



THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

The National Annual MNCH and MPDSR Report, FY 2024/2025

*Integrating Health Systems for Accountability and Impact: Advancing
Maternal and Newborn Survival Across the MNCH Continuum.*



OCTOBER 2025



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“Through evidence, accountability, and collective action, Uganda moves closer to a future where no woman or newborn dies from preventable causes.”

FOREWORD

Maternal and child health remain the cornerstone of national wellbeing. Uganda has made steady progress in improving maternal, newborn, and child health. Over the past five years (FY2020/21–FY2024/25), the institutional maternal mortality rate declined by 25%, while perinatal mortality reduced by 24%, reflecting a stronger health system and the impact of evidence-driven interventions.

This year’s National Annual MNCH and MPDSR Report marks a strategic shift integrating key MNCH indicators with MPDSR data to provide a more comprehensive view of performance, linking surveillance and response mechanisms with outcomes in service delivery and child survival.

Across the continuum of care, 40% of mothers began ANC in the first trimester, 56% attended more than four times, and 71% delivered in health facilities. Preventable deaths are still of great concern, with haemorrhage, hypertensive disorders, and sepsis leading maternal causes, while asphyxia, prematurity, and septicaemia among perinatal deaths highlighting ongoing challenges with the three delays.

In FY2024/25, the Ministry of Health strengthened leadership and accountability through continued MPDSR implementation, operationalization of the LMNS, and weekly Communities of Practice that enhanced real-time learning and regional action. LMNS platforms used MPDSR findings to inform district and regional plans and quarterly reviews.

Uganda remains committed to ending preventable maternal and newborn deaths in line with the SDGs and the RMNCAH Sharpened Plan II. Sustained investment in system readiness, consistent application of MPDSR recommendations, and strong multi-sector collaboration are key to achieving this goal.

I urge all stakeholders to use this report to guide action toward a future where no woman, newborn or child dies from preventable causes.

Dr. Charles Olaro
Director General Health Services



“The remarkable progress in maternal and newborn health reflects the power of partnership, dedication, and shared responsibility across all levels of care.”

ACKNOWLEDGEMENT

The Ministry of Health extends its sincere appreciation to all districts, health facilities, and partners whose dedication and collaboration made it possible to compile this National MNCH and MPDSR Performance Report. Their tireless efforts in implementing MCH interventions, conducting death reviews, and submitting timely data have been instrumental in strengthening evidence-based planning, accountability, and continuous improvement of maternal and child health services across the country.

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The Ministry of Health extends its sincere gratitude to all development and implementing partners for their continued collaboration and support in compiling this Annual Report. In particular, appreciation is extended to UNFPA, UNICEF, WHO, CHAI, the World Bank through UCREPP, the USG through UHA, BAMA, and Seed Global Health. The Ministry further acknowledges AOGU, UPA, NASMEC, and LMNS for their sustained leadership, advocacy, and technical guidance. The Ministry also appreciates the broader network of partners and professionals for their continued commitment and support.

These collective efforts reaffirm Uganda’s commitment to accountability, learning, and equity in advancing maternal, newborn, and child health.

Dr. Richard Mugahi
Commissioner Health Services, Reproductive and Child Health



ABBREVIATIONS

APH	Antepartum Haemorrhage
BPP	Birth Preparedness Plan
DHIS	District Health Information System
DHO	District Health Officer
EmONC	Emergency Obstetric and Neonatal Care
ENND	Early Neonatal Death
EWEC	Every Woman Every Child
FSB	Fresh Stillbirth
GH	General Hospital
HC	Health Centre
HMIS	Health Management Information System
IDSR	Integrated Disease Surveillance and Response
IMMR	Institutional Maternal Mortality Ratio
IPMR	Institutional Perinatal Mortality Rate
IPT	Intermittent Preventive Treatment
IRR	Identification, Retention and Response
KOICA	Korea International Cooperation Agency
LMNS	Local Maternity and Neonatal Systems
MMR	Maternal Mortality Ratio
MOH-SP	Ministry of Health Strategic Plan
MPDR	Maternal and Perinatal Death Reviews
MPDSR	Maternal and Perinatal Death Surveillance and Response
MSB	Macerated Stillbirth
NASMEC	National Safe Motherhood Experts Committee
NCU	Newborn Care Unit



NDP III	Third National Development Plan
NRH	National Referral Hospital
OPD	Outpatient Department
PPH	Postpartum Haemorrhage
QI	Quality Improvement
RM-NCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RRH	Regional Referral Hospital
SDG	Sustainable Development Goal
SIDA	Swedish International Development Cooperation Agency
SITES	Strategic Information Technical Support
SVD	Spontaneous Vaginal Delivery
TBA	Traditional Birth Attendants
UDHS	Uganda Demographic Health Survey
UHA	Uganda Health Activity
UKAID	Department for International Development
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization



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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

The health of women, newborns, children, and adolescents is a cornerstone of national development and human capital growth. Globally, the c Every Woman Every Child (EWEC) Strategy 2016–2030 and the Sustainable Development Goals (SDGs) call for ending preventable maternal, newborn, and child deaths, with targets of reducing the global Maternal Mortality Ratio (MMR) to less than 70 per 100,000 live births and neonatal mortality to less than 12 per 1,000 live births by 2030. Complementary initiatives such as the Every Newborn Action Plan (ENAP) and other international commitments emphasize the importance of quality care and strong accountability systems in achieving these milestones.



“Uganda is shifting from counting deaths to using data, accountability and action to strengthen maternal, newborn and child health across the continuum of care, marking a new phase of health system transformation anchored in evidence, learning and continuous improvement.”

In sub-Saharan Africa, regional frameworks such as the African Union's Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and CARMMA Plus, the Maputo Plan of Action (2016–2030), and the WHO-AFRO Regional Implementation Framework for the EWEC Strategy have advanced collective efforts to end preventable maternal and newborn deaths. Building on these, the UNFPA-led Start with HER Initiative, implemented through the H4+ HER Partnership with WHO, UNICEF, UN Women, UNAIDS, and the World Bank, supports countries to translate continental commitments into action by strengthening quality of care, data systems, and accountability for women's, newborn, and adolescent health. Together, these initiatives aim to accelerate progress toward the EWEC targets and advance universal RMNCAH coverage through strong leadership, sustainable financing, and regional accountability mechanisms.

Uganda has aligned its priorities with global and regional commitments through the Third National Development Plan (NDPIII) and its Human Capital Development Programme (HCDP), which is implemented through the Programme Implementation Action Plan (PIAP

2020/21–2024/25). This framework identifies health, education, and skills development as critical enablers of national transformation. Within this context, the RMNCAH Sharpened Plan and Investment Case II (2022/23–2026/27) guides implementation of targeted interventions to accelerate reductions in maternal and newborn deaths. The country set national targets for ANC 4 coverage (56%), Health facility deliveries (74%), couple years of protection-CYP (7 million), reduce maternal mortality ratio to 211 per 100,000 live births and the neonatal mortality rate to 19 per 1,000 live births by FY2024/25. The Uganda Demographic and Health Surveys (UDHS) showed that steady progress has been made in improving maternal and newborn outcomes. Maternal mortality declined from 336 deaths per 100,000 live births in 2016 (UDHS 2016) to 189 per 100,000 in 2022 (UDHS 2022), surpassing the NDPIII target. Similarly, neonatal mortality decreased from 27 to 22 deaths per 1,000 live births, moving Uganda closer to achieving its national and global targets. This report summarises progress in MNCH during the year and its contribution to reductions in maternal and newborn mortality.





1.2 RATIONALE FOR THE STRATEGIC EXPANSION OF THIS REPORT TO INTEGRATE KEY MATERNAL, NEWBORN, AND CHILD HEALTH (MNCH) INDICATORS

Since the institutionalization of the maternal and perinatal death surveillance and response system in 2013, Uganda has consistently produced annual MPDSR reports to strengthen accountability and improve the quality of care for women and newborns. Over the years, these reports have provided valuable insights into the causes of death and health system bottlenecks but have not fully captured the broader determinants of maternal, newborn, and child health outcomes.

adopts a broader performance monitoring approach that integrates key MNCH indicators with mortality data. This shift provides a comprehensive understanding of the continuum of care by linking surveillance and response mechanisms with trends in service coverage, quality of care, commodity availability, and child survival. The report therefore presents a holistic picture of the maternal, newborn, and child health status in Uganda.

To bridge this gap, the FY2024/25 report



1.3 THEME, GOAL AND OBJECTIVES

1.3.1 Theme

Integrating Health Systems for Accountability and Impact: Advancing Maternal and Newborn Survival Across the MNCH Continuum.

1.3.2 General Objective

To document the Health Sector's Response to Preventable Maternal, Perinatal, Newborn and Child Deaths and Lessons Learned.

1.3.3 Specific Objectives

- i. To analyse performance across key MNCH program areas along the continuum of care.
- ii. To describe the magnitude and trends of institutional maternal, perinatal, newborn, and child mortality.
- iii. To account for health system responses, corrective actions, and investments aimed at reducing preventable deaths.



1.4 METHODOLOGY

1.4.1 Data Sources

The data presented in this report were primarily collected from the Health Management Information System (HMIS) and the District Health Information System 2 (DHIS2). These platforms provided comprehensive aggregate data on health service utilisation and mortality. Specifically, the key sources included the monthly outpatient report (HMIS 105), monthly inpatient report (HMIS 108), and the maternal and perinatal death notification and review forms (HMIS MCH 004, HMIS MCH 020, HMIS MCH 019, and HMIS MCH 017).

In addition to these primary sources, the report drew on several complementary data sets. Implementing Partners' quarterly reports, Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Technical Working Group (TWG) meeting minutes, and quarterly Reproductive and Child Health (RCH) departmental reports provided further programmatic insights. The Ministry of Health (MoH) action tracker, developed from weekly Community of Practice meetings, and death reviews conducted by health facilities, was utilised to monitor ongoing actions and track progress.

Further qualitative and contextual information was obtained from reports of district and facility-level MPDSR committees. These reports documented individual case reviews,



“Every number in this report represents a collective effort from health care providers to data entry clerks to district analysts working to turn information into impact.”



Data Sources: HMIS 105, HMIS 108, HMIS MCH 004, HMIS MCH 017, HMIS MCH 019, HMIS MCH 020, DHIS2 platform, and supplementary Partner and LMNS reports.



Data extracted from the cleaned DHIS2 database as of
31 August 2025.

identified modifiable factors contributing to deaths, and outlined corrective actions taken at local levels. Additionally, to capture innovative practices and lessons learned, a call for documented success stories was issued to regional Local Maternity and Newborn Systems (LMNS) platforms and implementing partners. This enabled the collection of initiatives that have contributed to improved maternal, newborn, and child health (MNCH) outcomes.

1.4.2 Data Validation and Analytical Approach

Data validation was rigorously conducted by addressing data quality issues for key performance indicators. This process involved collaboration with district and Regional Referral Hospital (RRH) biostatisticians, as well as the Assistant District Health Officer (ADHO) for Maternal and Child Health (MCH), who were responsible for updating and cleaning the datasets. To ensure contextual accuracy and deepen the analysis, several key informant interviews were held with selected ADHOs, Local Maternity and Newborn Systems (LMNS) coordinators, and biostatisticians.

1.4.3 Analytical Methods

The analytical approach incorporated trend analysis of both national and subnational performance across time, alongside regional disaggregation to highlight geographical variations. Where feasible, the findings were triangulated across various data sources to enhance accuracy and consistency. All data utilised for analysis were extracted from the cleaned DHIS2 database as of 31st August 2025.

1.4.4 Limitations

Despite these efforts, certain limitations were encountered in the use of DHIS2 datasets. Specifically, incompleteness in selected sections of the HMIS 108 (maternal and child health indicators) and HMIS 105 (outpatient service statistics) constrained the scope of analysis. Additionally, variations in the quality of reports from MPDSR committees restricted the depth of case-specific analysis. These limitations were carefully considered during the interpretation of results, and caution is advised when comparing performance across districts, particularly where notable reporting gaps exist.



CHAPTER TWO

KEY INTERVENTIONS AND INNOVATIONS FY2024/2025



Continued scale-up of high-risk pregnancy clinics in 138 districts.



Roll-out of MPDSR Action Trackers and digital dashboards.



Strengthened data quality through monthly cleaning and quarterly DQAs.



Launch of the Teenage Pregnancy Surveillance and Response (TPSR) initiative



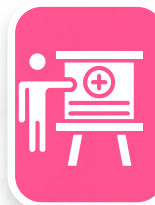
Corporate sector mobilization through the Corporate Society to support country-level responses.



Cross-country learning with Kenya, Ethiopia, and Zambia.



Expansion of LMNS with rotational chairpersons and newborn coordinators.



Improving skills through onsite mentorship and training of healthcare workers.



Nationwide awareness campaigns on PPH, PET, safe birth and Birth Asphyxia.

INTRODUCTION

This chapter presents the health sector's response to preventable maternal, perinatal, newborn, and child deaths during FY2024/25, highlighting lessons learned and progress made in strengthening service delivery and accountability. Efforts by the Ministry of Health and partners focused on improving the continuum of care through implementation of targeted Maternal, Newborn, and Child Health interventions and strengthening of the Maternal and Perinatal Death Surveillance and Response system. Guided by the RMNCAH Sharpened Plan II and NDP III priorities, the interventions were anchored in the WHO health system building blocks, emphasizing leadership, service delivery, human resources, health information, financing, and commodity security.

MPDSR processes were institutionalized across all regions through functional committees and active engagement of the Local Maternity and Newborn Systems platforms. Collaboration with national agencies, development partners, and professional associations enhanced accountability, data use, and follow-up of recommendations.

Targeted actions addressed major causes of maternal, newborn, and child mortality, including postpartum haemorrhage, hypertensive disorders, sepsis, birth asphyxia, pneumonia, diarrhoea, and malaria. These were mitigated through mentorship, improved commodity availability, and national awareness campaigns. Integration of surveillance data with service performance supported timely decision-making and corrective actions at national and subnational levels.

Overall, Uganda registered progress in reducing preventable deaths, strengthening

health system response, and expanding innovations such as high-risk pregnancy clinics and digital MPDSR tracking tools. These efforts demonstrate the country's commitment to learning, adaptation, and continuous improvement in advancing MNCH outcomes.



Mulago Specialised Women and Neonatal Hospital delivered its second baby conceived through In Vitro Fertilization (IVF), a healthy baby girl weighing 3.6kg.



2.1 ACCOMPLISHMENTS BY HEALTH SYSTEM BUILDING BLOCKS AT NATIONAL AND SUBNATIONAL LEVELS

Table 1: Select MNCH accomplishments by Health System Building Blocks at National and Regional levels

WHO BUILDING BLOCKS	ACCOMPLISHMENTS
Leadership & Governance	- High-level support supervision led by the Director General and Permanent Secretary reinforced stewardship and accountability for improved MNCH outcomes. These visits ensured that systems remain functional and all stakeholders at subnational level are aligned and actively contributing to the national goal of improving survival of mothers and newborns. - National RMNCAH TWG and its sub-committees (Maternal Health, Family planning, Infant and Child Health, Newborn Health, Adolescent Health) have met consistently over the last year and provided policy guidance in the thematic areas. The National implementation guideline on District Committees for Adolescent health, National Newborn and Child survival strategy were launched. - The Ministry of Health, through the Reproductive and Child Health Department, provided strategic direction and oversight for MPDSR implementation. National coordination was reinforced through the weekly MPDSR Community of Practice, which attracts over 1,000 regular participants, facilitating peer learning and cross-regional accountability. - Regional weekly Community of Practice learning sessions, characterized by rotational chairpersonship, promoted shared ownership while strengthening participants' capacity for systematic data analysis, response planning, and follow-up of recommendations. - Local Maternity and Newborn Systems (LMNS) remained the key accountability platform for MPDSR, with 15 regions holding weekly reviews to track progress and plan actions. Sixteen paediatricians were appointed as regional coordinators to strengthen newborn care networks. - The Teenage Pregnancy Surveillance and Response (TPSR) initiative was activated as a national multi-sectoral platform bringing together stakeholders from the Ministries of Health, Gender, and Education for weekly coordination and action tracking. District Adolescent Health Committees are leveraging this platform to strengthen local collaboration and drive timely, data-driven responses to teenage pregnancy. - NASMEC subcommittees on PPH, PET, and Safe Birth led national awareness campaigns and provided expert guidance. Building on this, Uganda through the Newborn working group held its first "My Baby's First Cry" campaign in June 2025 to end birth asphyxia, introducing a "Birth Asphyxia Bundle" to strengthen labour room readiness and newborn care.

WHO BUILDING BLOCKS	ACCOMPLISHMENTS
	• The National MPDSR Committee continued to provide policy guidance to align national responses with RMNCAH strategic targets. High-level engagements led by the Reproductive and Child Health Department facilitated direct feedback and accountability dialogues with district leadership in Butebo, Alebtong, Mbale, and other priority districts, ensuring that recommendations were effectively translated into action. • Cross-country exchanges strengthened regional leadership: lessons from Kenya informed Uganda's newborn training package, while delegations from Ethiopia, Kenya, and Zambia visited Uganda to benchmark MPDSR best practices. These engagements positioned Uganda as a regional learning hub for evidence-based maternal and newborn surveillance and response. • At least 10 health regions conducted quarterly maternal and perinatal death confidential inquiries, ensuring that lessons from reviews were translated into district-level plans. • District Health Officers integrated MPDSR priorities into district plans and performance reviews, while CAOs, RDCs, and local leaders provided oversight on key actions, strengthening ownership and accountability for maternal and newborn outcomes.
Service Delivery	• The 2023 national EmONC needs assessment identified gaps in facility functionality, guiding targeted interventions that enabled 78% of Health Centre IVs to provide comprehensive CEmONC services. Additionally, 27 Health Centre IIs were upgraded to IIIs, expanding access to quality maternal and newborn care. • Infrastructure in 11 Health Centre IIs was refurbished to enhance service readiness and improve the quality of care provided. • Emergency call centres were established in the Arua, Gulu, Kampala, and Masaka regions to support emergency response, with 57% of emergency cases in FY2024/25 involving female patients. • Nine High Dependency Units (HDUs) were constructed and equipped in refugee-hosting districts, including one at a National Referral Hospital (Kiruddu NRH), two at Regional Referral Hospitals (Yumbe and Kayunga), two at General Hospitals (Matany and Kisiizi), and four at Health Centre IVs (Midigo, Kasongo, Kyangwali, and Bujubuli). • The Ministry through its subnational structures continued to scale up implementation of high-risk pregnancy clinics, expanding from 114 districts in FY2023/24 to 138 districts in FY2024/25 to strengthen early identification and referral of women with high-risk pregnancies and pre-existing conditions.

WHO BUILDING BLOCKS	ACCOMPLISHMENTS
	- Through UCREPP, 70 operating theatres were equipped with surgical and anaesthesia equipment, including 40 Health Centre IVs with complete theatre sets. The project also enhanced newborn care by equipping 20 neonatal units and establishing a specialized Neonatal Intensive Care Centre of Excellence at Mbarara RRH, alongside new ICUs at Hoima, Arua, and Kabale RRHs. Partner support from ADARA, AVSI, Babies and Mothers Alive, Baylor, UCMB, Pathfinder, ENABEL, CHAI, Born on the edge and WHO further strengthened neonatal services through equipment provision including CPAPs, and neonatal unit upgrades. - An assessment of operational neonatal care units was conducted across CEmONC public health facilities, showing that 63% had established neonatal units, of which 57% were operational. The findings are being used to guide targeted actions in equipment provision, staffing, and mentorship, with the goal of strengthening neonatal care readiness and improving outcomes for small and sick newborns. - To support blood transfusion services, the Nakasero National Blood Bank received two (02) key equipment items which included a benchtop centrifuge and an automated blood component separator machine. In addition, 26 health facilities (including six (06) in refugee-hosting districts) were equipped with centrifuges and refrigerators to start blood transfusion services, while nine (09) facilities received equipment to enhance blood collection capacity. - Uganda Blood Transfusion Services (UBTS) increased blood collection from 268,000 units in FY2020/21 to 393,972 units in FY2024/25, a 68% rise over five years. During the same period, 342,000 units of safe blood were issued to over 600 health facilities, and capacity for processing platelets and fresh frozen plasma was expanded, primarily to support management of postpartum haemorrhage, pre-eclampsia and other pregnancy related complications. - Currently, 81 districts are fully implementing the Integrated Community Case Management (iCCM) strategy, with 67 districts supported by the Global Fund. Efforts are underway to expand coverage.
Medicines and Supplies	- Through Monitoring of RMNCAH basket commodities showed 89% stock availability at national warehouses. Despite occasional challenges, timely redistribution-maintained supply, raising facility-level availability from 67% to 72% in FY 2024/25. - Commodity security was enhanced through LMNS and quarterly reviews, using MPDSR and DHIS2 data to identify gaps and guide procurement. This enabled timely redistribution of key commodities, including oxytocin, misoprostol, iron and folate supplements, and blood products, coordinated by districts and partners. - Most districts maintained steady availability of key MNCH commodities, with Iron and Folic Acid at 81%, Oxytocin at 81%, Mama Kits at 87%, Misoprostol at 79%, and Ceftriaxone at 80%. These commodities supported the management of postpartum haemorrhage, sepsis, and hypertensive disorders. Ongoing EmONC mentorships emphasized rational use of uterotonics and blood products, linking commodity availability with improved clinical outcomes.

WHO BUILDING BLOCKS	ACCOMPLISHMENTS
	• Availability of essential newborn commodities was sustained across most facilities, including second-line antibiotics, anticonvulsants, respiratory care medicines, key supplies (Vitamin K, Chlorhexidine gel, TEO, Dextrose 10%), and blood group reagents. Child health commodities, including Amoxicillin, ORS, and Zinc, were also consistently available, ensuring continuity of care across the MNCH continuum. • A digital dashboard for monitoring blood and blood product stocks is disseminated weekly through the 16 LMNS platforms and displayed on the UBTS website, improving awareness, coordination, and timely management across facilities. • To sustain family planning services, the Uganda Reproductive Health Commodity Security (UCREPP) platform procured family planning commodities while Marie Stopes Uganda supported last-mile redistribution to districts facing stockouts. These efforts stabilized the supply of DMPA-SC, implants, and oral contraceptives, ensuring continuity of family planning and postpartum FP services.
Human Resources	• More than 1,200 health workers received training across maternal, newborn, and adolescent health services. This included 210 health workers trained on ICD-11/MCCoD to improve accuracy in cause-of-death certification for MPDSR, and 90 midwives and diploma nurses trained in neonatal resuscitation across seven training sites supported by CHAI and UNICEF. • A national clinical mentorship programme was implemented across 730 health facilities to strengthen competencies in caesarean section, anaesthesia, and newborn care. Regional Referral Hospitals have since led mentorships, supporting 626 health workers in FY2023/24 and FY2024/25. Through LMNS, additional mentorships reached 2,434 health workers across 76 districts received intrapartum and postpartum care mentorships including CQI and IPC. • Twelve monthly NASMEC webinars and weekly regional Community of Practice sessions were conducted through LMNS platforms to address knowledge and skills gaps among maternal and newborn health workers. These sessions included webinars on topics such as the Birth Asphyxia Bundle and management of prematurity, and other practical topics including use of the E-MOTIVE bundle for PPH, pre-eclampsia and eclampsia care, sepsis prevention, safe obstetric anaesthesia, management of ruptured uterus, and patient safety. • Technical support supervision visits were conducted across various LMNS levels to provide on-job coaching, continuous professional development and performance feedback aiming at improving service quality and adherence to clinical guidelines. • MPDSR findings continued to inform human resource planning and redistribution across districts. Several District Health Officers (DHOs) used MPDSR evidence to engage the Public Service Commission in recruiting additional midwives and anaesthetic officers to address workload pressures and service delivery gaps identified through reviews.

