LSCo (subset as allowed per policy)	HMIS
	Health facilities with trained midwives	HRIS
	HC IV and above provide CEmONC	SARA
	Lower facilities with delivery services provide BEmONC	SARA
	Proportion of resources allocated and spent based on commitments	
<b>Equity</b>	Malnourished children provided treatment (boys and girls)	HMIS
	Female to Male ratio of OPD	HMIS
	Concentration indices for priority indicators (Two-year interval)	LQAS
<b>Cross-cutting</b>	Household with latrine coverage	HMIS
<b>Overall summary (Geographical Equity)</b>	Health facilities below lower benchmark	Summary

## 4.7 Advocacy and bridging the financial gap

### 4.7.1 Advocacy

Advocacy and communication to mobilize stakeholders for this sharpened plan to its full implementation in order to accelerate the much desired reduction of maternal and child mortality and morbidity will be key to success.

It should strengthen partnerships for social and political support for the movement for Reproductive, Maternal, Newborn and Child survival in the country. This should help to galvanise efforts, leverage and/or mobilise resources for its implementation as well as generate synergies and complementarities.

The plan has to be communicated effectively to each group likely to impact on the implementation process and its outcomes of the strategic shifts. Internal stakeholders have been extensively involved in the process of development of the plan.

### 4.7.2 Bridging the Financial Gap

Private health insurance which is largely subsidized by employers for their employees accounts for less than 1% of total health expenditure and efforts could be made to expand its coverage.

The establishment of the National Health Insurance Scheme as a health financing mechanism, which is in advanced stages of planning, will gradually cover more people.

Already 15 community-based health insurance schemes exist in Uganda; coordinated by an umbrella organization, the Uganda Community Based Health Financing Association (UCBHFA).

# 05

## RENEWING THE PROMISE

### 5.1 A call to action – we all have a role to play

A number of stakeholders are committed to delivering the RMNCH Plan in the next 4 years. Their commitments are outlined below.

### 5.2 Government and policy makers (National and district levels)

Since 2010, the Uganda Government is committed to the reduction of maternal and newborn death in Uganda.

In this sharpened plan the government is committed to (i- providing evidence-based policy guidance and programmes prioritised to specific localities, contexts and populations, (ii-ensuring coordinated partnerships including strengthening of community systems and integration of RMNCH services, ensuring access to lifesaving RMNCH services for high burden districts and populations within districts,(iii- generate district and specific population strategic data to inform policies, development and funding frameworks for underserved populations, (iv-strengthen the capacity of districts to develop, implement, monitor RMNCH programs through, (iv-harmonise and promote standards, guidance and tools for priority RMNCH interventions, (v- to ensure that health financing strategies incorporate access to RMNCH services, use of data for evidence based decisions, estimate and forecast impact of individual and combined packages of RMNCH interventions at all levels including community level.

### 5.3 United Nations and Other Multi Bi Lateral Organization

The United Nations and other Multi and Bi lateral organizations commit to (i-provide leadership in advocacy for RMNCH outcomes for underserved populations through government structures, (ii-support scale up and implement prioritised RMNCH services, (iii-providing guidance and support in development standards, quality control, regulation, (iv-Promoting access to and the use of new service delivery approaches and technologies and (v-Enhance national capacity for surveillance, monitoring and evaluation.

### 5.4 Forums in Parliament

Members of the 9th parliament have chosen to make commitments to (i- draft and table a private member team on reproductive maternal newborn and child health, (ii- conduct constituency outreach activities to educate the population on RMNCH with a focus on fostering capacity to

demand rights to health services, family planning and child spacing and on improving health seeking behaviour to avoid “the first delay”, birth preparedness, maternal and infant nutrition, (iii-ensure the budgetary allocation for health is increased to 15% in accordance with the Abuja Declaration to enable recruitment and retention of midwives, functionality of village health teams and availability of RMNCH commodities and equipment.

## 5.5 Civil Society Organization

Civil Society Organisation’s complement role and renewed commitment is tailored towards working closely with government to (i- identify high burden districts using agreed criteria and also support community participation in the process, (ii- monitor and track Uganda’s commitments to A Promise Renewed (APR) feeding this back to the national health and development plans including reporting on the global process to stimulate actions at various levels, (iii- advocate and support the uptake of the country led MDG 4 and 5 sub national countdown-a tool used globally to track specific RMNCH indicators.

Tracking clearly defined district indicators will help to strengthen and guide the country in planning, as well as in allocating resources and ownership of the problem, (iv-leverage of resources and expertise in integrating health with other sectors and work more effectively towards a shared goal of ending preventable deaths, (v- mobilise citizens to call on government to increase investment in high impact maternal and child interventions including more universal immunization, nutrition, emergency obstetric and newborn care coverage and elimination of HIV mother to child transmission.

## 5.6 Cultural Institutions

In 2013, Queen Mothers and Women Cultural Leaders Network will advocate for expansion of services to reach all the under-served populations in their respective areas of jurisdiction. Cultural institutions will contribute to mobilization of citizens to access, utilise and adhere to high impact service intervention packages, address cultural norms, taboos and practices that are detrimental to RMNCH, utilise existing cultural institutions to address sexual and gender-based violence and support all efforts to uplift the status of women and girls within the cultural institutions.

