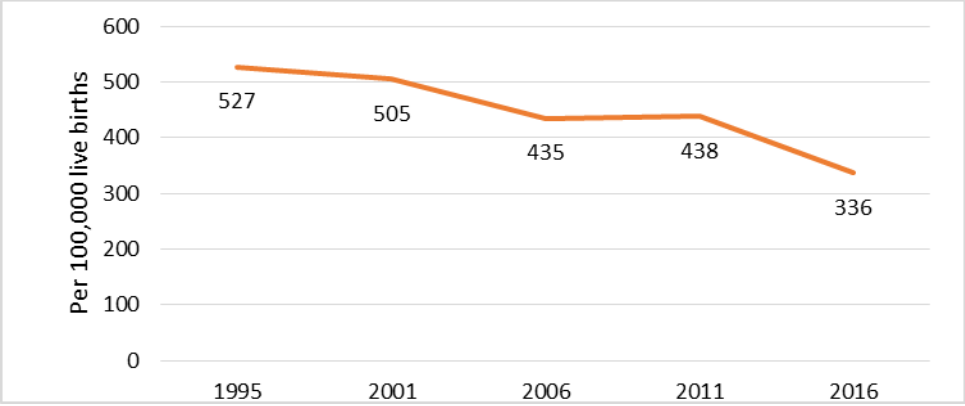
Uganda UNFPA Contribution to the Report

How the Government and organizations have disseminated and applied the technical guidance on the human rights based approach to eliminating preventable maternal mortality and morbidity in humanitarian settings (OHCHR, 2014).

In the post MDG era, ending preventable maternal mortality remains an unfinished agenda and one of the world's most critical challenge despite significant progress over the past decades. Under the Sustainable Development Goals (SDG) agenda, each country has been given a maternal and newborn mortality reduction goal to contribute to the global target of reducing maternal mortality to 70/100.000 live births. Uganda has made progress towards reduction of maternal and perinatal mortality. The 2016 Uganda Demographic Health Survey (UDHS 2016) indicated a decline of Maternal Mortality Ratio (MMR) from 438 (UDHS 2011) to 336 per 100,000 live births, Infant Mortality Rate (IMR) to 43 deaths per 1,000 live births from 54 deaths per 1000 live births. However, Neonatal Mortality Rate (NMR) has stagnated at 27 deaths per 1,000 live births falling short of the HSDP (2015/19) target of 16 deaths per 1,000 live births.

Under the leadership of Minister of Health, Uganda has developed the National Refuge Policy and the Integrated Health Response plan for Refugees for the next 5 years and SRHR is one the key components in the document. The plan is also aligned to the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Investment Case which focuses on increasing access for high-burden populations including refugees. It is based on strategic shifts to deliver high impact intervention packages at all levels of the health system and the Health sector Development Plan target of reduction of maternal mortality to 219/100,000 by 2020.

Trends in Maternal Mortality Ratio 1995 to 2016



Source: UDHS 1995, 2001, 2006, 2011, 2016

Maternal and perinatal deaths remain high and a major concern and focus for Ministry of Health (MoH). In an effort to contribute to the improvement of the quality of care to mothers and their newborns and to achieve SDGs, the MoH through the National Maternal and Perinatal Death Surveillance and Response (MPDSR) committee recommends having all maternal deaths notifiable, as well as have reviews of all the maternal and perinatal deaths in the country including in Humanitarian settings. All maternal deaths should be Integrated Disease Surveillance and Response (IDSR) system. Notification is done using the weekly reporting through the Integrated

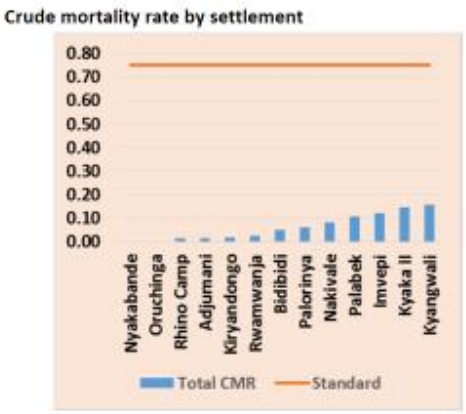
Disease Surveillance and Response (IDSR) platform so as to be able to provide real time data for response/action this is for all facilities in the country including Humanitarian settings. The IDSR platform is linked to the DHIS2 a web data- base that is used to capture and store national Health Management Information (HMIS).

