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

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 population that lives in poverty, promoting gender equality and empowerment of women, increasing access to safe water and expanding access to information and communication technology. Though the country is on track to achieving MDG 4 concerned efforts is still required to achieve the targets and even more on for MDG 5 regarding reduction of maternal mortality ratio whose progress is slow.

Over the year, Government and Development Partners have made commitments to actions to reduce excess maternal and child mortality. A Promise Renewed" is for the Government and Partners and all stakeholders to take stock of how far we have reached in terms of progress towards MDG 4 and 5 and other related targets; progress on commitments and to renew commitments towards achieving the targets.

In this regard government together with partners have developed this sharpened Reproductive, Maternal, Neonatal and Child Health (RMNCH) plan. The RNMCH sharpened plan is for 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 to avoid business as usual. It places a strong emphasis on strengthening accountability and monitoring mechanisms as well as partnerships for social mobilization, funding and technical assistance. It will not meant to replace the existing Road Map for reduction of maternal mortality and the Child Survival Strategy but to catalyse 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 deaths 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

Working together, we can end preventable deaths of Women and Children in Uganda from the leading killers and conditions. Women and children have a right to quality health care and to survival-fundamental rights that should be respected and protected. The aim is "Every pregnancy wanted, every birth safe, every newborn and child healthy". A well-coordinated and integrated approach can help realize this, based on advocacy for policy, services and financial resources; action; and accountability.

The sharpened plan goes to the heart of the challenge: recognizing that RMNCH cannot be adequately dealt with separately but only through-integrated programs along the continuum of care. It addresses the critical need for a coordinated and collaborative implementation across sectors. With accelerated and coordinated implementation, there will be tremendous gains efficient and effective use of often, 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.

Ending preventable maternal and child deaths requires a new way of "doing business". This plan views five strategic shifts or goals as the priority for a forward-looking, compelling and integrated sustainable RMNCH agenda for keeping the promise of the MDGs and remains beyond 2015. These will form the focus for action and a introduce paradigm shift that will overcome the obstacles to prevent avoidable death. They reflect a national commitment and also recognize the importance of leadership at a local level and encourage districts, partners, CSOs 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 (MDG 4 and 5). We have the tools and knowledge to change that trajectory 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 on MDG 4&5 targets. The plan examines why the country is making slow progress in attaining the targets; reviews the maternal, newborn and child mortality and morbidity situation in Uganda; sets an agenda for how to accelerate progress; establishes the time horizon for the acceleration to the MDG targets; and proposes five strategic shifts in doing business differently or greater impact. The plan is aligned with Uganda's Vision 2040, and is anchored in the National Development Plan (NDP) 2010/11 – 2014/15.

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 and partners and civil society organizations will be working together to assure the promise renewed. 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).

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. The five strategic shifts are:

Focus Geographically	• Increase efforts in the districts where half of U5 deaths occur, prioritising budgets and committing to action plans to end preventable deaths
High Burden Populations	• Refocus district to scaling up acess for the underserved population groups • Delivery of integrated service packages at the 3 service delivery platforms
High Impact Solutions	• Target delivery and PNC as the biggest opportunities for impact • Scale and sustain supply of high impact interventions • Invest in operations research to accelerate results
Education, Empowerment, Economy, Environment	• Educating girls and women • Empower women to make decisions • Address environmental Factors e.g. sanitation& Hygiene
Mutual Accountability	• Mutual accountability for result at all levels of the health system • Unify Maternal and child survival voice with shared goal and M&E • Update Roadmap to reflect state of knowledge and progress

The Lives Saved Tool (LIST) was used to identify and prioritize a handful of existing and doable evidence-based and focused interventions that have the greatest impact on reducing mortality and improving health. These priority interventions are anchored 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 an additional total of 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 MNC 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, preterm care, treatment of newborn and child infections)	• 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%	• 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

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF TABLES

LIST OF ACRONYMNS

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 and 5; Uganda is unlikely to achieve 2015 targets for these goals. There is glaring disparity between the rate of child and maternal death across wealth quintiles and geographical regions – disparities that will persist unless Uganda takes action.We have the tools and knowledge to change that trajectoryto bring an end to preventable deaths; with greater participation of all partners and stakeholders, a change in focus, and commitment to hold ourselves accountable.

In June 2012, the Child Survival Call to Action was launched in Washington, DC[1]; with the goals to: mobilize 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 and with mutual accountability by all partners, and usesthe 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 country plan (the Sharpened Plan) to address the slow progress on MDG 4&5 targets hence this Sharpened Reproductive, Maternal, New born and Child Health (RMNCH) plan. The sharpened plan examines why the country is making slow progress in attaining the targets for MDG 4&5; reviews the maternal, newborn and child mortality and morbidity situation in Uganda; sets an agenda for how to accelerate progress; establishes the time horizon for the acceleration to the MDG targets; and proposes five strategic shifts in doing businessdifferently or greater impact. The plan proposes evidence-basedinterventions, which have the highest impact on Maternal, Neonatal and Child mortality. It provides a starting point for stakeholder dialogue with renewed commitmentsand, with mechanisms for information and mutual accountability.

1 The Child Survival Call to Action was convened by the governments of USA, India and Ethiopia, in collaboration with UNICEF.

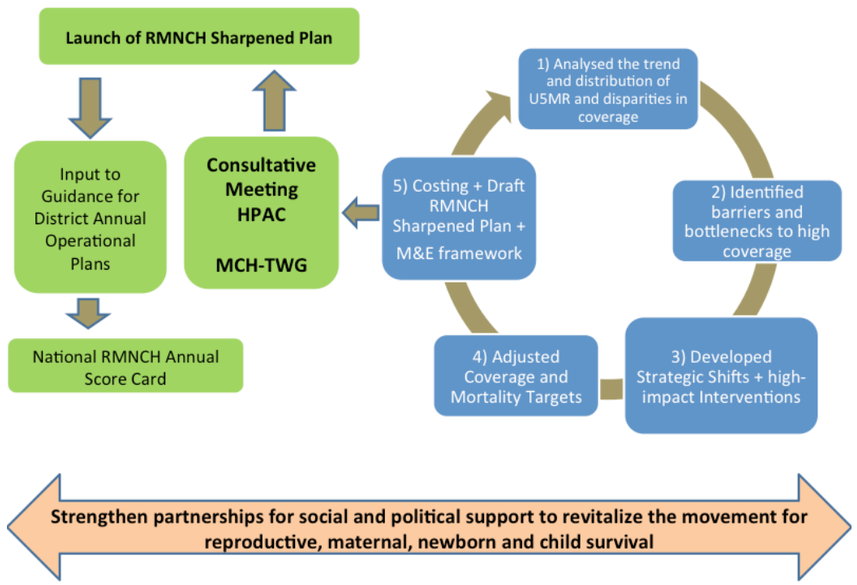
1.2 The National Health Context

This strategic plan is aligned and anchored 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 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 that government will focus on building an efficient health services delivery system which emphasizes 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 Decentralized policy stipulates the efficiency and effectiveness of service delivery guided by the constitution of Uganda (1995) and the local government act (1997); this plan is centred on strengthening health services and empowering districts and lower levels to make decisions to ensure equitable access to services.

The second National Health Policy (2010/11 – 2019/20) and the Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15 together define Maternal, Child and Newborn mortality reduction as the 3 outcomes of the health sector. The biggest challenge is to prioritize among the wider array of RMNNCH interventions within the context of limited funding and resources. The Roadmap for the Reduction of Maternal and Newborn Mortality, National Child Survival Strategy and, other strategies and related frameworkshave prioritized high impact interventions, which are appropriate for vulnerable population including the less advantaged.

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 the five months, starting in May 2013. Figure 1: summarises the key activities and main outputs associated with each action in the plan 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 UDHS to reveal patterns of disparities related to geographic locations (regions), wealth quintiles, gender, urban-rural divides, ethnic groups, educational levels, etc.

Step 2: Identifying Barriers and Bottlenecks:

The BottleneckAnalysis (BNA)[2]was used to determine and prioritize factors which limit the attainment of adequate coverage and the highest impact on RMNCH. Using tracer indicators, the bottleneck analysis considered the 3 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 iterative processes which included workshops, meetings of technical working groups and meetings with the academia, professional bodies, etc., new ways of doing business were reached (the strategic shifts) and a compendium of high impact interventions that will accelerate progress towards acceleration of MDG 4 and 5 targets were reached. The interventions were then subjected to the LiST and OHT 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 packages 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 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:

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

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

2017 when the midterm review of the next 5 year HSSIP will take place

2020 when the next 5 year HSSIP ends and when the next UDHS 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 on the achievement of MDG 4&5 and other related MDGs; and their drivers. It discusses the disparities therein. Using a "bottleneck" analysis the chapter highlights key root cause that underpins these disparities. Chapter 3 outlines the baseline examining 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 sets out the roadmap to addressing this situation. It begins by forecasting on how to bend the curve and 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. Chapters 5 consolidate the new commitments of the different stakeholders for the reduction of the reproductive maternal newborn and child health deaths.

1.6 Overview of the Uganda RMNCH Commitments

Uganda is a signatory to Global Commitments that aim at accelerating progress to MDG 4 and 5.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 towards the GSWC the government of Uganda committed to:

Ensure comprehensive Emergency Obstetric and Newborn Care (EmONC) services in hospitals increases from 70 to 100% and in health centres from 17 to 50%;

Ensure that basic EmONC services are available in all health centres;

Ensure that skilled providers are available in hard to reach/hard to serve areas;

Reduce the unmet need for family planning from 40% to 20%;

Increase focused antenatal care from 42% to 75%, with special emphasis on PMTCT and treatment of HIV;

Ensure at least 80% of under-5 children with diarrhoea, pneumonia or malaria have access to treatment; oral rehydration salts and Zinc within 24 hours,

Improve immunization coverage to 85%; and

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 it commitment to join the SUN Movement meant to bring organizations 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 ready to go to scale.

Uganda committed to this approach with a focus on five cross sectoral objectives set out in the Uganda Nutrition Action Plan Framework (UNAP): Improving Maternal Infants and Young Child Feeding; Enhancing Diet Diversity; Protecting Households from the Impacts Shocks; Strengthening the Policy, Legal and Institutional Frameworks; and Increasing National Awareness of Nutrition.

1.6.3 Global Vaccine Action Plan (GVAP) Pledge

Global Action Plan for Vaccines (GVAP) endorsed in May 2012, committed to provide equitable access to existing vaccines for people in all communities, polio eradication, new and improved vaccines until 2020. The government committed to increase and sustain coverage of all vaccines above 80% and introduce new vaccines namely pneumococcal, human papilloma, rotavirus and by 2015.

1.6.4 Family Planning 2020 (FP2020) Pledge

Family Planning 2020 (FP2020), launched in 2012 at the London Summit, committed to provide every woman with modern family planning choices and access by 2020. Uganda again 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 US $ 3.3M (7.8b UGX) to US $ 5M (12b UGX) for the next five years and mobilize an addition US $ 5M per year from donors. Uganda also committed to sustain the momentum from the London summit and ensure all partners are working to guarantee commodity security, voluntary planning and concrete measure to prevent coercion and discrimination, and ensure respect for home right: the data is available to support all the above through a score card, national health sub account; and publish an annual report to update all stakeholders on 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

WHO/UNICEF launched the GAPPD for the prevention and control of pneumonia and diarrhoea, which 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 former US president, Bill Clinton's visit to Uganda, attention was drawn to recommitting the public sector, civil society, private sector to diarrhoea and pneumonia treatment and advocating to implement the National Prevention – Protection and Treatment (PPT) of Diarrhoea and Pneumonia Strategy, which draws attention to a holistic and more coordinated approach to these two neglected diseases and addresses all age groups. His Excellency the President of Uganda announced the introduction of Rotavirus vaccine and Pneumococcal Vaccine.

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 a process to ensure global reporting, oversight and accountability. In response, Commission on Information and Accountability for Women's and Children's Health (CoIA) was convened and delivered a report in 2011: "Keeping Promises, Measuring Results", which put forth 10 recommendations 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 the following issues: Maternal mortality ratio; Under-five mortality; Stunting prevalence; Demand for family planning satisfied; Antenatal care; Antiretroviral for HIV-positive pregnant women; Skilled attendant at birth; Postnatal care for mothers and babies within two days of birth; Exclusive breastfeeding; Three doses of DPT-HiB coverage; and Antibiotic treatment for childhood pneumonia.Uganda is one of the pathfinder countries; committed to develop an accountability framework and to follow-up to 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, Mr. Ban Ki-moon, under the auspices of the Every Woman Every Child movement, and 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 the women and children who most need them, by providing a platform to help overcome 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 thirteen-life saving commodities, identify opportunities and gaps based on the recommendations and develop plans for implementing.

1.6.8 Preventing Premature Births & Deaths - "Born Too Soon" (BTS) Pledge

On the world prematurity day November 2012, to realise the MDG 4, government committed to a new goal to reduce deaths due to complication of preterm birth by 50% between 2010 and 2025. Specifically to incorporate targets for preterm care into the national policies and plans, increase the pace of scale up of high impact interventions to reduce deaths due to prematurity, especially management of women in preterm labour using antenatal corticosteroids, and Kangaroo Mother Care services. Working with Village Health Teams and their district counterparts strengthen linkages between communities and health facilities through early identification, referral and care of small babies. Uganda will commemorate the World Premature Day to create awareness and start the pathway to new commitments as we make progress.

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 which committed 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 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 greater number of children from dying of preventable causes. Uganda committed to translating it 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 with implementation 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 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 consultation meeting throughout 2013, facilitated by the core group chaired by UNICEF and WHO. Twenty countries have been identified to start analysing their situation in preparations for more detailed planning. Uganda has gone through this process in May 2013.

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

In line with a new campaign for elimination of transmission and HIV free survival for children, Uganda plan sets two ambitious targets for 2015, both from a 2009 baseline: reduce the number of children newly infected with HIV by 90%; and 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 is focusing on programmatic innovations for identifying HIV-infected children and retaining them on ART care and treatment, community mobilization and support for HIV-positive women and their children, and better integration of PMTCT services into stronger systems of maternal, newborn and child health care.