## 5.7 Faith Based Institutions

The Roman Catholic Church is committed to providing holistic health services especially to mostly needy population sub groups e.g. children, women (pregnant mothers, HIV positive people and orphans).

The Mufti and other top Muslim clerics will scale up advocacy on maternal child health by having their voices recorded and played by media houses for the consumption of the public as well as participating in radio talk shows for maternal child health in order to reach out to the most distant households in regions that have been identified as performing poorly.

This will be driven by scaling up the demand creation drive by integrating RMNCH with religious teachings, other religious events and messages and pre-marital counselling to emphasise and promote RMNCH.

## 5.8 Private Sector

The Private sector commits to work with partners to map out high burden districts to ensure private health facilities in high burden districts strengthen RMNCH services. Strengthen the 'Touch & Save Lives' Campaign in underserved populations, mobilise resources for research-based RMNCH interventions in the private sector and co-invest in building capacity of private health facilities to ensure accessible RMNCH services.

This will be strengthened through fostering the public-private partnership with increased RMNCH access to targeted communities.

## 5.9 Uganda Private Midwife Association

The Uganda Private Midwife Association is committed to saving lives of mothers and their newborn. As an association they will aim at providing PMTCT, EmOC, newborn care/resuscitation, post abortion care and treatment of malaria in pregnancy. They will also aim at scaling up family planning, sexual and gender based violence and adolescent health. Through these interventions they will focus on high burden underserved populations and hard to reach areas.

## 5.10 Health Care Workers and their Professional Associations

Several health workers and professional association such the Association of obstetricians and Gynaecologists of Uganda will provide technical assistance and advocacy for underserved populations. The professional associations will also support the development of standards and guidelines for the public and private sector in family planning and Emergency Obstetric and Newborn Care

Other professional bodies like the Uganda Paediatric Association will work with other professional bodies to improve the capacity of health workers as to provide quality reproductive health and MNCH services through in-service training and mentorship.

Health workers will be trained through BEmNOC and CEmONC to improve immunization coverage, prevention and treatment of malaria, pneumonia and diarrhoea and to improve nutrition especially in the underserved areas of Uganda.

**Table 6: Strategic Framework**

<b>GOAL: TO END PREVENTABLE MATERNAL AND CHILD DEATHS IN UGANDA</b>			
Impact	1. Reduced the Maternal Mortality Ratio from 438 per 1,000 live births to 211 per 100,000 live births by 2017		
	2. Reduced Under 5 Mortality Rate from 90 per 1,000 live births to 53 per 1,000 live births by 2017		
	3. Reduced the Infant Mortality Rate from 54 per 1,000 live births to 30 per 1,000 live births by 2017		
	4. Reduced the Neonatal Mortality Rate from 27 per 1,000 live births to 10 per 1,000 live births by 2017		
<b>PURPOSE: TO REDIRECT AND REFOCUS EFFORTS TOWARDS ACCELERATING THE ATTAINMENT OF MDG 4&amp;5 IN UGANDA</b>			
Key result	1. Coherent, prioritised and funded country led integrated RMNCH plan		
	2. Commitments and mutual accountability for sustained collective action by government, development partners, private sector, and CSOs		
	3. Transparency and evidence based planning and reporting to accelerate progress and deliver results		
<b>STRATEGIC OBJECTIVES</b>			
1.0 To accelerate greater coverage in high-burden districts and populations	2.0 To expand coverage of high impact interventions	3.0 To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths	4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths
<b>Key Result</b>			
1.1 Identification of High Priority Districts (HPDs) based on a 'composite health index' across districts	2.1 Enhanced access to and use of life-saving RMNCH commodities and equipment	3.1 RMNCH prevention targets and services integrated in non-health programs	4.1 Functioning transparency and mutual accountability mechanism
1.2 Differential planning for HPDs	2.2 Scaled and sustained demand and supply of highest impact, evidence-based interventions	3.2 Women are empowered to make RMNCH decisions	4.2 Unified MNC survival voice, shared targets, harmonized approaches and common metrics across levels and partnerships
1.3 Scaled up community- outreach based delivery platform formic packages to most burdened populations	2.3 Appropriate lifesaving task-shifting regulations and policies implemented	3.3 Environmental factors addressed e.g., sanitation and hygiene	4.3 Mutual assessments of progress in implementing agreed commitments
1.4 Reduced coverage disparities between regions and within districts	2.4 Enhanced uptake of community level RMNCH interventions		4.4 Increased visibility of RMNCH statistics
1.5 Equity-sensitive monitoring data			
<b>Indicators and Targets</b>			
• Proportion of regions, districts or sub-districts with previously the highest mortality rates registering a 50% reduction in mortality: Target 60% by 2017	• Proportion of facilities with no stock outs of lifesaving commodities raised to 80%	• Teenage pregnancy and motherhood reduced from 24% to <15%	• Proportion of planned quality RMNCH performance reports produced, debated and used to strengthen program management and resources allocation
• Proportion of regions, districts or sub-districts with previously highest mortality rates reduced to current national average: Target 70% by 2017	• Proportion of nurses, midwives, VHTs providing lifesaving interventions increased to >60%	• Girls married by age 18 reduced from 46% to <10%	• Proportion of commitments met on schedule by each partner
• Proportion of regions, districts or sub-districts with previously highest mortality rates with increased budget allocations to high impact interventions: Target 90% by 2017	• Increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (4+ ANC visits, EmONC, pre-term care, treatment of newborn and child infections)	• Unmet need for contraception reduced from 34.4% to <20%	• Proportion of resources allocated and spent based on previously made commitments and goals
• Percentage narrowing in midwives staffing differences between regions, districts or sub-districts with previously highest mortality rates compared to those with lowest mortality: Target 20% by 2017		• Stunting among children Under 5 years reduced from 33% to <25%	
• Out-of-pocket expenditures for the poor reduced to < 15%		• Anaemia in non-pregnant women reduced to <20%	
		• Households with access to improved sanitation increased from 16% to >80%	

