Committed to Maternal & Child Survival

A Promise Renewed

REPRODUCTIVE MATERNAL, NEWBORN AND CHILD HEALTH SHARPENED PLAN FOR UGANDA

November 2013
FOREWORD

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

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.

“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 fail 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 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.

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 US deaths occur, prioritising budgets and committing to action plans to end preventable deaths

High Burden Populations
• Refocus district to scaling up access 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
• Unity 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 ongoing interventions, which are necessary to sustain the current gains. The key results and targets of this plan, which are outlined in the matrix below, will be implemented alongside the ongoing interventions, which are necessary to sustain the current gains. The key results and targets of this plan are:

GOAL: TO END PREVENTABLE MATERNAL AND CHILD DEATHS IN UGANDA

<table>
<thead>
<tr>
<th>Impact</th>
<th>Target</th>
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<tbody>
<tr>
<td>Reduced the Maternal Mortality Ratio from 438 per 1,000 live births to 211 per 100,000 live births by 2017</td>
<td></td>
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<tr>
<td>Reduced Under 5 Mortality Rate from 90 per 1,000 live births to 53 per 1,000 live births by 2017</td>
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<tr>
<td>Reduced the Infant Mortality Rate from 54 per 1,000 live births to 30 per 1,000 live births by 2017</td>
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<tr>
<td>Reduced the Neonatal Mortality Rate from 27 per 1,000 live births to 10 per 1,000 live births by 2017</td>
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PURPOSE: TO REDIRECT AND REFOCUS EFFORTS TOWARDS ACCelerating the ACHIEVEMENT OF MDG 4&5 IN UGANDA

<table>
<thead>
<tr>
<th>Key Result</th>
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<tbody>
<tr>
<td>1. Coherent, prioritized and funded country led integrated RMNCH plan</td>
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<tr>
<td>2. Commitments and mutual accountability for sustained collective action by government, development partners, private sector, and CSOs</td>
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<td>3. Transparency and evidence-based planning and reporting to accelerate progress and deliver results</td>
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STRATEGIC OBJECTIVES

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Key Result</th>
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<tbody>
<tr>
<td>1.0 To accelerate greater coverage in high-burden districts and populations</td>
<td>2.0 To expand coverage of high impact interventions</td>
</tr>
<tr>
<td>2.0 To expand coverage of high impact interventions</td>
<td>3.0 To harness non-health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
</tr>
<tr>
<td>3.0 To harness non-health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Result</th>
<th></th>
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<tbody>
<tr>
<td>1.1 Identification of High Priority Districts (HPDs) based on a 'composite health index' across districts</td>
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<td>1.2 Differential planning for HPDs</td>
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<td>1.3 Scaled up community outreach based delivery platforms to the most burdened populations</td>
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<tr>
<td>1.4 Reduced coverage disparities between regions and within districts</td>
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<td>1.5 Equity-sensitive monitoring data</td>
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</table>

<table>
<thead>
<tr>
<th>Indicators and Targets</th>
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<tbody>
<tr>
<td>Proportion of regions, districts or sub-districts with previously the highest mortality rates registering a 90% reduction in mortality: Target 80% by 2017</td>
<td>Proportion of facilities with no stock outs of lifesaving commodities raised to 80%</td>
</tr>
<tr>
<td>Proportion of regions, districts or sub-districts with previously highest mortality rates reduced to current national average: Target 70% by 2017</td>
<td>Proportion of nurses, midwives, VHs providing lifesaving interventions increased to &gt;60%</td>
</tr>
<tr>
<td>Proportion of regions, districts or sub-districts with previously highest mortality rates with increased budget allocations to high impact interventions: Target 90% by 2017</td>
<td>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)</td>
</tr>
<tr>
<td>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</td>
<td>Proportion of planned quality RMNCH performance reports produced, debated and used to strengthen program management and resources allocation</td>
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<tr>
<td>Out-of-pocket expenditures for the poor reduced to &lt;</td>
<td>Proportion of commitments met on schedule by each partner</td>
</tr>
<tr>
<td></td>
<td>Proportion of resources allocated and spent based on previously made commitments and goals</td>
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<th>Description</th>
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<tr>
<td>ACS</td>
<td>Adreno-cortico-steroids</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>APR</td>
<td>A promise Renewed for Child Survival</td>
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<tr>
<td>ARVs</td>
<td>Anti-Retroviral Drugs</td>
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<td>BEmONC</td>
<td>Basic Emergency Obstetric Care</td>
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<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
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<td>BNA</td>
<td>Bottle Neck Analysis</td>
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<td>CARMMA</td>
<td>Campaign for Accelerated Reduction of Maternal Mortality in Africa</td>
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<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Neonatal Care</td>
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<td>DPT</td>
<td>Diphtheria Pertussis Tetanus Vaccine</td>
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<td>Exclusive Breast Feeding</td>
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<td>Early Infant Diagnosis</td>
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<td>Essential Medicines and Health Supplies List of Uganda</td>
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<td>International Federation of Gynaecologists and Obstetricians</td>
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<td>HIV/AIDS</td>
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<td>Health Policy Advisory Committee</td>
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<td>Health Sector Strategic Investment Plan</td>
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<td>iCCM</td>
<td>Integrated Community Case Management</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IMPAC</td>
<td>Integrated Management of Pregnancy and Child Birth</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<tr>
<td>IPT</td>
<td>Intermittent Presumptive Treatment</td>
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<td>ITN</td>
<td>Insecticide Treated Nets</td>
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<td>JMS</td>
<td>Joint Medical Stores</td>
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<td>LAM</td>
<td>Lactation Amenorrhoea</td>
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<td>Local Councils</td>
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<td>LMIS</td>
<td>Logistics Management Information System</td>
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<td>Leadership in Obstetrics &amp;Gynaecology for Impact &amp; Change</td>
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<td>LTFP</td>
<td>Long Term Family Planning</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NDA</td>
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<td>Oral Rehydration Salt</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>Post Natal Care</td>
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<td>QPPU</td>
<td>Quantification and Procurement Planning Unit</td>
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<td>RAIC</td>
<td>Rapid Assessment of Interventions and Commodities Tool</td>
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<td>RMNCH</td>
<td>Reproductive, Maternal, Neonatal and Child Health</td>
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<tr>
<td>RRH</td>
<td>Regional Referral Hospital</td>
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<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<td>SMC</td>
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<td>SRH</td>
<td>Sexual Reproductive Health</td>
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<td>Uganda Health Systems Strengthening Project</td>
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<td>Village Health Team</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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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 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.