1.6.12 Universal Insecticide Treated Mosquito Net (ITN) Distribution Pledge

In Another milestone is implementation of Universal ITN coverage, planned to commence in 2013 - it aims to have a net to every individual in a household by 2015. This year alone more than 21 million nets will be distributed through mass campaign; atleast two people in household will own one insecticide-treated mosquito net a major improvement over the dismally low availability in 2000. The proportion of children under five that sleep under ITNs has risen from 2% in 2000 to 38% in 2011with 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

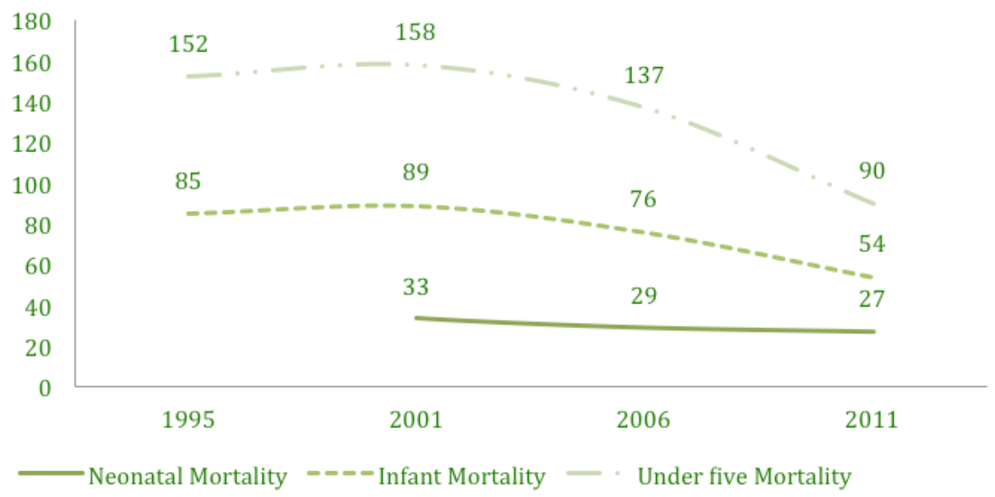
Uganda has already met two of its seventeen MDG targets – halving the number of people living in absolute poverty and achieving debt sustainability – and is on track to achieve another eight. There are areas where progress remains slow, has stagnated or has experienced a reversal. Trends in maternal mortality and HIV-AIDS are particularly worrying, given their direct impact on the lives of so many Ugandans. The child mortality trends remain on course. We review the progress on MDG 4 and 5.

2.1 Progress on MDG 4: Reducing Child Mortality by 2/3

2.1.1 Under-five mortalityrate

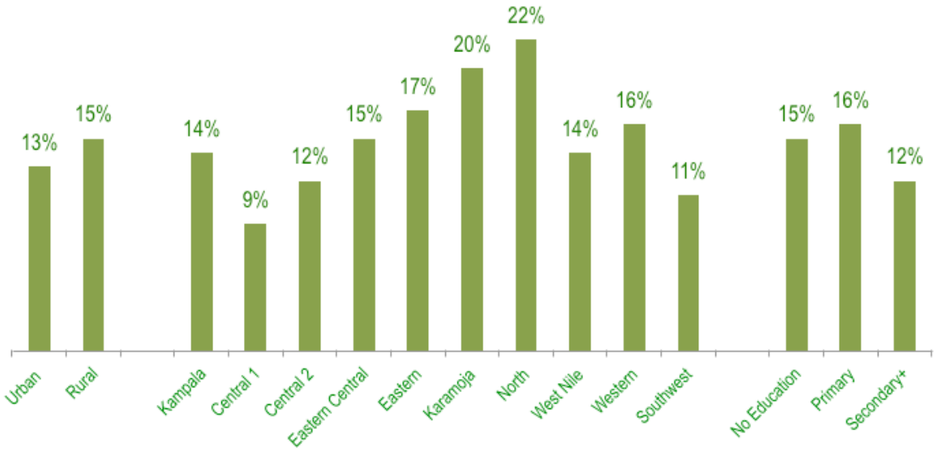
The number of Under-five deaths has fallen from 167 per 1,000 births in 1990 to 90 in 2011 equivalent to a 6.3% reduction per year. This means one in every 19 babies born in Uganda does not live to the first birthday; and one in 11 children will die before their fifth birthday. The pace needed to achieve 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



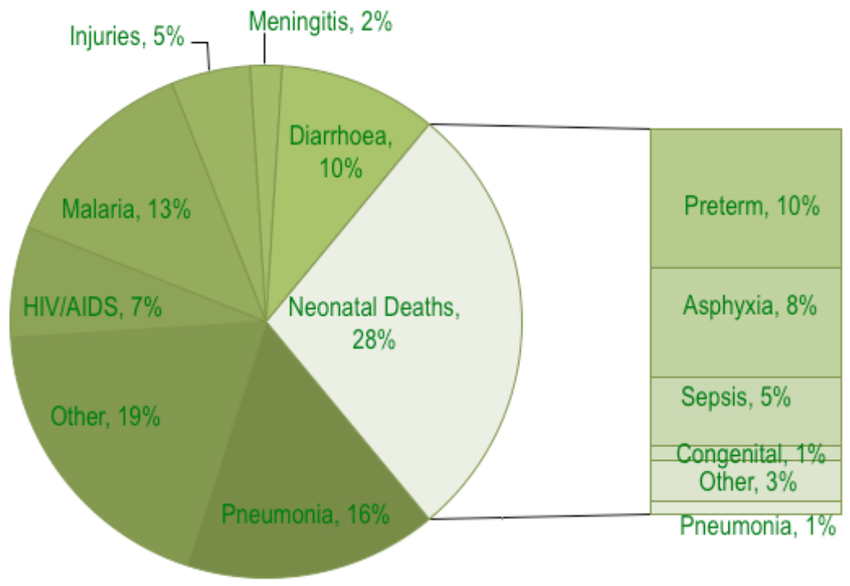
Child mortality is not evenly distributed across the country i.e. the chances of survival for Ugandan children depend upon where the baby's family lives; how wealthy the family is and the education level attained by the mother. For example, only 15 districts account for 36% of child deaths in the country. All regions still have high mortality above the MDG target of 56/1000 live births, but Kampala and the central regions have comparativelylower mortality rates. The highest mortality is in Karamoja, Southwest, West Nile and Western regions. Death is also more likely among children born in rural areas and inhouseholds in the lowest wealth quintile. Children born to better-educated mothers have a greater chance of survival - 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 account for more than 70% of the deaths in fewer than five (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 only slightly from 3.1 months in 2006 to 3.4 months in 2011, and still fall short of the 6months recommended by the WHO.

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



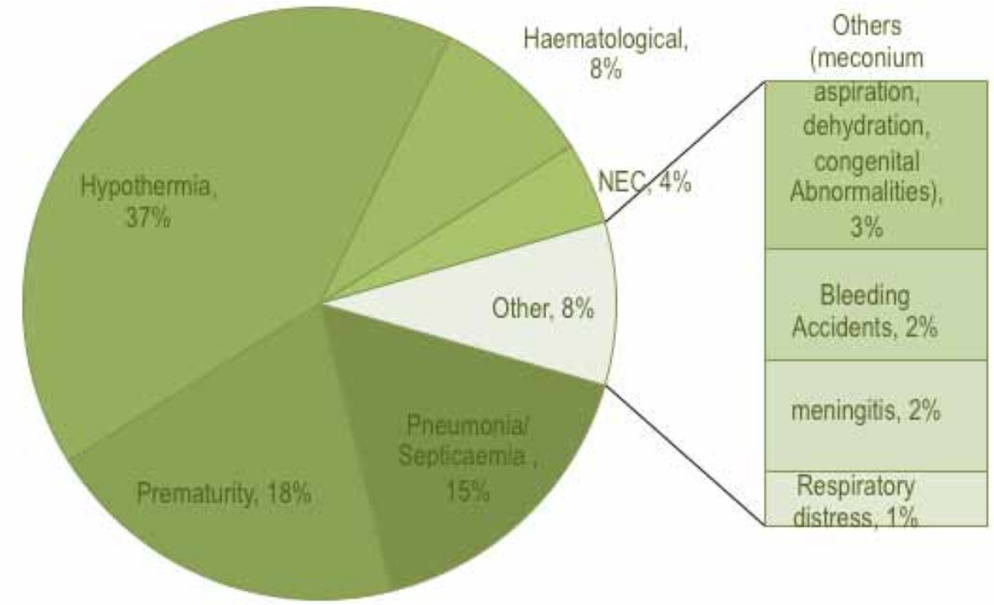
These are easily preventable through simple improvements in basic health services and proven interventions such as Oral Rehydration therapy, insecticide treated mosquito and vaccination. Together with inadequate micronutrient intake, severe malaria is the common cause of anaemia. Following a drive to expand malaria prevention and control measures, the heavy burden imposed by the disease has begun to be rolled back. Less improvement is 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 ofat least 80% of under-5 children with diarrhoea, pneumonia or malaria 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.

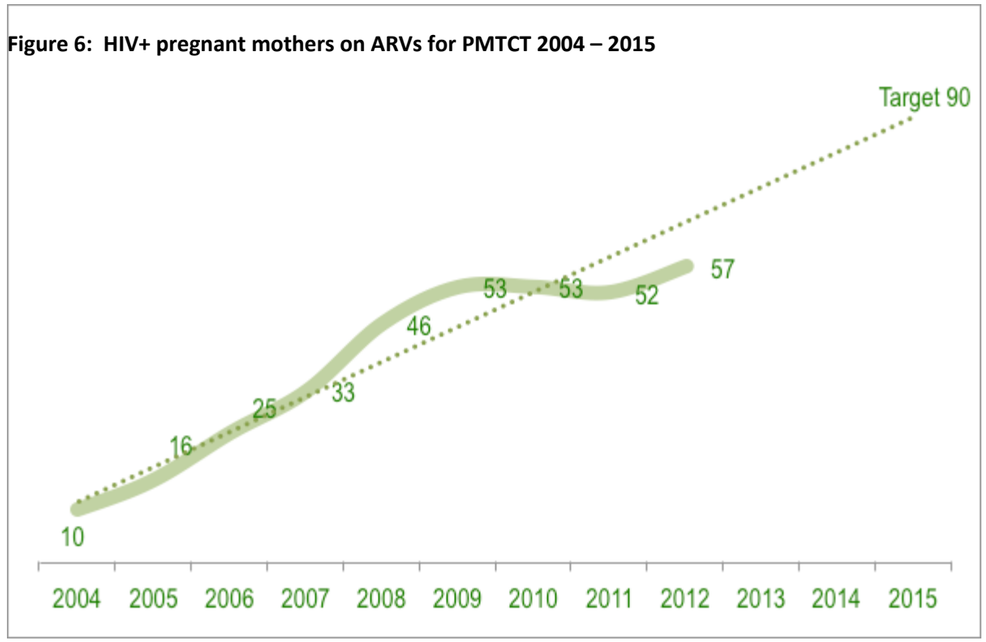
Reducing newborn deaths will be essential for further progress in infant mortality reduction in Uganda. The first 24 hours around labour, childbirth and the first week is the riskiest week of life and is a particular window of opportunity to prevent and manage newborn complications. Newborn babies die mostly from three complications related to: premature birth (born before 37 weeks of gestation), birth asphyxia and infection (figure 5).Yet only a half (54%) of the babies are born in the hands of skilled providers and only 34% received 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 among 15 to 24 age group has increased and also improved treated has indirectly contributed to a rise 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 eMTCT services stands at 57%.

Figure 5: Causes of Neonatal Mortality



To reverse the spread of HIV/AIDS government is revitalizing 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 and the mother continues for life. 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

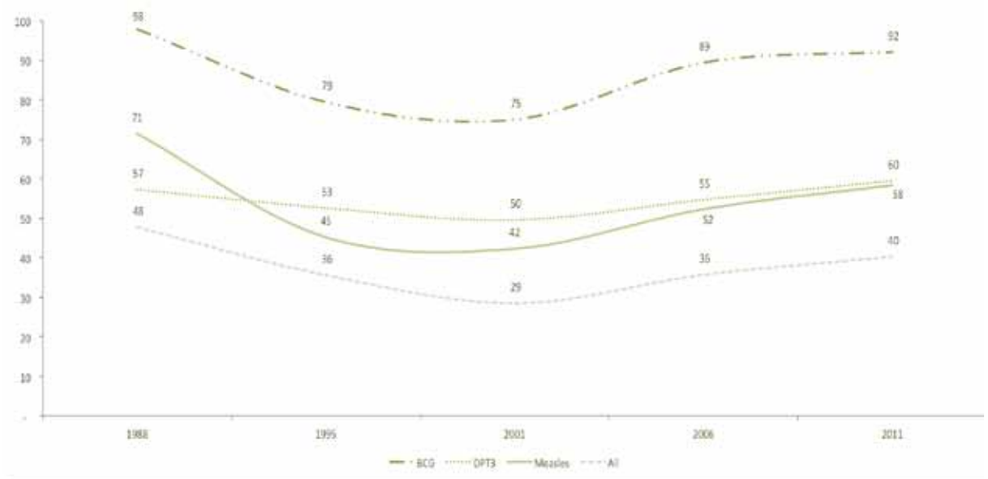


2.1.3 Proportion of 1 year old children immunized against measles

The proportion of one-year old children immunized against measles has risen from 60% in 1995 to 76% in 2011, which 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 immunization was highest in Karamoja (62%), Southwest (62%), and Western (60%); the same regions where 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 immunization revitalization strategic plan, which has seen a full immunization (BCG, Measles and three doses each of DPT, polio, hepatitis and heamophilus vaccine) coverage increased to 41 %(Figure 7) but there is substantial room for improvement. 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 1988to 2011



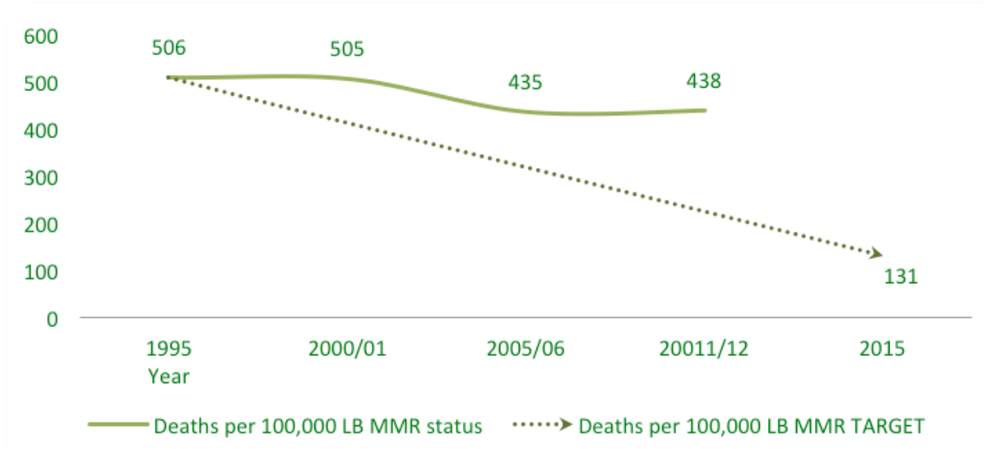
2.2 Progress on MDG 5: Reducing maternal mortality ratio by three quarters

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 1.