### 5.10.1 Log-Frame

The summary log-frame presented below is based on the strategic framework for the plan discussed in Section 4.3. It covers the Key Result Areas (KRA) of the plan in line with the 4 strategic objectives. An illustrative matrix for interventions and key activities under each result area is presented in Appendix 3. The indicators given in the log-frame summary will inform monitoring and evaluation for results- based management. Most of these indicators are included in the national HMIS and UDHS.

**Table 7: Summary Log-frame for the Sharpened RMNCH Plan**

Hierarchy of Aims	Objectively Variable Indicators (OVI)	Means of Verification	Timing of Data Collection	Responsibility	Assumptions
<b>Goal</b> To end preventable maternal and child deaths in Uganda	<ul style="list-style-type: none"> <li>Reduced the Maternal Mortality Ratio from 438 per 100,000 live births to 211 per 100,000 live births by 2017</li> <li>Reduced under 5 mortality rate from 90 per 1,000 live births to 53 per 1,000 live births by 2017</li> <li>Reduced the Infant Mortality Rate from 54 per 1,000 live births to 30 per 1,000 live births by 2017</li> <li>Reduced the Neonatal Mortality Rate from 27 per 1,000 live births to 10 per 1,000 live births by 2017</li> </ul>	Reports: <ul style="list-style-type: none"> <li>UDHS 2010/11</li> <li>UDHS 2015/16</li> <li>UDHS 2020/21</li> </ul>	2015/16	UBOS	
<b>Purpose</b> To redirect and refocus efforts towards accelerating the attainment of MDG 4&5 in Uganda	<ul style="list-style-type: none"> <li>Coherent, prioritised and funded country led integrated RMNCH plan</li> <li>Commitments and mutual accountability for sustained collective action by government, development partners, private sector, and CSOs</li> <li>Transparency and evidence based planning and reporting to accelerate progress and deliver results</li> </ul>	Reports <ul style="list-style-type: none"> <li>HMIS</li> <li>MPDR</li> <li>Score Card</li> </ul>	Quarterly Annually	MoH-M&E Unit DHO (MCH) Facility in-charges	MPDR quality improves
<b>Key Result 1</b> Greater coverage in high-burden districts and populations	<ul style="list-style-type: none"> <li>Proportion of regions, districts or sub-districts with previously the highest mortality rates registering a 50% reduction: Target 60% by 2017</li> <li>Proportion of regions, districts or sub-districts with previously highest mortality rates reduced to current national average: Target 70% by 2017</li> <li>Proportion of regions, districts or sub-districts with previously highest mortality rates with increased budget allocations to high impact interventions: Target 90% by 2017</li> <li>Proportion of narrowing in midwives staffing differences between regions, districts or sub-districts with previously highest mortality rates compared to those with lowest mortality: Target 20% by 2017</li> <li>Out-of-pocket expenditures for the poor reduced to &lt; 30%</li> </ul>	<ul style="list-style-type: none"> <li>UDHS</li> <li>HMIS</li> <li>Special Surveys</li> </ul>	2015/16 Quarterly Annually	MoH-M&E Unit DHO (MCH) Facility in-charges	
<b>Key Result 2</b> Expanded coverage of high impact interventions	<ul style="list-style-type: none"> <li>Proportion of facilities with no stock outs of lifesaving commodities raised to 80%</li> <li>Proportion of nurses, midwives, VHTs providing lifesaving interventions increased to &gt;60%</li> <li>Increase coverage of lifesaving interventions to over 80% (4+ ANC visits, EmONC, pre-term care, treatment of newborn and child killer infections)</li> </ul>	<ul style="list-style-type: none"> <li>HMIS</li> <li>Score Card</li> <li>Supervision reports</li> </ul>	Annual	MoH	
<b>Key Result 3</b> Non health sector interventions that impact on maternal, newborn and child vulnerability and deaths harnessed	<ul style="list-style-type: none"> <li>Teenage pregnancy and motherhood reduced from 24% to &lt;15%</li> <li>Girls married by age 18 reduced from 46% to &lt;10%</li> <li>Unmet need for contraception reduced from 34.4% to &lt;20%</li> <li>Stunting among children Under 5 years reduced from 33% to &lt;25%</li> <li>Anaemia in non-pregnant women reduced to &lt;20%</li> <li>Households with access to improved sanitation increased from 16% to &gt;80%</li> </ul>	<ul style="list-style-type: none"> <li>UDHS</li> <li>HMIS</li> <li>Special Surveys</li> </ul>	Annual	MoH	
<b>Key Result 4</b> Collective action and mutual accountability for ending preventable maternal, newborn and child deaths	<ul style="list-style-type: none"> <li>Number of parallel RMNCH project interventions</li> <li>Percent of aid disbursements released according to agreed schedules</li> <li>RMNCH program reports produced, debated and used to generate action</li> <li>Unified RMNCH program monitoring and evaluation system</li> </ul>	<ul style="list-style-type: none"> <li>Joint RMNCH program reviews</li> <li>NHA for RH &amp; CH</li> </ul>	Annual	MoH	