In June 2012, the Child Survival Call to Action was launched in Washington, DC; 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 use the media and other communication channels to sustain the momentum and gains well into the future. In April 2013, Uganda embarked on the development of an evidence based country plan (the Sharpened Plan) to address the slow progress on MDG 4 & 5 targets hence this Sharpened Reproductive, Maternal, Newborn 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 business differently or greater impact. The plan proposes evidence-based interventions, which have the highest impact on Maternal, Neonatal and Child mortality. It provides a starting point for stakeholder dialogue with renewed commitments, with mechanisms for information and mutual accountability.

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 centered 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 RMNCH 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 frameworks have 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 summarizes 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 Bottleneck Analysis (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, educational levels, etc.

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

In March 2011, Uganda signaled its commitment to join the SUN Movement 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 of 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 government allocation for family planning supplies from US $ 3.3M (7.8b UGX) in 2000 to US $ 5M (12b UGX) in 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 milestone 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 dismal 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.

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 mortality rate

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

Figure 2: Trends in Mortality 1995-2011
Child mortality is not evenly distributed across the country 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 comparatively lower 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 in households 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 6 months recommended by the WHO.

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

These are easily preventable through simple improvements in basic health services and proven interventions such as Oral Rehydration therapy, insecticide treated mosquito 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 of at least 80% of under-5 children with diarrhoea, pneumonia or malaria have access to treatment.

2.1.2 Infant mortality rate

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%.
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.

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.
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.

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.
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 indicators for comprehensives emergency obstetric care (CEmOC) the percentage of health centre IVs and hospitals that offer caesarean section increased from 45% in 2006 to 77% in 2011, 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 53% of births in rural areas assists almost 90% of all births in urban areas. Karamoja (31%) and the South-Western (42%) regions post the lowest coverage of births attended by a skilled provider. Institutional deliveries currently average at 60% nationwide and the proportion of births at health facilities follows a similar disparity trend, as illustrated in Figure 10.

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 emergency 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 utilization still 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 one visit. 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 to 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 are 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.

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 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 rise 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.
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.
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.
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 term 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.

2.4.1.3 Clinical/Individual Level Platform

Supply side bottleneck: The tracer intervention selected for this platform was basic emergency 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.
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:

- **Reproductive Health Commodities** comprising Female Condoms, Contraceptive Implants and Emergency Contraceptive Pills;
- **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;
- **Newborn Health Commodities** comprising Antenatal Corticosteroids for management of preterm labour, Injectable Antibiotics for Neonatal Sepsis, Newborn Resuscitation Devices and Chlorhexidine for Cord Care and;
- **Child Health Commodities** comprising Oral Rehydration Salts and Zinc treatment for Diarrhoea, Amoxicillin tablets for treatment of pneumonia in children

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.
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 example, teenage 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 17: Strengthening RMNCH along the continuum of care.

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 RMNC services 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 DHIIS2 (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-wives remain unfilled. WHO recommends one skilled birth attendant for every 175 pregnant women, but Uganda has only one midwife per 7000 births. The health system 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.

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

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 MDGS, 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 IMNCH (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 program to reduce maternal and perinatal death has been put in place for death notification and death audits. The aim is to review all deaths to identify avoidable factors for quality improvement coupled with confidential death 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. The MobileVRS is 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.

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 how their earnings are to be spent, 32% report that they make the decision jointly with their husband/partner while 13 percent report that the decision is mainly made by their husband/partner. There are variations in the proportion of women who make independent decisions about their earnings ranging from 24% in Eastern region to 79% in Kampala. This shows that women in urban areas are more likely to make independent decisions compared to those in rural areas. Efforts in the Ministry of Health to 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 every woman 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 included 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.