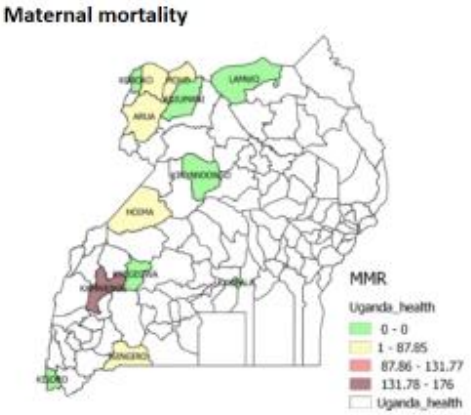
Maternal deaths have been reported in the health facilities in Humanitarian settlements, 1 in Kiryandongo from Host community, 2 in Yumbe both were refugees, 1 in Adjumani and for all, audits have been done. Independent inquiries by Ministry of Health, UNFPA and UNHCR have been done in Kiryandongo, Lamwo, Adjumani, Yumbe districts to understand circumstances and come up with actionable solutions and responses. These however do not seem to be reported in the weekly IDSR system an area that needs to be improved on.

Maternal Mortality and Morbidity

The crude mortality rate in October 2017 was 0.1, standard (0.75), neonatal death at 4.5(standard <20), No maternal death registered in during the reporting period (Standard is 00 deaths). These include both health facility and community deaths. Rwamwanja settlement had the highest proportion of maternal mortality (46%), Kyangwali (15.4%), Imvepi (15.4%), Palorinya (7.7%), Bidibidi (7.7%), and Nakivale (7.7%). The main causes OF Maternal deaths and morbidities include hemorrhage (PPH and APH) and severe anemia.

Crude and Maternal mortality in the settlements





Top 10 of Districts with Highest MMR (Maternal Deaths per 100,000 Live births)									
#.	DISTRICT	No. Deliveries	No. of Live Births	Fresh Still Births	Maternal Deaths	Maternal Death Audited	MMR (Maternal Deaths per 100,000 Live births)	Fresh Still Births per 1,000 Deliveries	Maternal Deaths Audited (%)
1	GULU	13779	13513	104	62	20	458.8	7.5	32.3
2	MASAKA	13680	13147	185	57		433.6	13.5	0.0

3	BUVUMA	833	814	11	3		368.6	13.2	0.0
4	KABAROLE	19602	20327	238	65	18	319.8	12.1	27.7
5	BUTAMBALA	4796	4480	59	14	2	312.5	12.3	14.3
6	HOIMA	19235	18151	353	54		297.5	18.4	0.0
7	BUSIA	12068	10324	155	27	4	261.5	12.8	14.8
8	IBANDA	6626	6467	77	15		231.9	11.6	0.0
9	MUBENDE	15573	15090	312	34	20	225.3	20.0	58.8
10	MOROTO	2368	2310	20	5		216.5	8.4	0.0

From the MPDSR report for the 10 districts with highest maternal mortality (297/100,000)

In addition, MOH has strengthened capacity and re-constitution of maternal perinatal death review committees in all districts, UNFPA has completed training of maternal perinatal death review committees in the 25 supported districts of *Kotido, Kaabong, Nakapiririt, Napak, Amudat, Moroto, Abim, Amuria, Katakwi, Kaberamaido, Bukedea, Ngora, Bududa, Bulamburi, Kibuku, Kiryandongo, Adjumani, Yumbe, Kitgum, Amuru, Apac, Bundibugyo, Kanungu, Moroto, Lamwo and Moyo* districts. In all these districts and at all health facilities (HC III to General Hospitals) there are established MPDSR committees. The committees are tasked to develop MPDSR action plans and conduct maternal/ perinatal death reviews on the outstanding cases. Subsequent to this process, the number of facilities notifying and reviewing maternal and perinatal deaths has increased and reviews are increasingly being used as a quality of care improvement tool.

The MPDSR 2016/2017 report indicates that there is still poor reporting in majority of the health facilities in Uganda. There is also lack of harmony between the audited maternal deaths; weekly reports HMIS 033b, and the monthly report HMIS 105. A considerable number of districts had no report on maternal deaths not even in the DHIS2 Visa –Vis Maternal deaths being reported the facilities. For instance, 2 maternal deaths were reported in Yumbe districts in the November and December 2017 but they are not captured in the weekly surveillance reports and DHIS2. UNFPA has supported MOH to collect, analyze, compile and disseminate the MPDSR report.

UNFPA supported the dissemination of the technical guidance on application of HRBA to preventable maternal mortality to MOH and other stake holders including in Humanitarian settings. GBV prevention and response has been addressed through provision of minimum standards like post rape kits, psychosocial support, case management and provision of women spaces. Provision of ASRHR information, youth friendly services and livelihood support. Training in MISP, CMR , mentoring and training of services in quality EmONC along the continuum of care (Pregnant mothers mapping and referral , ANC, Recruitment of midwives , provision of ambulance services , dignity kits , RH kits, delivery beds , tents). Provision of family planning method mix services in the settlements. Support supervisions and follow ups of maternal health services collaboration with MOH and UNHCR. UNFPA provided technical in puts in the Refugee Policy and Response plan to incorporate HRBA. UNFPA also supported the Quality of Care EmONC assessment in the 25 target districts including Humanitarian settings. This has highlighted gaps in provision of services and improvement plans have been developed which are expected to enhance service provision.