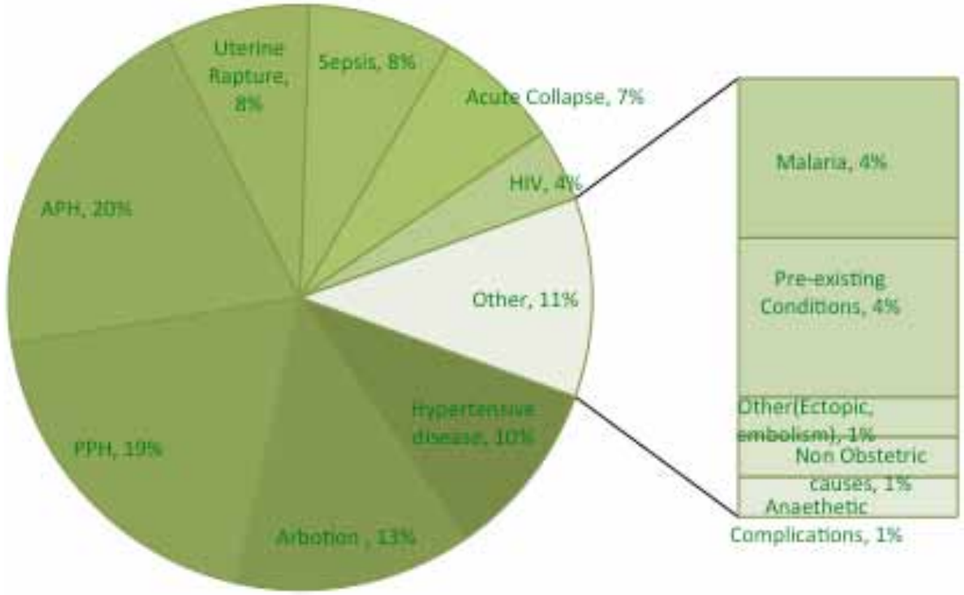
Figure 8: Trends of Maternal Mortality Ratio



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 11% and HIV/AIDS 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 in many maternal health indicators, this has not translated into significant reduction in the maternal mortality ratio and Uganda is unlikely to meet the MDG 5 targets. 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. International evidence suggests that good prenatal care can prevent up to a quarter of maternal deaths by increasing a woman's awareness of potential complication and danger signs during pregnancy. In addition many mothers do not receive any post natal check-up yet over 60% of maternal deaths occur 23-48 hours after delivery, most due to haemorrhage and hypertensive disorders or after 48 hours because of sepsis. Government investments in skilled births 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



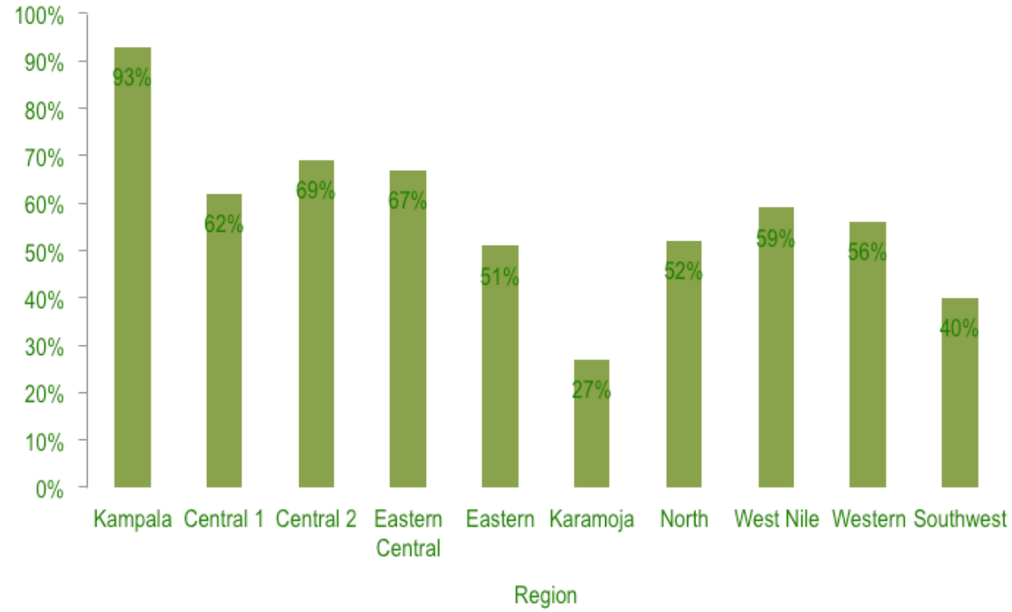
Compared to 2000, the number of health facilities expected to offer emergency obstetric care has improved from 3% to almost a half in 2011 providing obstetric care or having at least one staff member trained in managing complications in pregnancy and child births. This is compared to the country commitment of 100%. As tracer indictorsfor comprehensives emergence obstetric care (CEmOC) the percentage of health centre IVs and hospitals that offer caesarean section increased from 45% in 2006 to 77% in 2011, and 46% offer blood transfusion services.

2.2.2 Proportion of births attended by a skilled health personnel

The proportion of births assisted 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 compared with 53percent of births in rural areas assists almost 90percent of all births in urbanareas. Karamoja (31%) and the South-Western (42%) regions post the lowest coverage of births attended by a skilled provider. Institutional deliveries currently averageis at 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, which has probably lessened maternal and infant health risks by preventing an intended 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 high total fertility rate of 6.7; this has remained the same over a long period of time. Regional disparities exist, lowest in Karamoja region 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, worst observed in Kasese district at 31%, followed by Eastern region at 26% in 2011 from 43% in 2006. Very early motherhood not only increases the risk of dying in childbirth, it also jeopardizes the wellbeing of surviving mothers and their children. Stillbirths and child deaths are 50% more likely for babies born to mothers younger than 20 than for those aged 20-29. 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 categorized as induced abortions.

Uganda is however scaling up training for health workers to provide PAC, including counselling around health worker attitudes so the service is accessible.Scaling up lifesaving commodities and equipment including misoprostol and emergence contraceptives as well as other EmOC services are being implemented and a key to increasing PAC coverage. Gathering data about PAC coverage, ensuring quality and utilizationstill remains challenge.

2.2.5 Antenatal care coverage

The proportion of pregnant women who made the WHO recommended minimum of four antenatal visits has remained the same 47.2% in 1995 compared to 47.6% in 2011 compared to 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.

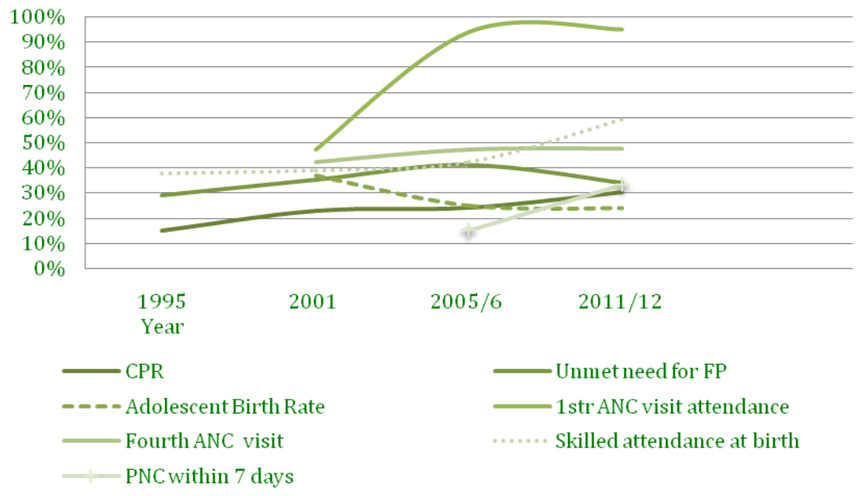
Central region has the lowest (88%) antenatal care attendance for at least onevisit.The national focus is "goal oriented ANC" an approach that emphasizes evidence based goal oriented actions to a pregnant woman from a time when a pregnancy is diagnosed up the time of delivery including eMTCT. Knowledge 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 yrs) 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 43% and lowest in Kampala at 17% and Karamoja regions 21%.Regional variations is as result of the delay by women to start the use of any family planning methods, this is as result of negative perceptions about family planning, preference for large families, negative 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 share of underweight children has reduced by half from 25.5% in 1995 to 13.8% in 2011. Because of chronic under nutrition a quarter of the children under-five, are stunted (have low height for their age). Malnutrition underlies 55% of infant and child deaths.

Mothers are who are undernourished are more likely to deliver low birth weight babies. Preventing this child deaths and improving maternal health outcomes requires addressing underlying risks of poor nutrition. Effective regulatory frameworks and guidelines e.g. on the international code on marketing breast milk substitute 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 antiretroviral drugs increased from 44% in 2008 to 62% in 2012.

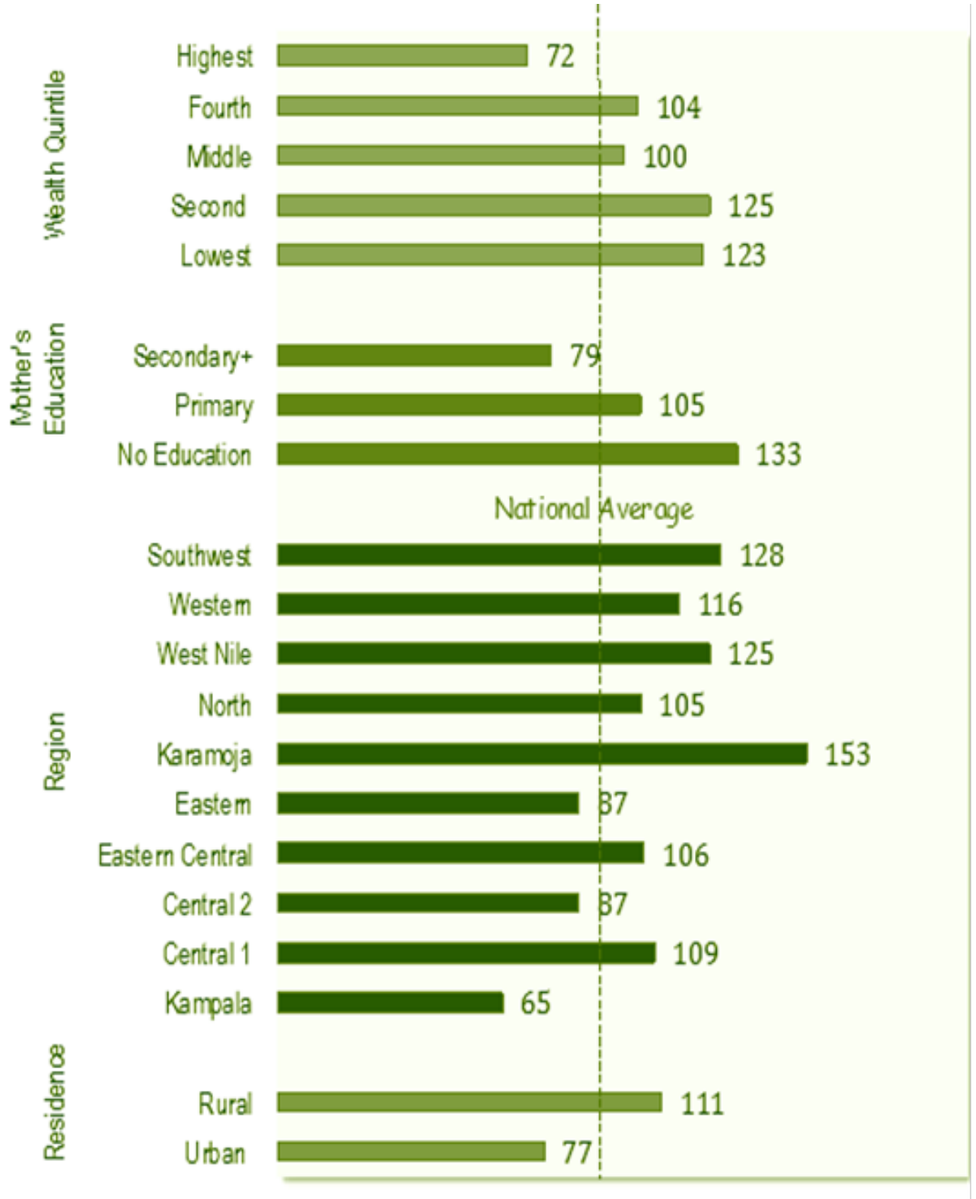
Even with the expansion in the eligible population, Uganda is on course to achieve the national target of providing antiretroviral drugs to 80% of those in need by 2015.Improved access to treatment has improved the number of deaths associated with HIV/AIDS but the prevalence rate among the 15 – 24 age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

2.3.3 Education

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

There have been substantial efforts to improve education levels, disparities however 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 an improved drinking water source and sanitation facilities has improved from 52% to 70% and 52% to 75% between 2001 and 2011 respectively.