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 we must 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 the 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.

**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 systems 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.

**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, diarrhea 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 encompass: political accountability to commitments; performance accountability to meet targets; economic accountability for reporting financial information; and importantly, accountability to provide quality care to patients. This shift calls for an effective, sound public system that is responsive to people’s needs, supports information sharing, permit scrutiny so that citizens can see exactly where their resources are spent. Political, managerial and social accountability will encourage implementation of commitments to RMNCH. For example, maternal death reviews will help the Ministry of Health to ensure a chain of accountability.

**Figure 22: RMNCH Strategic Shifts**

**4.3.1 Strategic Objectives**

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

**4.3.2 Guiding Principles**

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

- **Time bound nature:** Set 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-going interventions, which are necessary to sustain the current gains.

The priority interventions, which deliver the highest impact in averting mortality in both mothers and children, are clustered around labour and delivery management. Highest Impact Interventions on Maternal and Child Mortality are shown below (Figure 24 and 25). This strategy will focus on these.
Figure 24: Highest Impact Interventions and Their Relative Importance in Reducing Child Mortality

Antibiotics for pRtM 2,054
Promotion of breastfeeding 2,123
Zinc – for treatment of diarrhea 2,439
KMC - Kangaroo mother care 2,834
DPT/Hib/Hep Vaccination 2,799
Pneumococcal Vaccination 2,803
Neonatal resuscitation 3,220
Case management of severe neonatal infection 5,855
ITN/LLIN – Ownership of insecticide treated nets 6,225
Oral antibiotics: case management of 7,445
PMTCT - (including breastfeeding choices) 8,093
Antenatal corticosteroids for preterm labor 8,100
ORS - oral rehydration solution 8,150
Antimalarials - Artemisinin compounds for 10,330
Labor and delivery management 13,533
Total 85,773

Figure 25: Projected increase in Coverage by Priority Interventions

- Polo from 63% to 82% 19%
- BCG from 94% to 96% 2%
- Measles (vaccination) from 78% to 88% 10%
- Rotavirus from 0% to 88% 88%
- DPT/Hep/Hib from 72% to 82% 10%
- Pneumococcal vaccine from 0% to 85% 88%
- Exclusive Breastfeeding (first 6 m) prevalence from 63% to 75% 12%
- Antibiotics for treatment for dysentery from 32% to 65% 23%
- Clean postnatal practices (newborn) from 11% to 51% 50%
- KMC for preterm and LBW babies from 10% to 63% 53%
- Case Mgt of Severe Neonatal Inf from 36% to 100% 64%
- Zinc for treatment of Diarrhoea from 2% to 85% 83%
- Oral antibiotics- pneumonia in children from 47% to 75% 28%
- ORS (fluids from ORS) from 44% to 85% 41%
- ACTs - Malaria in children from 45% to 85% 34%
- Malaria case management in pregnancy from 30% to 60% 30%
- Maternal Sepsis/Post abortion care from 10% to 60% 50%
- Skilled Birth Attendance (CEMOC) from 58% to 89% 31%
- IPTp from 27% to 85% 58%
- ITNs ownership per household from 63% to 85% 25%
- MgSO4 for pre-eclampsia from 2% to 55% 53%
- CPR from 30% to 50% 20%
- ANC (4th Visit) from 47% to 70% 23%

* Baseline (2011)  % Point Increase
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

<table>
<thead>
<tr>
<th>Interventions</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and delivery management</td>
<td>1,836 3,387 6,114 8,463</td>
<td>20,300 15.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antimalarials – ACTs</td>
<td>1,697 3,249 4,655 5,895</td>
<td>15,496 12.0</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS - oral rehydration solution</td>
<td>1,407 2,625 3,666 4,527</td>
<td>12,225 9.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corticosteroids for preterm labour</td>
<td>1,096 2,324 3,659 5,072</td>
<td>12,151 9.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMTCT - (including breastfeeding choices)</td>
<td>1,455 2,849 3,675 4,116</td>
<td>12,095 9.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral antibiotics for pneumonia in children</td>
<td>1,221 2,339 3,353 4,256</td>
<td>11,169 8.7</td>
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<td></td>
<td></td>
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<tr>
<td>ITN/LLIN ownership</td>
<td>947 1,881 2,805 3,705</td>
<td>9,338 7.1</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of severe neonatal infection</td>
<td>1,046 1,931 2,642 3,165</td>
<td>8,784 6.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Neonatal resuscitation</td>
<td>449 936 1,414 1,992</td>
<td>4,831 3.8</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Vaccination</td>
<td>431 852 1,263 1,659</td>
<td>4,205 3.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT/Hib/Heb Vaccination</td>
<td>429 851 1,262 1,658</td>
<td>4,200 3.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KMC - Kangaroo mother care</td>
<td>647 1,050 1,191 1,064</td>
<td>3,952 3.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zinc - for treatment of diarrhoea</td>
<td>425 789 1,097 1,349</td>
<td>3,660 2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of breastfeeding</td>
<td>332 651 957 1,245</td>
<td>3,185 2.5</td>
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<tr>
<td>Antibiotics for pPRoM</td>
<td>275 585 927 1,295</td>
<td>3,082 2.4</td>
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<tr>
<td>Labour and delivery management</td>
<td>1,223 1,923 2,669 3,944</td>
<td>71.8</td>
<td></td>
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<tr>
<td>Post abortion case management</td>
<td>42 81 116 143</td>
<td>382 4.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean birth practices</td>
<td>75 158 249 347</td>
<td>829 9.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMTSL—active management of the third stage of labour</td>
<td>50 107 168 234</td>
<td>559 6.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MgSO4 management of eclampsia</td>
<td>35 72 113 153</td>
<td>373 4.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics for pPRoM</td>
<td>23 47 75 104</td>
<td>249 2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive use</td>
<td>8 20 35 51</td>
<td>114 1.3</td>
<td></td>
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</tr>
</tbody>
</table>