WHO BUILDING BLOCKS	ACCOMPLISHMENTS
	Regional LMNS platforms played a key role in guiding deployment decisions by linking staffing patterns with mortality trends and service utilization data. However, workforce shortages persisted in several regions following reductions in donor funding, highlighting the need for sustained domestic financing and strengthened health worker retention strategies
Health Financing	- Essential MNCH activities were sustained through joint support from the Government of Uganda, UNFPA, UNICEF, the World Bank, USG, ELMA Foundation, USAID, KOICA, and SIDA. These resources supported training, mentorship, and commodity procurement, ensuring continuity of maternal and newborn services. - Parliamentary advocacy through the RMNCAH caucus secured renewed commitments for budget protection and family planning financing. - Additional funding of USD 3.7 million was mobilized through a matching grant between the Government of Uganda, UNFPA, and GFF to expand access to reproductive health commodities. - The Corporate Society for Safe Motherhood mobilized approximately UGX 800 million from private sector partners to complement public financing, supporting the procurement of essential supplies and equipment for selected health facilities. - Performance-linked incentives under the Uganda Intergovernmental Fiscal Transfers (UgIFT) through the PHC grant enhanced accountability and increased resource allocation to facilities based on results in maternal and newborn health.
Health Information	- HMIS tools were reviewed and updated to align with new reporting requirements, and biostatisticians and health workers were trained in revised data management and indicator interpretation and expect that these changes will improve data consistency and completeness. - Regional integrated performance review meetings were conducted across 8 regions, with RMNCAH as a core component driving data-driven discussions on clinical skills, mentorship, and service quality improvement. - Quarterly MNCH analytical summaries and performance dashboards, including MPDSR updates, were routinely shared through LMNS meetings and digital platforms, fostering a strong culture of evidence-based decision-making. - A monthly DHIS2 data cleaning initiative and quarterly Data Quality Assessments (DQAs) were conducted across six (06) regions, aimed at reducing data inconsistencies and improving reporting accuracy. This needs to be scaled up across all regions. - Weekly MPDSR reports, monthly MCH dashboards, and the RMNCAH scorecard continued to be produced and disseminated as tools for accountability, planning, and action.

WHO BUILDING BLOCKS	ACCOMPLISHMENTS
	- The MPDSR Action Tracker was rolled out to the subnational level across eight regions, marking an important milestone in improving accountability within the Local Maternity and Neonatal Systems (LMNS). This digital tool made it easier to follow up on agreed actions, strengthened traceability of responses, and supported timely closure of recommendations arising from maternal and perinatal death reviews. - During the year, 30 health facilities used the online tracker to monitor action plans from 2,274 reviewed maternal and perinatal deaths, generating 2,600 recommendations with a 96% completion rate. Completion was 90% for maternal and 96% for perinatal deaths. Nine facilities, including Aber, Goli, Kaabong, Kuluva, Nebbi, Obongi, Pakwach, St. Joseph's Maracha, and Yumbe, fully implemented all recommendations in FY 2024/25.



Training on the E-MOTIVE Bundle 1



2.2 COLLABORATIVE LEARNING AND ADAPTATION

Collaborative learning remained central to translating evidence into practice across the MNCH continuum. Through LMNS platforms, NASMEC subcommittees, national review sessions, and the MPDSR Community of Practice, stakeholders shared experiences, demonstrated good practices, and exchanged technical knowledge through mentorship and expert-led discussions.

Table 2 summarizes key learnings and high-impact practices from these engagements, including mentorship and expert sessions that clarified technical standards, strengthened emergency response, enhanced data use, and fostered practical solutions across all levels of the health system.

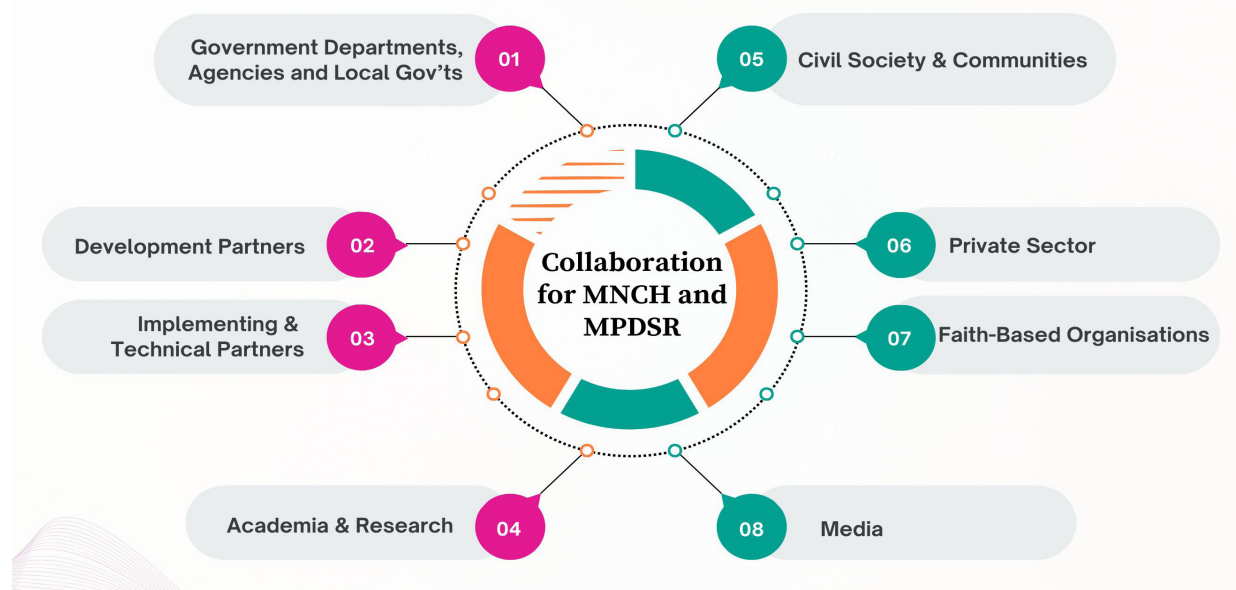
Table 2: Collaborative learning and adaptation

TOPIC/PRESENTATION	REGION	KEY LESSONS AND ACHIEVEMENTS
Infection Prevention and Control Good Practices	Yinga HC III, Terego	▪ Showed how strict adherence to IPC standards can halve maternal and neonatal infections even in resource-limited, refugee-hosting settings. Emphasized leadership, routine drills, and staff ownership as key to sustaining compliance.
Improving Newborn Survival in West Nile Region	Yumbe RRH	▪ Demonstrated that structured mentorship and linking perinatal death reviews to QI plans significantly improve newborn survival. This serves as a model for continuous learning and mentorship integration.
Overview of the Postpartum Haemorrhage (PPH) Awareness Campaign	NASMEC – PPH Subcommittee	▪ Emphasized team drills, blood preparedness, and PPH bundle adherence under the theme “Ending Maternal Death due to Excessive Bleeding after Childbirth — Our Collective Responsibility.” ▪ Strengthened joint midwife/doctor led response systems through improved readiness, post-delivery monitoring, documentation, and utero-tonic use.
Cervical Lacerations: Examination and Repair	Kawempe National Referral Hospital	▪ Highlighted timely recognition and repair of genital tract trauma using the ‘walk-the-cervix’ technique. ▪ Reinforced that coordination and early diagnosis will prevent avoidable deaths from missed tears.
Correct Use of Heat-Stable Carbetocin	NASMEC – PPH Subcommittee	▪ Showed that heat-stable carbetocin offers reliable PPH prevention without cold-chain dependence, particularly in remote facilities. ▪ There is need to provide standardized protocols on uterotonic use in the country.
Feasibility and Accessibility of Non-Pneumatic Anti-Shock Garment (NASG) Use	NASMEC – PPH Subcommittee / Makerere SPH	▪ Demonstrated NASG as a cost-effective life-saving device that stabilizes patients in shock and bridges referral delays. ▪ Facilities need to integrate NASG into emergency response kits and referral protocols.
Improving Newborn Survival through Perinatal Death Surveillance	Kawempe NRH	▪ Showed how case-based perinatal death audits linked to action tracking improved labour monitoring and neonatal outcomes.
Unlocking Better Outcomes: The PPH Management Bundle	NASMEC – PPH Subcommittee	▪ Reinforced full implementation of the PPH bundle from risk screening to escalation and documentation. ▪ Consistent teamwork and communication improve haemorrhage control and maternal outcomes.

TOPIC/PRESENTATION	REGION	KEY LESSONS AND ACHIEVEMENTS
EmONC Dashboard and Critical Gaps Identified in the National Assessment	NASMEC	- Introduced an EmONC dashboard for tracking readiness indicators and guiding mentorship priorities. - Dashboard aims to Enhance data visibility as essential for informed decision-making and resource allocation.
RMNCAH QI/QoC Learning Network: FY 2024/25 Priorities and Roadmap	MoH RMNCAH / QI Secretariat	The model highlighted how <i>structured learning collaboratives</i> promote accountability and consistency in quality-of-care delivery nationwide.
Transforming TBAs into Referral Agents Using the iDARE Approach	Malaba HC IV, Tororo	Using the iDARE behaviour-change model, TBAs supported in identifications of pregnant women early, accompany them for ANC, and encourage them to deliver in a health facility.
Use of Vasopressors in Obstetric Anaesthesia	Association of Anaesthesia Providers Uganda	- Provided guidance on safe obstetric anaesthesia emphasizing early hypotension management with vasopressors. - There is need to balance safety and timeliness of vasopressor use during emergencies.
Strengthening HB Testing to Improve MNH Outcomes	Buhweju District	- Demonstrated how routine point-of-care HB testing identifies anaemia early, enabling timely treatment and reducing transfusion needs. - Facilities learned to integrate HB screening into routine maternal assessments as a low-cost, high-impact intervention.
EPI Interventions to Improve Vaccine Utilisation	Muko HC IV (Rubanda)	Linked immunization with maternal and child health services through microplanning, cold-chain maintenance, and defaulter tracing increases vaccine coverage.
Kangaroo Mother Care and Developmental Care for Preterm Infants	St. Francis Hospital Nsambya / Newborn Working group	Reinforced that continuous skin-to-skin contact and breastfeeding in KMC improve preterm survival and neurodevelopment outcomes.
Fluid and Feeding Management in Small and Sick Newborns	Mbarara RRH / Newborn Working group	- Clarified individualized fluid and feeding therapy for preterm and low-birth-weight infants, reducing risks of dehydration and promoting growth. - Structured feeding protocols for preterm and low-birth-weight infants were recognized as key to recovery and growth.
Newborn Referral and Transport: From Birth to Care	Mbale RRH / Newborn Working group	Highlighted best practices for stabilizing and transporting newborns, including warmth maintenance, airway management, and coordinated communication between facilities.

TOPIC/PRESENTATION	REGION	KEY LESSONS AND ACHIEVEMENTS
Prevention of Peri-Partum Sepsis: A Practical Approach	Kawempe National Referral Hospital / NAS-MEC Infectious Diseases Subcommittee	- Promoted FAST-M bundle (Fluids, Antibiotics, Source control, Transfer, Monitoring) and A-MEWS chart for early sepsis recognition. - Integration of sepsis drills improved team response and antibiotic stewardship. - Prevention begins at delivery with strict IPC, clean birth practices, and early detection at postnatal wards
Addressing Common Errors in Medical Certification of Cause of Death (MCCoD)	Ministry of Health	- Mentorship on ICD-11 and MCCoD improved accuracy in death certification. - Health workers were taught to distinguish between the immediate, intermediate, and underlying causes of death and to use ICD-11 codes appropriately. - Credible MPDSR analysis begins with correct diagnosis documentation.
Strengthening Ambulance Fuel Coordination	Kamuli District (Local Government Experience)	- An innovative centralized ambulance management and coordination model was established to improve referral reliability and ensure 24/7 emergency response. - The model involves fuel pooling by lower-level facilities, coordinated authorization, and real-time accountability systems that have significantly enhanced efficiency, transparency, and timely evacuation of mothers and newborns.
Confidential Inquiry: Maternal Death Case from Namwendwa HC IV	Jinja Regional Referral Hospital	- The inquiry highlighted missed opportunities – lack of timely blood transfusion, inadequate post-operative observation, and delayed surgical re-exploration. - Key lessons included ensuring blood availability before surgery, instituting hourly postoperative monitoring, and maintaining theatre readiness for re-entry when bleeding persists.
Overview, Stakeholder Engagement and Referral Pathways for Mother and Newborn Care	Mbarara RRH / NASMEC Safe Birth Subcommittee	Demonstrated structured referral pathways using feedback forms and WhatsApp tracking to improve turnaround and shared accountability.
Respectful and Intrapartum Care: Key Approaches for Safe Birth	Madi-Opei HC IV (Lamwo District)	Showed how respectful maternity care through the Five Safes (safe environment, safe hands, safe delivery, safe anaesthesia, and safe referral) as a guiding checklist improved cooperation, safety, and dignity during childbirth.
Safe Birth Isn't Over Until Baby Breathes: The Birth Asphyxia Bundle	St. Francis Hospital Nsambya / Newborn Working group	- Presented the PREWAVED bundle (Prediction, Readiness, Warmth, Airway, Ventilation, Escalation, Documentation), which reduced neonatal deaths through preparedness and prompt resuscitation. - Structured preparedness and real-time documentation are critical for saving newborn lives

Figure 1: MoH Strategic Stakeholder Collaboration for MNCH and MPDSR



In FY 2024/25, the Ministry of Health, through the Reproductive and Child Health Department, strengthened partnerships to advance RMNCAH interventions through dialogue, accountability, and follow-up on key actions. Annual stakeholder mapping continued throughout the year, ensuring partner efforts aligned with national priorities, avoided duplication, and promoted coordinated implementation.

Collaboration within government involved key departments such as SCAPP, Nursing and Midwifery, Pharmacy, EPI, Planning, Clinical Services, and AIDS Control together with agencies including NMS, UBTS, NIRA, KCCA, the Bank of Uganda, and District Local Governments.

The Ministry worked closely with development partners including UNICEF, UNFPA, WHO, the World Bank, USG, CDC, ELMA Philanthropies, the Global Fund, UK Aid, and KOICA to strengthen health systems, improve quality of care, and support innovation in maternal, newborn, and child health.

Engagement with implementing partners such as Save the Children, JHPIEGO, URC, CHAI, EGPAF, FHI 360, AMREF, Baylor, Pathfinder, Path, Seed Global Health, PSI Uganda, Mothers2Mothers, LifeNet, Uganda Health Federation, BAMA Foundation, Marie Stopes Uganda, CARE, Plan International, ENABEL, ADARA, CUAMM, IPAS, AVSI, World Vision, Living goods and Bulamu HealthCare continued to expand access and improve service delivery.

Collaboration also extended to civil society and community-based organizations, including Samasha, White Ribbon Alliance, RHU, Naguru Teenage Centre, Born on the Edge, 3FHi, and the RMNCAH CSO platform, as well as private-sector actors such as UHF, Stanbic Bank, Rotary Uganda, MTN Uganda, and Café Javas under the Corporate Society for Safe Motherhood, with strong media engagement from NTV, NBS, and Vision Group.

Faith-based networks including UPMB, UCMB, and UMMB together with health facilities at all levels, remained central in improving the quality of maternal and newborn care.

This is **not an exhaustive list**, but it reflects the broad and dynamic collaboration that continues to strengthen leadership, coordination, and accountability in implementing RMNCAH and MPDSR priorities.

Table 3: Uganda's Commitments and Progress at a Glance

Indicator	Baseline (UDHS 2016)	Current (UDHS 2022)	NDPIII / RMNCAH Plan II FY2024/25 Target	SDG 2030 Target	Status
Maternal Mortality Ratio (per 100,000 live births)	336	189	211	<70	NDPIII target surpassed, Progressing towards SDG target
Neonatal Mortality Rate (per 1,000 live births)	27	22	19	≤12	Progressing
Infant Mortality Rate (per 1,000 live births)	43	36	34		On track
Under-Five Mortality Rate (per 1,000 live births)	64	52	30	≤25	On track
Institutional Maternal Mortality Ratio (per 100,000 deliveries)	118 (FY2020/21)	82.6 (FY2023/24)	70	<70	On track
Institutional Perinatal Mortality Rate (per 1,000 births)	18.5 (FY2020/21)	16.4 (FY2023/24)	14	≤12	On track
Health Facility Delivery (%)	73%	86%	74% (HSSP)		On track
Antenatal Care 4+ Visits	60%	68%	72%		Progressing



CHAPTER THREE



RESULTS AND KEY PERFORMANCE INDICATORS

3.1 INTRODUCTION

This chapter presents national and subnational trends in key Maternal, Newborn and Child Health (MNCH) and Maternal and Perinatal Death Surveillance and Response (MPDSR) indicators for FY 2024/25, showing Uganda's progress toward the RMNCAH Sharpened Plan II, NDPIII, and SDG targets. The analysis integrates MNCH and MPDSR data to reflect performance across the continuum of care from family planning to antenatal, maternity, postnatal, newborn, and child health services and mortality.

During the period, data completeness and timeliness improved across reporting platforms, supported by stronger coordination, active LMNS platforms, and weekly MPDSR Communities of Practice that enhanced real-time learning and follow-up of

recommendations, and death cases notified.

3.1.1 RMNCAH Commodity Availability

Commodity security remained key to sustaining MNCH service delivery. By the end of FY 2024/25, facility-level RMNCAH commodity availability increased from 67% to 72%, while central warehouse levels remained above 89%. This progress was driven by improved coordination between NMS and district health offices, use of a digital blood and commodity stock dashboard, and redistribution through LMNS and UCREPP-supported mechanisms, reflecting steady progress in maintaining uninterrupted supply of essential maternal and newborn health commodities across facilities nationwide.

Table 4: Availability of the 50 RMNCAH Commodities at Health Facilities in FY 2024/25

INDICATOR	Q4 FY2022/23	Q4 FY2023/24	Target FY2024/25	Q4 FY2024/25
Average availability of RMNCAH commodities at reporting facilities	57	67	90	72
Availability of RMNCAH commodities at central warehouses (NMS and JMS)	79	55	80	89

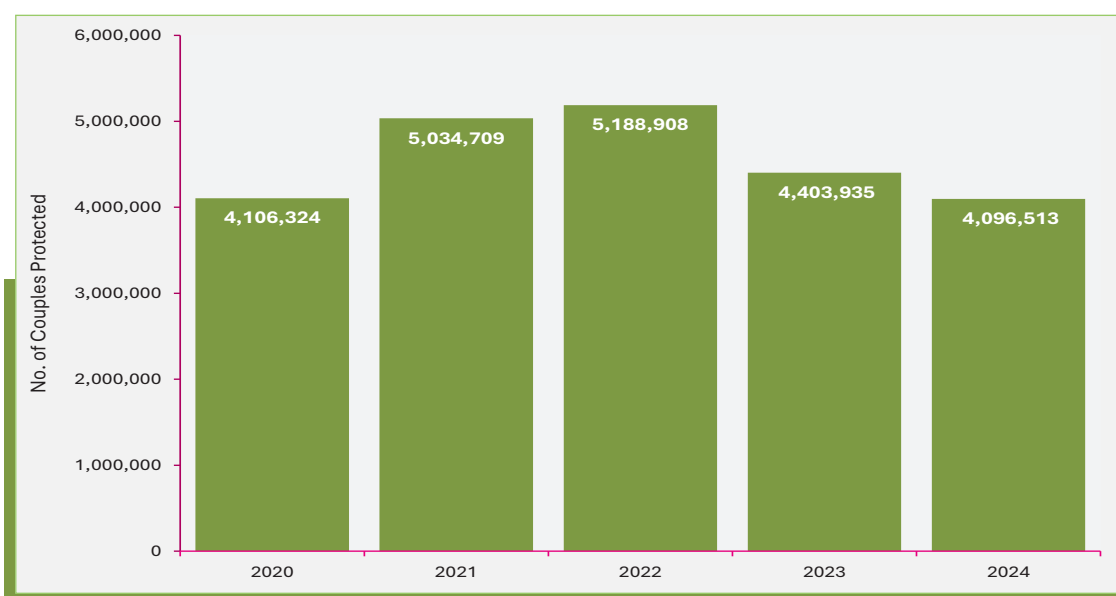


3.2 MNCH PERFORMANCE INDICATORS

3.2.1 Reproductive and Family Planning

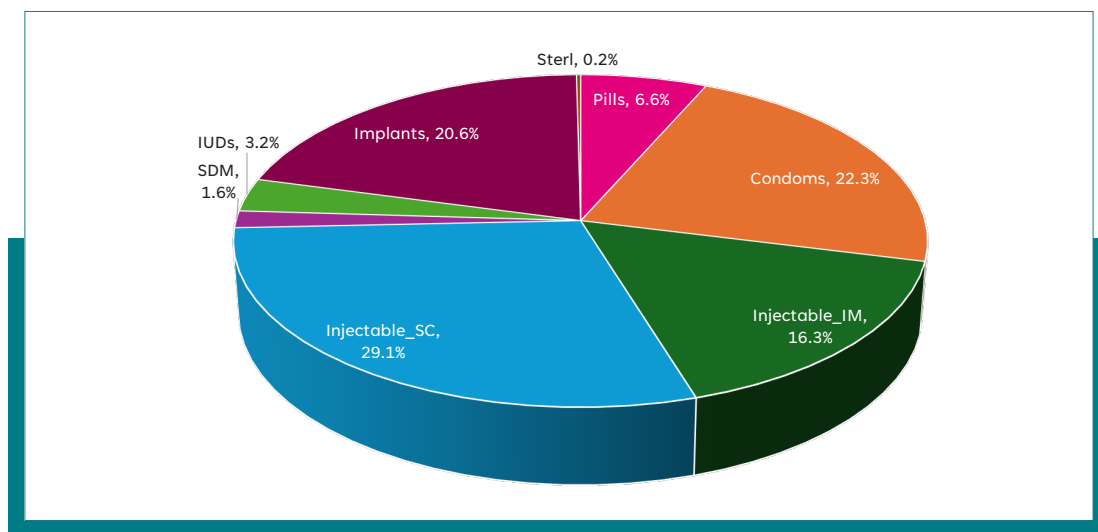
Reproductive health and family planning services remain central to Uganda's efforts to reduce unintended pregnancies and maternal deaths. This section presents trends in family planning uptake and access for FY 2024/25, showing steady national progress alongside regional disparities, and highlights how service integration and community-based approaches have supported these gains.

Figure 2: Trends in Couple Years of Protection (CYP) – National



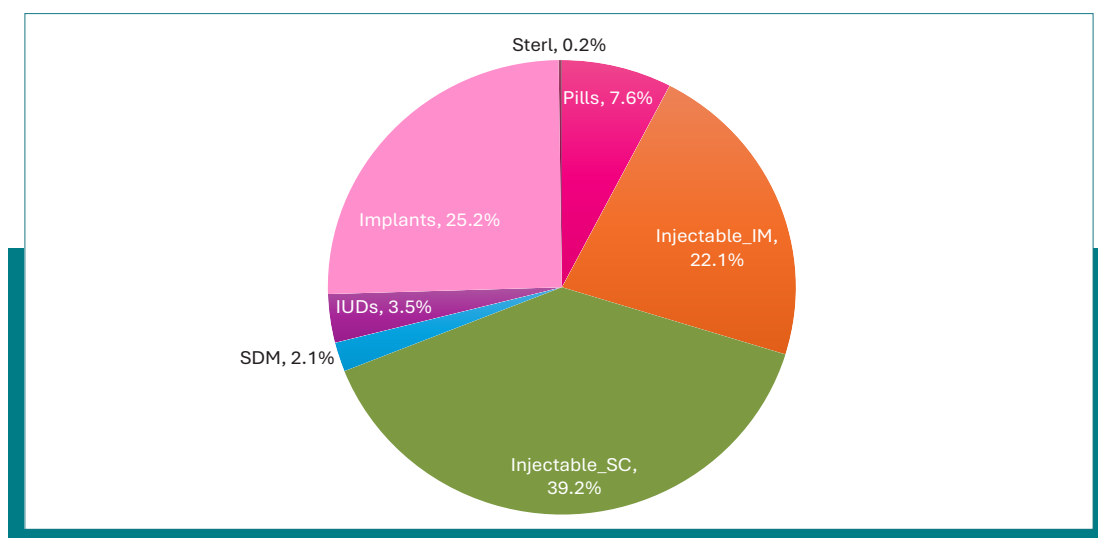
Couple Years of Protection (CYP) reached 4.1 million in 2024, averting an estimated 1,228,954 unintended pregnancies. This trend may be due to a shift in the contraceptive method mix, with increased use of condoms and oral contraceptives and fewer new users of long-term methods.