**06**

# **APPENDICES**

## Appendix 1: M&E Framework for Priority Interventions

Life Cycle Phase	Goal	Objective verifiable indicator Indicator Description	Baseline	Target (2017)	Means of verification Responsible person	Collection method	Source	Frequency	Assumption
Pre-pregnancy & Adolescence	To reduce maternal mortality in Uganda to 211/100,000 live births by 2017	Unmet need for modern contraception (married women)	34.4%	20%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Increased use of implants
		Modern contraception (reproductive age)	29.9%	35%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 Years Annual	Increased use of long term contraception
		Teenage pregnancy and motherhood	24%	15%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 Years Annual	Continued roll out of SSE
		% Women with problems in accessing health care	65%	30%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Sustained socio-economic growth
		% First) ANC visit in 1 <sup>st</sup> trimester	21%	50%	MoH [M&E] unit	Routine & Non-routine data	UDHS, HMIS	5 Years Annual	Increased capacity of health facilities
		% Women attending 4+ ANC visits (anytime during pregnancy)	35%	80%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Increased capacity of health facilities
		% Pregnant women taking 2+ doses IPT	44%	60%	MoH [M&E] unit	Routine & Non-routine data	UDHS, MIS HMIS	5 & 2.5 years Annual	Increased capacity of health facilities
		% Maternal anti-retroviral for PMTCT	84%	95%	MoH [M&E] unit	Routine & Non-routine data	UDHS, HMIS	5 years Annual	Continued roll out of Option B+
		% Pregnant women told about Pregnancy danger signs	47%	80%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Availability of Job aides at lower levels
		% Pregnant women sleeping under ITNs	47%	80%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Sustainable partnerships in ANCLIN distribution
Pregnancy		% Institutional deliveries	58%	70%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Increased capacity of health facilities offering delivery services
		Increase coverage of active management of 3 <sup>rd</sup> stage	?	80%	MoH [M&E] unit	Routine data	HMIS	Annual	All institutional deliveries use uterotonics
Birth		% Health facilities with EmONC	24%	50%	MoH [M&E] unit	Routine & Non-routine data	UDHS, SPA HMIS	5 & 2.5 years Annual	Staff retained in peripheral facilities

Life Cycle Phase	Goal	Objective verifiable indicator				Means of verification			Assumption
		Indicator Description	Baseline	Target (2017)	Responsible person	Collection method	Source	Frequency	
Post-natal		% Postnatal care for Mothers within 48 hours	33%	70%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Functioning VHT strategy for mobilization
		% Postnatal care for newborns within 48 hours	11%	70%	MoH [M&E] unit	Routine data	HMIS	Annual	Functioning VHT strategy for mobilization
Neonatal	To reduce neonatal mortality rates from 27/1,00 in 2011 to 10/1,000 by 2017	% eligible HIV+ mothers that access ARVs	84%	95%	MoH [M&E] unit	Routine & Non-routine data	UAIIS HMIS	5 years Annual	Continued roll out of Option B+
		% of mothers initiating breast feeding within 1 hour	62%	80%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	None
		% Cases of Severe Neonatal Infection Managed	Baseline	95%	MoH [M&E] unit	Routine & Non-routine data,	UDHS HMIS	5 years Annual	Availability of facility amenities (water, light and sanitation)
		% Districts implementing district wide Kangaroo care for LBW	10%	63%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Available space and
Childhood	To reduce Under-5 mortality rates from 90/1,00 in 2011 to 53 per 1,000 live births by 2017	% Facilities with IMCI-trained clinicians	39%	90%	MoH [M&E] unit	Routine & Non-routine data	UDHS, HMIS	5 years Annual	Staff retention in peripheral units
		% Districts with >80% full immunisation coverage	0%	90%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Improved cold chain management
		Prevalence of malaria in U5s	45% (2009)	<25%	MoH [M&E] unit	Non-routine data	MIS	2 5 years	Sustained LLIN distribution
		% children fully immunized	52%	80%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Improved cold chain management
		% Under-5 children that slept under LLINs	42%	90%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Sustained LLIN distribution at ANC
		% HIV+ children of HIV+ mothers accessing ARVs	52%	90%	MoH [M&E] unit	Routine & Non-routine data	UDHS, UAIIS HMIS	5 years Annual	Option B+ scale up
	% children with fever treated with ACT	Baseline	80%	MoH [M&E] unit	Non-routine data sources	UDHS, MIS	5 years	VHT strategy implementation	
	% children with fever treated within 24 hours	42%	80%	MoH [M&E] unit	Non-routine data sources	UDHS, MIS	5 years	VHT strategy implementation	