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.
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.
Figure 29: Intervention costs

![Pie chart showing intervention costs](chart.png)

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 $)

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

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 RMNCH requirements
• Revise staffing norms for midwives at Health Centres based on actual facility coverage
• Training and mentoring midwives and nurses to use emergency lifesaving parenteral commodities
• Scale up in service mentoring of health workers in interpersonal communication
• Strengthen 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 newborn care birth preparedness, breastfeeding, clean delivery, cord care, and hypothermia prevention
• 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-sector 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**

![Mutual Accountability Process Diagram](image)

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**

![Illustrative of a Score Card](image)
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

<table>
<thead>
<tr>
<th>Indicator (%)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-pregnancy &amp; Adolescence</td>
<td>Couples accepting a contraceptive method postpartum</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Pregnant women receiving IFA</td>
</tr>
<tr>
<td></td>
<td>Pregnant women taking 2 or more doses of IPT</td>
</tr>
<tr>
<td></td>
<td>Sera-positive pregnant women treated with ARVs</td>
</tr>
<tr>
<td>Delivery</td>
<td>Women provided with a uterotonic immediately after delivery</td>
</tr>
<tr>
<td></td>
<td>Women identified for pre-eclampsia and provided MgSO4</td>
</tr>
<tr>
<td>EmOC/Newborn care</td>
<td>Women in P/Term labour receive at least 1 dose of dexamethasone</td>
</tr>
<tr>
<td></td>
<td>Newborns treated for puerperal sepsis</td>
</tr>
<tr>
<td></td>
<td>Newborns treated for puerperal sepsis</td>
</tr>
<tr>
<td>Postnatal period</td>
<td>Newborn infection cases treated with parental antibiotics</td>
</tr>
<tr>
<td>Childhood</td>
<td>DPT 3 coverage and dropout rate</td>
</tr>
<tr>
<td></td>
<td>US diarrhoea cases provided ORS and Zinc</td>
</tr>
<tr>
<td></td>
<td>Newborns treated for puerperal sepsis</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Newborns treated for puerperal sepsis</td>
</tr>
<tr>
<td></td>
<td>Sero-positive infants treated with ARVs</td>
</tr>
<tr>
<td>Health Systems</td>
<td>Health facilities with stock-outs of Lifesaving Commodities</td>
</tr>
<tr>
<td></td>
<td>VRTs w stock-outs of LSCs (subset as allowed per policy)</td>
</tr>
<tr>
<td></td>
<td>Health facilities with trained midwives</td>
</tr>
<tr>
<td>Health facilities with stock-outs of Lifesaving Commodities</td>
<td>HC IV and above provide CEmONC</td>
</tr>
<tr>
<td></td>
<td>Lower facilities with delivery services provide BEmONC</td>
</tr>
<tr>
<td>Equity</td>
<td>Proportion of resources allocated and spent based on commitments</td>
</tr>
<tr>
<td></td>
<td>Malnourished children provided treatment (boys and girls)</td>
</tr>
<tr>
<td></td>
<td>Concentration indices for priority indicators (Two-year interval)</td>
</tr>
<tr>
<td>Cross-cutting</td>
<td>Households with latrine coverage</td>
</tr>
<tr>
<td>Overall summary (Geographical Equity)</td>
<td>Health facilities below lower benchmark</td>
</tr>
</tbody>
</table>

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).
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 4 and 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 in radio 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 Health Care Workers and their Professional Associations

Several health workers and professional associations such as the Association of Obstetricians and Gynaecologists of Uganda will provide/support Technical Assistance and advocacy for the capacity of health workers to provide quality reproductive health and MNCH services through in-service training and mentorship. Health workers will be trained in EmONC, improving immunization coverage, prevention and treatment of malaria and 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.

The Uganda Private Midwife Association are committed to saving lives of mothers and their newborn. As an association, they aim at providing PMTCT, EmOC, newborn care, and maternal and neonatal care.