Figure 3: Estimated method Mix FY2024/25



In FY2024/25, contraceptive use is concentrated on short-term methods, with subcutaneous injectables (29.1%) and condoms (22.3%) comprising over half of total usage. Implants (20.6%) and intramuscular injectables (16.3%) also feature significantly, while IUDs (3.2%), pills (6.6%), and permanent methods (0.2%) remain low. This pattern reflects provider preferences, limited access to long-acting options, and insufficient counselling raising concerns about discontinuation and unintended pregnancies. Excluding condoms, injectables dominate even more, making up over 60% of the method mix, with limited uptake of IUDs and permanent methods, indicating missed opportunities for broader use of long-term contraception.

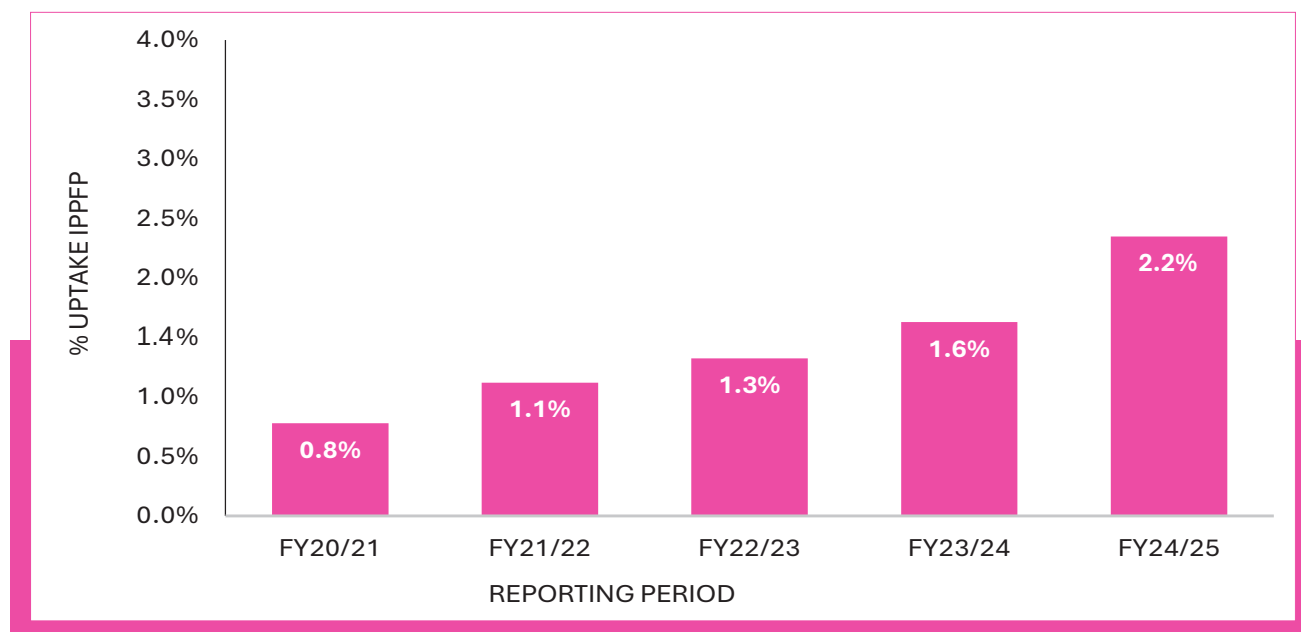
Figure 4: Without Condoms FY2024/25



When excluding condoms from the method mix analysis for FY2024/25, injectables both subcutaneous and intramuscular emerge as the predominant contraceptive methods used. Injectables collectively account for over 60% of all contraceptive methods provided during this period. In contrast, the uptake of IUDs and permanent methods remains notably low.

This distribution highlights a heavy reliance on short-term methods, particularly injectables, while long acting and permanent contraceptive options are significantly underutilised. The limited adoption of these longer-term methods suggests missed opportunities to broaden contraceptive choices and improve continuity of use, which could help reduce the risks of discontinuation and unintended pregnancies.

Figure 5: Trends in Uptake of immediate Postpartum FP (iPPFP)



Uptake of immediate postpartum family planning (iPPFP) rose by 1.4 percentage points from FY 2020/21 to FY 2024/25, reflecting gradual progress in postpartum contraceptive use. The results suggest limited counselling during ANC and maternity services and inconsistent availability of methods at delivery points. Strengthening integration of family planning into postnatal care, ensuring method availability, and improving client counselling before discharge remain key to increasing uptake and preventing repeat unintended pregnancies.

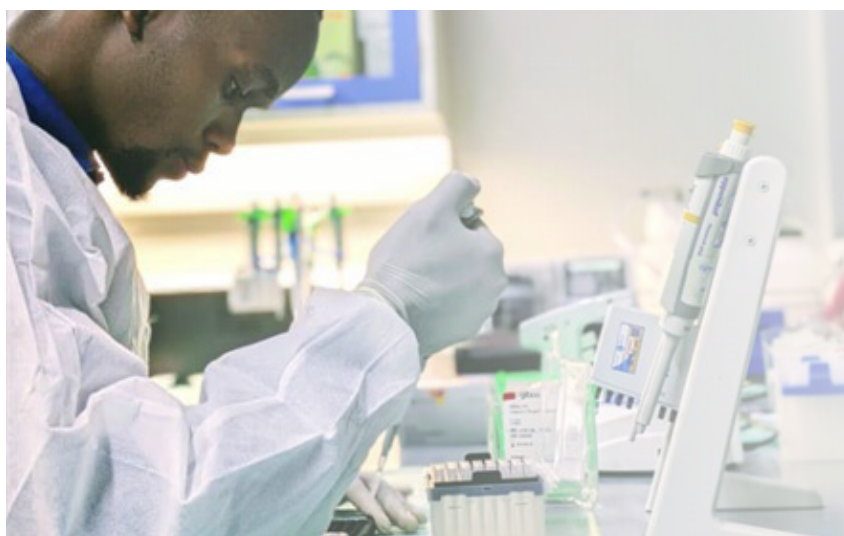
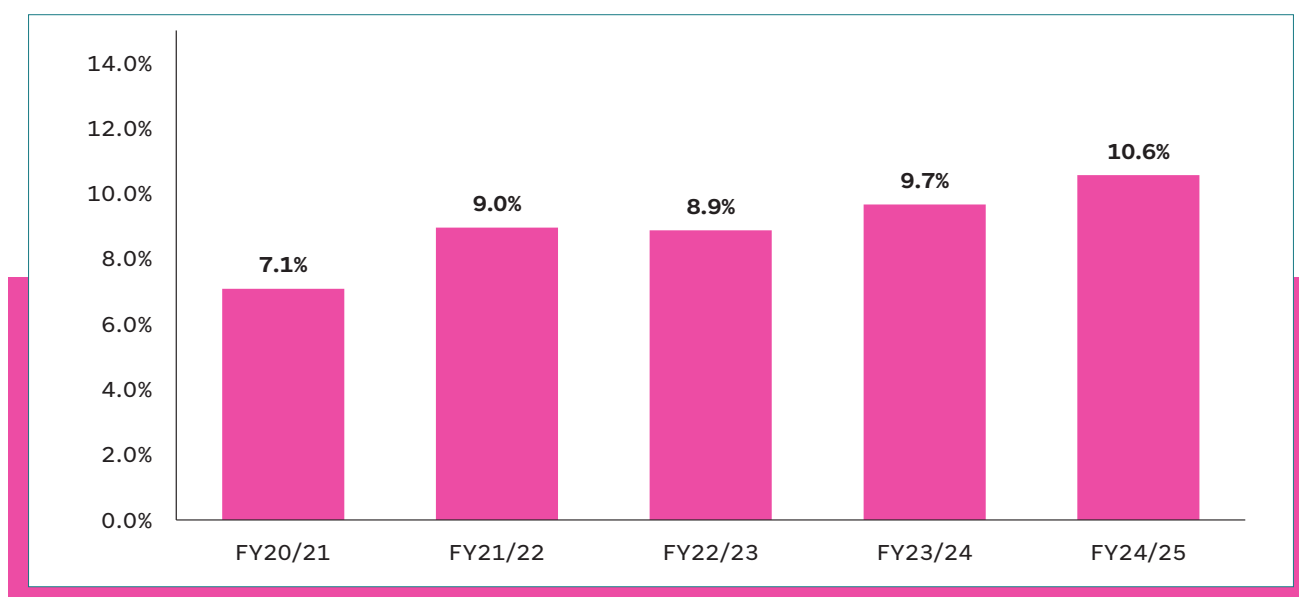


Table 5: Regional Distribution of IPPFP uptake

UPTAKE OF IMMEDIATE POSTPARTUM FAMILY PLANNING (IPPFP) %					
Region	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25
Acholi	1.2%	1.5%	1.1%	1.0%	0.9%
Ankole	1.0%	1.1%	0.9%	2.0%	3.2%
Bugisu	0.7%	0.7%	0.7%	1.6%	3.2%
Bukedi	0.3%	0.5%	0.9%	1.1%	2.8%
Bunyoro	0.6%	1.1%	1.3%	1.2%	1.7%
Busoga	1.5%	2.7%	1.9%	2.4%	3.1%
Kampala	0.2%	0.4%	5.0%	4.7%	2.9%
Karamoja	0.2%	0.3%	0.6%	0.8%	1.5%
Kigezi	1.7%	1.5%	1.4%	2.2%	2.3%
Lango	1.5%	4.4%	3.4%	3.6%	5.1%
North Buganda	1.1%	0.8%	0.5%	0.5%	0.8%
South Buganda	0.4%	0.7%	0.8%	0.8%	1.8%
Teso	0.4%	0.4%	0.5%	0.5%	1.1%
Tooro	0.8%	0.8%	0.9%	1.9%	2.2%
West-Nile	0.1%	0.2%	0.7%	0.8%	0.6%
National	0.8%	1.1%	1.3%	1.6%	2.2%

Regional trends show increased uptake in Lango, Bugisu, Bukedi, Karamoja, and Kampala, with Lango recording the highest uptake at 5.1% in FY 2024/25. Regions such as Acholi and North Buganda declined over the same period. These differences highlight uneven integration of family planning into maternity care, calling for targeted support and capacity building in low-performing areas to ensure consistent availability of postpartum service delivery.

Figure 6: Post-abortion Family Planning (PAFP) Uptake Trend



National post-abortion family planning (PAFP) uptake increased from 7.1% in FY2020/21 to 10.6% in FY2024/25, representing a 49% rise over the period. Despite this progress, overall uptake remains low given the high risk of repeat unintended pregnancies. Persistent gaps in routine counselling, contraceptive availability, and integration of PAFP into emergency and post-abortion care services continue to limit access and coverage.

Several persistent challenges continue to hinder the scale-up of post-abortion family planning (PAFP) services. Key gaps include inconsistent counselling for women after abortion, limited availability of contraceptive methods, and weak integration of PAFP into both emergency and post-abortion care services. Addressing these challenges requires stronger efforts to ensure that comprehensive PAFP services are routinely provided and accessible to all women in need.

Table 6: Regional Trend on Uptake of Post-abortion Family Planning (%)

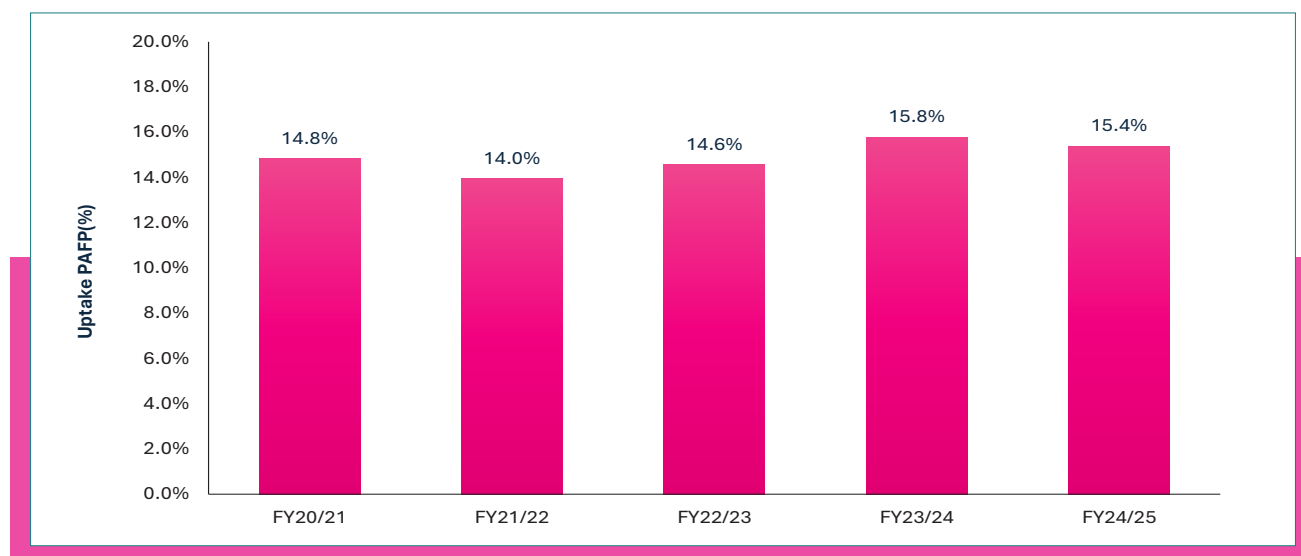
Region	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25
Acholi	5.1%	7.1%	5.7%	7.2%	9.6%
Ankole	7.3%	8.5%	12.9%	14.9%	9.9%
Buganda North	8.5%	10.7%	9.7%	8.9%	8.4%
Buganda South	13.0%	15.0%	16.9%	16.7%	16.6%
Bugisu	9.6%	10.6%	14.6%	16.5%	16.6%
Bukedi	8.8%	11.8%	9.2%	13.7%	20.7%
Bunyoro	3.9%	4.7%	3.9%	3.5%	2.6%
Busoga	6.3%	10.8%	9.4%	13.7%	16.2%
Kampala	16.3%	16.4%	14.7%	16.4%	19.3%
Karamoja	3.3%	3.8%	3.1%	3.8%	5.0%
Kigezi	4.4%	7.3%	6.4%	5.5%	5.2%
Lango	6.5%	11.7%	9.3%	9.2%	13.2%
Teso	2.1%	2.9%	2.2%	2.5%	2.9%
Tooro	5.1%	6.7%	8.1%	6.1%	4.5%
West Nile	3.6%	3.4%	4.2%	3.3%	4.0%
National	7.1%	9.0%	8.9%	9.7%	10.6%

Although national uptake of post-abortion family planning (PAFP) has increased over the period FY2020/21 to FY2024/25, this positive national trend, masks considerable regional disparities. Regions such as Bukedi, Kampala, and Buganda South have achieved the highest uptake rates, while others, notably Teso (2.9%) and Bunyoro (2.6%), remain significantly below the national average.

The overall increase in national PAFP uptake

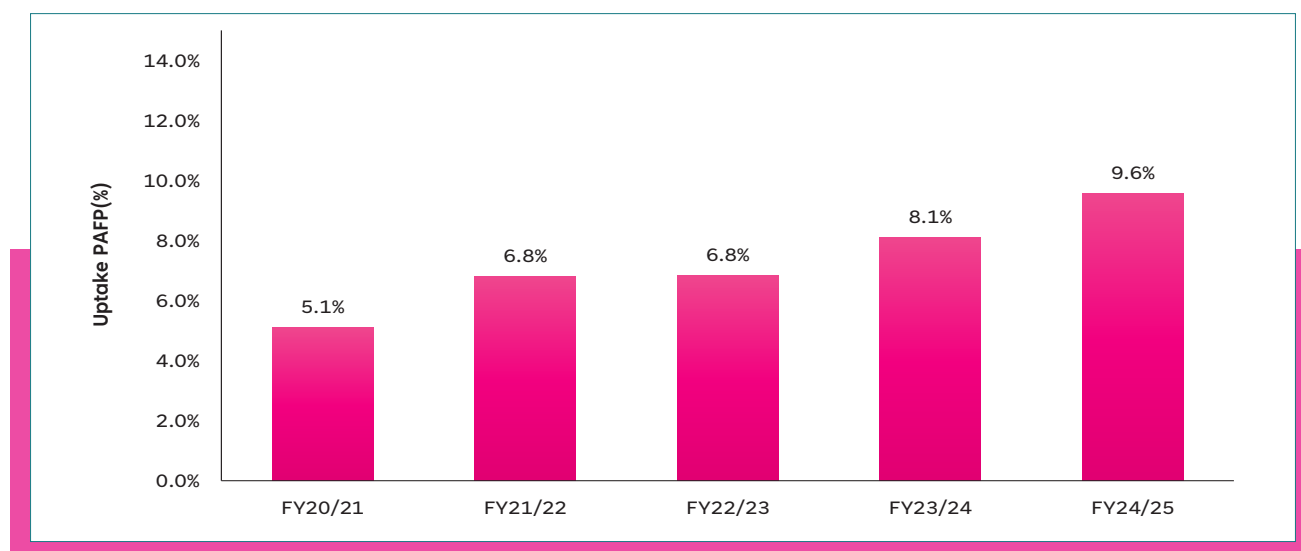
reflects effective integration of post-abortion family planning services within post-abortion care in some regions. Success in areas such as Bukedi demonstrates the value of structured service delivery models, strong partner engagement, and consistent prioritization of PAFP at the facility level. On the other hand, persistently low uptake in regions like Teso and Bunyoro highlights ongoing challenges that limit access to and utilization of PAFP services in these areas.

Figure 7: Uptake of PAFP among adolescents (10–19yrs) FY2024/25



Over the past five years, post-abortion family planning (PAFP) uptake among adolescents aged 10–19 years has ranged between 14% and 16%. Persistent barriers, such as limited adolescent-friendly services and provider biases, may contribute to this stagnated uptake. These findings highlight the need for targeted interventions to address the specific challenges adolescents face in accessing PAFP and to ensure they are included in broader family planning efforts.

Figure 8: PAFP among 20+Yrs FY2024/25

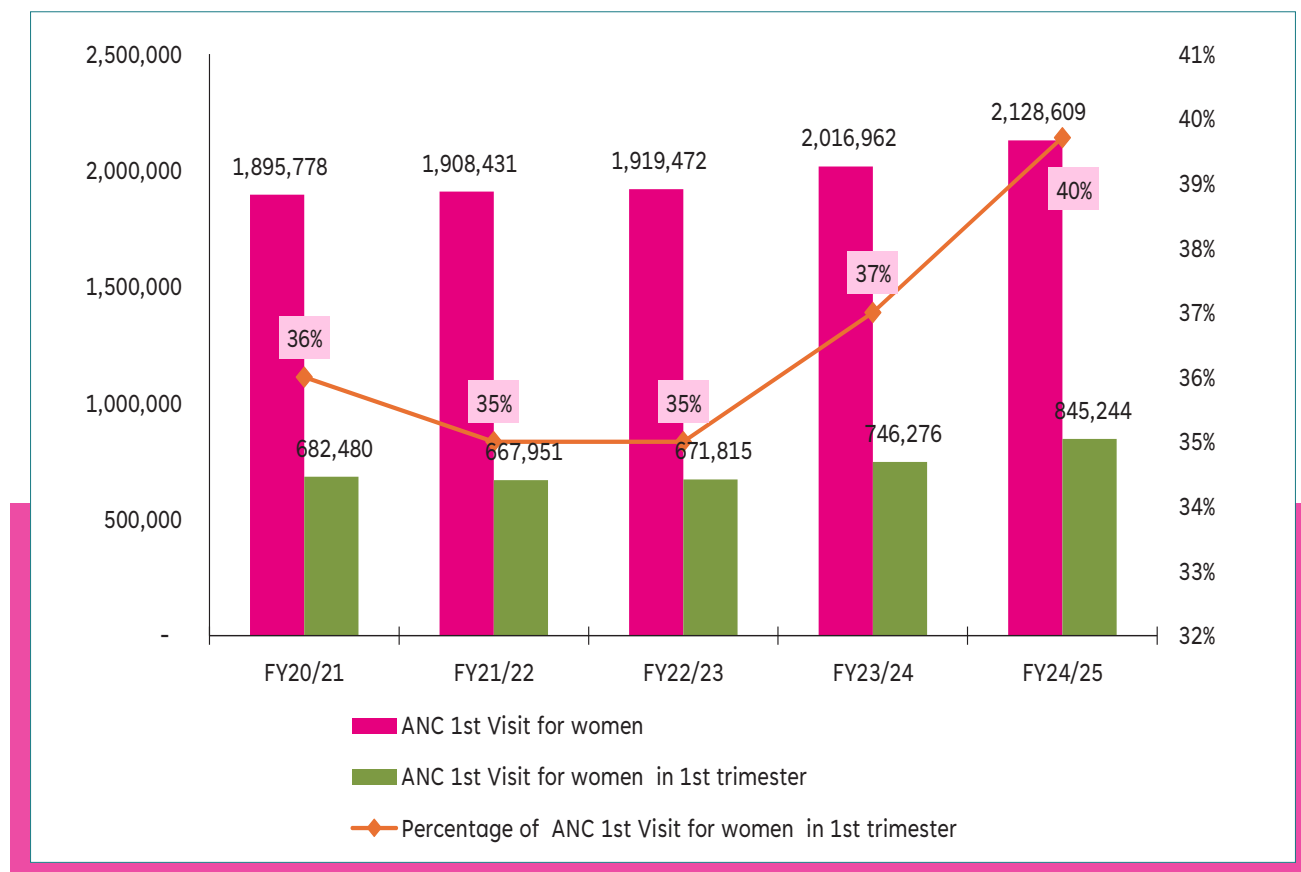


Post-abortion family planning (PAFP) uptake rose by 4.5 percentage points from FY 2020/21 to FY 2024/25, reaching 9.6% among women aged 20 years and above. While there is progress, overall uptake remains low, reflecting missed opportunities for contraceptive counselling and follow-up care. Strengthening post-abortion counselling, ensuring a wider method mix, and improving continuity of care will be essential to sustain gains and expand.

3.2.2 Antenatal Care

Antenatal care (ANC) is a key entry point for detecting pregnancy-related risks and promoting healthy outcomes for mothers and newborns. This section presents trends in ANC coverage and quality for FY 2024/25, highlighting progress in early initiation and completion of visits, alongside remaining gaps in contact coverage, quality, and regional equity.

Figure 9: Pregnant women attending Antenatal care (ANC 1) in the 1st trimester [n=2,128,609]



The proportion of women initiating antenatal care (ANC) in the first trimester has gradually improved over the past five years. Each reporting period has seen a steady rise in early ANC attendance, indicating progress in encouraging timely engagement with antenatal services among pregnant women.

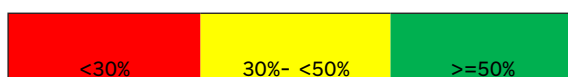
Despite the overall growth in ANC attendance, the rate of early initiation remains modest. Most women continue to begin ANC later than recommended, which may affect the

effectiveness of preventive and supportive interventions during pregnancy.