Life Cycle Phase	Goal	Objective verifiable indicator				Means of verification			Assumption
		Indicator Description	Baseline	Target (2017)	Responsible person	Collection method	Source	Frequency	
Cross-cutting areas	To reduce Maternal, Newborn and Childhood mortality rates in Uganda to the set targets by 2017	% children with ARI treated with antibiotics	47.4%	90%	MoH [M&E] unit	Non-routine data sources	UDHS	5 years	Policy on antibiotics at community level
		% Children with diarrhoea receiving Zinc	2%	30%	MoH [M&E] unit	Non-routine data sources	UDHS	5 years	Increased private sector contribution
		% Under-5 that receive vitamin A supplementation	57%	90%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS	5 years Annual	Sustainable partnerships; long-term funding
		% children Under-5 that take ORT/Fluids for diarrhoea	55%	90%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Sustainable partnerships; long-term funding
		% DHOs with capacity to analyse data, plan and implement RMNCH programs	Baseline	95%	MoH [M&E] unit	Routine & Non-routine data	UDHS HMIS, Supervision reports	5 years Annual	ADHOs (MCH) per district
		Prevalence of stunting among children Under-5 years	33%	<20%	MoH [M&E] unit	Routine & Non-routine data	UDHS, HMIS	5 years Annual	Minimal social disasters
		% Anaemia in pregnancy	Baseline	20%	MoH [M&E] unit	Routine & Non-routine data	UDHS, MIS	5 years	Sustained socioeconomic growth
		% Anaemia in Non-Pregnant Women	Baseline	19%	MoH [M&E] unit		HMIS	Annual	
		% Households with improved sources of drinking water	70%	80%	MoH [M&E] unit	Routine & Non-routine data	UDHS	5 Years	Sustained socioeconomic growth
		% households with improved sanitation	16%	80%	MoH [M&E] unit	Routine & Non-routine data	UDHS	5 Years	
% facilities holding MPDRs	12.8%	90%	MoH [M&E] unit	Routine & Non-routine data	SPA HMIS, MPDR	5 years Annual	Incentivised QI		

Notes: RH = Reproductive Health; CH = Child Health; EH = Environmental Health; UDHS = Uganda Demographic & Health Survey; MTR = Mid-Term Review; UAIS = Uganda AIDS Indicator Survey; MIS = Malaria Indicator Survey

## Appendix 2: Mutual Accountability Matrix

Area of commitment Based on Key RMNCH Plan Outputs	Joint Outcome Indicators					
	Government	Donor	Multilateral	CSOs	Private Sector	Community
<b>1. Accelerating greater coverage in high-burden districts and populations</b>						
1.1 Intensified implementation in high burden districts	A	A	P	A	P	P
1.2 Scaled up community- outreach based delivery platform for RMNCH packages to most burdened populations	A	A	P	P	A	P
1.3 Reduced coverage disparities between regions and within districts	A	P	P	P	A	P
1.4 Reliable and equity-sensitive monitoring system and data driven efforts	A	A	P	R	A	P
<b>2. Expanding coverage of high impact interventions that directly reduce maternal, newborn and child mortality</b>						
1.1 Enhanced access to and use of life-saving RMNCH commodities and equipment	A	A	P	P	A	P
1.2 Scaled and sustained demand and supply of highest impact, evidence-based interventions	P	P	P	A	P	P
1.3 Appropriate lifesaving task-shifting regulations and policies implemented	A	P	P	P	A	P
1.4 Enhanced uptake of community level RMNCH interventions	A	A	A	A	A	A
<b>3. To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths</b>						
1.1 RMNCH prevention targets and services Integrated in non-health programs	A	A	P	P	P	P
1.2 Women are empowered to make RMNCH decisions	A	A	P	A	P	A
1.3 Environmental factors addressed e.g., sanitation and hygiene	A	P	P	P	P	A

Area of commitment Based on Key RMNCH Plan Outputs	Joint Outcome Indicators					
	Government	Donor	Multilateral	CSOs	Private Sector	Community
<b>4. Collective action and mutual accountability for ending preventable maternal, newborn and child deaths</b>						
1.1 Functioning transparency and mutual accountability mechanism	A	A	P	P	P	A
1.2 Unified MNC survival voice, shared targets, harmonized approaches, common metrics across levels and partnerships	A	A	A	A	A	A
1.3 Reviews of progress in implementing commitments	A	A	A	A	A	P
1.4 Well-coordinated and harmonized support to overcome system constraints	A	A	A	A	A	P

- Number of parallel RMNCH project interventions
- Percent of aid disbursements released according to agreed schedules
- RMNCH programme reports produced, debated and used to generate action
- Unified RMNCH programme monitoring and evaluation system

NOTES:

A=Accountable

P= Participate

### Appendix 3: Illustrative Intervention Planning Matrix

Output 1: This is geared at increasing national coverage and at the same time to reduce geographical inequities in accessibility, quality and utilisation of childbirth and newborn care services.