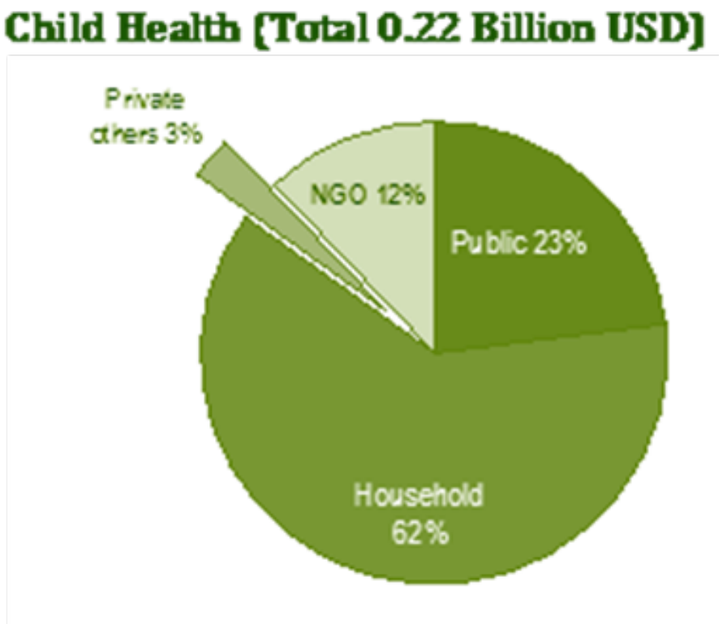
Open defecation is still practiced by an estimated 3.3 million people, mainly in rural areas; elimination of this practice is an essential step towards reducing child mortality from disease. Large disparities in access to both improved drinking water sources and improved sanitation exist across the country, between urban and rural populations. Better knowledge of proper sanitations among better-educated mothers is a key drive for diarrhoea mortality.

2.3.5 RMNCH Financing

Expenditure on reproductive and child health was $0.22b (US dollar) each, compared to $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 population in need. Annual health total expenditure has increased from $1.5b (US dollar) to 3.2b (US dollar) between FY 2008/9 and FY 2009/10; 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 subsiding of health services at PNFPs. 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 relationships 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 the deep understanding of the process that leads to the success provision and utilization of services and it provides an easy way to prioritize the bottlenecks with the highest impact on coverage.

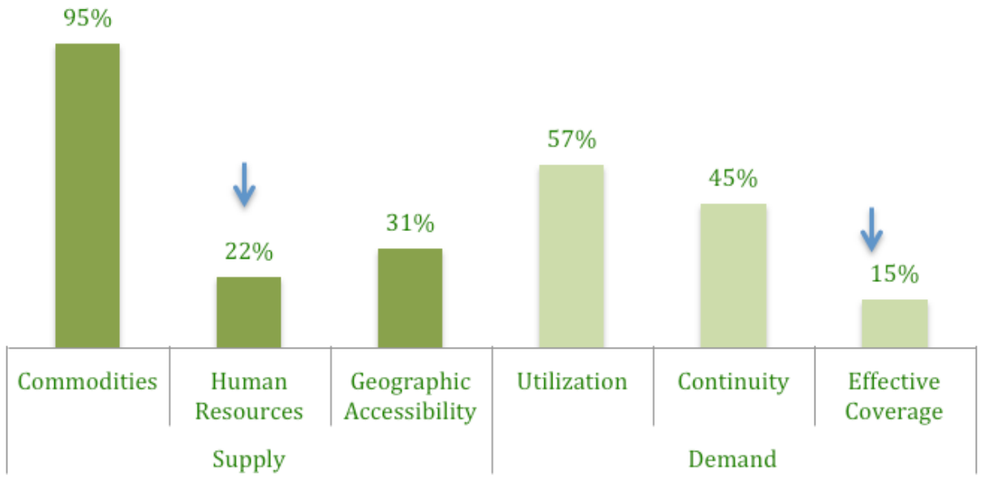
Five critical tracer interventions of interest were selected for analysis to serve as proxies for all interventions in a given service delivery platform. The health system was examined against arrange of supply (availability of commodities, human resources and geographical access), demand (initial and continuous utilization) 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 12 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 iCCM, defined as inadequate number of VHTs trained to provide services. The root cause of this bottleneck is high cost of training. The factors contributing to this high turn of VHTs necessitating 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 requisite skills. Yet most of them lack opportunities for training.

Demand side bottleneck: The main bottleneck is non-care giver compliance to use of 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 to improve caregiver knowledge and demand for ORS. Lack of clean water for mixing ORS however, hampers uptake.

Figure 14: Bottlenecks in ORS use

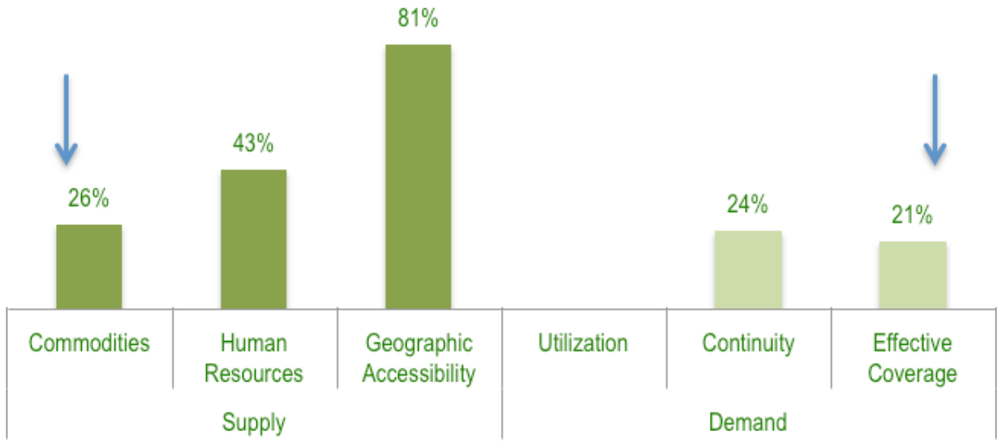


2.4.1.2 Population wide scheduled services

Supply side bottleneck: The tracer intervention selected for this platform was long term family planning (LTFP), as illustrated in Figure 15 below. 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 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 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

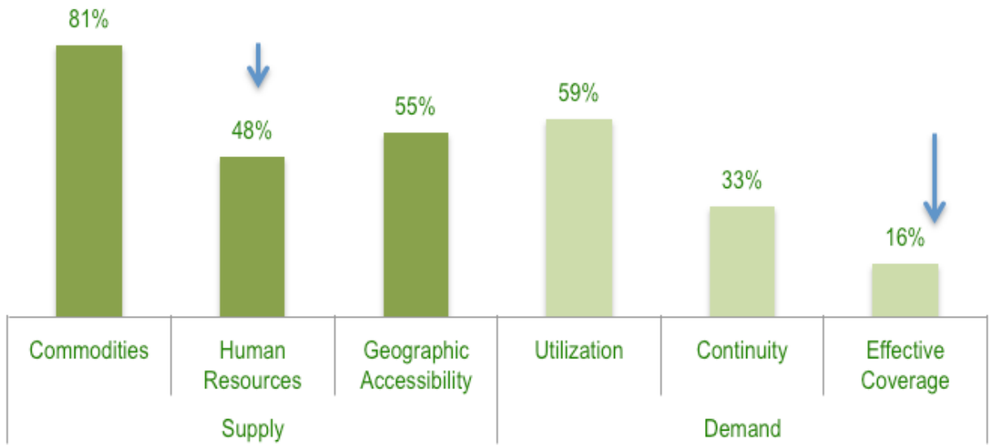


2.4.1.3 Clinical/Individual Level Platform

Supply side bottleneck: The tracer intervention selected for this platform was basic emergence obstetric and newborn care (Bemoan) 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 Bemoan is not fully integrated in the training, especially competence based training.

Demand side bottleneck: The key bottleneck here is the failure of mothers who have delivered to come to attend postnatal care at 6 weeks. This is lack of continuum of care is attributable to mothers low awareness of the importance of postnatal care checks. This is further compounded by poor geographical access, lack of male involvement, financial barriers and long waiting time at the clinics.

Figure 16: Bottlenecks in Bemoan



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 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 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 preterm 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

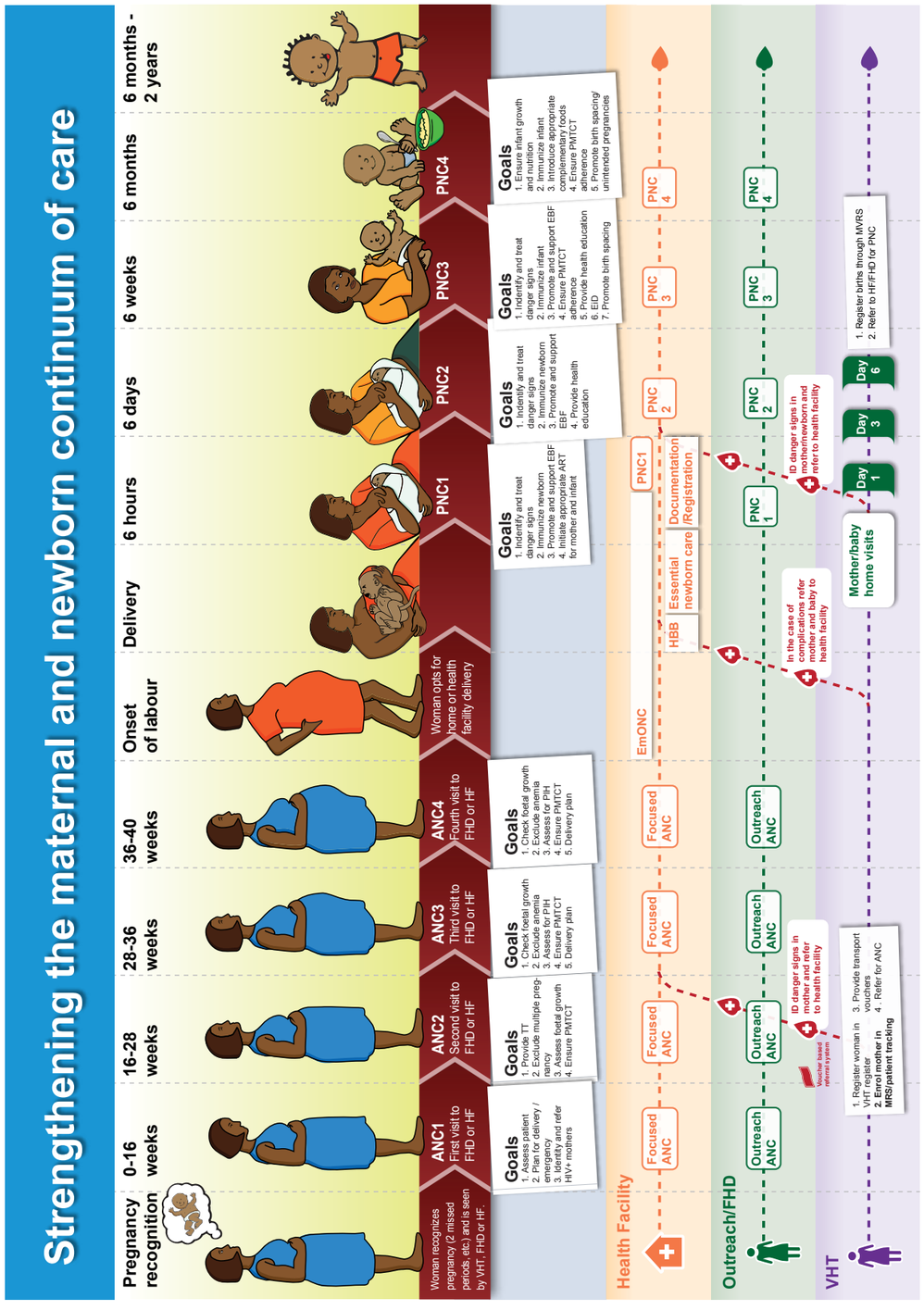
ESTABLISHING A BASELINE: WHERE ARE WE

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 at all levels and its partners. These actions are reflected below.

3.1 Integrated delivery of RMNCH Interventions

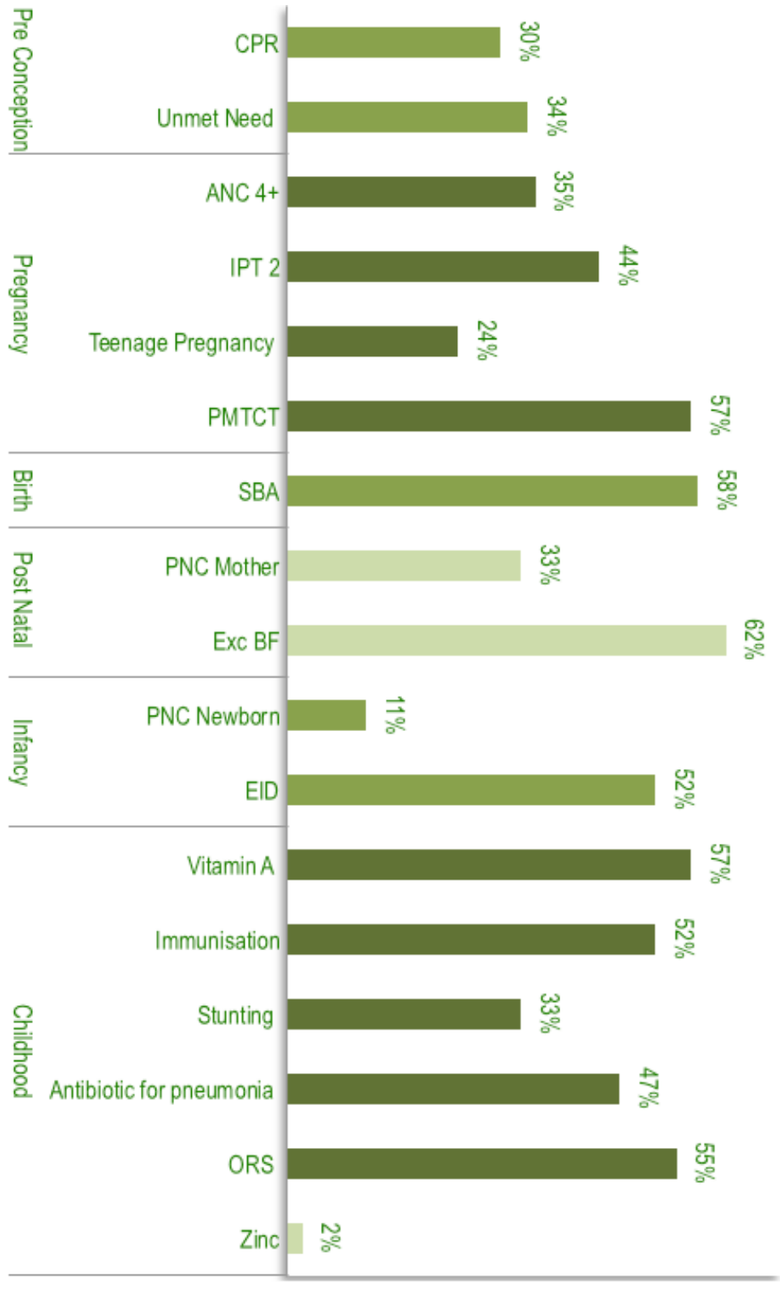
Continuous care across life stages and from home to hospital is crucial for health – for complete physical mental and social wellbeing. In the context of RMNCH this takes on a greater significance because a child's health is closely linked to mothers from conception through to birth and beyond. Progress 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, 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 15 shows the varying degree of coverage of interventions in the continuum of care further reflecting the missed opportunities for integration. For exampleteenage pregnancy, zinc for diarrhoea management, PNC for Newborn and mothers are remarkably low in coverage 2% to 24%, compared to exclusive breastfeeding, which is at 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 institutionalized 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 RMNCHservices should be organised is 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.