Several factors contribute to the continued delay in early ANC initiation. These include limited demand generation efforts at the community level, delayed recognition of pregnancy, and gaps in early referral and outreach services. Addressing these barriers is crucial for further improving early ANC uptake and optimising maternal and child health outcomes.

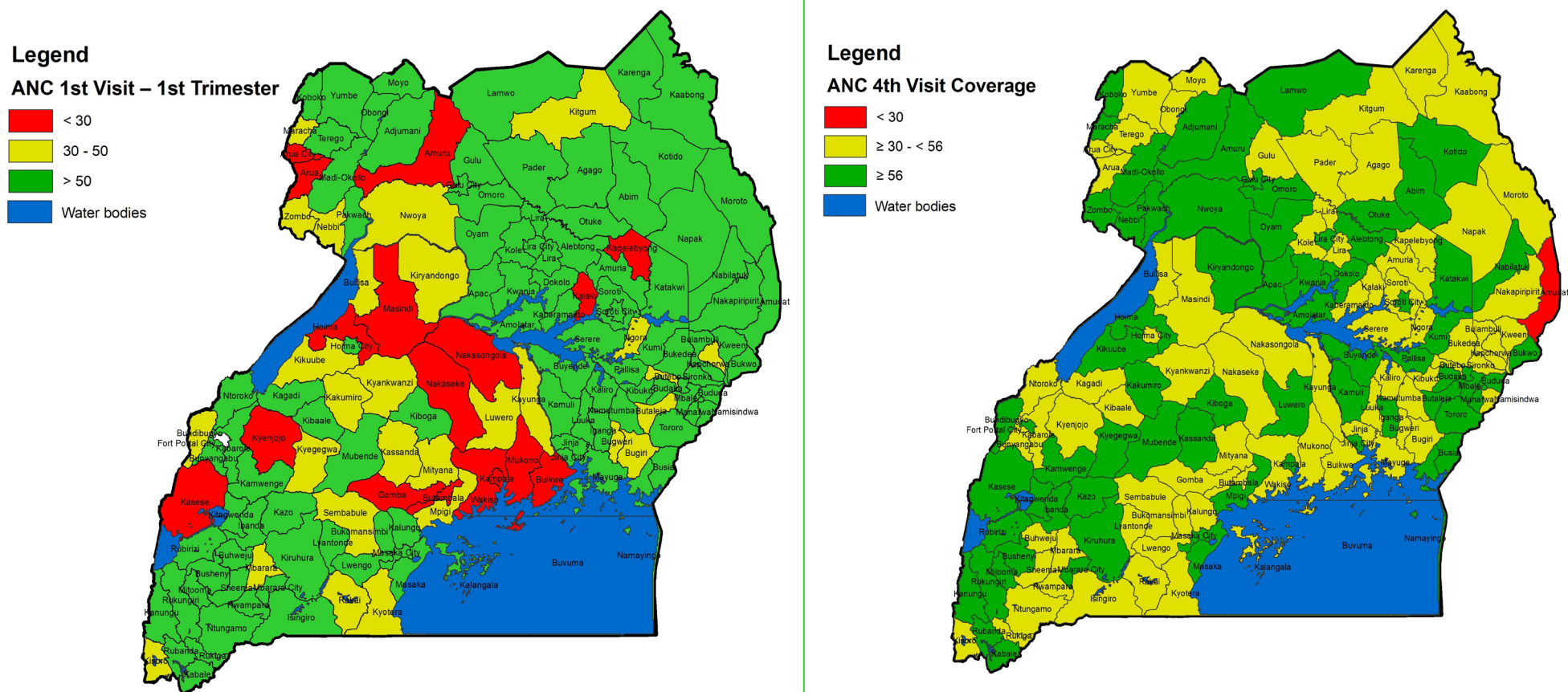
Table 7: Antenatal Coverage

Region	Percentage of pregnant women attending ANC 1 in 1st trimester		Antenatal 4th visit (ANC 4 coverage)		Antenatal 8th visit (ANC 8 coverage)	
	FY23/24	FY24/25	FY23/24	FY24/25	FY23/24	FY24/25
Acholi	37%	38%	55%	59%	4%	5%
Ankole	43%	50%	53%	63%	2%	3%
Bugisu	50%	55%	48%	65%	3%	6%
Bukedi	44%	43%	53%	57%	2%	3%
Bunyoro	30%	34%	43%	58%	2%	2%
Busoga	33%	40%	47%	56%	2%	4%
Kampala	27%	27%	73%	73%	15%	6%
Karamoja	45%	44%	54%	50%	2%	3%
Kigezi	41%	45%	57%	54%	3%	3%
Lango	46%	51%	58%	70%	3%	5%
North Buganda	29%	32%	48%	53%	2%	2%
South Buganda	30%	33%	33%	38%	1%	2%
Teso	38%	40%	44%	47%	2%	3%
Tooro	32%	34%	50%	57%	2%	3%
West Nile	42%	45%	53%	58%	5%	6%
National	36%	40%	49%	56%	3%	3%



Over the past two years, more women have started antenatal care (ANC) in the first trimester, with regions like Lango and Bugisu showing strong gains. National ANC 4 coverage has improved, but ANC 8 attendance remains low, highlighting ongoing challenges in maintaining care throughout pregnancy. Barriers include late pregnancy recognition, weak community mobilisation, and referral system issues. Targeted interventions should focus on boosting early ANC demand, improving service quality and appointment management, and strengthening follow-up to support continuous care for all recommended ANC visits.

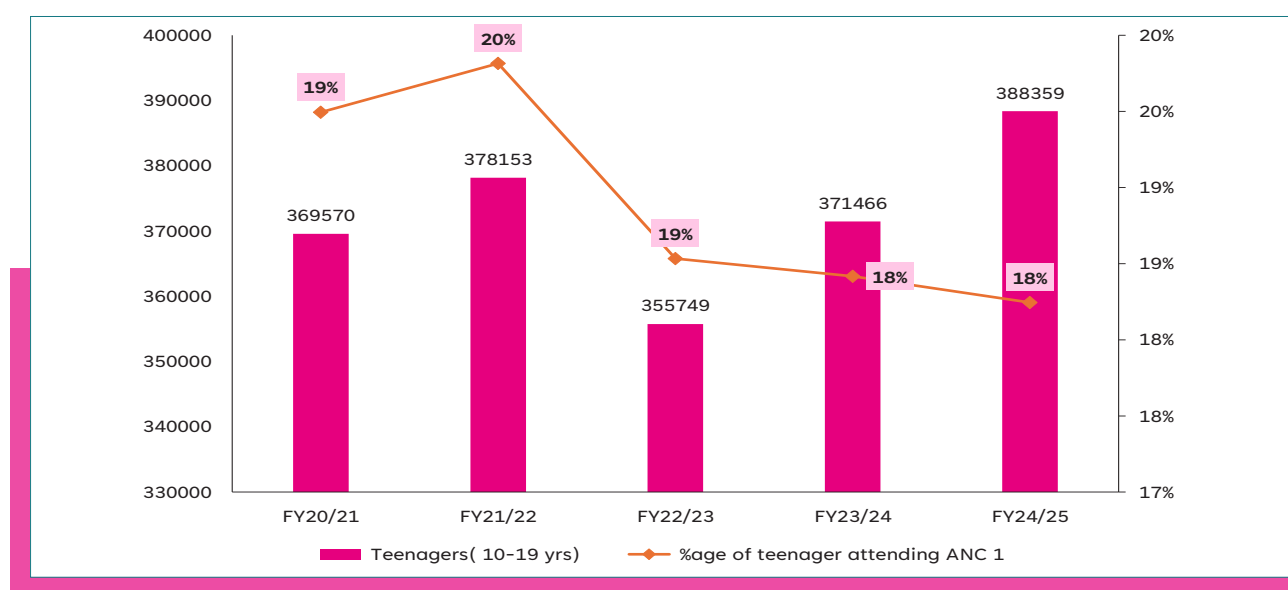
Figure 10: Map showing percentage ANC 1st for women in 1st trimester (left) and ANC 4th visit coverage (right)



Districts in the central and mid-western regions recorded the lowest performance for first antenatal care (ANC) visits coverage during the first trimester. Despite this initial shortfall, these same districts achieved better coverage for the fourth ANC visit, with all performing at 56% or higher. To improve early ANC attendance, enhanced efforts are needed to mobilise women at the community level. This is particularly important to address myths and misconceptions related to non-disclosure of early pregnancy, which often contribute to delays in seeking care. Early booking for ANC and higher coverage of the fourth visits are linked to better uptake of recommended interventions and improved pregnancy outcomes.

Among the 146 LG's, 32 districts (22%) recorded 1st trimester ANC above 50%, while 48 (33%) achieved ANC 4 coverage above 60%.

Figure 11: Teenage pregnant women attending ANC



The number of adolescents (10–19 years) attending their first antenatal care visit (ANC1) increased by approximately 18,800 between FY 2020/21 and FY 2024/25, representing a 5% rise over the five-year period. Despite this improvement, adolescents continue to account for one in every five ANC 1 clients.

This trend points to early pregnancy challenges that extend beyond the health sector and may be influenced by limited access to age-appropriate sexuality education, inadequate youth-friendly services, and weak community dialogue. To reverse this pattern, efforts should focus on strengthening school- and community-based sexuality education, expanding confidential and adolescent-friendly health services, and promoting parent and community engagement to create supportive environments for young people.

Table 8: Trends in Uptake of ANC and eMTCT Interventions, FY2020/21–FY2024/25

Key ANC and eMTCT Interventions	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25
Intermittent Preventive Treatment for malaria in pregnancy – third dose (IPT3)	57%	56%	54%	54%	64%
Iron and Folic Acid Supplementation (IFA)	66%	66%	65%	66%	70%
Insecticide-Treated Net (ITN)	46%	53%	73%	70%	70%
Haemoglobin Screening (HB)	21%	23%	22%	22%	28%
Human Immunodeficiency Virus Test (HIV Test)	89%	88%	90%	98%	100%
Syphilis Screening Test for first time during this pregnancy (Syphilis Test)	88%	84%	85%	89%	94%
Women on ART for eMTCT at ANC 1 with a suppressed VL	100%	91%	92%	92%	94%
Prophylactic Infant ART	95%	96%	101%	108%	102%
Hepatitis B Testing (HEP B)	16%	20%	41%	59%	58%
Obstetric Ultrasound Scan (USS)	13%	15%	18%	23%	28%

All	<50%	50%- <80%	>=80%
HB screening	<30%	30%- <60%	>=60%

Target=65

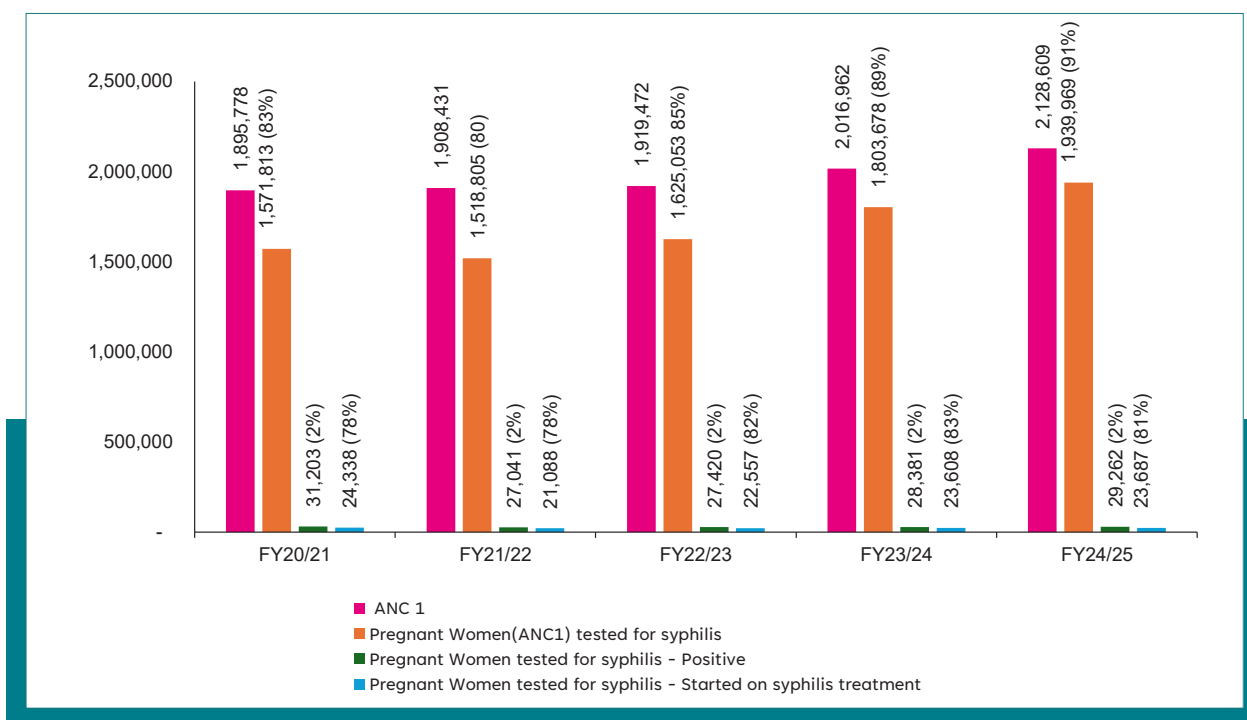
Coverage of key ANC interventions continued to improve over the five-year period. Iron and folic acid supplementation showed a modest but steady increase, while HIV and syphilis testing remained consistently high, demonstrating sustained integration of these services within routine ANC. Malaria prevention efforts also strengthened, with both IPTp3 uptake and ITN distribution showing improved performance.

Significant progress was observed in ultrasound coverage, which more than doubled, and in Hepatitis B testing, which increased nearly fourfold during the same period. However, haemoglobin screening highlighted marginal

improvement and continues to perform below the national target.

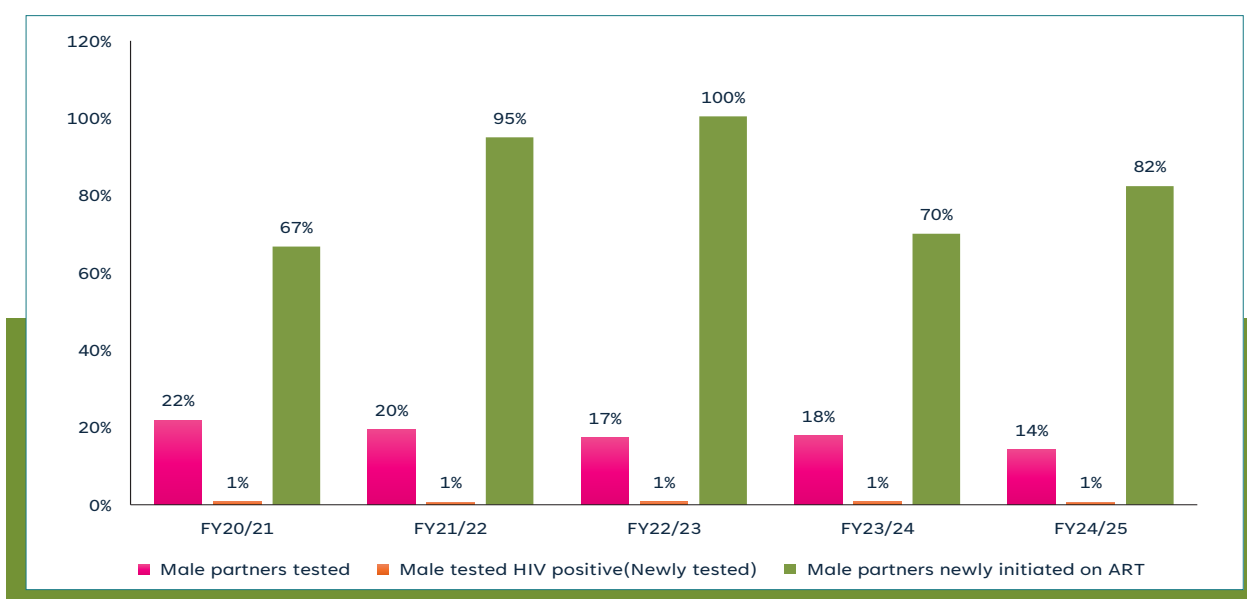
These achievements highlight the benefits of prioritising maternal nutrition, infection screening, and malaria prevention, supported by more reliable supply chain. However, persistent weaknesses in diagnostic capacity still affect service quality. Low haemoglobin screening coverage is linked to non-functional equipment, inadequate test kits, and reagent shortages, while ultrasound and Hepatitis B testing remain limited by a shortage of skilled providers and irregular equipment maintenance.

Figure 12: Trends in Syphilis Testing and Treatment among ANC attendees



Syphilis testing among pregnant women attending ANC surpassed 98% in FY 2024/25, highlighting improved integration of screening into routine maternal care. However, only about 75% of those who tested positive received treatment. Bridging this gap requires ensuring that high testing coverage is complemented by timely treatment initiation and effective follow-up in all facilities providing ANC services.

Figure 13: Male testing at the antenatal first visit

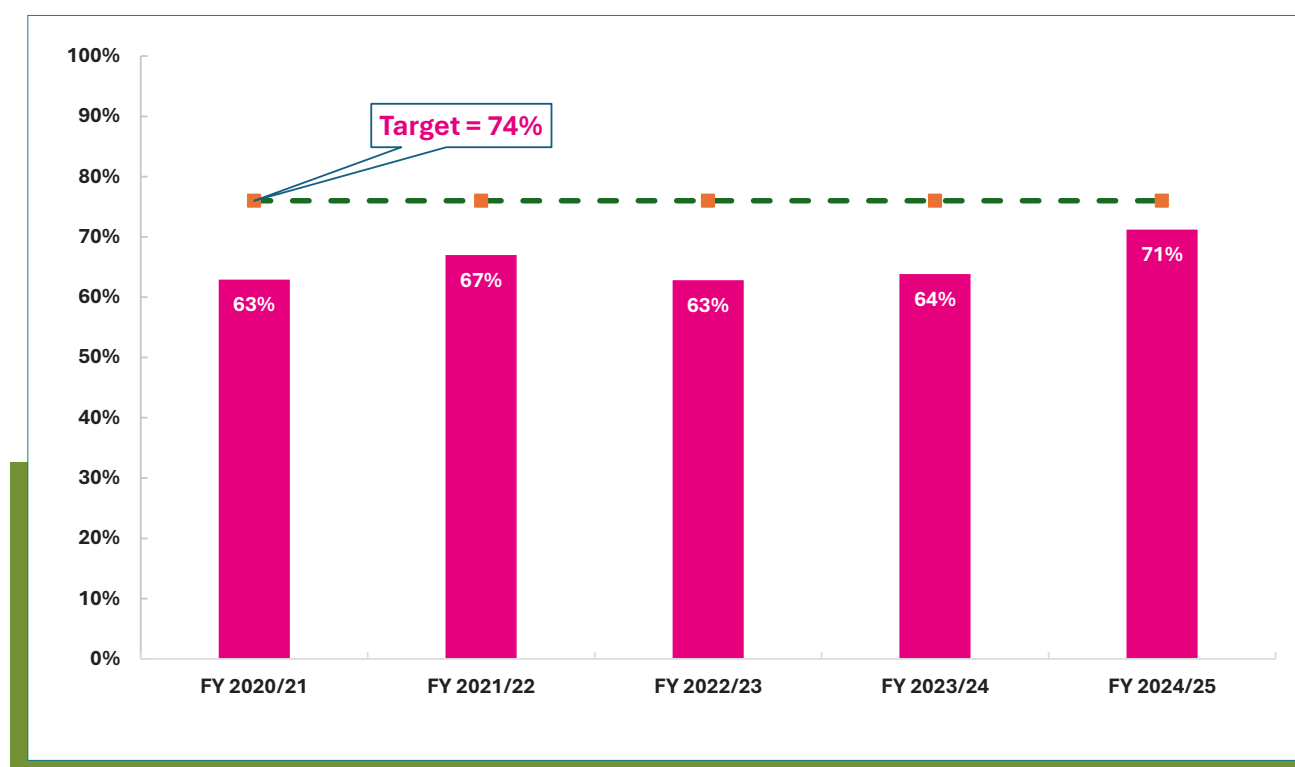


The proportion of male partners tested at the first antenatal visit has declined over the past five years, dropping from more than one in five to fewer than one in six. Initiation of newly tested males on ART is still low. This trend highlights persistent barriers and an increased risk of maternal reinfection, which can undermine efforts to prevent mother-to-child transmission. To address these challenges, it is essential to strengthen community-led and peer-driven male engagement initiatives, and to build provider capacity for effective couple counselling and creating more inclusive environments for men within antenatal care settings.

3.2.3 Maternity Care

Maternity care forms a key part of the maternal and newborn health continuum, directly influencing survival outcomes for mothers and infants. During FY 2024/25, Uganda continued to strengthen maternity services, with improvements in institutional deliveries, quality of care, and emergency response.

Figure 14: Trends in Health Facility Delivery Rates



The national health facility delivery rate increased notably, from 64% in FY2023/24 to 71% in FY2024/25. This marks significant progress towards reaching the national HSSP target of 74%, reflecting ongoing improvements in maternal and newborn health outcomes. This positive trend suggests improved access to healthcare services, allowing more expectant mothers to choose health facilities for their deliveries. Additionally, perceptions of good quality care within these facilities have played a vital role in encouraging institutional deliveries, further boosting the upward trend in delivery rates.

Table 9: Health Facility Delivery Rates by Region

Region	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
Acholi	62%	69%	65%	66%	71%
Ankole	59%	64%	64%	66%	77%
Bugisu	68%	84%	75%	73%	95%
Bukedi	79%	81%	73%	76%	83%
Bunyoro	59%	63%	55%	56%	71%
Busoga	55%	56%	54%	56%	70%
Kampala	102%	108%	104%	100%	93%
Karamoja	59%	60%	59%	65%	62%
Kigezi	70%	76%	72%	74%	67%
Lango	57%	59%	55%	61%	73%
North Buganda	66%	69%	65%	66%	69%
South Buganda	49%	52%	48%	47%	52%
Teso	62%	62%	59%	63%	69%
Tooro	70%	78%	72%	68%	77%
West Nile	64%	66%	63%	66%	70%
Uganda	63%	67%	63%	64%	71%

Key: <66% 66-<76% ≥76%

Five regions of Ankole, Bugisu, Bukedi, Kampala, and Tooro met the national health facility delivery target of 76%, while only Karamoja and South Buganda fell behind, with delivery rates of 62% and 52% respectively. Nationally, institutional delivery rates increased by 11% from FY 2023/24 to FY 2024/25.



achieved higher delivery rates. In contrast, areas facing challenges such as distant facilities, health worker shortages, and limited community mobilisation showed minimal progress, despite national improvements in infrastructure and supplies.

To drive further progress, the Government and partners should expand CEmONC provision in

underperforming districts, maintain consistent functionality and staffing at Health Centre IVs, and reinforce referral networks. Community engagement should be enhanced through local leadership support and practical incentives. Prioritising human resource deployment to hard-to-reach locations and institutionalising performance monitoring and cross-district learning are also recommended.