### Table 6: Strategic Framework

<table>
<thead>
<tr>
<th>Impact</th>
<th>Key Result</th>
<th>Strategic Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduced the Maternal Mortality Rate from 148.8 per 1,000 live births to 21.1 per 100,000 live births by 2017</td>
<td>1.1 Identification of High Priority Districts (HPDs) based on a ‘composite health index’ across districts</td>
<td>1.0 To accelerate greater coverage in high-burden districts and populations</td>
</tr>
<tr>
<td>2. Reduced Under 5 Mortality Rate from 69.5 per 1,000 live births to 33 per 1,000 live births by 2017</td>
<td>1.2 Differential planning for HPDs</td>
<td>1.0 To accelerate greater coverage in high-burden districts and populations</td>
</tr>
<tr>
<td>3. Reduced the Infant Mortality Rate from 58 per 1,000 live births to 35 per 1,000 live births by 2017</td>
<td>1.3 Scaled up community-outreach based delivery platform</td>
<td>1.0 To accelerate greater coverage in high-burden districts and populations</td>
</tr>
<tr>
<td>4. Reduced the Neonatal Mortality Rate from 27 per 1,000 live births to 10 per 1,000 live births by 2017</td>
<td>1.4 Reduced coverage disparities between regions and within districts</td>
<td>1.0 To accelerate greater coverage in high-burden districts and populations</td>
</tr>
<tr>
<td>5. To expand coverage of high impact interventions</td>
<td>1.5 Equity-sensitive monitoring data</td>
<td>1.0 To accelerate greater coverage in high-burden districts and populations</td>
</tr>
<tr>
<td>6. To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
<td>2.1 Enhanced access to and use of lifesaving RMNCH commodities and equipment</td>
<td>2.0 To expand coverage of high impact interventions</td>
</tr>
<tr>
<td>7. To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
<td>2.2 Scaled and sustained demand and supply of highest impact, evidence-based interventions</td>
<td>2.0 To expand coverage of high impact interventions</td>
</tr>
<tr>
<td>8. To increase the uptake of community-level RMNCH interventions</td>
<td>2.3 Appropriate lifesaving task-shifting regulations and policies implemented</td>
<td>2.0 To expand coverage of high impact interventions</td>
</tr>
<tr>
<td>9. To ensure that all women and girls access quality RMNCH services</td>
<td>2.4 Enhanced uptake of community-level RMNCH interventions</td>
<td>2.0 To expand coverage of high impact interventions</td>
</tr>
<tr>
<td>10. To function with transparency and mutual accountability mechanisms</td>
<td>3.1 RMNCH prevention targets and services integrated in non-RMNCH programs</td>
<td>3.0 To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
</tr>
<tr>
<td>11. To ensure that all women and girls access quality RMNCH services</td>
<td>3.2 Women are empowered to make RMNCH decisions</td>
<td>3.0 To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
</tr>
<tr>
<td>12. To reduce the burden of maternal, newborn and child vulnerability and deaths</td>
<td>3.3 Environmental factors addressed e.g., sanitation and hygiene</td>
<td>3.0 To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
</tr>
<tr>
<td>13. To increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (A+ANC visits, EmONC, preterm care, treatment of newborn and child infections)</td>
<td>3.4 Percentage narrowing in midwives staffing differences between regions, districts or sub-districts with lowest mortality: Target 20% by 2017</td>
<td>3.0 To harness non health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
</tr>
<tr>
<td>14. To reduce the undernutrition and malnutrition among newborns and children under 5 years of age, as measured by weight for age and length for age</td>
<td>4.1 Proportion of facilities with no stock outs of lifesaving commodities raised to 80%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>15. To improve the quality of RMNCH commodities and services provided</td>
<td>4.2 Proportion of nurses, midwives, VHTs providing lifesaving interventions increased to &gt;60%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>16. To increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (A+ANC visits, EmONC, preterm care, treatment of newborn and child infections)</td>
<td>4.3 Functioning transparency and mutual accountability for ending preventable maternal, newborn and child deaths</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>17. To ensure that all women and girls access quality RMNCH services</td>
<td>4.4 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>18. To reduce the burden of maternal, newborn and child vulnerability and deaths</td>
<td>4.5 Proportion of planned quality RMNCH interventions increased to &gt;80%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>19. To increase the uptake of community-level RMNCH interventions</td>
<td>4.6 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>20. To reduce the undernutrition and malnutrition among newborns and children under 5 years of age, as measured by weight for age and length for age</td>
<td>4.7 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>21. To improve the quality of RMNCH commodities and services provided</td>
<td>4.8 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>22. To increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (A+ANC visits, EmONC, preterm care, treatment of newborn and child infections)</td>
<td>4.9 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>23. To ensure that all women and girls access quality RMNCH services</td>
<td>4.10 Proportion of planned quality RMNCH interventions increased to &gt;80%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>24. To increase the uptake of community-level RMNCH interventions</td>
<td>4.11 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>25. To reduce the burden of maternal, newborn and child vulnerability and deaths</td>
<td>4.12 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>26. To improve the quality of RMNCH commodities and services provided</td>
<td>4.13 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>27. To increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (A+ANC visits, EmONC, preterm care, treatment of newborn and child infections)</td>
<td>4.14 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>28. To ensure that all women and girls access quality RMNCH services</td>
<td>4.15 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>29. To increase the uptake of community-level RMNCH interventions</td>
<td>4.16 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>30. To reduce the burden of maternal, newborn and child vulnerability and deaths</td>
<td>4.17 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>31. To improve the quality of RMNCH commodities and services provided</td>
<td>4.18 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>32. To increase in proportion of women, newborn and children who receive timely lifesaving interventions to over 80% (A+ANC visits, EmONC, preterm care, treatment of newborn and child infections)</td>
<td>4.19 Proportion of plans reduced to &lt;20%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
</tr>
<tr>
<td>33. To ensure that all women and girls access quality RMNCH services</td>
<td>4.20 Teenage pregnancy and motherhood rates reduced from 24% to 13%</td>
<td>4.0 To develop and sustain collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
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</table>
The summary log-frame presented below is based on the strategic framework for the plan 4.2. Objectives & Key Result Areas. The indicators given in the log-frame summary will result in 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