HMIS registers adequately capture most of the planning data. With the DHIS2 (the electronic HMIS) system being rolled out to sub district levels, the quality of HMIS data is improving. Patient statistics are however not used for quantification, forecasting, allocation and distribution of resources let alone for making planning decisions at relevant levels. In addition, weak reporting from PHP and the absence of routine reporting on RMNCH indicators need urgent attention. Besides, there is little demand for information by users and stakeholders especially at the district levels.

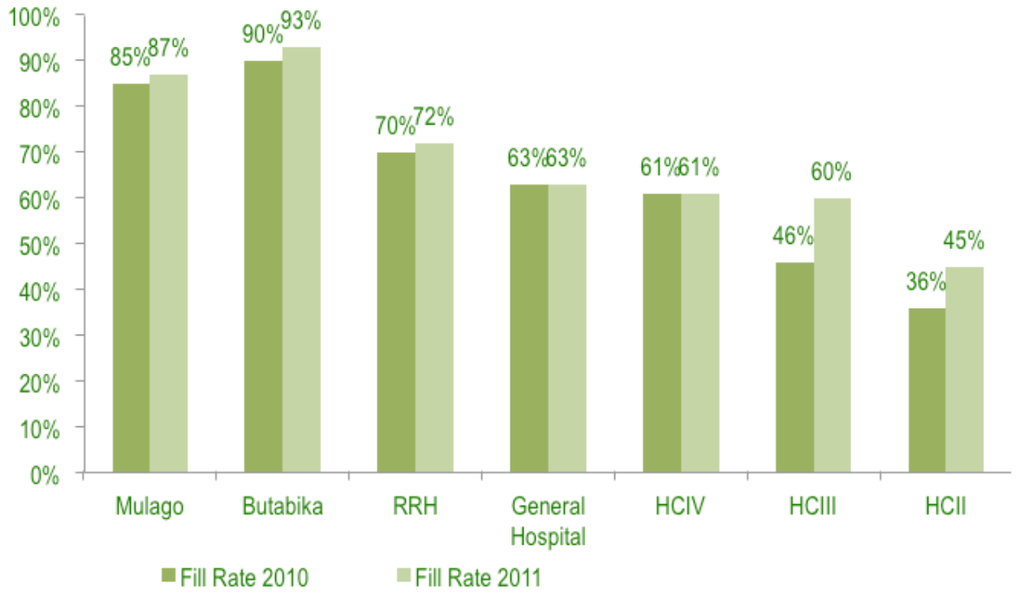
3.2.2 Health work force

This shortage of midwives is compounded by inequitable and inefficient distribution. Uganda has made progress in improving the health work force in particular in the last five 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 anaesthetics. According to the current staffing norms, HC III and IVs are provided 2 and 3 midwives respectively. However this number is inadequate besides the fact that many of the established positions for mid-wivesremain 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 program 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 DHO (MCH) 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 VHT 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 IEC/BCC 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 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 supported Voucher-and-Accreditation Interventions to Improve Reproductive Health Service Delivery Business Models, Making Pregnancy Safer Initiative, Focused ANC, Making Pregnancy Safer Initiative through Integrated Management of Pregnancy and Child Birth (IMPAC), IPT, ITN, PMTCT Option B+, Kangaroo Mother Care, Maama Kit, 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, Born Too soon campaign etc.

3.4.2 Saving Mothers Giving Life Initiative

Since June 2012 Saving Mothers giving life US government supported agencies and Ministry of Health have collaborated to bolster maternal health program and reduce 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 – and excellent progress has been made in the short period of time. From the set extensive monitoring and evaluation was integrated into all program activities and the number of pregnant women delivering in facilities has increased in all districts from 2585 to 4707 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

Help life initiative program of Karamoja (UNICEF) consists of pack off innovations namely; help life birth cushion for women who opt to deliver in a sitting position, help life partograph, solar kit and mobi- station.

3.4.4 The Mother Child Health Passport – Handheld Records

Health Systems Strengthening 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 is in the context of attaining MDG 4 and MDG5, makes it the leading wedge to health systems strengthening for RMNCH. This hand held record provides great priority to the community health strategy – since it is in the communities that the mothers are to be found. Its aim is to provide continuity in health care records from pregnancy through to early childhood with an aim of improving quality of care and caregiver knowledge to demand for services. Launched in May 2012, the government is gradually rolling out this passport. The priority given to 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 a second trained helper.It was designed to be easily incorporated along with other on-going maternal and newborn care initiatives and strategies. In Uganda HBB has been integrated with IMNCI (essential newborn care) and has been utilized in a variety of settings.

3.4.6 Computerized 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 computerized learning tool intended to provide electronic training for healthworkers is being introduced in Uganda. Where 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 programto reduce maternal and perinatal deathshas 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 enquiry by independent assessors. All deaths are notified through the ministry of health surveillance system and reported in a weekly bulletin.

3.4.8 Integrated Community Case Management including Antenatal Community Registration

An initiative for bringing closer to the home 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 under five children 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. The initiative has been rolled out in 34 districts and currently, 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 MDG 4 &5 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 an 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 (MobileVRS) using mobile phone technology for registration of births and for issuing of birth certificates.TheMobileVRSis integrated into the current system. UNICEF is currently developing the capacity of the URSB, sub-county chiefs and hospitals to integrate the MobileVRS into their routine work by providing equipment, training and supervision. This will rapidly increase the number of registered children to over 50%.

3.4.11 m-Trac and U-reporting

Under the national e-Health policy, a government led mobile phone SMS-based monitoring system built on the weekly surveillance HMIS 033B form, which includes 17 notifiable diseases, OPD and malaria case management data, and selected medicines (ACTs and Rapid Diagnostic Tests), which was coded into simple SMS strings is being implemented. Health Facility workers used their own phones to submit this data via a cross network, toll-free shortcode. Commonly known as mTrac this system has greatly improved disease surveillance and medicines monitoring, and generate community action for improved health system accountability to reduce ACT stock outs at facility and community level.

In collaboration with the scouts and other youth organization nationwide, U-report also uses SMS messages and communication channels like radio, TV and website to provide a platform for strengthening dialogue around core development issues. Over 250,000 young Ugandans are now signed up as U-reporter and this number grows daily. U-reporters are a type of “social monitor”- they are sent weekly polls to gather data on community services and youth issues, and in turn they receive the results as well as useful facts for action and advocacy. Youth from different parts of Ugandan compare how their region is doing in providing essential; services and they can share practical advice and advocacy information. The most critical U-report issues are featured weekly on TV and radio shows and also in newspaper.

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 health-care services between women and men largely stem from unequal power relation which influences decision making for health in the household. The UDHS shows that about 55 percent of the women mainly decide by themselves howtheir earnings are to be spent, 32% report that they make the decision jointly with their husband/ partnerwhile 13 percent report that the decision is mainly made bytheir husband/partner. There are variations in the proportion of women who make independent decisions about their earnings ranging from 24% inEasternregion to 79%in Kampala.This shows that women in urban areas are more likelyto make independentdecisionscompared to those in rural areas.Efforts in the Ministry of Healthto create an enabling environment for promoting RMNCH include capacity building and development of training guidelines on how to integrate HRBA in health programming. The principles in this approach promote respect for the choices by women including companionship during maternity care, and ensure that everywoman has the right to privacy and confidentiality, 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. Action being strengthened including 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 MCHTWG providing 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 MDG 4 and 5 up to 2035 will have far reaching implications for the countries 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, neonatal mortality, nutrition, achieved much less. In the course of developing this plan, we became aware of a gap between national progress and reality on the ground or disparities at subnational level. We realized that the next development agenda must build on the real experiences, ideas and solutions of people at the grassroots, and that wemust do our best to be inclusive and not leave anyone behind. But also to realize that health service provision may not always be the policy instrument best placed to reduce deaths and also look outside the health sector. Government commitment to accountability for results and resources also has been a relatively weak driver of past progress towards the MDGs.

This sharpened RMNCH plan for Uganda provides an overview of where Uganda plans to move in terms of preventing these avoidable deaths, with emphasis on developments towards attaining 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 and partners and civil society organizations will be working 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 recognize

the importance of leadership at a local level and encourage districts, partners, CSOs and other players to implement them.

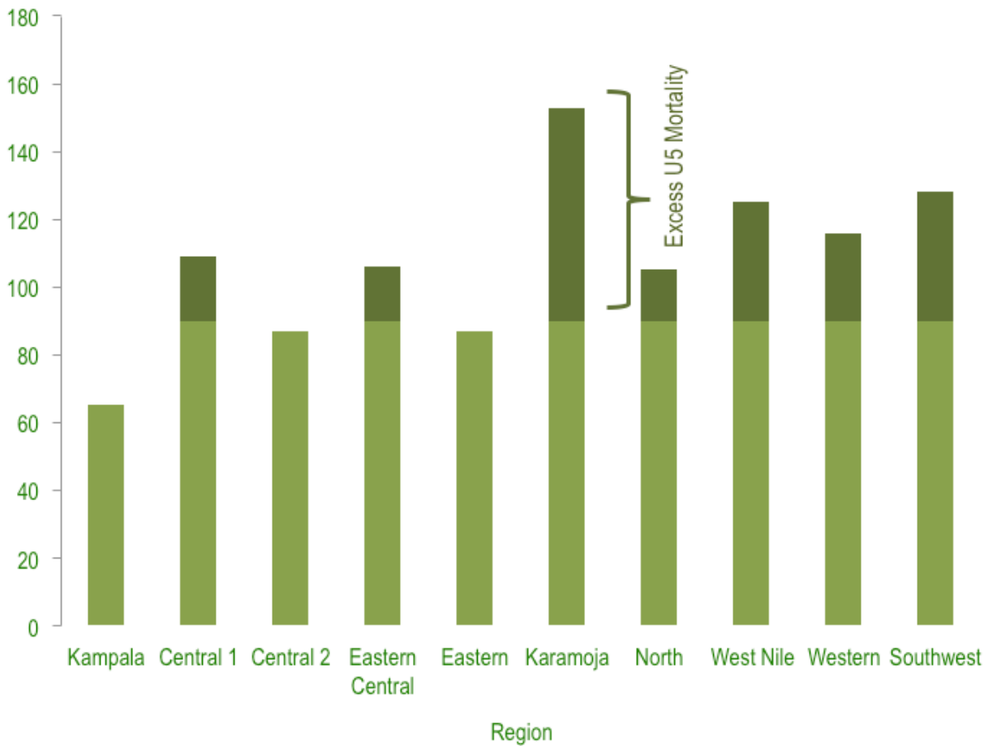
The five strategic shifts are:

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), prioritizing 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 prioritization and participation from all stakeholders.

Figure 20: Regions with excess Under-five Mortality

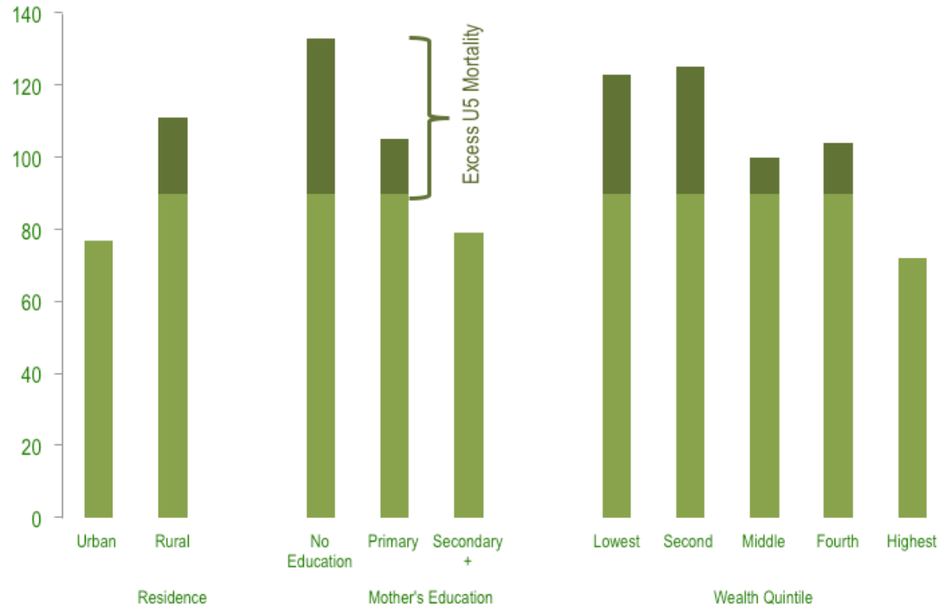


Shift 2: Increasing access for high-burden populations:

> ***Identify and increase effort among population groups with the highest disease burden and number of deaths prioritizing resources and refocusing health system to expand access to these underserved, most burdened places including 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 safe abortion and post-abortion care for in school and out of school adolescents, etc.