Table 10: Trends in health facility delivery volume by level of care

Level	FY 2020/21		FY 2021/22		FY 2022/23		FY 2023/24		FY 2024/25	
	Deliveries	%	Deliveries	%	Deliveries	%	Deliveries	%	Deliveries	%
NRH	31,090	2%	33,635	2%	31,575	2%	29,259	2%	29,675	2%
RRH	76,944	6%	79,505	5%	84,155	6%	88,837	6%	90,631	6%
GH	233,003	17%	241,687	17%	243,293	17%	256,516	17%	263,367	17%
HC IV	272,965	21%	302,615	21%	294,770	21%	316,204	21%	350,523	22%
HC III	607,718	46%	689,444	47%	639,703	45%	665,379	45%	724,294	46%
HC II	101,272	8%	105,571	7%	108,325	8%	113,610	8%	116,712	7%
Clinic	8,495	1%	9,212	1%	9,430	1%	10,712	1%	11,675	1%
Overall	1,331,487	100%	1,461,669	100%	1,411,251	100%	1,480,517	100%	1,586,877	100%

Nearly half of all deliveries in FY 2024/25 occurred at Health Centre III level (46%), confirming their central role in providing maternity services close to communities. HC IV facilities showed steady growth, rising from 21% to 22% over the five-year period, while hospitals (GHs, RRHs, and NRHs) collectively accounted for about one-quarter of total deliveries. Lower-level facilities such as HC IIs and clinics maintained smaller shares at 7% and 1%, respectively.

The dominance of HC IIIs and IVs highlights their pivotal contribution to safe facility deliveries, while the growth at HC IV level signals improved readiness to handle comprehensive services. Continued investment in staffing, commodity availability, and referral capacity at these levels will be key to sustaining progress and ensuring that all women deliver safely within the health system.



“Uganda’s health system continues to demonstrate strong capacity in providing maternity care, with government facilities accounting for the majority of institutional deliveries, and Health Centre IIIs serving as the backbone of maternal and newborn service delivery, delivering more mothers than any other level of care.”

Table 11: Trends in health facility deliveries by ownership type

Level	FY 2020/21		FY 2021/22		FY 2022/23		FY 2023/24		FY 2024/25	
	Deliveries	%	Deliveries	%	Deliveries	%	Deliveries	%	Deliveries	%
GOV	1,068,723	80%	1,181,115	81%	1,150,334	82%	1,210,480	82%	1,313,208	83%
PNFP	202,905	15%	218,157	15%	197,366	14%	200,937	14%	203,674	13%
PFP	59,859	4%	62,476	4%	63,646	5%	69,246	5%	69,995	4%
Overall	1,331,487	100%	1,461,748	100%	1,411,346	100%	1,480,663	100%	1,586,877	100%

Government facilities remained the main providers of maternity care, with their share of deliveries rising from 80% in FY 2020/21 to 83% in FY 2024/25. Deliveries in PNFP facilities declined from 15% to 13%, while PFP facilities maintained 4–5%.

This pattern highlights the dominant role of the public sector in ensuring access to safe delivery services. Sustaining progress will require continued investment in staffing and supplies at government health centres, strategic partnerships with PNFPs to reach underserved areas, and stronger regulation of PFPs to maintain quality and affordability.

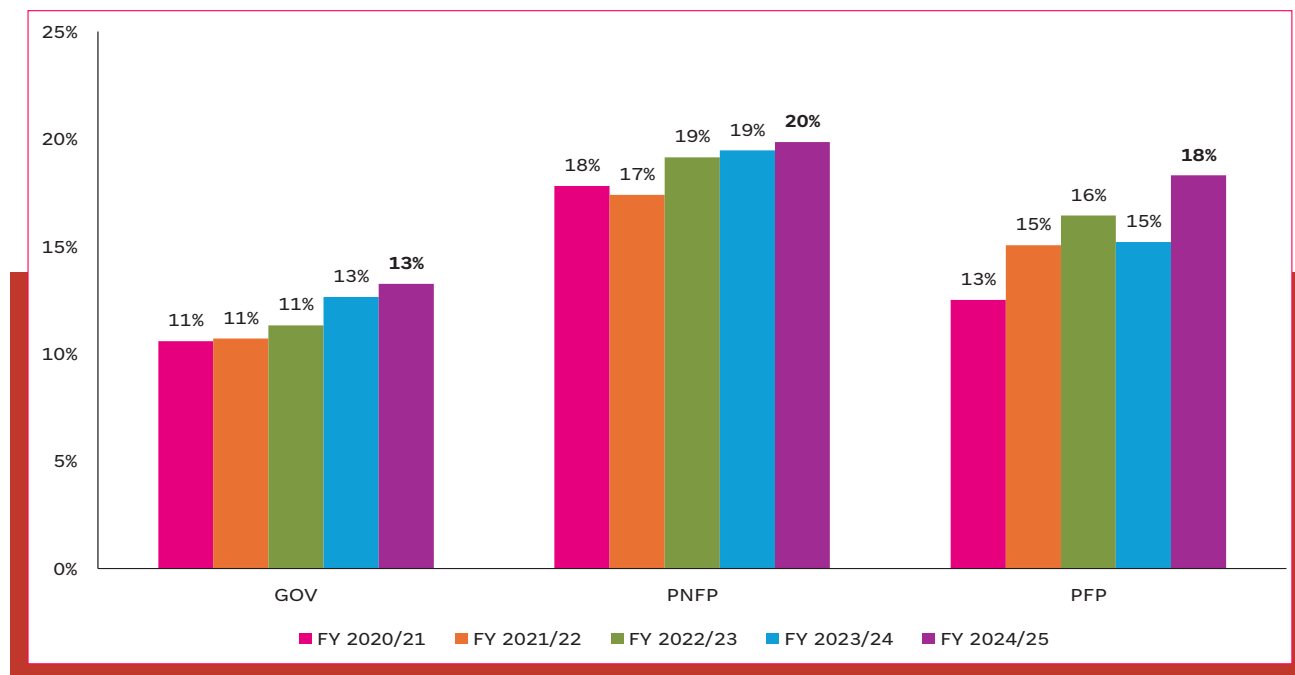
Table 12: C-section rate by region

Region	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
Acholi	8%	9%	9%	9%	10%
Ankole	15%	15%	14%	15%	16%
Bugisu	9%	7%	8%	8%	9%
Bukedi	5%	5%	6%	7%	7%
Bunyoro	12%	11%	12%	14%	13%
Busoga	7%	7%	7%	9%	10%
Kampala	28%	28%	33%	33%	34%
Karamoja	5%	4%	4%	4%	5%
Kigezi	16%	16%	16%	18%	17%
Lango	8%	8%	8%	8%	8%
North Buganda	13%	15%	15%	17%	18%
South Buganda	12%	13%	15%	17%	19%
Teso	8%	9%	9%	10%	11%
Tooro	14%	13%	14%	16%	17%
West Nile	11%	12%	12%	13%	13%
National	12%	12%	13%	14%	14%

Key:	<5%	5-15%	>15%
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The national C-section rate has remained within the WHO-recommended range of 5–15% over the last five financial years (FY2020/21-FY2024/25). At regional level, Kampala remains high at 34% and other regions above the threshold included Kigezi, Tooro, South Buganda, North Buganda, and Ankole. Four regions, Karamoja, Bukedi, Lango, and Bugisu are below 10% throughout the five-year period.

Figure 16: C-section rates by ownership Type



Government facilities reported a C-section rate of 13% in FY2024/25, which is within the WHO-recommended range, while PNFP and PFP facilities had higher rates, at 20% and 18% respectively.

Table 13: C-section rates by Level of Care

Level of care	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
NRH	44%	43%	47%	51%	49%
RRH	35%	37%	34%	37%	38%
General Hospital	32%	33%	34%	35%	35%
HC IV	14%	15%	17%	19%	22%
HC III	0%	0%	0%	1%	1%
Clinic/HC II	1%	1%	1%	1%	1%
Overall	12%	12%	13%	14%	14%

Key	<5%	5-15%	>15%
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C-section rates remained above 30% in national, regional, and general hospitals throughout FY 2020/21–FY 2024/25, while HC IVs showed steady improvement from 14% to 22%, reflecting better surgical capacity. Most surgical deliveries were concentrated at higher-level facilities, indicating reliance on hospitals for complicated births but also suggesting possible overuse in urban areas.

A total of 1,788 C-sections were reported

from 41 HC IIs and clinics, mainly private-for-profit facilities, raising regulatory concerns since many lack accreditation, skilled staff, or adequate infrastructure for safe surgery. Strengthening oversight, expanding safe surgical services in underserved regions, and ensuring C-sections are performed only where standards are met will be essential to safeguard maternal and newborn outcomes.

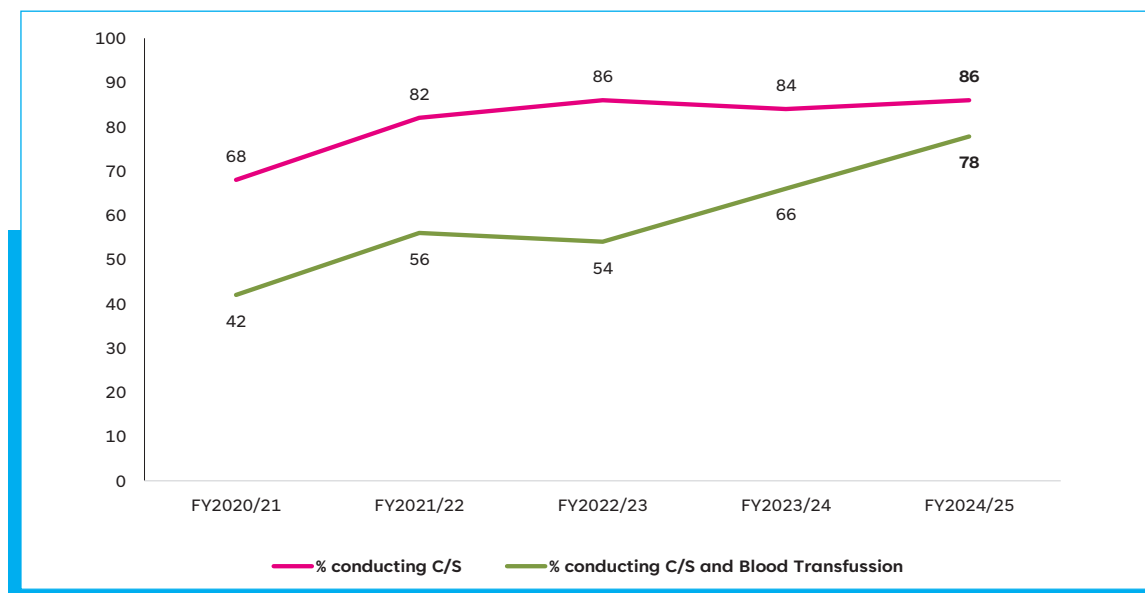
Health Centre IVs that are not providing essential emergency obstetric services. See Appendix II

A review of the data shows a widespread issue, with numerous facilities in various regions not offering either C-section or blood transfusion services, and in many cases, both. This is particularly concerning as these are the designated lower-level facilities for providing such services. For example, Kawaala HCIV and Naguru Police HCIV in Kampala do not offer blood transfusions, while several others, such as Bulucheke HCIV and Buliisa HCIV, do not offer either. This lack of service provision directly impacts maternal and neonatal health outcomes and points to a critical need for targeted investment and capacity building.

The root causes of non-functionality in these Health Centre IVs can be attributed to several interrelated factors. Firstly, infrastructural limitations such as incomplete operating theatres and the absence of essential

equipment like blood fridges severely restrict service delivery. Secondly, persistent supply chain challenges lead to frequent stockouts of critical supplies, including blood products and essential drugs, undermining the continuity of emergency care. Thirdly, a shortage of adequately trained personnel, including surgeons and anaesthetists, further hampers the ability of these centres to perform C-sections and manage obstetric emergencies. Additionally, inadequate maintenance of existing facilities and equipment contributes to ongoing operational challenges. Overall, these systemic issues highlight the urgent need for comprehensive interventions focused on infrastructure development, workforce strengthening, and robust supply chain management to restore and sustain the functionality of Health Centre IVs across the affected regions. **See Appendix II.**

Figure 17: Trends for HC IVs performing c/s only and those providing both c/s and blood transfusion services



The proportion of HC IVs performing caesarean sections has steadily increased over the past five years, exceeding 80% since FY2021/22. The availability of both caesarean section and blood transfusion services at these facilities has also improved, rising from under 50% in FY2020/21 to nearly 80% by FY2024/25. This progress highlights targeted efforts to enhance HC IVs as comprehensive emergency obstetric care centres. Nonetheless, a notable gap persists between the number of HC IVs capable of performing caesarean sections and those also equipped for blood transfusion. This indicates ongoing challenges with blood supply, facility infrastructure, and skilled staffing, which undermine effective management of obstetric emergencies, particularly those involving haemorrhage.

Figure 18: Operational HC IVs by ownership

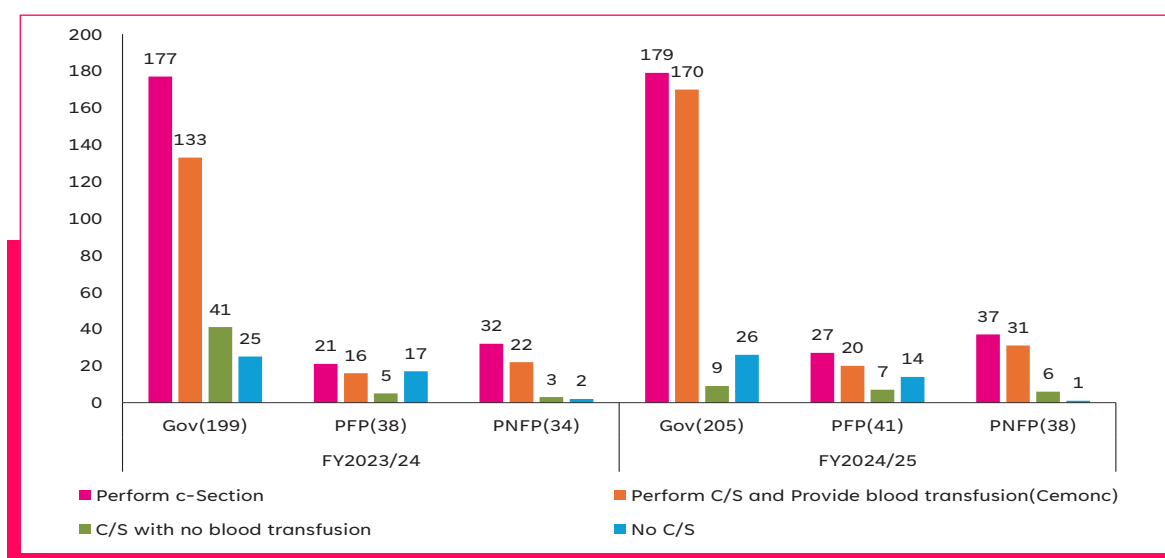


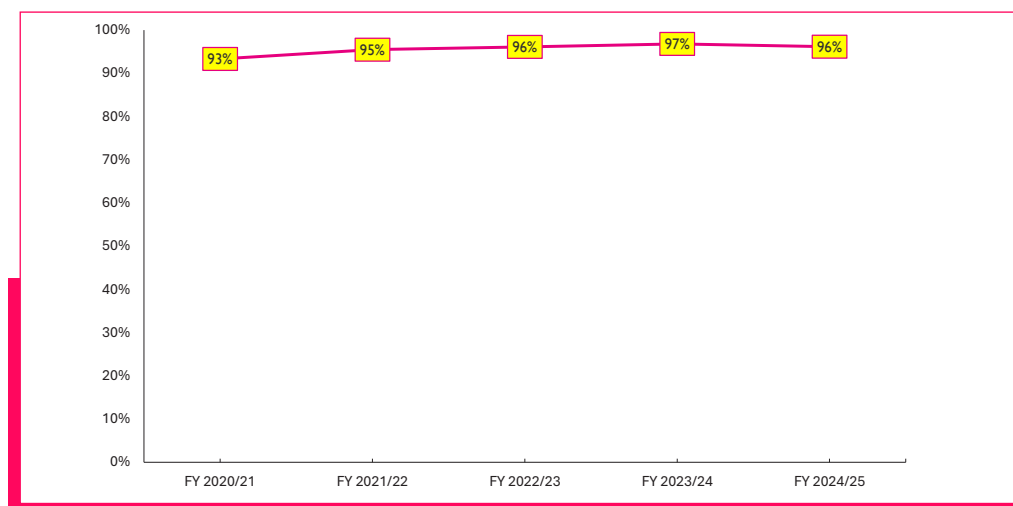
Table 14: Percentage of Public HC IVs offering C-sections and blood transfusion services - FY 2024/25

Region	Number of HC IVs	Number of HC IVs offering both C-section and Blood services	Percentage of HC IV that are operational as CEmONC sites
Acholi	10	9	90%
Ankole	24	23	96%
Bugisu	12	10	83%
Bukedi	8	8	100%
Bunyoro	11	9	82%
Busoga	19	19	100%
Kampala	5	2	40%
Karamoja	6	3	50%
Kigezi	18	11	61%
Lango	11	9	82%
North Buganda	19	17	89%
South Buganda	22	21	95%
Teso	12	7	58%
Tooro	16	12	75%
West Nile	12	10	83%
National	205	170	83%

Key:	<65%	65-<75%	≥75%
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Nationally, the proportion of public Health Centre IVs offering both C-section and blood transfusion services has risen from 67% to 83% over the last two financial years, reflecting a 24% improvement in the country's emergency obstetric care readiness. Bukedi and Busoga regions have achieved full coverage at 100%, whereas Kampala, Karamoja, and Teso remain behind at 40%, 50%, and 58% respectively. These disparities indicate a pressing need for targeted interventions to strengthen obstetric emergency capacity in the underperforming regions.

Figure 19: Use of uterotonics rates in management of 3rd stage of labour

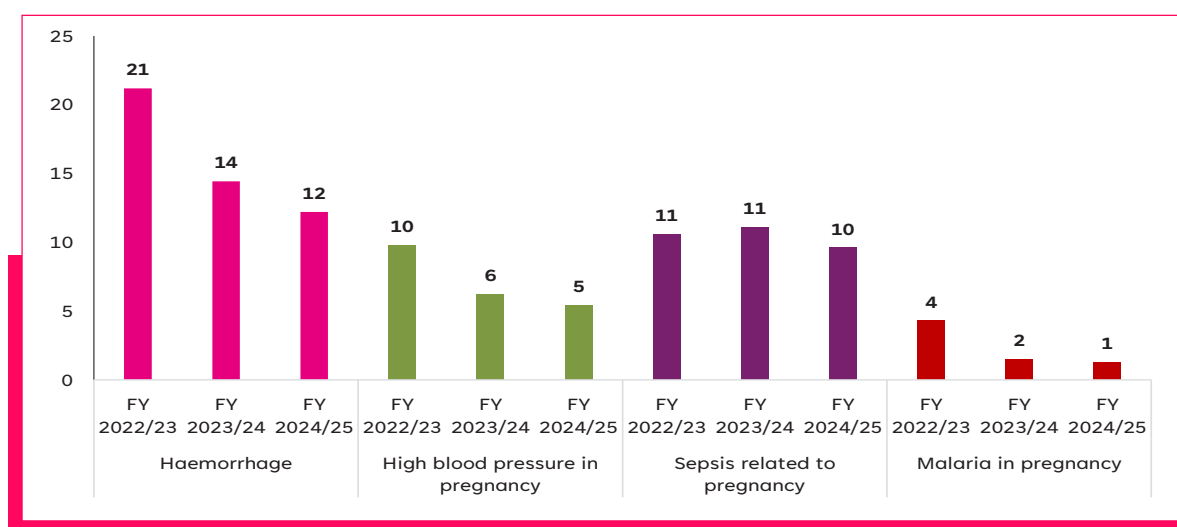


Use of Uterotonics in the 3rd Stage of Labour

National coverage of uterotonic use for active management of the 3rd stage of labour is high at **92%**, demonstrating consistent adherence to guidelines. However, stockouts of oxytocin and misoprostol were reported in multiples, risking sustainability of this performance.

Sustaining near-universal uterotonic coverage requires a continuous focus on supply chain efficiency, temperature-sensitive storage of oxytocin, and backup use of misoprostol at lower-level facilities.

Figure 20: Case fatality rates per 1000 cases admitted for selected Maternal conditions



The case fatality rates in this report are calculated using data from the HMIS108 In-patient report on obstetric complications. Case fatality rate is a crucial indicator of healthcare quality, where elevated rates signal barriers in service delivery within the health system. Notably, there has been a substantial reduction in case fatality rates over the last 3 financial years: obstetric haemorrhage CFR decreased by 43%, high blood pressure in pregnancy CFR reduced by 50%, sepsis CFR by 9%, and malaria in pregnancy CFR declined by an impressive 75%. These improvements reflect significant progress in the quality of care delivered and underscore the importance of maintaining these gains to ensure continued improvement in maternal outcomes.

3.2.4 Postnatal Care

The postnatal period is critical for maternal and newborn health, with most deaths occurring soon after childbirth due to preventable issues like haemorrhage, infection, and hypertension. Early and continued postnatal care, including timely follow-ups and essential interventions, significantly reduces these risks. Key strategies include prompt assessments, access to emergency obstetric services, reliable supply chains for medicines, skilled staff, and strong facility infrastructure. Addressing service quality and regional disparities remains vital. This section reviews trends in postnatal care coverage for FY 2024/25, highlighting both progress and ongoing challenges, and emphasises the need for continued investment in the workforce, supplies, and facilities to improve outcomes nationwide.

Table 15: Regional trends in postnatal timing

PNC Timing	PNC at 24 hrs			PNC at 6 days			PNC at 6 Weeks		
Region	FY 2022/23	FY 2023/24	FY 2024/25	FY 2022/23	FY 2023/24	FY 2024/25	FY 2022/23	FY 2023/24	FY 2024/25
Acholi	95%	97%	97%	28%	28%	30%	70%	76%	80%
Ankole	98%	96%	98%	29%	31%	35%	80%	80%	78%
Bugisu	89%	92%	96%	41%	45%	52%	56%	64%	68%
Bukedi	90%	90%	91%	35%	35%	35%	58%	58%	66%
Bunyoro	100%	93%	94%	28%	26%	25%	57%	61%	64%
Busoga	92%	91%	90%	29%	30%	38%	57%	62%	62%
Kampala	94%	91%	91%	29%	33%	28%	59%	59%	61%
Karamoja	94%	96%	96%	49%	51%	50%	45%	47%	61%
Kigezi	96%	96%	97%	30%	27%	30%	58%	59%	60%
Lango	98%	97%	98%	27%	36%	34%	40%	42%	52%
North Buganda	90%	90%	90%	26%	27%	30%	50%	50%	50%
South Buganda	90%	91%	89%	19%	22%	24%	48%	44%	42%
Teso	98%	97%	97%	44%	47%	47%	44%	38%	42%
Tooro	93%	94%	94%	39%	38%	33%	35%	38%	40%
West Nile	97%	98%	97%	50%	53%	56%	36%	38%	31%
Grand Total	94%	94%	94%	33%	34%	36%	51%	53%	55%

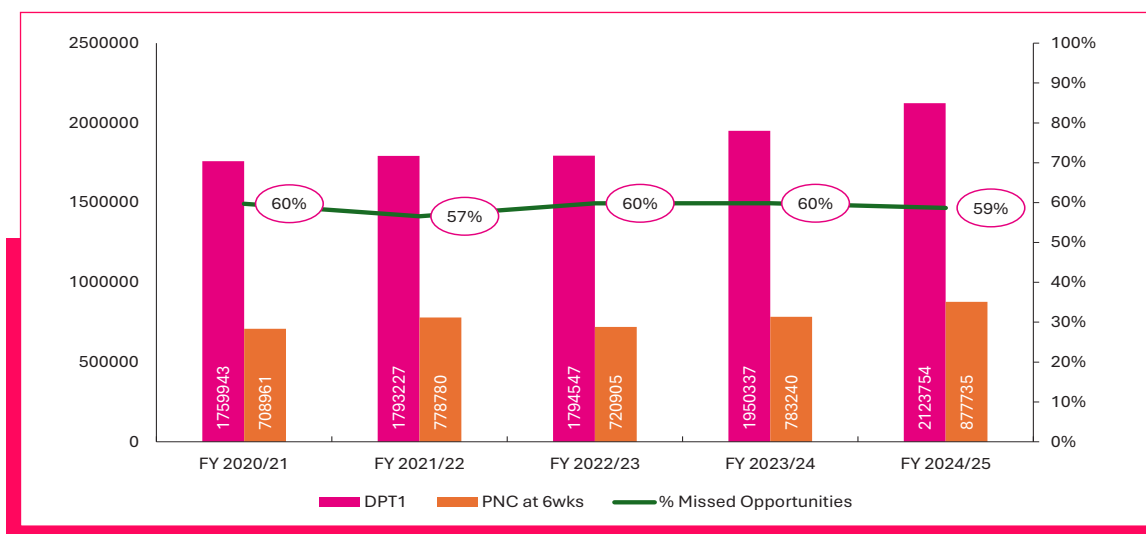
Key:	PNC at 24hrs		
	<85%	85-<95%	≥95%
	PNC at 6 days & 6 weeks		
	<45%	45-<70%	≥70%

The data on postnatal care (PNC) timing demonstrates a pronounced disparity in coverage across different stages. National PNC coverage at 24 hours is commendably high at 94%, indicating strong uptake immediately after birth. However, there is a steep decline for subsequent visits, with coverage dropping to just 36% at 6 days and 55% at 6 weeks.