<table>
<thead>
<tr>
<th>Hierarchy of Aims</th>
<th>Objective Variable Indicators (OVI)</th>
<th>Means of Verification</th>
<th>Timing of Data Collection</th>
<th>Responsibility</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>To end preventable maternal and child deaths in Uganda</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Reduced the Maternal Mortality Ratio from 438 per 100,000 live births to 211 per 100,000 live births by 2017</td>
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<td></td>
<td>• Reduced under 5 mortality rate from 90 per 1,000 live births to 53 per 1,000 live births by 2017</td>
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<tr>
<td></td>
<td>• Reduced the Infant Mortality Rate from 54 per 1,000 live births to 30 per 1,000 live births by 2017</td>
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<tr>
<td></td>
<td>• Reduced the Neonatal Mortality Rate from 17 per 1,000 live births to 10 per 1,000 live births by 2017</td>
<td></td>
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</tbody>
</table>

| 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 |

| 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%                                        |

| Key Result 2       | 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) |

| 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 <12%                                       |
|                   | • Girls married by age 38 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 36% to >80%                           |

| Key Result 4       | 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                                             |

<table>
<thead>
<tr>
<th>Reporting</th>
<th>Methods</th>
<th>Frequency</th>
<th>Responsibility</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Reports: UDHS 2010/11, UDHS 2015/16, UDHS 2020/21</td>
<td>2015/20</td>
<td>UBOS</td>
<td></td>
</tr>
<tr>
<td>Purpose</td>
<td>Reports: HMIS, MDR, Score Card</td>
<td>Quarterly</td>
<td>M&amp;E Unit, DHO, Facility in-</td>
<td>MPR quality improves</td>
</tr>
<tr>
<td>Key Result 1</td>
<td>Reports: UDHS, HMIS, Special Surveys</td>
<td>Quarterly</td>
<td>M&amp;E Unit, DHO, Facility in-</td>
<td></td>
</tr>
<tr>
<td>Key Result 2</td>
<td>Reports: HMIS, Score Card</td>
<td>Quarterly</td>
<td>M&amp;E Unit, DHO, Facility in-</td>
<td></td>
</tr>
<tr>
<td>Key Result 3</td>
<td>Reports: UDHS, HMIS, Special Surveys</td>
<td>Annual</td>
<td>M&amp;E Unit, DHO, Facility in-</td>
<td></td>
</tr>
<tr>
<td>Key Result 4</td>
<td>Reports: Joint RMNCH program reviews</td>
<td>Annual</td>
<td>MoH</td>
<td></td>
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</tbody>
</table>
### Appendix 1: M&E Framework for Priority Interventions