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; riskiest period of life around child birth and first days of life; neglected biggest yet easily preventable child killers: pneumonia, diarrhoea including 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 and implementation 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 intervention 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 removal of financial barriers to accessing RMNCH services, thus enhancing realization 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 programs 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; results-based financing; and innovation. Accountability will encompasses: 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 horizon 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 for joint assessment and improved aid effectiveness. Avoid re-inventing the wheel by using existing programs 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 to 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 prioritize a handful of existing and doable 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 plans of the Ministry of Health. They will be implemented alongside the on-goinginterventions, 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 24 and 25). This strategy will focus on these.

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

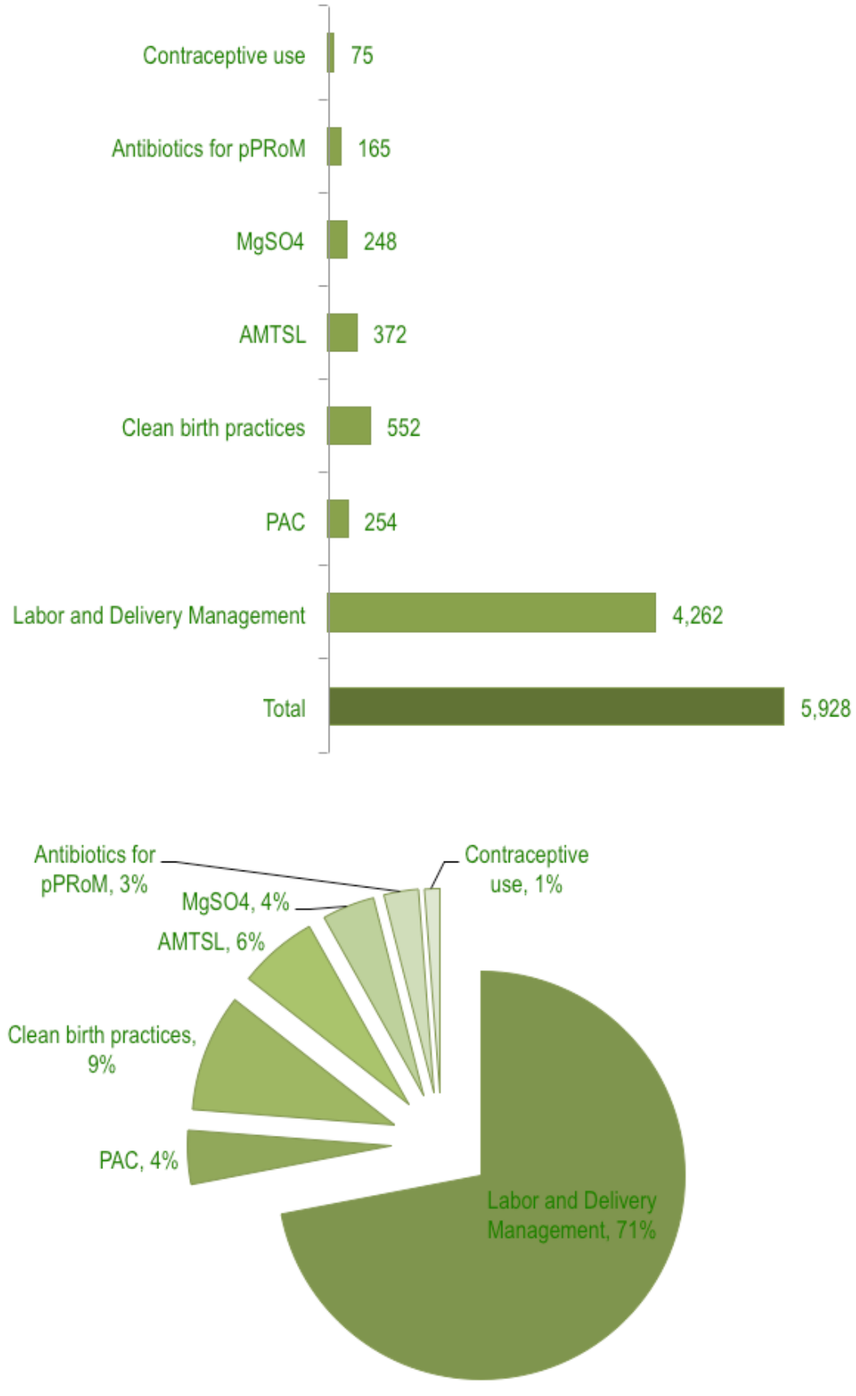
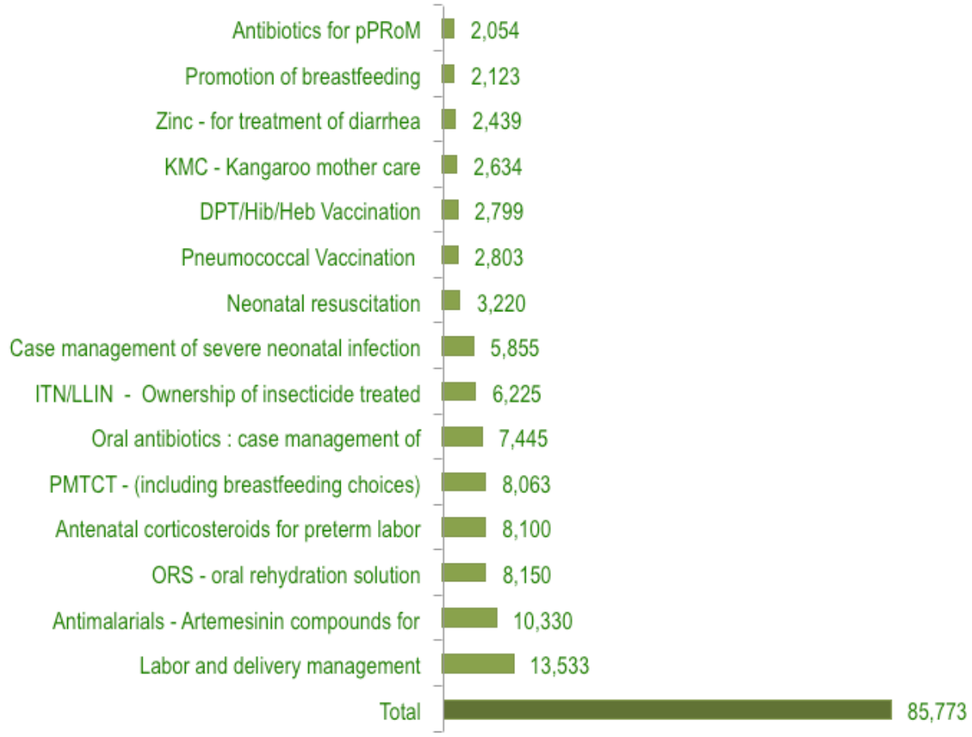


Figure 24: Highest Impact Interventions and Their Relative Importance in Reducing Child Mortality



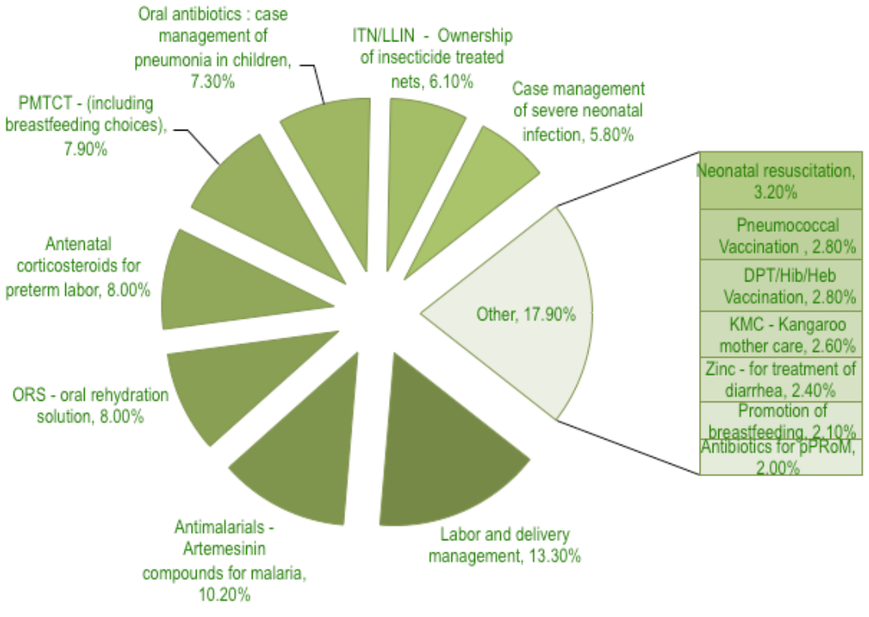
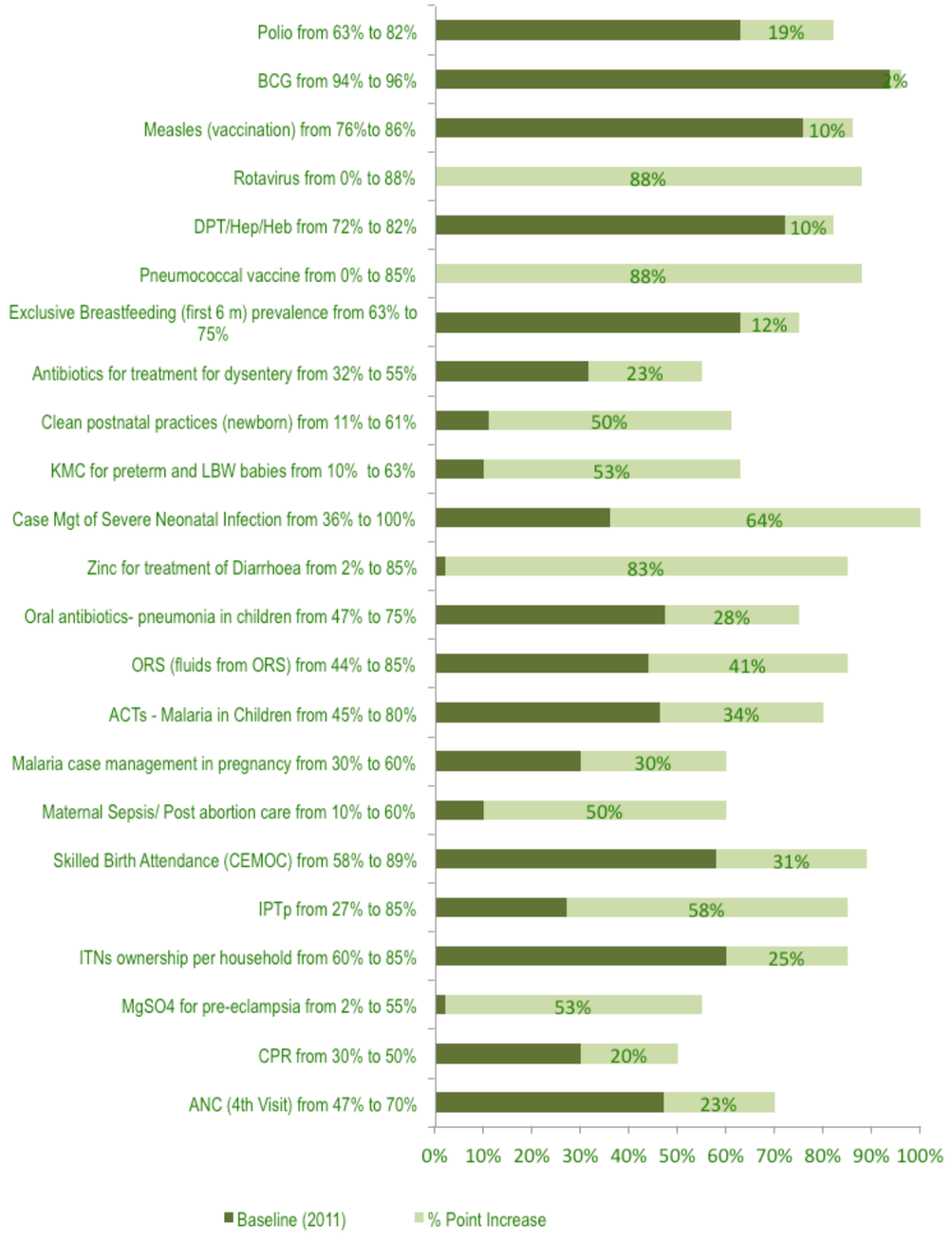


Figure 25 below shows the prioritised high impact interventions that have been selected along the continuum of care.

Figure25: 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 translates 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, economic productivity, diffusion of 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 preterm 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 diarrhea	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 21, 22 and 23 below.