This drop-off in follow-up care represents a critical missed opportunity, depriving mothers and newborns of essential preventative interventions that could address life-threatening postpartum complications, promote infant health, and support family planning. While regions such as West Nile and Bugisu perform relatively well in the 6-day visit, Acholi, Ankole, and Bugisu demonstrate stronger coverage at 6 weeks highlighting potential models for improving continuity of care nationwide.

To strengthen early PNC, it is vital to integrate these services into existing immunisation and vital statistics platforms, enhance community follow-up through community health workers (CHWs), and intensify targeted mobilisation efforts in regions with lower performance. Such measures will be crucial for closing gaps in postnatal care and ensuring sustained maternal and newborn health.

Figure 21: Trends in National PNC missed opportunities at DPT1 visit (6 wks)



The proportion of mothers receiving six-week postnatal care remains low, with missed opportunities averaging 59–60% over five years. Although PNC visits increased from 708,901 in FY2020/21 to 877,735 in FY2024/25, this growth lags behind immunisation contacts, which rose from 1.76 million to 2.12 million.

Mothers often prioritise infant immunisation over their own postnatal checks, influenced by beliefs, practical barriers like transport costs and distance, home responsibilities, insufficient discharge counselling, and lack of follow-up. Health systems focus more on infants than mothers, widening the gap. Strengthening integration between immunisation and PNC services, improving tracking, and coordinating community follow-up are necessary to address these persistent gaps.



Table 16: PNC missed opportunities at DPT1 visit (6 wks) by Region

Region	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
Acholi	69%	62%	66%	67%	59%
Ankole	63%	60%	60%	59%	49%
Bugisu	53%	43%	52%	47%	39%
Bukedi	44%	38%	46%	48%	50%
Bunyoro	60%	56%	67%	72%	70%
Busoga	65%	61%	63%	62%	58%
Kampala	73%	72%	61%	58%	65%
Karamoja	51%	47%	49%	44%	39%
Kigezi	46%	43%	48%	48%	46%
Lango	52%	52%	58%	59%	59%
North Buganda	63%	60%	61%	63%	65%
South Buganda	75%	75%	78%	77%	76%
Teso	37%	36%	38%	38%	40%
Tooro	57%	54%	59%	64%	69%
West Nile	57%	55%	56%	53%	52%
Overall	60%	57%	60%	60%	59%

Key:	<30%	30-<50%	>50%
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In FY 2024/25, an average of 59% of mothers and newborns missed out on postnatal care (PNC) during the DPT1 immunisation visit, highlighting a significant gap in the provision of essential checks. The issue is particularly acute in South Buganda (76%), Bunyoro (70%), and North Buganda (65%), where missed opportunities are most prevalent. In contrast, regions such as Teso, Bugisu, and Karamoja have demonstrated stronger performance, with only 40% missed opportunities.

These stark regional disparities underscore the inconsistent integration of PNC into routine immunisation services especially in high-burden areas where follow-up is weak and Village Health Team (VHT) engagement remains limited. To address these persistent gaps, it is imperative to strengthen the linkage between postnatal care and immunisation, enhance record-keeping practices, and invest in robust community follow-up systems. Without these critical improvements, too many mothers and newborns will continue to be overlooked during this vital window of care.

3.2.5 Newborn Health

Newborn health remains a national priority, playing a crucial role in improving child survival rates. In the financial year 2024/25, trends in newborn outcomes reveal both advancements and ongoing challenges within the health system. Significant progress has been made in the area of neonatal care, particularly with the expansion and uptake of Kangaroo Mother Care (KMC).

These improvements reflect increased efforts to provide appropriate support for vulnerable newborns, thereby bolstering the survival prospects of preterm and low-birth-weight infants.

Table 17: Trends in prevalence of low birth weight and Initiation to KMC

Financial Year	Live births	No. of Live births <2.5 Kg (%)	% Preterm babies	% initiated on KMC
FY 20/21	1307779	70,053 (5.4%)	2.4%	62.2%
FY 21/22	1441196	72,697 (5.0%)	2.3%	66.4%
FY 22/23	1393152	76,492 (5.5%)	2.6%	63.1%
FY 23/24	1465913	77,506 (5.3%)	2.6%	69.0%
FY 24/25	1562032	80,740 (5.2%)	2.5%	72.1%

The proportion of preterm and low birth weight (LBW) babies has remained largely unchanged over the past five financial years. Nevertheless, there has been notable progress in the initiation of Kangaroo Mother Care (KMC). This persistent stagnation points to gaps in preconception support and the overall quality of antenatal care.

To effectively address the prevalence of LBW, it is essential to strengthen preconception care through interventions such as counselling, nutritional assessment, and screening for common illnesses. Additionally, improving the quality of antenatal care including interventions like intermittent preventive treatment (IPT), deworming, and enhanced nutritional support will be key to achieving better outcomes for mothers and newborns.

Table 18: Trends in prevalence low birth weight and initiation on KMC by Region

Region	No of Live births		Live births < 2.5 Kg		No. of LBW initiated on KMC		Prevalence of low birth weight (<2500g) among newborn		% of eligible neonatal babies (<2500g) initiated on KMC	
	FY 23/24	FY 24/25	FY 23/24	FY 24/25	FY 23/24	FY 24/25	FY 23/24	FY 24/25	FY 23/24	FY 24/25
Acholi	65,904	68,876	4,633	4,988	2,597	3,901	7.0%	7.2%	56.1%	78.2%
Ankole	120,468	132,787	4,478	4,670	3,391	3,648	3.7%	3.5%	75.7%	78.1%
Bugisu	92,840	100,344	2,552	2,916	1,964	2,308	2.7%	2.9%	77.0%	79.1%
Bukedi	91,240	92,458	4,174	4,063	2,807	3,432	4.6%	4.4%	67.2%	84.5%
Bunyoro	86,573	93,652	5,272	5,136	3,988	3,914	6.1%	5.5%	75.6%	76.2%
Busoga	129,608	146,194	6,940	7,201	4,493	5,506	5.4%	4.9%	64.7%	76.5%
Kampala	85,718	84,383	7,553	7,628	4,559	3,469	8.8%	9.0%	60.4%	45.5%
Karamoja	40,278	42,709	2,695	3,172	1,674	2,033	6.7%	7.4%	62.1%	64.1%
Kigezi	54,942	57,154	2,230	2,449	1,599	1,983	4.1%	4.3%	71.7%	81.0%
Lango	85,669	90,046	5,438	5,769	4,079	4,296	6.3%	6.4%	75.0%	74.5%
North Buganda	150,932	159,787	6,588	7,120	4,018	4,213	4.4%	4.5%	61.0%	59.2%
South Buganda	144,429	158,368	5,810	5,904	2,991	2,906	4.0%	3.7%	51.5%	49.2%
Teso	80,259	81,578	4,739	4,995	3,751	3,801	5.9%	6.1%	79.2%	76.1%
Tooro	117,921	123,377	6,056	6,088	4,541	5,277	5.1%	4.9%	75.0%	86.7%
West Nile	119,132	130,319	8,348	8,641	7,052	7,531	7.0%	6.6%	84.5%	87.2%
Grand Total	1,465,913	1,562,032	77,506	80,740	53,504	58,218	5.3%	5.2%	69.0%	72.1%

Regions with high prevalence of low birth weight include Kampala (with a significant urban poor population), Karamoja, Acholi, and Teso areas often characterised by the aftermath of conflict and ongoing food insecurity. Additionally, Bunyoro and West Nile are notable due to their substantial refugee communities.

To address the challenges in these regions, a multisectoral strategy is recommended that incorporates initiatives to tackle food insecurity, manage conflict and resettlement, as well as targeted efforts to provide age-appropriate information designed to reduce teenage pregnancies. These interventions are tailored to the specific vulnerabilities and contextual realities of each region.

Table 19: Percentage of eligible neonatal babies (<2500g) initiated on KMC by Level

HF Level	FY-20/21	FY-21/22	FY-22/23	FY-23/24	FY-24/25
HC II	37.0%	38.5%	34.3%	37.9%	43.5%
HC III	56.0%	61.6%	61.8%	67.4%	70.2%
HC IV	63.9%	66.8%	62.5%	68.5%	78.4%
General Hospital	74.7%	78.1%	74.9%	81.3%	79.6%
RRH	50.6%	61.5%	64.8%	72.8%	85.5%
NRH	94.4%	90.5%	51.5%	52.5%	25.1%
Grand Total	62.4%	66.5%	63.2%	69.3%	72.4%

Overall, lower-level health facilities (with the exception of HC IIs), General Hospitals, and Regional Referral Hospitals have performed better than National Referral Hospitals. However, performance at the National Referral Hospital showed a notable decline of 27%, which is likely linked to documentation challenges.

Table 20: Proportion of live babies born with birth asphyxia successfully resuscitated

Period	Live births	Birth asphyxia	% Born with birth asphyxia	Birth Asphyxia resuscitated	% Successfully Resuscitated
FY 21/22	1,441,196	42,753	3.0%	38,141	89.2%
FY 22/23	1,393,152	43,384	3.1%	38,906	89.7%
FY 23/24	1,465,913	46,945	3.2%	42,824	91.2%
FY 24/25	1,562,032	42,021	2.7%	38,674	92.0%

Over the past five financial years, the number of live births in health facilities increased steadily from 1.3 million in FY2020/21 to 1.56 million in FY2024/25.

The proportion of newborns born with birth asphyxia has remained relatively stable at around 3%, with a slight decline to 2.7% in FY2024/25.

This trend highlights improved intrapartum care, that has been achieved through capacity-building initiatives, including the scale-up of newborn resuscitation training, mentorship, and provision of essential equipment, which have strengthened facility readiness to manage birth asphyxia.

Table 21: Proportion of live babies born with birth asphyxia by region

Region	Live births		Birth asphyxia (%)		Birth Asphyxia Successfully resuscitated (#)		% Successfully Re-suscitated	
	FY23/24	FY24/25	FY23/24	FY24/25	FY23/24	FY24/25	FY23/24	FY24/25
Acholi	65,904	68,876	1,837 (2.8%)	1,985 (2.9%)	1,603	1,802	87.3%	90.8%
Ankole	120,468	132,787	3,264 (2.7%)	2,345 (1.8%)	3,065	2,152	93.9%	91.8%
Bugisu	92,840	100,344	3,526 (3.8%)	2,062 (2.1%)	2,560	1,884	72.6%	91.4%
Bukedi	91,240	92,458	2,307 (2.5%)	1,962 (2.1%)	2,127	1,816	92.2%	92.6%
Bunyoro	86,573	93,652	3,110 (3.6%)	3,421 (3.7%)	2,840	3,166	91.3%	92.5%
Busoga	129,608	146,194	4,895 (3.8%)	5,306 (3.6%)	4,491	4,760	91.7%	89.7%
Kampala	85,718	84,383	3,140 (3.7%)	2,944 (3.5%)	3,016	2,601	96.1%	88.3%
Karamoja	40,278	42,709	1,367 (3.4%)	1,215 (2.8%)	1,290	1,131	94.4%	93.1%
Kigezi	54,942	57,154	1,151 (2.1%)	1,095 (1.9%)	1,043	997	90.6%	91.1%
Lango	85,669	90,046	2,883 (3.4%)	2,886 (3.2%)	2,660	2,723	92.3%	94.4%
North Buganda	150,932	159,787	4,391 (2.9%)	4,082 (2.6%)	3,859	3,766	87.9%	92.3%
South Buganda	144,429	158,368	4,601 (3.2%)	3,254 (2.1%)	4,312	2,959	93.7%	90.9%
Teso	80,259	81,578	2,689 (3.4%)	2,335 (2.9%)	2,545	2,216	94.6%	94.9%
Tooro	117,921	123,377	3,609 (3.1%)	3,512 (2.8%)	3,448	3,332	95.5%	94.9%
West Nile	119,132	130,319	4,175 (3.5%)	3,617 (2.8%)	3,965	3,369	95.0%	93.1%
National	1,465,913	1,562,032	46,945 (3.2%)	42,021 (2.7%)	42,824	38,674	91.2%	92.0%

Notable improvements were recorded in Ankole (1.8%) and Kigezi (1.9%), showing steady reductions over the five years. Regions like Bunyoro (3.7%), Busoga (3.6%), and Kampala (3.5%) continue to register higher rates, highlighting areas where intrapartum care and timely intervention (including referral pathways) need to be strengthened.

Newborn resuscitation success increased by about 5 percentage points from FY 2020/21 to FY 2024/25, reaching 92% nationally. Regions such as Teso, Tooro, Lango, and Karamoja achieved above 94%, while Bugisu and South Buganda recorded notable improvements compared to previous years.

The suggests ongoing training, mentorship, and availability of resuscitation equipment. Slight declines in Kampala and Busoga highlight challenges of documentation and workload in high-volume settings.

Table 22: Proportion of live babies born with birth asphyxia by Level

HF Level	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
HC II	1.9%	1.7%	1.4%	1.5%	1.4%
HC III	1.5%	1.3%	1.2%	1.5%	1.2%
HC IV	3.4%	3.2%	3.1%	3.3%	3.1%
General Hospital	6.2%	6.0%	6.7%	6.2%	5.4%
RRH	6.5%	8.3%	8.2%	8.4%	5.7%
NRH	8.5%	5.6%	7.3%	7.1%	6.6%
Grand Total	3.2%	3.0%	3.1%	3.2%	2.7%

Birth asphyxia remained low in lower-level facilities (HC II–IV), consistently below 3% over the past five years. General and Regional Referral Hospitals recorded higher rates, averaging 6–8% in earlier years but declining to 5.4% and 5.7% respectively in FY2024/25. National Referral Hospitals improved from 8.5% in FY2020/21 to 6.6% in FY2024/25, reflecting better intrapartum and pre-referral care. Strengthening partograph use at all levels remains essential.

Table 23: Proportion of live babies born with birth asphyxia successfully resuscitated by level

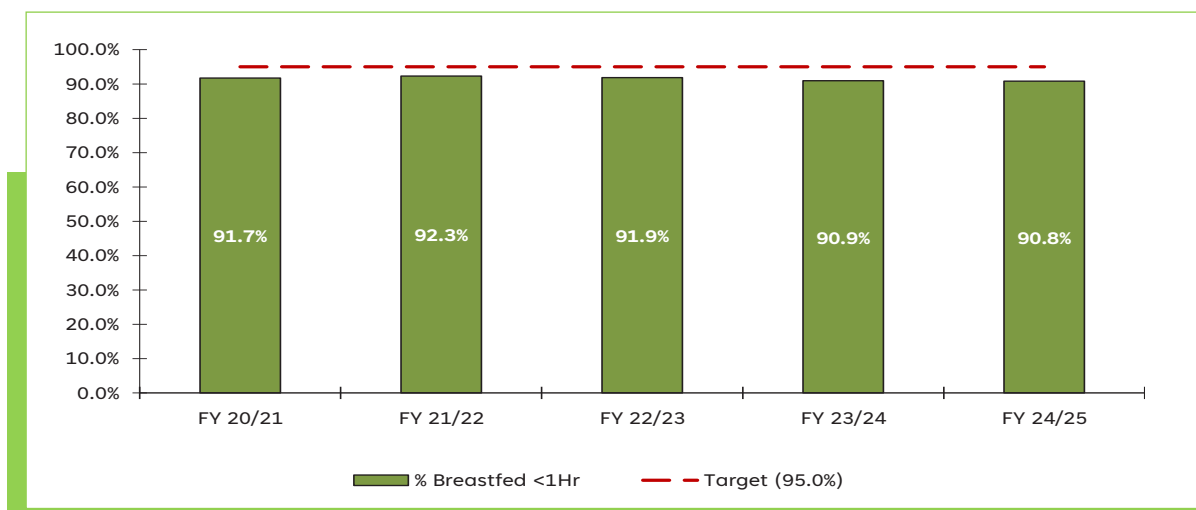
HF Level	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
HC II	90.8%	93.1%	94.6%	95.6%	93.0%
HC III	88.0%	90.8%	90.2%	93.2%	91.5%
HC IV	87.4%	90.4%	89.9%	93.4%	93.6%
General Hospital	88.6%	90.6%	91.2%	91.0%	91.8%
RRH	81.5%	81.0%	81.8%	83.4%	92.6%
NRH	90.1%	88.9%	95.6%	95.5%	84.6%
Grand Total	87.6%	89.2%	89.6%	91.2%	92.0%

Key

	<90%		90<100%		100%
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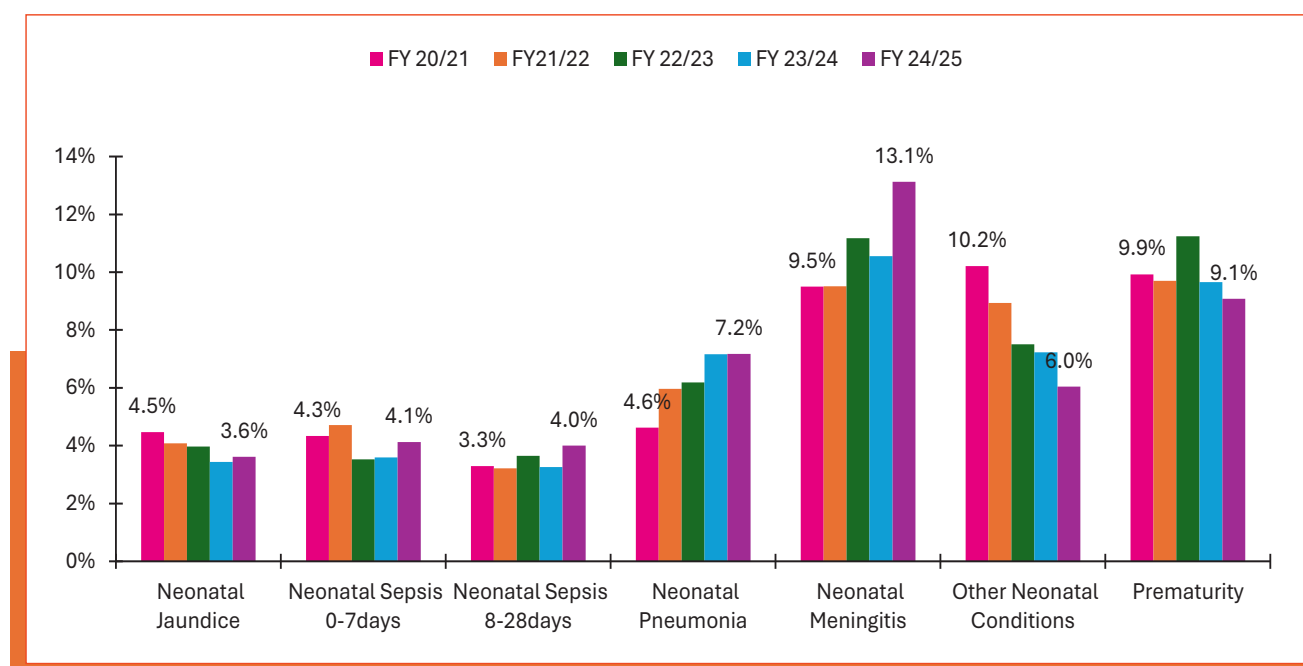
Lower-level facilities (HC II–HC IVs) maintained strong performance above 90% in recent years. Regional Referral Hospitals showed marked progress, rising from 81.5% to 92.6%, while National Referral Hospitals fluctuated, ending at 84.6%.

Figure 22: Early initiation of breastfeeding (% of mothers initiating breastfeeding in 1st hour)



The proportion of mothers initiating breastfeeding within the first hour after births has remained below the 95% target over the past five years. Strengthening the role of health workers in guiding mothers immediately after delivery, together with improved postnatal care, will be key to closing these gaps.

Figure 23: Case Fatality Rate for Neonatal Conditions



Deaths due to other neonatal conditions (including birth asphyxia) declined steadily from 10.2% to 6%, while prematurity-related fatalities showed slower progress, remaining above 7% by FY2024/25. Neonatal meningitis remains the most fatal condition, peaking at 13.1% in FY2024/25 from 9.1% in FY2020/21.

Table 24: Case Fatality Rate for top 3 Neonatal Conditions – FY24/25

Region	Birth Asphyxia and Other Neonatal Conditions		Prematurity		Neonatal Meningitis	
	Admissions	Institutional Death Rate	Admissions	Institutional Death Rate	Admissions	Institutional Death Rate
Acholi	1700	7.3%	830	10.5%	5	0.0%
Ankole	1117	10.4%	847	6.6%	53	7.5%
Bugisu	1724	9.1%	1200	10.8%	50	44.0%
Bukedi	2598	3.3%	681	4.0%	15	13.3%
Bunyoro	3527	5.4%	1310	6.9%	27	3.7%
Busoga	2673	5.3%	1156	7.7%	35	17.1%
Kampala	7592	4.8%	5893	6.8%	156	8.3%
Karamoja	738	7.7%	482	25.3%	8	12.5%
Kigezi	952	10.2%	1036	17.1%	19	5.3%
Lango	1205	6.7%	754	6.0%	4	25.0%
North Buganda	5211	4.9%	2785	7.2%	58	10.3%
South Buganda	2546	7.9%	1562	13.6%	33	6.1%
Teso	702	16.7%	533	15.9%	6	0.0%
Tooro	4452	5.5%	2201	9.5%	23	30.4%
West Nile	3609	5.6%	1729	9.1%	11	0.0%
Grand Total	40346	6.0%	22999	9.1%	503	13.1%

Birth asphyxia case fatality was 6.0% nationally in FY2024/25, with most regions below 10% except Teso (16.7%) and Ankole (10.4%). Prematurity had a higher fatality of 9.1%, reaching 25.3% in Karamoja and above 15% in Kigezi and Teso. Neonatal meningitis remained the most fatal at 13.1% nationally, with Bugisu (44.0%) and Tooro (30.4%) reporting the highest rates.

These trends show progress in managing birth asphyxia but underline persistent challenges with preterm care and infection management. Regions with high case fatality often face limited newborn intensive care, gaps in specialized equipment, and delays in diagnosis and treatment.

Expand newborn intensive care services, strengthen early diagnosis and treatment of neonatal infections, and scale up mentorship and supportive supervision to reduce regional disparities. Ensure steady supply of essential commodities for preterm and sick newborn care.

STATUS OF NEONATAL CARE UNITS IN PUBLIC HEALTH FACILITIES

The Ministry of Health conducted a nationwide assessment of Neonatal Care Units across all public hospitals and Health Centre IVs providing newborn care. In this assessment, functional referred to the availability of a designated area specifically allocated for newborn care, while operational was defined as a neonatal care unit actively providing services demonstrated by at least ten admissions per month, availability of a minimum of three essential pieces of newborn equipment, and access to a functional oxygen system (free-flow oxygen).