<table>
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</thead>
<tbody>
<tr>
<td>Pregnancy &amp; Adolescence</td>
<td>To reduce maternal mortality in Uganda to &lt; 115/100,000 live births by 2017</td>
<td>Unmet need for modern contraception (married women)</td>
<td>34%</td>
<td>20%</td>
<td>MoH (M&amp;E) unit</td>
<td>Non-routine data sources</td>
<td>UDHS</td>
<td>5 Years</td>
<td>Increased use of implants</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modern contraception (reproductive age)</td>
<td>29%</td>
<td>33%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS</td>
<td>5 Years</td>
<td>Increased use of long term contraception</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teenage pregnancy and motherhood</td>
<td>24%</td>
<td>15%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS</td>
<td>5 Years</td>
<td>Continued roll out of SIE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Women with problems in accessing health care</td>
<td>65%</td>
<td>30%</td>
<td>MoH (M&amp;E) unit</td>
<td>Non-routine data sources</td>
<td>UDHS</td>
<td>5 Years</td>
<td>Sustained socio-economic growth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% First ANC visit in 1st trimester</td>
<td>21%</td>
<td>50%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS, Annual</td>
<td>5 Years</td>
<td>Increased capacity of health facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Women attending 4+ ANC visits (anytime during pregnancy)</td>
<td>35%</td>
<td>80%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS, Annual</td>
<td>5 years</td>
<td>Increased capacity of health facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Pregnant women taking 2+ doses IPT</td>
<td>44%</td>
<td>60%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS, Annual</td>
<td>5 &amp; 2.5 years</td>
<td>Increased capacity of health facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Maternal antiretroviral for PMTCT</td>
<td>84%</td>
<td>93%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS, Annual</td>
<td>5 years</td>
<td>Continued roll out of Option B+</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Pregnant women told about Pregnancy danger signs</td>
<td>47%</td>
<td>80%</td>
<td>MoH (M&amp;E) unit</td>
<td>Non-routine data sources</td>
<td>UDHS</td>
<td>5 Years</td>
<td>Availability of Job aides at lower levels</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>% Pregnant women sleeping under ITNs</td>
<td>47%</td>
<td>80%</td>
<td>MoH (M&amp;E) unit</td>
<td>Non-routine data sources</td>
<td>UDHS</td>
<td>5 Years</td>
<td>Sustainable partnerships in ANC LLIN distribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% Institutional deliveries</td>
<td>58%</td>
<td>70%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS, Annual</td>
<td>5 years</td>
<td>Increased capacity of health facilities offering delivery services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase coverage of active management of 3rd stage</td>
<td>7%</td>
<td>80%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine data</td>
<td>HMIS</td>
<td>Annual</td>
<td>All institutional deliveries via supervision</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>% Health facilities with EmONC</td>
<td>24%</td>
<td>30%</td>
<td>MoH (M&amp;E) unit</td>
<td>Routine &amp;Non-routine data</td>
<td>UDHS, Annual</td>
<td>5 &amp; 2.5 years</td>
<td>Staff retain in peripheral facilities</td>
<td></td>
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<tr>
<td>Indicator Description</td>
<td>Baseline</td>
<td>Target (2017)</td>
<td>Responsible Person</td>
<td>Collection Method</td>
<td>Source</td>
<td>Frequency</td>
<td>Assumption</td>
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</tr>
<tr>
<td>% Under-5 children with fever treated with ACT</td>
<td>42%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>% Under-5 children with ARI treated with antibiotics</td>
<td>33%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
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<tr>
<td>% households with improved sanitation</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>% facilities with MPDRs</td>
<td>12%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% households with improved sources of drinking water</td>
<td>25%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% resolution of clients at health facility with ARI</td>
<td>32%</td>
<td>85%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of children with fever treated within 24 hours</td>
<td>42%</td>
<td>80%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>% of clients with fever treated with ACT</td>
<td>32%</td>
<td>85%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
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<tr>
<td>% of clients with fever treated within 12 hours</td>
<td>33%</td>
<td>&lt;20%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 24 hours</td>
<td>65%</td>
<td>80%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<td>% of clients with fever treated within 48 hours</td>
<td>47%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<td></td>
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<tr>
<td>% of clients with fever treated within 72 hours</td>
<td>65%</td>
<td>&lt;20%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
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<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<td>% of clients with fever treated within 96 hours</td>
<td>33%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 120 hours</td>
<td>25%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 144 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 168 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 192 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 216 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 240 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
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<tr>
<td>% of clients with fever treated within 288 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
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<tr>
<td>% of clients with fever treated within 336 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 384 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 432 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
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<tr>
<td>% of clients with fever treated within 480 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 576 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 648 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 720 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 864 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1008 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1152 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1296 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1440 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1664 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1816 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 1976 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 2136 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 2304 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 2472 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 2640 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 2808 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 2976 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 3144 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 3312 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 3480 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clients with fever treated within 3648 hours</td>
<td>15%</td>
<td>90%</td>
<td>MoH [M&amp;E] unit</td>
<td>Routine &amp; Non-routine data</td>
<td>UDHS, MIS 5 years</td>
<td>Annual</td>
<td>Sustained socioeconomic growth</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Mutual Accountability Matrix

