1. Introduction

The Republic of Uganda is situated in East African and covers an area of 241,039 square kilometres. Uganda has an estimated population of 32 million persons, and increasing rapidly at an estimated growth rate of 3.3% per annum. It is estimated that 56% of the population is below the age of 18 years, and about a fifth (18.5%) are below five years old. The resulting population structure creates a broad base of dependency on a smaller fraction of the working population.

Health context

The Uganda national health system comprises of the public sector – which includes all Government facilities under MOH, health services of the Ministries of Defence, Internal Affairs, and Ministry of Local Government. The private sector includes private health providers (PHP), Private Not for Profit (PNFP) providers, and the Traditional and Complementary Medicine Practitioners (TCMPs). The MoH provides leadership over the health sector, setting the policy orientation, and provision for all health services. Private sector health efforts are coordinated through the Public Private Partnerships for Health (PPPH) technical working group at the MOH. The GoU subsidizes PNFPs to boost their complementary role in enhancing access to health care particularly in far to reach districts.

Uganda runs a decentralized health system. The 1995 constitution and the 1997 Local Government act mandates the District Local Government to plan, budget and implement health policies and health sector plans.

The service delivery levels in Uganda comprise of tertiary level of care – which are the national and regional referral, health centre IV (county-level general hospitals); and health centres III and II and I. Health centre IV provides basic promotive, preventive and curative services, including emergency surgical and obstetric care, as well as providing supervision and support for planning and implementation of health care in lower health centre levels within its zone. Health Centre IIIIs provide basic preventive, promotive, and curative care, including basic obstetric

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1 Source: UNPFA Annual Report 2009/2010
2 HSSP III 2010/11 – 2014/15
care, and supportive supervision for the HCIIs. The first level of care is community based, and run mainly through the Village Health Teams (VHTs).

**RMNCH Indicators (Country Profile)**
There has been a steady improvement in maternal, newborn and child health indicators in the last 10 years. Of note is the significant reduction in under-five and infant mortality rates (UDHS 2011\(^3\)). A number of country level programmatic successes are likely to be contributing to improved child survival in Uganda. Key among is the successes in the IMCI programme coverage, which has registered a significant increase the use of IMCI guidelines to 63% in 2008/09 from 45% in 2004/05. The ministry of health also carries out Child Days Plus, which have contributed to the increase in immunization coverage. Another example is the integration of infant and young child feeding (IYCF) into different programmes such as PMTCT, reproductive health and the expanded program on immunization (EPI). Another is the countrywide social mobilization campaigns that have helped increase demand for immunization services especially during Supplemental Immunization Activities (SIA).

With regard to maternal mortality, data from recent UN estimates point to a significant reduction in maternal mortality rate, though this will need to be compared with findings from UDHS 2011(still under analysis).

\(^3\) Ref: UDHS 2011
Significant gains have also been recorded along the care continuum, notably the increase in proportion of births by a skilled attendant, and the contraceptive prevalence rate. The change in other indicators along the care continuum is however minimal. The stalling of neonatal mortality rates raises questions on the capacity of skilled providers to provide newborn care.
It is also important to note the marked disparities in coverage of interventions across geographical settings, between rural and urban populations, and within wealth and education quintiles. Several challenges have been cited as possible reasons for slow progress and these include human resource shortage, and inadequate infrastructure including transport and communication equipment for referral, and gaps in supply chain.

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4 UDHA 2006
management gaps. These challenges are especially prominent in hard to reach areas, as is reflected by the significant disparities in the poorest and the wealthiest quintiles, especially for skilled attendance at birth, and for unmet need for family planning.

**Health Policy Context**

The National Development Plan (NDP, 2010/11–2014/15) provides the overall development framework for the GOU. The overall goal of the NDP is to accelerate economic growth to reduce poverty through the achievement of seven development objectives, one of which is to increase the availability of and access to quality social services including health service delivery. The NDP places priority on health systems strengthening implementation of programs of national interest, namely reproductive health and child survival, HIV/AIDS, tuberculosis, malaria, and nutrition. The National Health Policy 2010–2020 aligns with these priorities and provides the policy framework for operational instruments such as the Health Sector Strategic Plan (HSSP 2010/2011 – 2014/2015), and the health sector strategic investment plan (HSSIP 2010/11 – 2014/15).