Figure 24: Proportion of Public Health Facilities with Neonatal Care Units by Level of Care

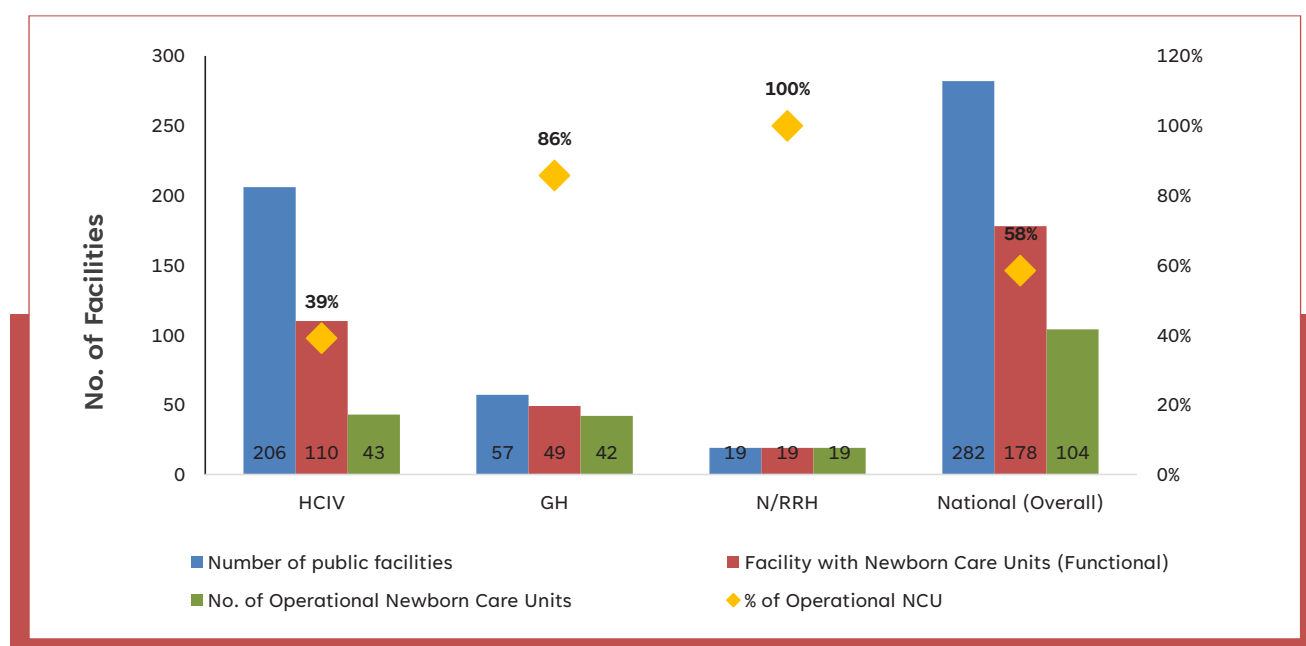


Figure 24 shows that 282 health facilities were assessed, of which 178 had newborn care units and 104 (58%) were operational. Operational newborn care units were highest in referral hospitals (100%) and general hospitals (86%), but remained low at health centre IVs, where only 39% were functional.

Health Centre IVs are intended to provide emergency obstetric and newborn care at sub-district level. Weak operational capacity at this level contributes to delayed or missed care for newborns at those facilities.

Strengthening HC IVs through adequate equipment, skilled staff, and consistent oxygen supply is therefore critical, not only to improve newborn survival but also to ease referral burdens and reduce preventable case fatalities linked to complications during childbirth.

Table 25: Proportion of Public CEmONC Health Facilities with Newborn Care Units by Health Region

Region	Number of facilities	No. of Health facilities with Neonatal Units	% of Facilities having Neonatal Units	No. of Health facilities with operational Neonatal Units	% of fully operational Neonatal Units
Kampala	14	11	78.6%	7	64%
Karamoja	28	17	60.7%	2	12%
Bukedi	15	8	53.3%	4	50%
Bunyoro	13	6	46.2%	6	100%
Teso	16	13	81.3%	11	85%
West Nile	24	23	95.8%	12	52%
Tooro	10	5	50.0%	5	100%
South Buganda	9	4	44.4%	4	100%
North Buganda	24	8	33.3%	1	13%
Acholi	14	7	50.0%	3	43%
Busoga	29	22	75.9%	13	59%
Bugisu	28	14	50.0%	9	64%
Lango	17	7	41.2%	5	71%
Kigezi	23	17	73.9%	11	65%
Ankole	18	16	88.9%	11	69%
Total	282	178	63.1%	104	58%

Overall, 63.3% of CEmONC facilities had newborn care units, yet only 58.5% were fully functional. Coverage remains uneven, with regions such as Karamoja, Bukedi, Teso, and Kigezi still below 50%, but the greater challenge lies in functionality. In Teso, Bukedi, Karamoja, Bugisu, Lango, Kigezi, and Ankole, fewer than half of existing units are functional, pointing to systemic weaknesses.

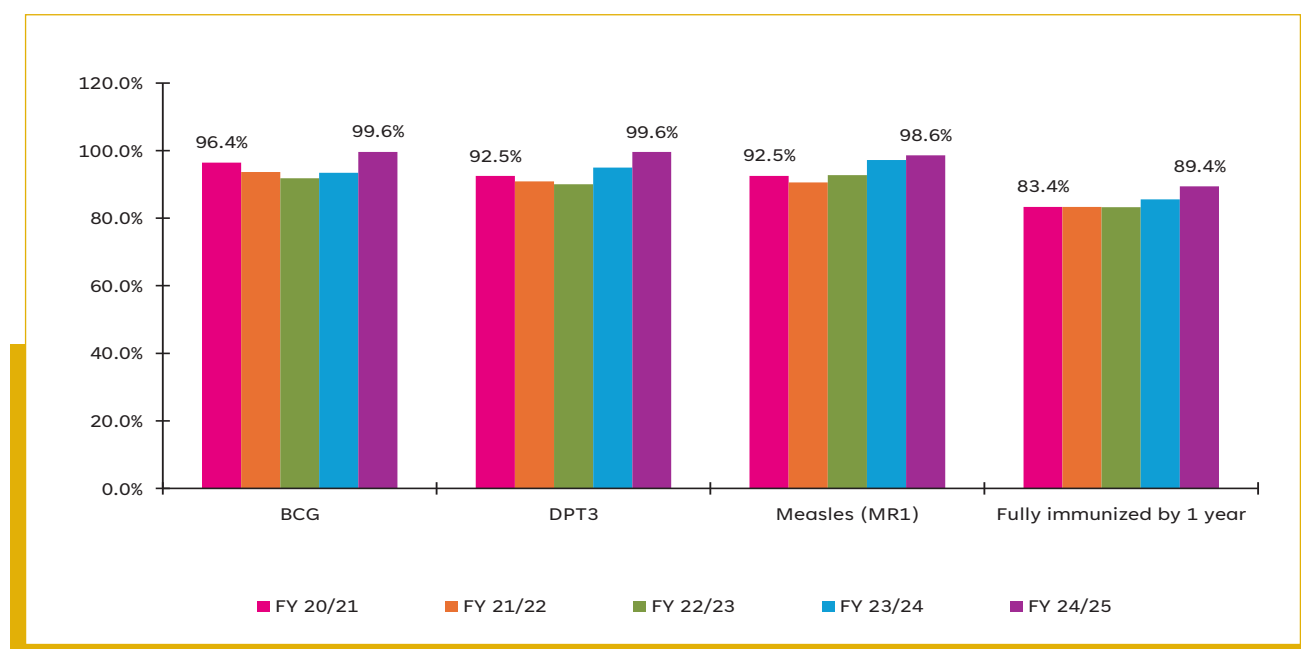
The underlying causes lack of essential equipment like incubators and oxygen systems, coupled with shortages of skilled neonatal staff mean that even where units exist, they cannot deliver lifesaving care. This shifts the strategic imperative from simply expanding coverage to ensuring that all established units are fully functional and able to respond effectively to newborn complications.

Regions with low functionality also show higher case fatality rates for birth asphyxia and prematurity/low birth weight, underscoring the direct link between non-functional units and preventable newborn deaths. For MPDSR, these findings highlight missed opportunities in quality of care: while increasing coverage is important, it will not translate into survival gains unless functionality is assured. Priority should therefore be directed at equipping and staffing existing newborn care units, ensuring oxygen availability, and strengthening accountability for functionality to reduce avoidable neonatal mortality.

3.2.6 Child Health

Child health remains a key pillar of Uganda's RMNCAH agenda and a driver of SDG 3 targets. In FY 2024/25, progress was noted in immunization coverage and management of childhood illnesses, reflecting sustained investment and service integration. However, malaria, pneumonia, and diarrhea remain major causes of child morbidity, calling for stronger prevention, consistent supplies, and timely care-seeking.

Figure 25: Immunization coverage (Measles, DPT3, fully immunized child by under 1yr, dose at birth)

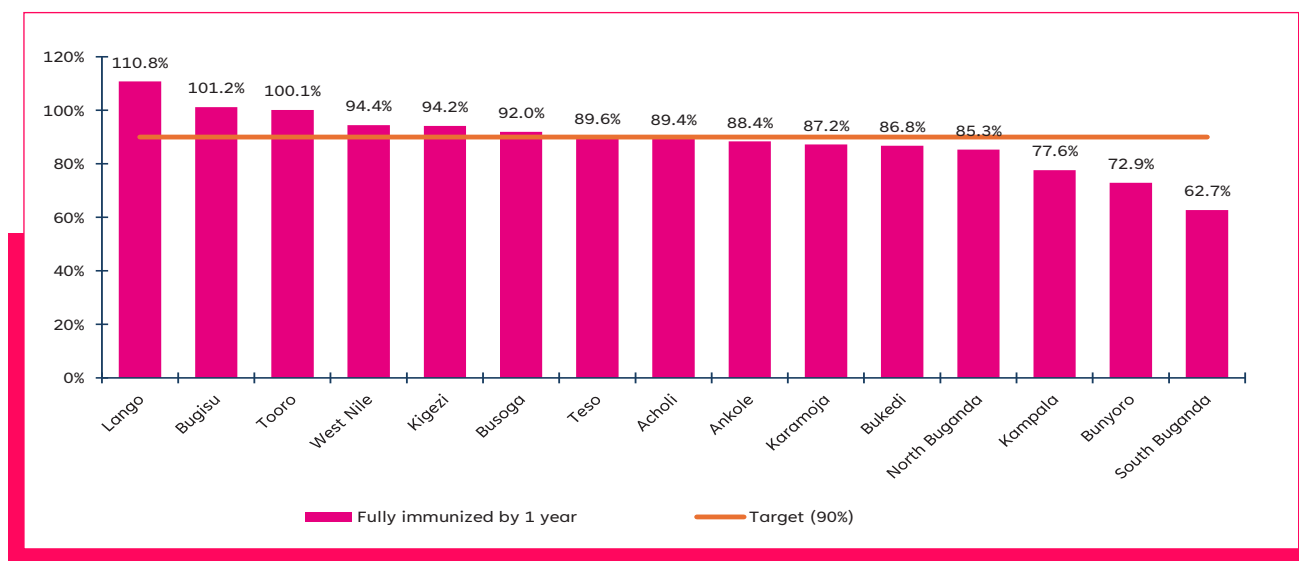


Immunisation coverage for BCG, DPT3, and Measles (MR1) has remained consistently high, exceeding 90% by FY2024/25. However, the proportion of children fully immunised by one year, though improved from 83.4% in FY2020/21 to 89.4% in FY2024/25, remains just below the 90% target.



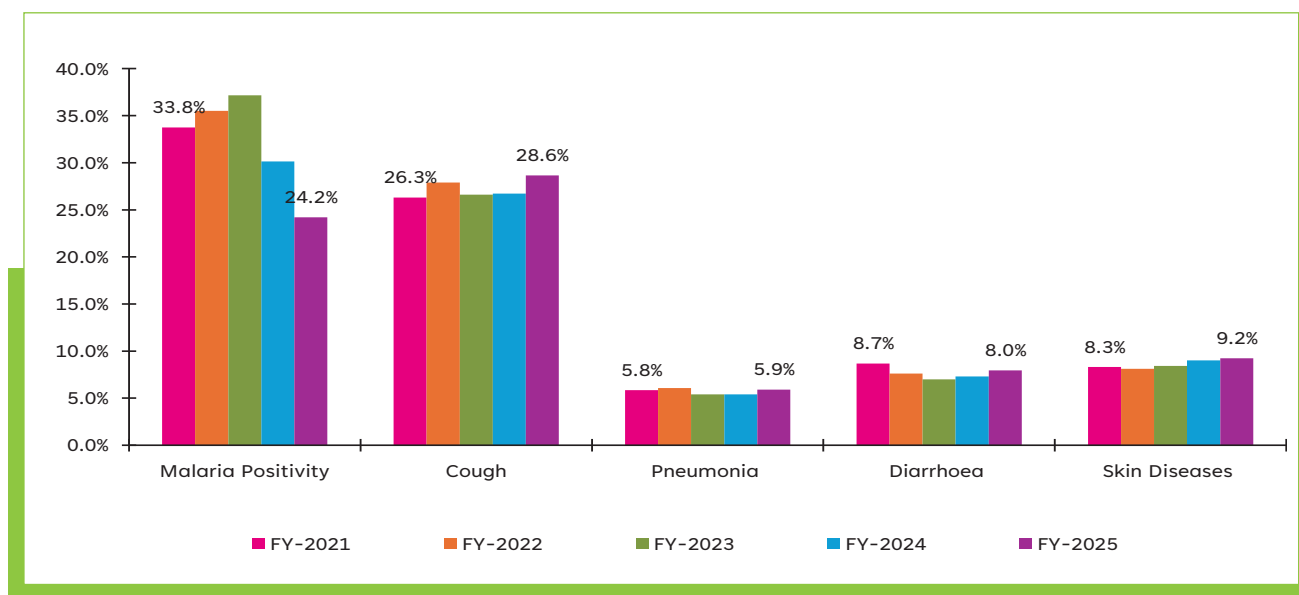
“Uganda continues to make commendable progress in immunisation coverage, but achieving universal protection for every child requires sustained focus on underperforming regions.”

Figure 26: Fully immunized by 1 year by Region · FY24/25



Regional disparities persist: while Lango, Bugisu, Tooro, and West Nile surpassed the target, regions such as South Buganda (62.7%) and Bunyoro (72.9%) lagged significantly.

Figure 27: Prevalence of Top 5 childhood illnesses at OPD



In FY2024/25, Childhood morbidity patterns show cough (28.6%), malaria (24.2%), diarrhoea (8%), pneumonia (5.9%), and skin diseases (4.6%) dominating OPD visits.

Table 26: Prevalence of common childhood illnesses at OPD –Malaria by Region

Region	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Lango	49.1%	53.6%	57.7%	50.8%	46.3%
Acholi	50.7%	44.2%	50.4%	47.4%	40.0%
Busoga	49.8%	50.4%	54.6%	44.1%	38.3%
Teso	30.4%	41.6%	48.1%	42.5%	36.9%
Karamoja	54.7%	48.2%	42.1%	38.7%	36.0%
Bunyoro	34.4%	35.2%	39.9%	33.0%	32.8%
Bukedi	26.1%	52.1%	53.2%	35.3%	26.5%
North Buganda	30.1%	26.0%	26.6%	22.0%	19.4%
Tooro	26.9%	27.9%	31.0%	22.6%	19.0%
Bugisu	18.2%	19.3%	23.6%	19.3%	17.9%
West Nile	55.3%	54.4%	51.8%	42.3%	17.4%
South Buganda	15.1%	18.1%	20.6%	15.3%	10.9%
Ankole	16.5%	19.6%	20.0%	14.5%	10.8%
Kampala	5.1%	5.2%	5.2%	5.7%	4.4%
Kigezi	4.8%	6.1%	6.6%	4.8%	3.2%
Grand Total	33.8%	35.5%	37.1%	30.1%	24.2%

National malaria prevalence declined to 24.2% in FY2024/25, however remained disproportionately high in regions of Lango, Acholi, Busoga, Teso, Karamoja, Bunyoro, and Bukedi above the national average.



Table 27: Percentage Trend in the Prevalence of the 3 common childhood illnesses at OPD by Region

Region	Cough – No pneumonia					Diarrhoea					Pneumonia				
	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25
Acholi	46.7%	48.3%	44.4%	44.7%	46.4%	12.2%	10.0%	10.2%	10.0%	12.5%	11.8%	10.3%	9.8%	9.8%	9.8%
Ankole	34.7%	35.0%	34.8%	35.0%	35.8%	11.1%	9.5%	9.7%	9.7%	9.6%	10.8%	10.0%	8.6%	8.4%	8.8%
Bugisu	33.5%	35.0%	35.4%	35.1%	35.6%	10.0%	9.1%	8.3%	9.8%	9.5%	7.3%	8.3%	8.7%	8.6%	9.5%
Bukedi	31.8%	32.2%	31.1%	30.6%	31.2%	10.2%	8.3%	8.7%	8.9%	8.6%	7.3%	7.6%	7.4%	7.9%	7.6%
Bunyoro	33.3%	28.0%	26.8%	30.9%	33.4%	8.4%	7.7%	7.9%	8.5%	12.3%	6.4%	6.5%	6.0%	6.3%	6.2%
Busoga	28.1%	28.6%	29.0%	29.5%	32.1%	9.8%	8.7%	8.0%	8.3%	8.7%	6.2%	6.6%	5.8%	5.8%	6.4%
Kampala	30.7%	32.2%	28.4%	27.6%	27.5%	10.9%	7.5%	6.9%	8.4%	9.2%	5.4%	6.1%	6.0%	6.0%	7.0%
Karamoja	26.6%	28.2%	26.3%	28.7%	28.3%	9.8%	8.6%	7.4%	7.7%	7.6%	5.3%	5.1%	4.6%	5.1%	7.2%
Kigezi	30.4%	31.9%	27.7%	23.0%	25.4%	8.5%	8.0%	7.4%	7.2%	8.5%	4.3%	5.2%	5.1%	5.4%	6.7%
Lango	24.8%	27.2%	27.2%	26.1%	26.9%	8.7%	7.4%	7.1%	7.1%	7.2%	5.9%	6.0%	4.7%	4.1%	4.8%
North Buganda	20.4%	22.7%	24.2%	26.3%	32.1%	7.4%	6.6%	5.8%	6.4%	7.4%	4.6%	6.1%	4.9%	4.8%	4.8%
South Buganda	21.0%	24.7%	23.6%	23.7%	26.0%	7.8%	6.5%	5.8%	5.6%	5.6%	5.6%	5.2%	4.5%	4.3%	4.4%
Teso	17.3%	18.9%	19.8%	19.9%	19.8%	5.8%	6.0%	5.5%	5.6%	6.1%	5.5%	4.3%	3.9%	4.3%	4.2%
Tooro	14.9%	19.3%	19.2%	19.0%	21.4%	7.1%	6.5%	5.3%	4.7%	5.2%	2.6%	3.3%	3.0%	3.2%	3.1%
West Nile	12.6%	15.5%	14.0%	14.3%	14.7%	4.4%	4.4%	3.5%	3.8%	3.4%	2.1%	2.9%	2.0%	2.1%	2.3%
National	26.3%	27.9%	26.6%	26.7%	28.6%	8.7%	7.6%	7.0%	7.3%	8.0%	5.8%	6.1%	5.4%	5.4%	5.9%

Figure 28: Prevalence of common childhood illnesses at OPD - Diarrhoea by region, FY24/25

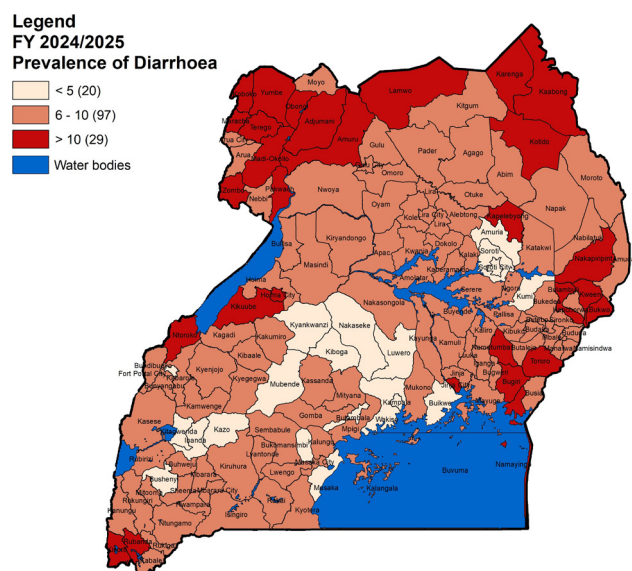


Figure 29: Prevalence of common childhood illnesses at OPD - Pneumonia by region, FY24/25

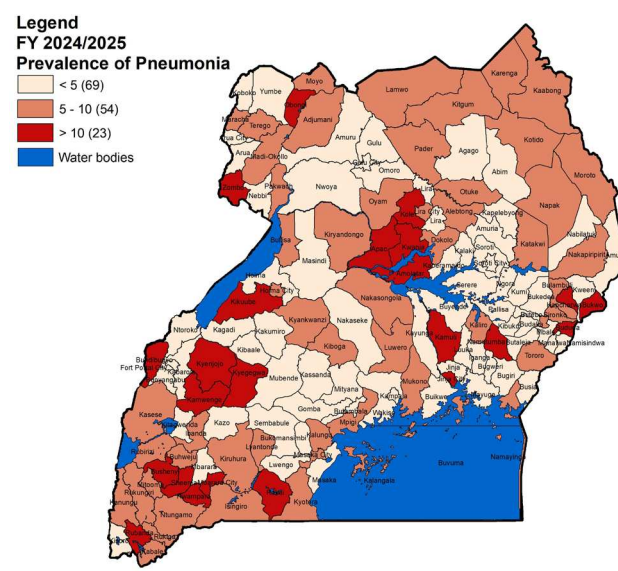
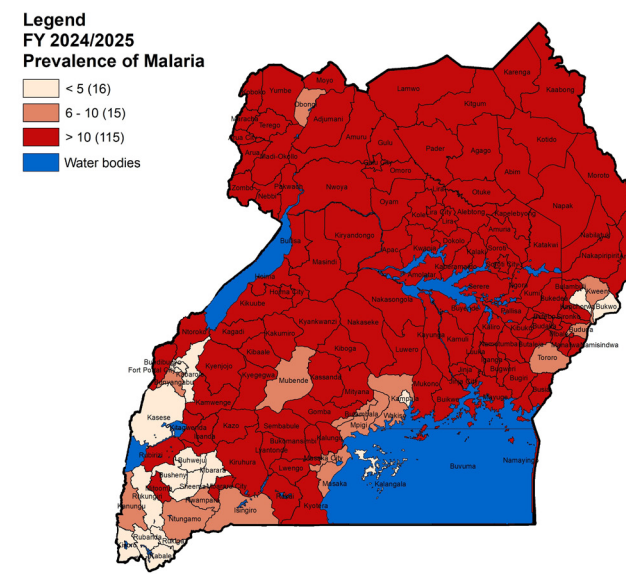


Figure 30: Prevalence of common childhood illnesses at OPD - Malaria by region, FY24/25



These findings point to a dual challenge: maintaining high coverage for individual antigens while closing gaps in completing the full immunisation schedule, especially in underperforming regions. At the same time, the high outpatient burden from malaria, respiratory infections, and diarrhoeal disease highlights the need for increasing focus on preventive services. There are regional variations in the prevalence of the different childhood conditions which calls for targeted interventions.