Strategy 1.1 Focusing on increasing access and coverage of priority high Impact RMNCH Interventions.

Intervention	Key Activities	Implementation Focus	Indicator	
			Verifiable Indicator	Baseline 2017
<b>Preconception</b>				
1.1 Increased access and use of Family Planning	<ul style="list-style-type: none"> <li>Reduce unmet need for contraception among married women</li> </ul>	<ul style="list-style-type: none"> <li>Focus on poor rural women and adolescents</li> <li>Harness missed opportunities during postpartum period</li> <li>Focusing on long acting and permanent method</li> <li>Extra effort on Karamoja, Eastern, East Central, North, West Nile and South Western Region</li> </ul>	CPR	30% 35%
<b>Antenatal Period</b>				
1.2 Focused Antenatal care to track high risk pregnancies	1.3 ANC attendance starting in first trimester	<ul style="list-style-type: none"> <li>Empower male partners with knowledge about ANC services</li> <li>Focus on attendance in first trimester</li> <li>Focus on improving quality of ANC</li> <li>Rural populations</li> </ul>	ANC visit in 1st trimester	21% 50%
	1.4 Pregnant women given 2+ doses IPT		% Women attending 4+ ANC visits % Pregnant women taking 2+ doses IPT	35% 44% 70% 84%
<b>Delivery/Birth</b>				
1.5 Skilled obstetric care and essential newborn care and resuscitation	Skilled Births Attendance	<ul style="list-style-type: none"> <li>Focus on Karamoja, Southwest, Western, Eastern and North</li> </ul>	% Institutional deliveries	57% 89%
	Active management of third stage	<ul style="list-style-type: none"> <li>All regions in the country</li> <li>All health facilities (private and public) offering delivery services</li> </ul>	Active management of third stage	18% 60%
	Antibiotics for Pre-term/Pre-labour rupture of membranes (P/PROM)		Antibiotics for P/PROM	2% 60%
	Detection and management of pre/eclampsia (MgSO4)		Management of pre/eclampsia	2% 60%**
	Oxytocin/Misoprostol in preventing post-partum bleeding		Oxytocin/Misoprostol	10% 60%
	Post abortion care/puerperal sepsis		PAC and puerperal sepsis	10% 60%
	Essential Newborn Care (normal baby)		Proportion of women initiating early breastfeeding	35% 63%

Intervention	Key Activities	Implementation Focus	Indicator		
			Verifiable Indicator	Baseline	2017
1.6 Emergency obstetric and newborn care	<ul style="list-style-type: none"> <li>Increase coverage of EmONC delivery points</li> </ul>	All HC IV and above provide CE/EmONC and lower facilities with delivery services provide BE/EmONC	% Health facilities with EmONC	24%	90%
	<ul style="list-style-type: none"> <li>Caesarean Section</li> </ul>	Countrywide for all HC IV and above	C-Section rate	2%	5%
	<ul style="list-style-type: none"> <li>Antenatal steroids for pre-term labour</li> </ul>	Provision of ACS at all levels where delivery occurs	ACS for pre-term labour	5%	60%
	<ul style="list-style-type: none"> <li>Management of LBW and pre-term babies</li> </ul>	Focal interventions are: kangaroo mother care and provision of assisted feeding	Kangaroo mother care among LBW	2%	50%
<b>Postnatal Period</b>					
1.7 Postnatal attendance with skilled care (within 48 hours)	<ul style="list-style-type: none"> <li>Post natal care for mothers at all facilities</li> </ul>	Countrywide implementation			
	<ul style="list-style-type: none"> <li>Registration, counselling, referral and follow up for mothers and newborn at community level</li> </ul>	Implement Countrywide	% Postnatal care for Mothers within 48 hours	33%**	70%
	<ul style="list-style-type: none"> <li>Postnatal home visits by VHTs at least three visits to the mother and six to the newborn within six weeks of delivery/birth</li> </ul>	Focus on missed opportunities: (About half (47%) of women stay in health facility either for less than one day after vaginal birth)	% Postnatal care for newborns within 48 hours	11%**	70%
<b>Childcare</b>					
1.8 Treatment of Newborn Infections (Sepsis, Pneumonia, Diarrhea)	<ul style="list-style-type: none"> <li>Treatment of newborn infections at facility level with parenteral antibiotics</li> </ul>	Countrywide implementation	Case fatality rate		
	<ul style="list-style-type: none"> <li>Care-seeking and prompt referral for newborn infections</li> </ul>	HC IIs provide pre-referral treatment			
1.9 Treatment of Diarrhoea Malaria and Pneumonia	<ul style="list-style-type: none"> <li>Management of diarrhoea in children with ORS along with Zinc</li> </ul>	Diarrhoea is highest in East Central and Eastern regions	% Children with diarrhoea receiving Zinc	2%	85%
	<ul style="list-style-type: none"> <li>Use of recommended antibiotics in children aged 2 months to 5 years with non-severe pneumonia</li> </ul>	Zinc coverage still very low and can be rapidly raised to ORS levels	% children Under-5 that take ORT/Fluids for diarrhoea	55%	85%
	<ul style="list-style-type: none"> <li>Use of ACTs in treatment of Malaria</li> </ul>	Eastern, East central, Northern, Karamoja, Southwest have the lowest coverage of pneumonia treatment	% children with ARI treated with antibiotics	47.4%	75%
		Countrywide	% children who took ACT on same day	46%	80%