Specific to Maternal Newborn and Child Health is the Road Map to accelerate Reduction of Maternal and Neonatal Morbidity and Mortality formulated in 2007, and the National Child Survival Strategy developed 2009. Other policies include the New Born Health Strategy, revised version of the 1995 National Population Policy, the adolescent Sexual and Reproductive Health Policy, the reproductive Health Commodities Security Strategic Plan 2009 – 2014, the HIV/AIDS Strategic Plan, the National Malaria Control Strategic Plan, the Nutrition Policy, the Gender Policy, and others.

Uganda implements many of the global MNCH standards and programmatic areas currently being tracked by countdown 2015. These include compliance with the International Code of Marketing of Breastmilk Substitutes. Uganda ministry of health policy approves the use of new ORS formula and zinc for management of diarrhea and community treatment of pneumonia with antibiotics. In addition to this, national IMCI guidelines have been adapted to cover newborns zero to one week of age, costed implementation plan(s) for maternal, newborn and child health are available, and midwives are authorized to administer a core set of life saving interventions. And specific to maternal health, a presidential directive obligates notification of all maternal deaths. Of note though is the fact that Uganda doesn’t grant maternity protection in accordance with ILO Convention 183 (Reference?).

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5 Countdown 2015, accountability 2011
6 Ref
The policies developed to support RMNCH have led to improved budget allocations to the sub-sector. The Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, 2007 – 2015 is also costed and has been used to channel resources and harness action towards antenatal and obstetric services, and access to Family Planning commodities. However despite this supportive policy environment, policy implementation has remained constrained by resource and other structural challenges including limited human resources, equipment and supplies; delays in release of funds from MoH to National Medical Stores (NMS) affecting the delivery of supplies; limited funding and capacity at district level which affects distribution of commodities to the district and lower levels and inadequacies in transport, (GoU MoH 2008; 2010c).

**Uganda Government Commitments to the UN Global Strategy on Women and Children’s Health**

In September 2011, Uganda committed to:

1. Ensure that comprehensive Emergency Obstetric and Newborn Care (EmONC) services in hospitals increase from 70% to 100% and in health centers from 17% to 50%;
2. Ensure that basic EmONC services are available in all health centers;
3. Ensure that skilled providers are available in hard to reach/hard to serve areas;
4. Reduce the unmet need for family planning from 40% to 20%;
5. Increase focused Antenatal Care from 42% to 75%, with special emphasis on PMTCT and treatment of HIV;
6. Ensure that at least 80% of under 5 children with diarrhea, pneumonia or malaria have access to treatment; to access to oral rehydration salts and Zinc within 24 hours,
7. Improve immunization coverage to 85%; and
8. Introduce pneumococcal and human papilloma virus (HPV) vaccines.

Uganda’s commitments cover the whole continuum of care, with a special emphasis on the Human Resources for Health component of the health system. A notable omission is commitment on nutrition interventions.

These commitments align with the MDG targets for goals 4 and 5, and with the array of policy plans outlined above. The commitments are also well aligned with priorities of many development partners and provide a good reference point for many actors in the area of RMNCH even if they were only made in late 2011, at a point where many of these actors were already well into their RMNCH programme. One positive output

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7 Source: interviews
from these commitments is the fact that it has rallied all actors in the RMNCH subsector behind common goals and targets, and also placed them on a shared platform for planning, implementation, reporting and results measuring.

2. The key concerns

**Burden of disease**
Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda\(^8\). Febrile illness is reported as a leading cause of children less than five years. The national health sector strategic plan has accordingly prioritized Maternal and Child Health as one of the four clusters in the Uganda National Minimum Health Care package.

Some of the causes include; malnutrition, lack of drugs, inadequate human resources, poor infrastructure and challenges of WASH among rural communities.

**Health financing**
The country is heavily dependent on donor funding with at least 40% of the national budget coming from external sources. According to the HSSP III, households constitute a major source of the National Health Care expenditure at 49.7% followed by donors at 34.9%, the central government at 14.9% and international NGOs at 0.4% (HSSP III). Even where no user fees are charged at the lower health centers, households still have to pay for purchase of medicines prescribed and not available at the health center, or ‘under the table’ fees in instances where health care personnel require a facilitation fee to provide the needed services. HSSP III estimates per capita cost of health care delivery to be US$ 41.2 (2008/09), which was not matched by the MTEF budget the same year estimated to be only US$12.5 per capita. With regard to RMNCH, key informants mentioned that it was not easy to accurately provide the percentage of the health sector budget that goes directly into RMNCH, as most of the interventions interlinked with other health subsectors.