<table>
<thead>
<tr>
<th>Area of commitment Based on Key RMNCH Plan Outputs</th>
<th>Government</th>
<th>Donor</th>
<th>Multilateral</th>
<th>NGOs</th>
<th>Private Sector</th>
<th>Community</th>
<th>Joint Outcome Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accelerating greater coverage in high-burden districts and populations</td>
<td>A</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• All ADHO (RMNCH) in place; 75% District RMNCH plans implemented and 80% RMNCH budgets funded</td>
</tr>
<tr>
<td>1.1 Increased implementation in high burden districts</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Reduced disparity gaps of coverage to less than 5%</td>
</tr>
<tr>
<td>1.2 Scaled up community-outreach based delivery platform for RMNCH packages to most populated jurisdictions</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>• Proportion of poor women in reproductive age with problems accessing health services reduced from 65% to &lt;30%</td>
</tr>
<tr>
<td>1.3 Reduced coverage disparities between regions and within districts</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>• Reduced out-of-pocket expenditures for the poor from 65% to less than 30%</td>
</tr>
<tr>
<td>1.4 Reliable and equity-sensitive monitoring system and data driven efforts</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>2. Expanding coverage of high impact interventions that directly reduce maternal, newborn and child mortality</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>2.1 Enhanced access to and use of life-saving RMNCH commodities and equipment</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Proportion of facilities with no stock outs of lifesaving commodities raised to 80%</td>
</tr>
<tr>
<td>2.2 Scaled and sustained demand and supply of highest impact, evidence-based interventions</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Proportion of nurses, midwives, VHTs providing lifesaving interventions increased to &gt;60%</td>
</tr>
<tr>
<td>2.3 Appropriate lifesaving task-shifting regulations and policies implemented</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>• Over 80% women, newborn and children who receive timely lifesaving interventions (≥4 ANC visits, EmONC, preterm care, treatment of newborn and child killer infections)</td>
</tr>
<tr>
<td>2.4 Enhanced uptake of community level RMNCH interventions</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>3. To harness non-health sector interventions that impact on maternal, newborn and child vulnerability and deaths</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Teenage pregnancy and motherhood reduced from 24% to &lt;15%</td>
</tr>
<tr>
<td>3.1 RMNCH prevention targets and services integrated in non-health programs</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Girls married by age 18 reduced from 46% to &lt;30%</td>
</tr>
<tr>
<td>3.2 Women are empowered to make RMNCH decisions</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>A</td>
<td>P</td>
<td>• Unmet need for contraception reduced from 34-4% to &lt;20%</td>
</tr>
<tr>
<td>3.3 Environmental factors addressed e.g., sanitation and hygiene</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Stunting among children Under 5 years reduced from 33% to &lt;25%</td>
</tr>
<tr>
<td>4. Collective action and mutual accountability for ending preventable maternal, newborn and child deaths</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Anemia in non-pregnant women reduced to &lt;20%</td>
</tr>
<tr>
<td>4.1 Functioning transparency and mutual accountability mechanism</td>
<td>A</td>
<td>A</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>• Households with access to improved sanitation from 16% to &gt;80%</td>
</tr>
<tr>
<td>4.2 Unified RMNCH survival voice, shared targets, harmonized approaches, common metrics across levels and partnerships</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>4.3 Reviews of progress in implementing commitments</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>4.4 Well-coordinated and harmonized support to overcome system constraints</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

NOTE:  
A=Accountable   P= Participate

Appendix 3: Illustrative Intervention Planning Matrix

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

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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Key Activities</th>
<th>Implementation Focus</th>
<th>Indicator</th>
<th>Verifiable Indicator</th>
<th>Baseline</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Increased access and use of Family Planning</td>
<td>• Reduce unmet need for contraception among married women</td>
<td>• Focus on poor rural women and adolescents</td>
<td>CPR</td>
<td>30%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Antenatal Period

| 1.3 ANC attendance starting in first trimester | • Empower male partner with knowledge about ANC services | ANC visit in 1st trimester | 23% | 50% |
| | | | | | |
| 1.4 Pregnant women given 2+ doses IPT | | % Women attending 4+ ANC visits | 35% | 70% |

Delivery/Birth

| 1.5 Skilled obstetric care and essential newborn care and resuscitation | | | | | |
| | | | | | |

| 1.6 Skilled Births Attendance | | | | | |
| | | | | | |

| 1.7 Active management of third stage | | | | | |
| | | | | | |
| Antibiotics for Prophylaxis/Pre labour rupture of membranes (PPROM) | | | | | |
| Detection and management of pre-eclampsia (MgSO4) | | | | | |
| Oxytocin/Misoprostol in preventing post-partum bleeding | | | | | |
| Post abortion care/puerperal sepsis | | | | | |
| Essential Newborn Care (normal baby) | | | | | |

| 1.8 Active management of third stage | | | | | |
| | | | | | |
| Antibiotics for PPROM | | | | | |
| Management of pre/eclampsia | | | | | |
| Oxytocin/Misoprostol | | | | | |
| Suturing by third stage | | | | | |
| Proportion of women initiating early breastfeeding | | | | | |

NOTES: A=Accountable   P= Participate
### Intervention Key Activities Implementation Focus

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Key Activities</th>
<th>Implementation Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6</td>
<td>Increase coverage of EmONC delivery points.</td>
<td>Countrywide implementation</td>
</tr>
<tr>
<td>1.7</td>
<td>Postnatal Period: • Postnatal care for mothers at all facilities, • Postnatal care for newborns within 48 hours.</td>
<td>Countrywide implementation</td>
</tr>
<tr>
<td>1.8</td>
<td>Children: • Management of diarrhea and pneumonia in children</td>
<td>Countrywide implementation</td>
</tr>
<tr>
<td>1.9</td>
<td>Use of recommended antibiotics in children aged 2 months to 5 years.</td>
<td>Countrywide implementation</td>
</tr>
</tbody>
</table>

**Baseline 2017 - Verifiable Indicator**

<table>
<thead>
<tr>
<th>EmONC</th>
<th>% Health facilities with Emergency obstetric and newborn care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission</td>
<td>2017: Countrywide implementation</td>
</tr>
<tr>
<td>1.6</td>
<td>Increase coverage of EmONC delivery points.</td>
</tr>
<tr>
<td>1.7</td>
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**Baseline 2017 - Verifiable Indicator**

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<td>1.9</td>
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</table>
Planning Process, June 2007


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


37. Republic of Uganda Ministry of Health 2009 Uganda Reproductive Health Commodities Situation Analysis 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


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


46. Uganda 2005 National Family Planning Advocacy Strategy 2005-2010 Kampala: Health Promotion and Education Division, Reproductive Health Division, Ministry of Health


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