# BILIOGRAPHY

## BIBLIOGRAPHY

1. Adam T, et al. Achieving the millennium development goals for health: cost effectiveness analysis of strategies for maternal and neonatal health in developing countries, *BMJ* 2005;331:1107-10
2. Framework and Guidance for the Landscape Analysis of Life-Saving Reproductive, Maternal, Newborn and Child Health Interventions and Commodities
3. Government of Uganda, Ministry of Health: Uganda National Malaria Control Strategic Plan 2010/11 – 2014/15
4. IHP+ (2013) Joint Annual Health Sector Reviews: A review of experience, February 2013
5. Millennium Development Goals Report for Uganda 2010 Special theme: Accelerating progress towards improving maternal health
6. Ministry of Finance, Planning and Economic Development (2010) 'Millennium development report for Uganda: Accelerating progress towards improving maternal health,' Government of Uganda: Kampala
7. Ministry of Finance, Planning and Economic Development (2010) 'National Development Plan FY 2010/11- 2014/15,' Government of Uganda: Kampala
8. Ministry of Finance, Planning and Economic Development (2012) 'National budget framework paper FY 2012/13 – FY 2016/17: Incorporating the medium term macroeconomic plan, programmes for social and economic development and the indicative revenue and expenditure framework,' Government of Uganda: Kampala
9. Ministry of Health (2005) Strategic Plan Maternal, Perinatal And Child Death Review, 2009/10 - 2014/15
10. Ministry of Health (2005) Uganda Malaria Control Strategic Plan 2005/6 – 2009/10 Kampala: Malaria Control Programme
11. Ministry of Health (2006) Health Sector Strategic Plan II: 2005/6 to 2009/10 Kampala: Government of Uganda: Ministry of Health
12. Ministry of Health (2008) Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2006-2015 Kampala: Government of Uganda: Ministry of Health
13. Ministry of Health (2008) Situation Analysis of Newborn Health in Uganda: Current Status and Opportunities to improve care and survival Kampala: Government of Uganda, Save the Children, UNICEF, WHO
14. Ministry of Health (2010) Human Resources For Health Audit Report, October 2010
15. Ministry of Health (2012) Facilitator's Notebook On-Job-Training (OJT) Family Planning Learning Resource Package Uganda
16. Ministry of Health (2000) National Supervision Guidelines for Health Services
17. Ministry of Health (2006) Uganda HIV/AIDS Sero-behavioural Survey 2004-2005 Calverton, Maryland, USA: Ministry of Health and ORC Macro Kampala
18. Ministry of Health (2007) 'Child Survival Strategy for Uganda 2008-2015' Government of Uganda: Kampala

19. Ministry of Health (2007) Health Planning Guidelines, Supplement To the Local Government Planning Process, June 2007
20. Ministry of Health (2008) Uganda Service Provision Assessment 2007 Kampala: Government of Uganda: Ministry of Health Macro International
21. Ministry of Health (2010) 'Health sector strategic Plan FY 2010/11-2014/15,' Government of Uganda: Kampala
22. Ministry of Health (2010) 'Newborn Component of the Child Survival Strategy-Implementation Framework' Government of Uganda: Kampala
23. Ministry of Health (2011) 'An Assessment of the Uganda essential medicines kit-based supply system,' USAID/SURE Program, Ministry of Health: Kampala
24. Ministry of Health (2011) 'Annual health sector performance review 2010/2011'' Government of Uganda: Kampala
25. Ministry of Health (2011) 'Annual Uganda AIDS indicator survey,' Government of Uganda: Kampala
26. Ministry of Health (2012) Annual Health Sector Performance Report 2011/12
27. Ministry of Health (2012) Human Resources For Health Bi-Annual Report, Volume 2, October 2012
28. Ministry of Health (2012) Management Of Medicines And Health Supplies Manual
29. Ministry of Health (2013) Governance and Management Structures
30. Ministry of Health (MOH) [Uganda] and ORC-Macro 2006 Uganda HIV/AIDS Sero-behavioural Survey 2004-2005 Calverton, Maryland, USA: Ministry of Health and ORC Macro
31. Ministry of Health, (2008) Annual Health Sector Performance Report: Financial Year 2007/8 Kampala: Government of Uganda: Ministry of Health
32. Ministry of Health, Health Systems 20/20, and Makerere University School of Public Health April 2012 Uganda Health System Assessment 2011 Kampala, Uganda and Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc
33. Muwonge, M et al (2010) Health Budgeting in Uganda: A reality check German Foundation for World Population (DSW) with Reproductive Health Uganda (RHU): Kampala
34. Population Secretariat (2012) 'Population programmes in Uganda: A geographical and interventions mapping at national and sub-national levels,' Government of Uganda: Kampala
35. Reproductive Health Uganda 2009 From Advocacy to Access: Uganda 1999 National Health Policy Kampala: Ministry of Health
36. Republic of Uganda Ministry of Health 2007 Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda Kampala: Ministry of Health
37. Republic of Uganda Ministry of Health 2009 Uganda Reproductive Health Commodities Situation Analysis Kampala: Ministry of Health
38. Republic of Uganda Ministry of Health 2009 Uganda Reproductive Health Commodities Security Strategic Plan 2009-2014 Kampala: Ministry of Health