Low public financing has occasioned the high levels of external funding for the health sector. This is also reflected in the subsector budgets, a study by DSW and RHU (2010)\(^9\) noted that the GoU only financed 5% of contraceptive needs while 85% was financed by USAID. This presents

\(^8\) HSSP III
\(^9\) DSW RHU, 2010.
concerns of sustaining RMNCH interventions beyond donor intervention, and draws attention to the need for the GoU to match the commitments made on RMNCH with adequate budget appropriation to the sector.
3. The priority areas of intervention for the small grant;

Basing on the above the coalition will focus on the following priorities;

**Health financing,**
- Inadequate financing to the health sector, below 15% of the national budget
- Out of pocket payments e.g. for transport to health facility are a significant deterrent to a segment of the population.
- No national health insurance scheme therefore risk for catastrophic payments.

**Supply Chain Management challenges**
- The need to review mechanisms for drug supply like the Push system for lower health centre level.

**EmONC- Access to services, coverage and functionality of health facilities for EmONC**
- Limited access to emergency obstetric care (EmOC) remains a major deterrent to improved maternal and newborn health outcomes in Uganda.
- The proportion of facilities providing appropriate EmOC is low, with national met need for EmOC being only 40%, and only 11.7% of women deliver in fully functional comprehensive EmOC facilities.
- Gaps are related to infrastructure (roads, transport, communication, water electricity), supplies (EmONC commodities, including blood supplies), HR capacity (numbers, and EmONC skills, and attitudes (motivation), financing.
- Petition 16 of 2011, which seeks Constitutional Court legal redress through a declaration that ‘non-provision of essential maternal health commodities and services in government health facilities leading to the death of expectant mothers is an infringement on their rights to life and health’. The petition recognizes the increasing maternal deaths as a ‘crisis’ and advocates for higher budgets for the health sector, particularly for hire of more health personnel.

4 The goal and objectives

The overall goal is to reduce the deaths of mothers and children from preventable causes by 2015.

Objectives

I. To mobilize and build awareness of all RMNCH stake-holders to take action on Governments commitments under the UN global strategy for improving MNCH by 2015.

II. To improve staffing levels of qualified health staff to over 60% of staffing norm by 2015.

III. To increase budget allocation to the health sector from 8% to 15% of the national budget by 2015

IV. To increase comprehensive Emergency Obstetric and Newborn Care (EmONC) services in hospitals increase from 70% to 100% and in health centers from 17% to 50%;

The key strategies to be adopted.

10 Source: Press statement courtesy of CEHURD.
The coalition will adopt the following strategies to achieve the above objectives;

a) Mobilization and awareness creation – The major activities will include meetings, workshops, media and dialogues where stake-holders will be facilitated to interact together. Media will also be used to enhance information flow. Emphasis will be put on building awareness among CBOs and community based structures.

b) Action research and cases studies for evidence collection – The coalition will invest in collecting case studies, testimonies and action researched to build knowledge and evidence for influencing. Issue papers and the emerging research reports will be published and widely shared.

c) Strengthening collaboration and networking—The coalition will hold regular coordination meetings to share information, learn form each and also lay strategies for engagement. Specifically, local level coalition meetings will be supported to strengthen linkages between district 1 level dialogues and national level advocacy initiatives.

d) Policy influencing – The coalition will undertaking lobbying for changes in policies and practices at the district and national levels in-line with the agreed priority areas. Support will be given to district level dialogues by local coalitions on health and the issues will be linked to national level policy lobbying processes. Again, media will be key in influencing policy related decisions at the district and national levels.

e) Monitoring , learning and impact assessment – Using a participatory approach, the coalition will agree of the key indicators to track progress on the above set objectives, including sources of data and means of verification. On quarterly basis, the secretariat will share progress on the indicators during the regular coordination and reflection meetings for information, learning and action. The coalition will also play an actively role in the FY13 country count down processes in collaboration with the Ministry of Health.

5 Organization and coordination

The coalition will select a steering committee that will provide oversight and direction to the coalition. A secretariat will be established to provide operational support to the coalition. World Vision Uganda and ACHEST will continue to be the contact agencies for strengthening coalition of RMNCH in Uganda and providing linkages to the region and international levels.