Figure 26: Projected Under-Five Mortality Reduction by 2017

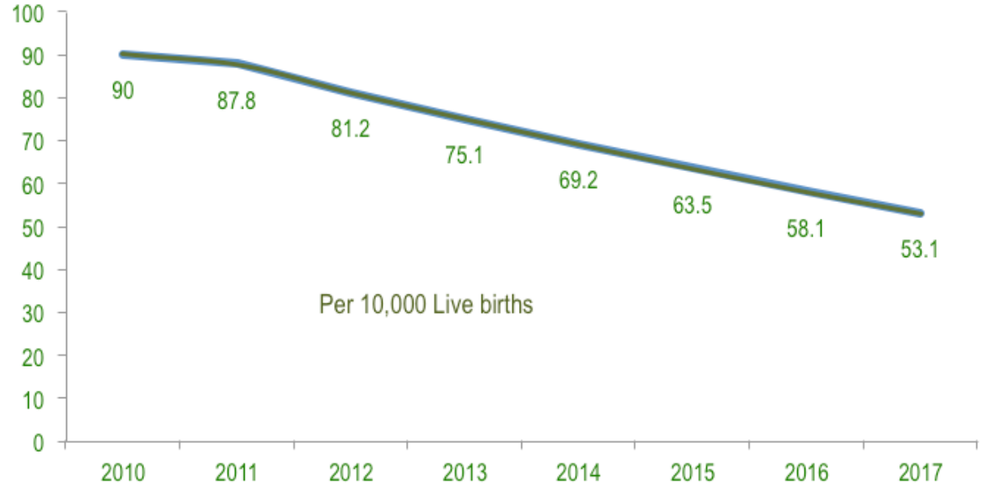


Figure 27: Projected Infant and Neonatal Mortality Reduction by 2017

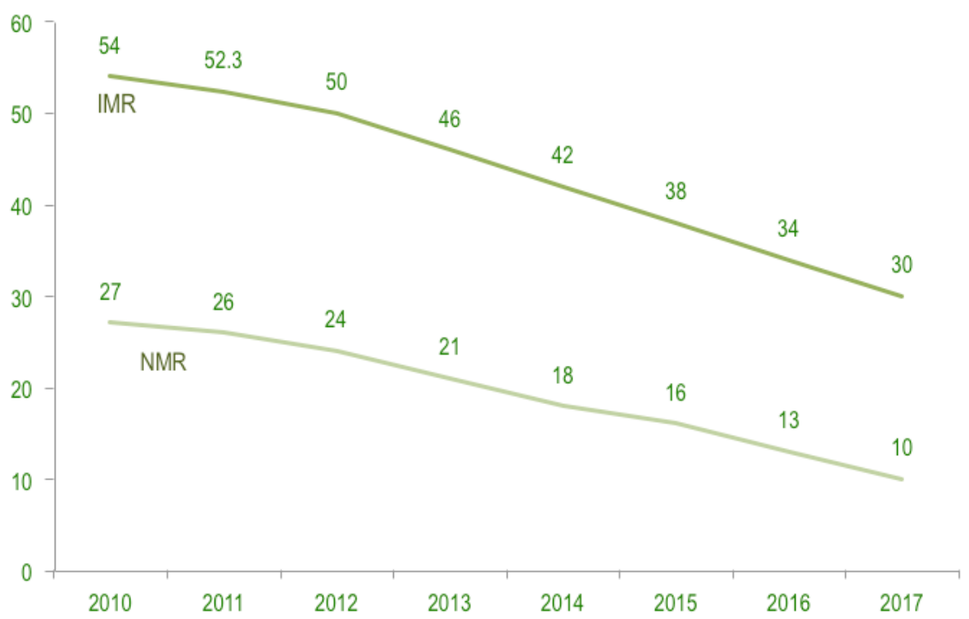
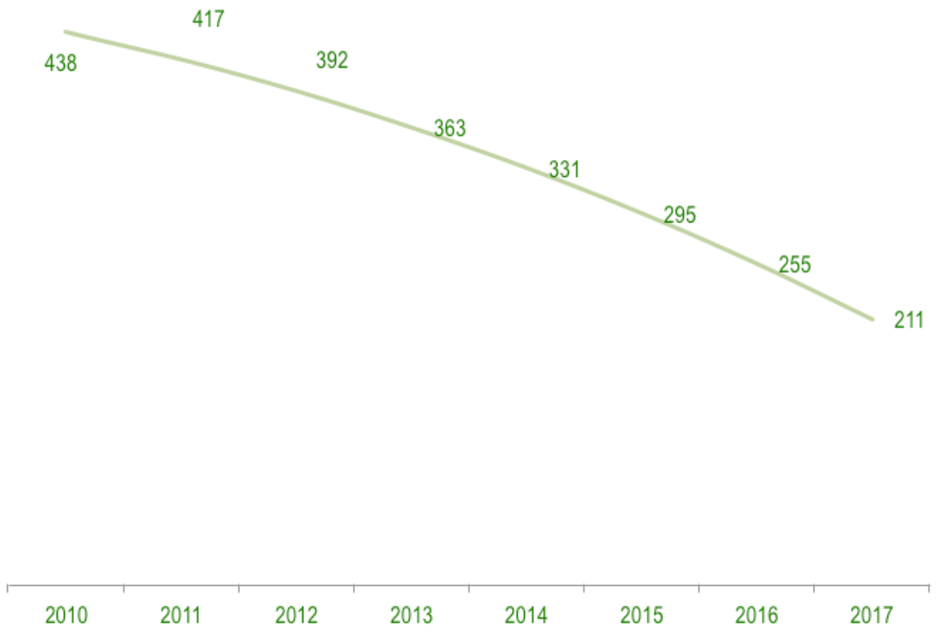


Figure 28: Projected Maternal Mortality Reduction by 2017



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); and prioritization of the critical interventions and actions to strengthen systems in ways that address the highest priority issues (including improving equity) 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 program priorities once the level of funding was known. The cost provided here however, does not include health systems costs which are provided 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%
Total	**109,614**	**125,483**	**137,622**	**148,609**	**160,514**	**681,844**	**100%**

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 mgt	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%
Total	**99,955**	**112,220**	**124,508**	**136,559**	**148,628**	**621,871**	100%

The total drug and supplies costs (intervention costs) required amount to US $ 681.915 million (Table 8). Of the total cost, U$ 621.93 million (91%) is accounted for by medicines and medical supplies for the different interventions in the plan while, U$ 59.972million (9%) is program support costs. The total costs range from U$ 109.627 million in 2013 to 160.528million in 2017 (Table 8 and Figure 26).

Malaria treatment, Immunization, diarrhoea management, child birth care, PMTCT and family planning account for 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

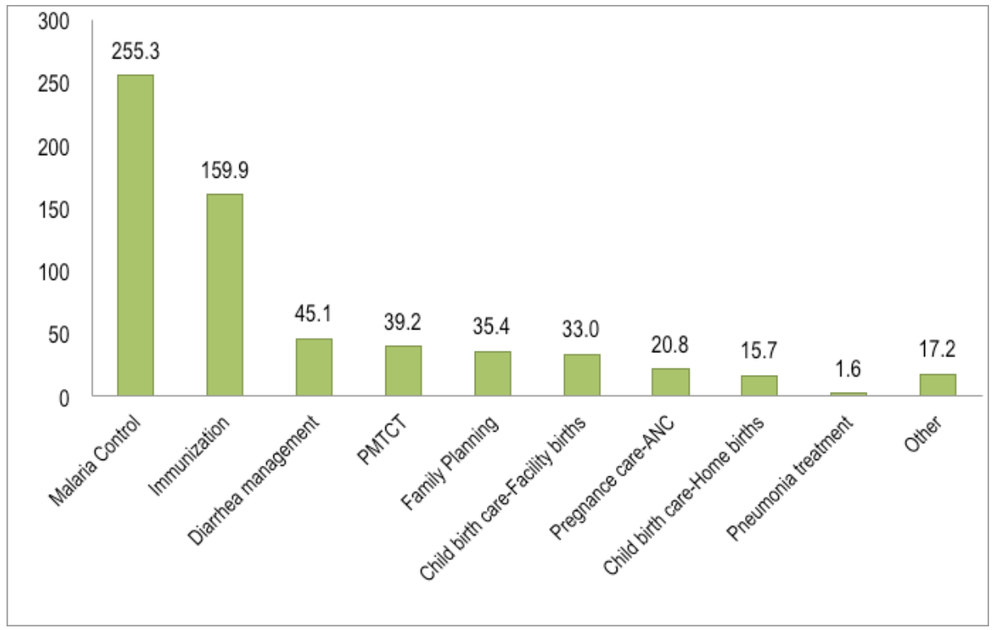


Figure 29 above shows the graphical distribution of intervention costs. As seen from the graph, malaria treatment, Immunization and diarrhoea management stand out as most cost demanding intervention for reducing child deaths. Child birth care follows on cost intensity for reducing both maternal and child deaths.

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

Programme Category	2013	2014	2015	2016	2017	Total	Percent
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%
Total	9,659	13,263	13,114	12,050	11,886	59,972	**100%**

Comparing resources with results, the accelerated RMNCH plan will costs additional US$681.915million and prevent a total of additional 137,573 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 etc.

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 prioritized 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 TWG 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 DHO (RMNCH) and supporting their functions especially in High Priority Districts.

Reduce out of pocket expenditure for poor

- Scale up RH Voucher systems
- Social marketing of subsidised lifesaving commodities
- Negotiate free examination for pregnant women and new born 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 MoH procurement plan
- Develop formularies and syringes for sick newborn treatment and integrate them in EDML for all levels
- Establish private sector commodities supply system for RMNCH lifesaving commodities
- Review guidelines to allow for redistribution 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 QPPU 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 difficult to reach districts
- Review the mandatory retirement of midwives in 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 RNMCH 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 Emmons 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 in counselling on essential maternal and newborn care birth preparedness, breastfeeding, clean delivery, cord care, and hypothermia prevention

Service delivery

- Institutionalise QA/QI 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. cartograms in RMNCH kits
- Provide integrated routine outreaches that cover all key maternal and new born 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 Emmons readiness

Strengthen monitoring and evaluation

- Train district and hospital based staff in use of scorecard
- Support supervision in M&E to improve compliance with increased RMNCH requirements
- Training and facilitation of MPDR committees and Professional Councils to act on review findings and to undertake independent audits/verifications
- Support M&E unit to develop RMNCH programme specific reports
- Produce and effectively disseminate annual RMNCH programme report
- RMNCH program 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 HSDs
- Disseminate guidelines on Male involvement in RMNCH
- Social marketing 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-sect oral approach

The Inter-Ministerial committee is mandated to work on crossing cutting issues including water and sanitation, nutrition etc. This committee will prioritize 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 reduction task force 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 program are supportive to RMNCH principles and responsive the local health needs. The MCH Technical Working Group and (sub) committees will provide technical coordination for the RMNCH plan.

A 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 DHO-MCH shall 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 structures 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 Accountability

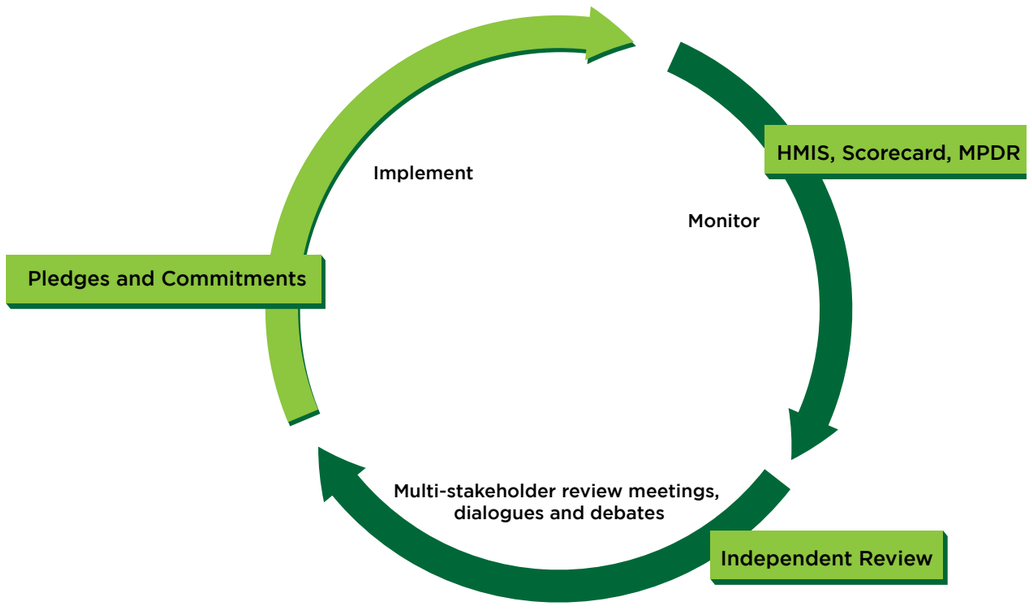
4.6.1 Information and Mutual Accountability

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 implementing 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 subnational accountability mechanisms and practices towards: fostering agreement on RMNCH objectives and targets to be achieved and the activities to achieve these objectives; mobilising and linking investments with RMNCH results; and enabling 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 optimize resources to meet government's RMNCH priorities. Government and partners will strengthen RMNCH monitoring and coordination mechanisms through regular MCH-TWG meetings. CSOs 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 29).