39. Strengthening monitoring and evaluation practices Strengthening monitoring and evaluation practices in the context of scaling-up the IHP+ compact and in the context of scaling-up the IHP+ compact and Country Health Systems Surveillance
40. Tan-Torres Edejer T, et al. Achieving the millennium development goals for health: cost effectiveness analysis of strategies for child health in developing countries. *BMJ* 2005; 331:1177;
41. TARSC, HEPS (2013) Women's Health and Sexual and Reproductive Health in Uganda: A review of evidence, TARSC, HEPS, EQUINET: Harare
42. Task Force on Infant and Maternal Mortality (December 2003) Infant and Maternal Mortality in Uganda Kampala: Government of Uganda: Ministry of Finance, Planning and Economic Development
43. The Partnership for Maternal, Newborn & Child Health 2011 A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH) Geneva, Switzerland: PMNCH
44. US Mission Uganda (2011) Global Health Initiative: Uganda, A Strategy for Accelerating Reductions in Maternal and Neonatal Mortality. December 9, 2011
45. UDHS (2011) 'Uganda demographic and health survey 2011' Uganda Bureau of Statistics, Government of Uganda: Kampala
46. Uganda 2005 National Family Planning Advocacy Strategy 2005-2010 Kampala: Health Promotion and Education Division, Reproductive Health Division, Ministry of Health
47. Uganda AIDS Commission (2007) National HIV/AIDS Strategic Plan 2007/8-2011/12: Moving towards Universal Access Kampala: Uganda AIDS Commission
48. Uganda Bureau of Statistics (2006) Uganda Demographic and Health Survey, 2006 Kampala: Uganda Bureau of Statistics, Kampala, Uganda and ORC Macro International Inc, Calverton, Maryland, USA
49. Uganda Bureau of Statistics (UBOS) and Macro International Inc 2007 Uganda Demographic and Health Survey 2006 Kampala, Uganda and Calverton, Maryland, USA: UBOS and Macro International Inc
50. Uganda Family Planning Landscape Assessment April 2010
51. Strengthening monitoring and evaluation practices Strengthening monitoring and evaluation practices in the context of scaling-up the IHP+ compact and in the context of scaling-up the IHP+ compact and Country Health Systems Surveillance
52. Tan-Torres Edejer T, et al. Achieving the millennium development goals for health: cost effectiveness analysis of strategies for child health in developing countries. *BMJ* 2005; 331:1177;
53. TARSC, HEPS (2013) Women's Health and Sexual and Reproductive Health in Uganda: A review of evidence, TARSC, HEPS, EQUINET: Harare
54. Task Force on Infant and Maternal Mortality (December 2003) Infant and Maternal Mortality in Uganda Kampala: Government of Uganda: Ministry of Finance, Planning and Economic Development
55. The Partnership for Maternal, Newborn & Child Health 2011 A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH)

Geneva, Switzerland: PMNCH

56. US Mission Uganda (2011) Global Health Initiative: Uganda, A Strategy for Accelerating Reductions in Maternal and Neonatal Mortality. December 9, 2011
57. UDHS (2011) 'Uganda demographic and health survey 2011' Uganda Bureau of Statistics, Government of Uganda: Kampala
58. Uganda 2005 National Family Planning Advocacy Strategy 2005-2010 Kampala: Health Promotion and Education Division, Reproductive Health Division, Ministry of Health
59. Uganda AIDS Commission (2007) National HIV/AIDS Strategic Plan 2007/8-2011/12: Moving towards Universal Access Kampala: Uganda AIDS Commission
60. Uganda Bureau of Statistics (2006) Uganda Demographic and Health Survey, 2006 Kampala: Uganda Bureau of Statistics, Kampala, Uganda and ORC Macro International Inc, Calverton, Maryland, USA
61. Uganda Bureau of Statistics (UBOS) and Macro International Inc 2007 Uganda Demographic and Health Survey 2006 Kampala, Uganda and Calverton, Maryland, USA: UBOS and Macro International Inc
62. Uganda Family Planning Landscape Assessment April 2010
63. United Nations Population Fund (2012) 'Annual report 2010/2011,' Government of









**USAID**  
FROM THE AMERICAN PEOPLE



United Nations  
**UGANDA**