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 Scorecard system based on routine HMIS data. A quarterly dashboard monitoring system at national level will be compiled in the first month of the next quarter. Districts will undertake similar exercises for their HSDs 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 6) is based on the five strategic shifts identified in plan. The five domains are: 1) Geographical focus 2) Increasing 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: The RMNCH scorecard 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 prioritize them. The national scorecard 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

Uganda

NATIONAL INDICATORS

Maternal mortality ratio (2010)	310	Under 5 mortality rate (2011)	90	Neonatal deaths among under 5 deaths (2011)	32.8%	Proportion of children under 5 stunted	33.4%
Source: MMEIG, 2012		UN-IGME, 2012		UN-IGME, 2012		DHS, 2011	

SUB-NATIONAL INDICATORS

Pre-pregnancy → Pregnancy → Birth → Postnatal → Neonatal → Infancy → Childhood

Region	Demand for family planning satisfied	Antenatal care (four or more visits)	Antiretrovirals for HIV-positive pregnant women	Skilled attendant at birth	Postnatal care for mothers within 2 days of delivery	Postnatal care for babies within 2 days of birth	Exclusive breastfeeding (< 6 months of age)	Three doses of DPT immunization	Antibiotic use for suspected childhood pneumonia
Kampala	74.3			93.0	61.2	29.1		73.5	65.5
Central 1	58.5			62.0	39.4	10.6		66.4	53.9
Central 2	48.8			69.9	39.3	7.7		61.7	51.8
East Central	43.3			67.1	24.5	8.3		52.8	33.3
Eastern	40.5			51.9	35.5	13.8		74.2	37.4
Karamoja	27.6			30.8	26.8	18.6		89.5	29.8
North	36.0			53.4	27.8	13.0		73.4	43.6
West Nile	25.3			58.5	40.5	11.1		82.0	53.5
Western	51.8			55.8	28.8	8.7		77.6	68.6
Southwest	44.5			41.5	18.8	1.2		79.2	39.4
National total	**46.7**	**47.6**	**54.0**	**58.0**	**33.0**	**10.8**	**63.2**	**71.5**	**47.4**
Source	DHS, 2011	DHS, 2011	UNAIDS, 2011	DHS, 2011	DHS, 2011	DHS, 2011	DHS, 2011	DHS, 2011	DHS, 2011

Notes: Currently married women only

Legend: <25% coverage; 25% - 49% coverage; 50% - 75% coverage; >75% coverage; Not available

Selection of Indicators: The scorecard 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 scorecard is a management tool based on a prioritized 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
Pre-pregnancy & Adolescence	Couples accepting a contraceptive method postpartum	HMIS
Pregnancy	Pregnant women receiving IFA	HMIS
	Pregnant women taking 2 or more doses of IPT	HMIS
	Sera-positive pregnant women treated with ARVs	HMIS
Delivery	Women provided with a uterotonic immediately after delivery	HMIS
	Women identified for pre-eclampsia and provided MgSO4	HMIS
EmOC/Newborn care	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
Postnatal period	Newborn infection cases treated with parental antibiotics	HMIS
Childhood	DPT 3 coverage and dropout rate	HMIS
	U5 diarrhoea cases provided ORS and Zinc	HMIS
	U5 pneumonia cases provided with antibiotics	HMIS
Outcomes	Stillbirths; Neonatal, Child and Maternal Deaths	HMIS
Health Systems	Health facilities with stock-outs of Lifesaving Commodities	HMIS
	VHTs w 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	
Equity	Malnourished children provided treatment (boys and girls)	HMIS
	Female to Male ratio of OPD	HMIS
	Concentration indices for priority indicators (Two-year interval)	LQAS
Cross-cutting	Household with latrine coverage	HMIS
Overall summary (Geographical Equity)	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, New born 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 (see Table 4) 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 planning stages, 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

5.2 Government and policy makers (National, districts and local levels)

Since 2010 the government of Uganda 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 programs prioritized 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) harmonising and promoting standards, guidance and tools for priority RMNCH interventions , v) ensure health financing strategies incorporate access to RMNCH services and use of data for evidence based decision and to 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 outcomesfor underserved populations through government structures, ii) Support scale up and implement prioritized RMNCH services, iii) Providing guidance and support in development standards, quality control and 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 Parliamentarian Forums

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 Organization’s complement role and renewed commitment will be to work 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 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 4and 5 subnational 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) mobilize 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 the 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, utilize and adhere to high impact service intervention packages, Addressing cultural norms, taboos and practices that are detrimental to RMNCH, Utilize 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; e.g., prevent early marriages, promote.

5.7 Faith Based Institutions

The Roman Catholic Church is committed to providing holistic health services especially to most needy population sub groups e.g. Children, Women (Pregnant Mothers, HIV Positives, and Orphans).The Mufti and other top Muslim clerics will scale up advocacy on MCH by having their voices recorded and played by media houses for the consumption of the public, as well as participating inradio talk shows for MCH in order to reach out to the most distant households in these regions that have been identified as worst performing. 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 strengthened through fostering Public-Private-Partnership with increased RMNCH access to targeted communities.

5.9 Uganda Private Midwife Association

The Uganda Private Midwife Association are 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/support Technical Assistance and advocacy for underserved populations. The professional association will support thedevelopment of standards and guidelines for the public and private sector in FP and EmNOC. Other professional bodies like the Uganda Paediatric Association will work with other Professional Bodies to improve the capacity of health workers to provide quality reproductive health and MNCH services through in-service training and mentorship. Health workers will be trained BEmNOC and CEmONC; improving immunization coverage, prevention and treatment of malaria, pneumonia and diarrhoea; and improving nutrition especially in the under-served areas of Uganda.

Table 6: Strategic Framework

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 MNC 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 < 15%	• 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, preterm care, treatment of newborn and child infections)	• 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%	• 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

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
Goal To end preventable maternal and child deaths in Uganda	• Reduced the Maternal Mortality Ratio from 438 per 100,000 live births to 211 per 100,000 live births by 2017 • Reduced under 5 mortality rate from 90 per 1,000 live births to 53 per 1,000 live births by 2017 • Reduced the Infant Mortality Rate from 54 per 1,000 live births to 30 per 1,000 live births by 2017 • Reduced the Neonatal Mortality Rate from 27 per 1,000 live births to 10 per 1,000 live births by 2017	Reports: • UDHS 2010/11 • UDHS 2015/16 • UDHS 2020/21	2015/16	UBOS	
Purpose To redirect and refocus efforts towards accelerating the attainment of MDG 4&5 in Uganda	• Coherent, prioritised and funded country led integrated RMNCH plan • Commitments and mutual accountability for sustained collective action by government, development partners, private sector, and CSOs • Transparency and evidence based planning and reporting to accelerate progress and deliver results	Reports • HMIS • MPDR • Score Card	Quarterly Annually	MoH-M&E Unit DHO (MCH) Facility in-charges	MPDR quality improves
Key Result 1 Greater coverage in high-burden districts and populations	• Proportion of regions, districts or sub-districts with previously the highest mortality rates registering a 50% reduction: 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 • 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 • Out-of-pocket expenditures for the poor reduced to < 30%	• UDHS • HMIS • Special Surveys	2015/16 Quarterly Annually	MoH-M&E Unit DHO (MCH) Facility in-charges	
Key Result2 Expanded coverage of high impact interventions	• 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 coverage of lifesaving interventions to over 80% (4+ ANC visits, EmONC, preterm care, treatment of newborn and child killer infections)	• HMIS • Score Card • Supervision reports	Annual	MoH	
Key Result 3 Non health sector interventions that impact on maternal, newborn and child vulnerability and deaths harnessed	• 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%	• UDHS • HMIS • Special Surveys	Annual	MoH	
Key Result4 Collective action and mutual accountability for ending preventable maternal, newborn and child deaths	• Number of parallel RMNCH project interventions • Percent of aid disbursements released according to agreed schedules • RMNCH program reports produced, debated and used to generate action • Unified RMNCH program monitoring and evaluation system	• Joint RMNCH program reviews • NHA for RH & CH	Annual	MoH	

06 APPENDICES

Appendix 1: M&E Framework for Priority Interventions

Life Cycle Phase	Goal	Objective verifiable indicator			Means of verification				Assumption
		Indicator Description	Baseline	Target (2017)	Responsible person	Collection method	Source	Frequency	
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	5 Years	Increased use of long term contraception
							HMIS	Annual	
		Teenage pregnancy and motherhood	24%	15%	MoH [M&E] unit	Routine &Non-routine data	UDHS	5 Years	Continued roll out of SSE
							HMIS	Annual	
		% Women with problems in accessing health care	65%	30%	MoH [M&E] unit	Non-routine data sources	UDHS	5 Years	Sustained socio-economic growth
Pregnancy		% First) ANC visit in 1st trimester	21%	50%	MoH [M&E] unit	Routine &Non-routine data	UDHS,	5 Years	Increased capacity of health facilities
							HMIS	Annual	
		% Women attending 4+ ANC visits (anytime during pregnancy)	35%	80%	MoH [M&E] unit	Routine &Non-routine data	UDHS	5 years	Increased capacity of health facilities
							HMIS	Annual	
		% Pregnant women taking 2+ doses IPT	44%	60%	MoH [M&E] unit	Routine &Non-routine data	UDHS, MIS	5 & 2 5 years	Increased capacity of health facilities
							HMIS	Annual	
		% Maternal antiretroviral for PMTCT	84%	95%	MoH [M&E] unit	Routine &Non-routine data	UDHS,	5 years	Continued roll out of Option B+
							HMIS	Annual	
		% 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 ANC LLIN distribution
Birth		% Institutional deliveries	58%	70%	MoH [M&E] unit	Routine &Non-routine data	UDHS	5 years	Increased capacity of health facilities offering delivery services
							HMIS	Annual	
		Increase coverage of active management of 3rd stage	?	80%	MoH [M&E] unit	Routine data	HMIS	Annual	All institutional deliveries use uterotonics
		% Health facilities with EmONC	24%	50%	MoH [M&E] unit	Routine &Non-routine data	UDHS, SPA	5 & 2 5 years	Staff retained in peripheral facilities
							HMIS	Annual	

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
		% eligible HIV+ mothers that access ARVs	84%	95%	MoH [M&E] unit	Routine &Non-routine data	UAIS HMIS	5 years Annual	Continued roll out of Option B+
Neonatal	To reduce neonatal mortality rates from 27/1,00 in 2011 to 10/1,000 by 2017	% 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, UAIS 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	
		% 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
Cross-cutting areas	To reduce Maternal, Newborn and Childhood mortality rates in Uganda to the set targets by 2017	% 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	Government	Donor	Multilateral	CSOs	Private Sector	Community	Joint Outcome Indicators
1. Accelerating greater coverage in high-burden districts and populations							
1.1 Intensified implementation in high burden districts	A	A	P	A	P	P	• All ADHO (RMNCH) in place; 75% District RMNCH plans implemented and 80% RMNCH budgets funded • Reduced disparity gaps of coverage to less than 5% • Proportion of poor women in reproductive age with problems accessing health services reduced from 65% to <30% • Reduced out-of-pocket expenditures for the poor from 65% to less than 30%
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	
2. Expanding coverage of high impact interventions that directly reduce maternal, newborn and child mortality							
1.1 Enhanced access to and use of life-saving RMNCH commodities and equipment	A	A	P	P	A	P	• Proportion of facilities with no stock outs of lifesaving commodities raised to 80% • Proportion of nurses, midwives, VHTs providing lifesaving interventions increased to >60% • Over 80% women, newborn and children who receive timely lifesaving interventions (4+ ANC visits, EmONC, preterm care, treatment of newborn and child killer infections)
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	
3. To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths							
1.1 RMNCH prevention targets and services Integrated in non-health programs	A	A	P	P	P	P	• 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 from 16% to >80%
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	
4. Collective action and mutual accountability for ending preventable maternal, newborn and child deaths							
1.1 Functioning transparency and mutual accountability mechanism	A	A	P	P	P	A	• 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
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	

NOTES: *A=Accountable* *P= Participate*

Appendix 3: Illustrative Intervention Planning Matrix

Output 1: Increase national coverage while reducing geographical inequities in accessibility, quality and utilisation of childbirth and newborn care services

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

Intervention	Key Activities	Implementation Focus	Indicator		
			Verifiable Indicator	Baseline	2017
Preconception					
1.1 Increased access and use of Family Planning	• Reduce unmet need for contraception among married women	• Focus on poor rural women and adolescents • Harness missed opportunities during postpartum period • Focusing on long acting and permanent method • Extra effort on Karamoja, Eastern, East Central, North, West Nile and South Western Region	CPR	30%	35%
Antenatal Period					
1.2 Focused Antenatal care to track high risk pregnancies	1.3 ANC attendance starting in first trimester	• Empower male partners with knowledge about ANC services • Focus on attendance in first trimester • Focus on improving quality of ANC • Rural populations	ANC visit in 1st trimester	21%	50%
			% Women attending 4+ ANC visits	35%	70%
	1.4 Pregnant women given 2+ doses IPT		% Pregnant women taking 2+ doses IPT	44%	84%
Delivery/Birth					
1.5 Skilled obstetric care and essential newborn care and resuscitation	• Skilled Births Attendance	• Focus on Karamoja, Southwest, Western, Eastern and North • All regions in the country • All health facilities (private and public) offering delivery services	% Institutional deliveries	57%	89%
	• Active management of third stage		Active management of third stage	18%	60%
	• Antibiotics for Preterm/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	Indicator			Implementation Focus
		Verifiable Indicator	Baseline	2017	
1.6 Emergency obstetric and new born care	• Increase coverage of EmONC delivery points	% Health facilities with EmONC	24%	90%	All HC IV and above provide CEmONC and lower facilities with delivery services provide BEmONC
	• Caesarean Section	C-Section rate	2%	5%	Countrywide for all HC IV and above
	• Antenatal steroids for preterm labour	ACS for preterm labour	5%	60%	Provision of ACS at all levels where delivery occurs
	• Management of LBW and preterm babies	Kangaroo mother care among LBW	2%	50%	Focal interventions are: Kangaroo mother care and provision of assisted feeding
Postnatal Period					Countrywide implementation
1.7 Postnatal attendance with skilled care (within 48 hours)	• Post natal care for mothers at all facilities	% Postnatal care for Mothers within 48 hours	33%**	70%	Implement Countrywide
	• Registration, counselling, referral and follow up for mothers and new born at community level				Focus on missed opportunities:
	• Postnatal home visits by VHTs at least three visits to the mother and six to the newborn within six weeks of delivery/birth	% Postnatal care for newborns within 48 hours	11%**	70%	(About half (47%) of women stay in health facility either for less than one day after vaginal birth) Focus on Karamoja and South Western regions
Childcare					Countrywide implementation
1.8 Treatment of Newborn Infections (Sepsis, Pneumonia, Diarrhea)	• Treatment of newborn infections at facility level with parenteral antibiotics	Case fatality rate			HC IIs provide pre-referral treatment
	• Care-seeking and prompt referral for newborn infections				
1.9 Treatment of Diarrhoea Malaria and Pneumonia	☐ Management of diarrhoea in children with ORS along with Zinc	% Children with diarrhoea receiving Zinc	2%	85%	Diarrhoea is highest in East Central and Eastern regions Zinc coverage still very low and can be rapidly raised to ORS levels
		% children Under-5 that take ORT/Fluids for diarrhoea	55%	85%	
	☐ Use of recommended antibiotics in children aged 2 months to 5 years with non-severe pneumonia	% children with ARI treated with antibiotics	47 4%	75%	Eastern, East central, Northern, Karamoja, Southwest have the lowest coverage of pneumonia treatment
	☐ Use of ACTs in treatment of Malaria	% children who took ACT on same day	46%	80%	Countrywide

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 Uganda2008-2015' 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 Uganda2009 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. United Nations Population Fund (2012) 'Annual report 2010/2011,' Government of


USAID
FROM THE AMERICAN PEOPLE


United Nations
UGANDA


Civil Society Coalition On Maternal
Newborn And Child Health