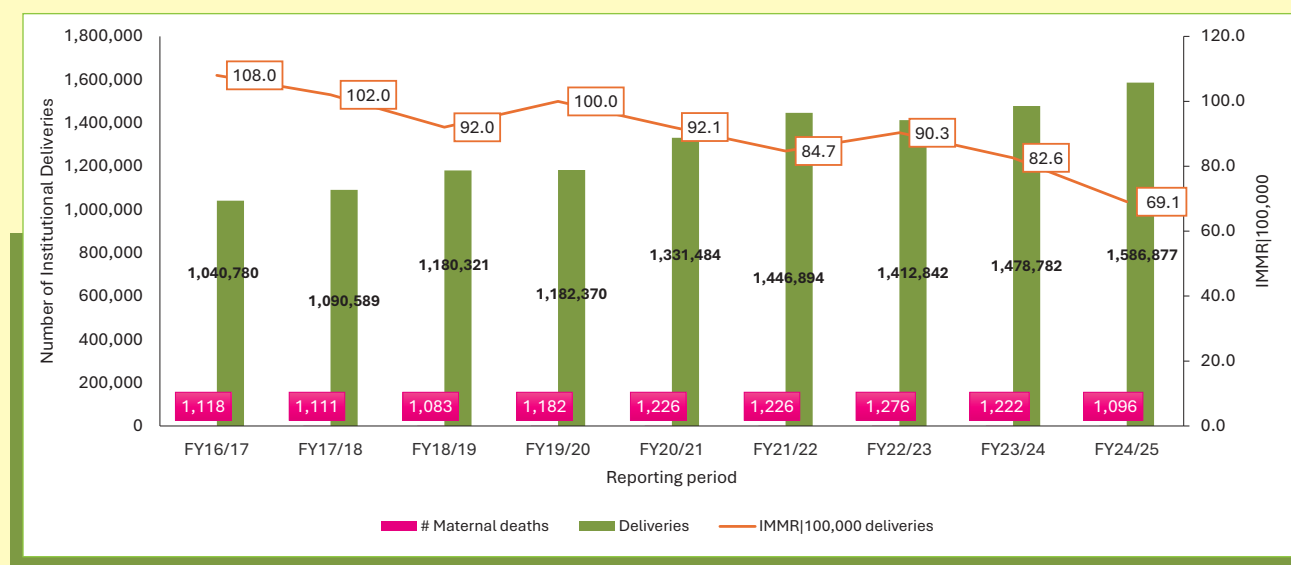
The strategic priority is to ensure not just broad coverage but equity and functionality of child health services. For immunisation, this means having updated EPI micro-plans, intensifying tracing of lost-to-follow-up in low-performing regions, and community outreaches RED/REC (reach every district/reach every child) approach. For morbidity reduction, investments should target malaria and pneumonia control through community case management, improved diagnostics, and strengthened supply chains for essential medicines.



3.3 INSTITUTIONAL MATERNAL DEATHS

3.3.1 National trends in IMMR/100,000 deliveries in the past 9 years

Figure 31: National trends in IMMR/100,000 deliveries in the past 9 years



Over the past five years, Uganda has registered an increase in the number of institutional deliveries. The IMMR reduced from 92.1 per 100,000 deliveries in FY2020/21 to 69.1 per 100,000 deliveries in FY2024/25, marking a 24.97% reduction in the same period.

This trend can be attributed to strengthened data-driven accountability at both national and sub-national levels, safe motherhood campaigns, improved coordination at regional level through LMNS, setting up and functionalising BEmONC and CEmONC facilities.

To sustain these gains, functionalise all pending CEmONC facilities, increase the investment in reproductive health supplies and commodities, and implement high-impact maternal and newborn practices.

3.3.2 Regional trends in Institutional deliveries, maternal deaths reported, and mortality rates

Table 28: Regional trends in Institutional deliveries, maternal deaths reported, and mortality rates

Region	No. health facility Deliveries				No. Maternal deaths				Institutional Maternal mortality ratio/ 100,000 deliveries				IMMR Change over the last 2 FY
	FY21/22	FY22/23	FY23/24	FY24/25	FY21/22	FY22/23	FY23/24	FY24/25	FY21/22	FY22/23	FY23/24	FY24/25	
Acholi	65,143	64,142	66,622	70,743	67	66	45	75	102.9	102.9	67.5	106.0	↑
Ankole	111,388	114,028	120,123	134,425	91	89	77	59	81.7	78.1	64.1	43.9	↓
Bugisu	100,244	93,492	93,553	102,382	67	114	97	78	66.8	121.9	103.7	76.2	↓
Bukedi	91,236	85,023	91,042	95,368	39	46	51	40	42.7	54.1	56.0	41.9	↓
Bunyoro	89,770	83,807	88,497	95,695	102	103	83	64	113.6	122.9	93.8	66.9	↓
Busoga	124,806	124,510	131,265	148,510	93	116	123	91	74.5	93.2	93.7	61.3	↓
Kampala	87,966	87,879	86,029	85,050	196	180	183	169	222.8	204.8	212.7	198.7	↓
Karamoja	33,702	35,517	40,572	43,491	23	12	30	25	68.2	33.8	73.9	57.5	↓
Kigezi	55,478	53,464	55,178	57,573	30	38	35	27	54.1	71.1	63.4	46.9	↓
Lango	78,765	74,902	86,728	91,207	55	45	53	59	69.8	60.1	61.1	64.7	↑
North Buganda	148,430	146,242	152,348	161,864	122	126	126	122	82.2	86.2	82.7	75.4	↓
South Buganda	145,614	140,932	145,322	159,700	122	87	109	98	83.8	61.7	75.0	61.4	↓
Teso	74,030	74,074	81,140	82,700	58	63	44	45	78.3	85.1	54.2	54.4	↑
Tooro	126,099	122,315	119,635	126,290	76	96	80	74	60.3	78.5	66.9	58.6	↓
West-Nile	114,223	112,515	120,728	131,879	85	95	86	70	74.4	84.4	71.2	53.1	↓
Uganda	1,446,894	1,412,842	1,478,782	1,586,877	1,226	1,276	1,222	1,096	84.73	90.3	82.6	69.1	↓

Key (IMMR)

	≤63
	64-90
	>90

Most sub-regions recorded declines, with marked reductions in Ankole, Busoga, South Buganda, and West Nile. However, some regions including Acholi, Lango, and Teso experienced a rise in IMMRs. Kampala consistently carried the heaviest burden, with an IMMR of 198.7 in FY2024/25, nearly three times the national average.

The overall decline reflects strengthened maternal health services, with some regions making notable progress in reducing institutional deaths. However, the rise in Acholi, Lango, and Teso points to gaps in quality of care, referral communication, and emergency obstetric readiness. In Acholi, most deaths occurred early in the year, where challenges in referral preparedness from lower facilities were noted. The LMNS held dialogues with facility teams and attached specialists to key

referring districts to strengthen coordination and pre-referral consultations. In addition, a confidential inquiry was conducted and revealed gaps in team coordination, which were addressed through district leadership engagement and realignment of critical cadres resulting in improved teamwork and no further maternal deaths in the subsequent months.

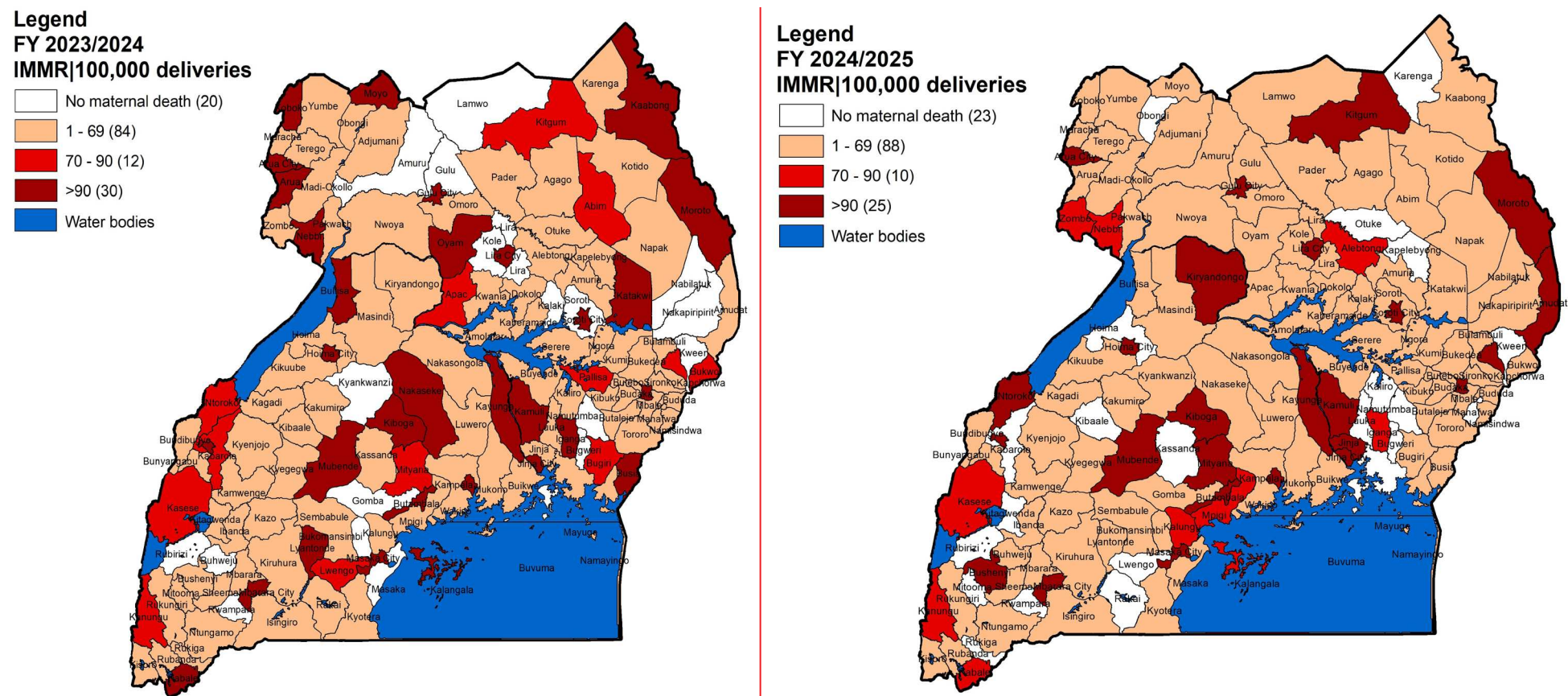
Intensified interventions are needed in Acholi, Lango, Teso, and Kampala to reverse rising or high mortality trends. Priorities include improving emergency obstetric care, strengthening referral systems, and enhancing accountability mechanisms at facility and regional levels. Best practices from high-performing regions such as Ankole, Bunyoro, and West Nile should be scaled nationally to sustain progress and narrow disparities.



Refurbished operating theatres in Padibe HCIV, Rhino camp HCIV, Busanza HCIV, and Kisoro General Hospital

3.3.3 Institutional maternal mortality ratio by district, FY2024/25

Figure 32: Maps comparing District IMMR for the past two financial years



In FY2024/25, 111 of districts (76%) achieved the annual RMNCAH Sharpened Plan (2022/23–2027/28) IMMR reduction target of below 70 deaths per 100,000 deliveries, an improvement from 57.6% (84 districts) in FY2023/24. During the same period, 25 districts (17.1%) including all those hosting Regional Referral Hospitals recorded high IMMRs above 90 per 100,000 deliveries. This represents a reduction from 34 districts (23%) in FY2022/23.

In addition, 23 districts (15.7%) did not report

any maternal deaths throughout FY2023/24, compared to 19 districts in FY2022/23.

The Local Maternity and Neonatal Systems (LMNS) should engage these 23 districts with zero reported maternal deaths to further evaluate their maternal health care services and validate the situation, including potential contributing factors. This will help determine whether the results reflect genuine gains in maternal survival or possible gaps in reporting, and ensure lessons learned can be shared and applied across other districts.

3.3.4 Trends in Institutional maternal death reported and mortality ratio by age

Table 29: Maternal mortality by age category

Maternal age category	FY2020/21		FY2021/22		FY2022/23		FY2023/24		FY2024/25	
	No. (proportion) of maternal deaths	IMMR/100,000 deliveries	No. (proportion) of maternal deaths	IMMR/100,000 deliveries	No. (proportion) of maternal deaths	IMMR/100,000 deliveries	No. (proportion) of maternal deaths	IMMR/100,000 deliveries	No. (proportion) of maternal deaths	IMMR/100,000 deliveries
≤ 19 Yrs	148 (12%)	63.2	122 (10%)	46.5	152 (12%)	62.9	133 (10.9%)	53.8	133 (12.1%)	51.2
20 - 24 Yrs	273 (22%)	60.5	272 (22%)	56.6	284 (22%)	61.3	308 (25.2%)	62.9	274 (25.0%)	52.9
≥ 25 Yrs	805 (66%)	125.4	832 (68%)	118.2	840 (66%)	118.7	781 (63.9%)	105.1	689 (62.9%)	85.1
Overall	1,226	92.4	1,226	84.7	1,276	90.3	1,222	82.6	1,096	69.1

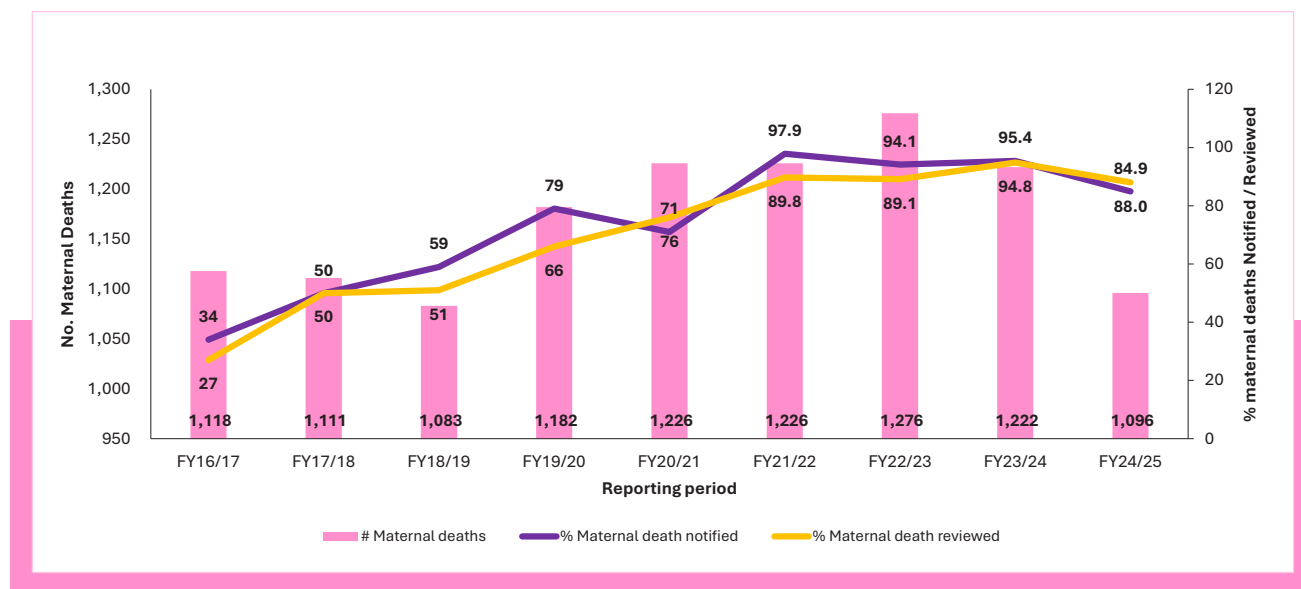
Between FY2023/24 and FY2024/25, IMMR declined across all age groups, with the largest reduction of 20 per 100,000 deliveries observed among women aged 25 years and above. Adolescents (≤19 years) account for one in every ten maternal deaths.

IMMR among adolescents reduced from 63.2 in FY 2020/21 to 51.2 in FY 2024/25 IMMR. This is attributed to the emerging general success

of the MPDSR, increased family planning uptake among sexually active adolescents, stronger multisectoral action, targeted high impact interventions like Group ANC, provision of age-appropriate information on health, integrated outreaches, especially in hard-to-reach areas, wider access and use adolescent friendly services, better data use making pregnancy prevention and care timelier.

3.3.5 National trends in Institutional Maternal Deaths Reporting, notification and reviews

Figure 33: Trends in Maternal Deaths Reporting, notification and reviews



Over the past five years, maternal deaths reached their highest level at 1,276 in FY2022/23 before dropping to 1,096 in FY2024/25. The proportion of deaths notified improved steadily and peaked at almost full coverage (98%) in FY2021/22, but this has since slipped back to 85%. Reviews showed the same pattern, climbing to 95% in FY2023/24

and then declining to 88% in FY2024/25. These trends show that important progress has been made in strengthening the system, but the recent decline is a reminder that reporting and reviews must be sustained if accountability and learning are to be maintained.

3.3.6 Regional trends in Institutional Maternal Deaths Reporting, notification and reviews

Table 30: Regional trends in Institutional Maternal Deaths Reporting, notification and reviews

Region	No. Maternal deaths				% maternal death notifications				% maternal death reviews			
	FY21/22	FY22/23	FY23/24	FY24/25	FY21/22	FY22/23	FY23/24	FY24/25	FY21/22	FY22/23	FY23/24	FY24/25
Acholi	67	66	45	75	104.5%	98.5%	102.2%	90.7%	97.0%	101.5%	102.2%	93.3%
Ankole	91	89	77	59	126.4%	77.5%	114.3%	62.7%	113.2%	97.8%	100.0%	88.1%
Bugisu	67	114	97	78	106.0%	100.0%	89.7%	94.9%	103.0%	95.6%	84.5%	82.1%
Bukedi	39	46	51	40	89.7%	106.5%	98.0%	82.5%	87.2%	95.7%	96.1%	80.0%
Bunyoro	102	103	83	64	87.3%	79.6%	92.8%	87.5%	68.6%	74.8%	95.2%	98.4%
Busoga	93	116	123	91	86.0%	92.2%	82.1%	71.4%	87.1%	81.9%	99.2%	98.9%
Kampala	196	180	183	169	98.5%	99.4%	98.9%	92.3%	95.9%	98.3%	98.9%	89.9%
Karamoja	23	12	30	25	108.7%	108.3%	110.0%	84.0%	108.7%	91.7%	113.3%	96.0%
Kigezi	30	38	35	27	106.7%	84.2%	100.0%	88.9%	100.0%	94.7%	102.9%	88.9%
Lango	55	45	53	59	107.3%	106.7%	111.3%	89.8%	105.5%	104.4%	113.2%	98.3%
North Buganda	122	126	126	122	68.0%	77.0%	84.9%	84.4%	68.9%	80.2%	84.9%	82.8%
South Buganda	122	87	109	98	88.5%	90.8%	89.0%	73.5%	64.8%	77.0%	86.2%	89.8%
Teso	58	63	44	45	106.9%	117.5%	120.5%	111.1%	89.7%	95.2%	111.4%	42.2%
Tooro	76	96	80	74	118.4%	94.8%	88.8%	90.5%	98.7%	69.8%	81.3%	97.3%
West-Nile	85	95	86	70	97.6%	107.4%	94.2%	72.9%	97.6%	96.8%	90.7%	80.0%
National	1,226	1,276	1,222	1,096	97.5%	94.1%	95.4%	84.9%	89.4%	89.1%	94.8%	88.0%

Key for Notifications & Reviews FY21/22-FY23/24

>100	90-100	65 -90	<65
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Key for Notifications & Reviews FY2024/25

>100	95-100	65 -95	<65
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During the last two years, regional performance varied widely. The biggest drops were seen in Ankole and Teso, while Bunyoro, Busoga, and Lango maintained high review rates. Kampala continued to perform well despite handling a heavy caseload.

The decline in some regions highlights reduced follow-up of review committees and gaps created by the withdrawal of donor catalytic

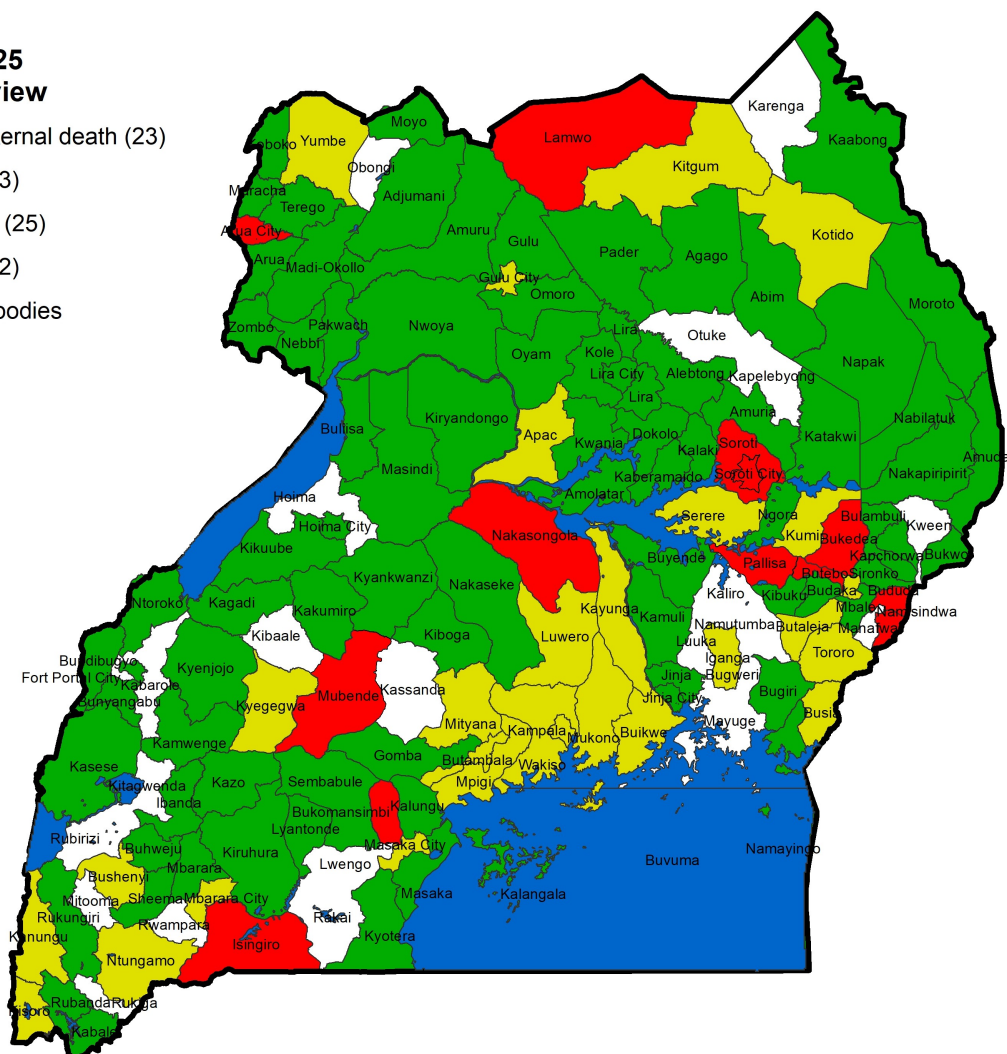
support. Regions with active LMNS structures and strong partner engagement sustained good performance, showing that regular coordination and committed leadership promote accountability. Strengthen LMNS coordination and district-led follow-up of reviews, integrate MPDSR activities into routine supervision, and support regions to sustain performance even without external funding.

3.3.7 Institutional maternal deaths reported and review rates by district.

Figure 34: Institutional maternal deaths reported and review rates by district.

Legend
FY 2024/2025
(%) MD Review

- No Maternal death (23)
- < 65 (13)
- 65 - 95 (25)
- > 95 (82)
- Water bodies



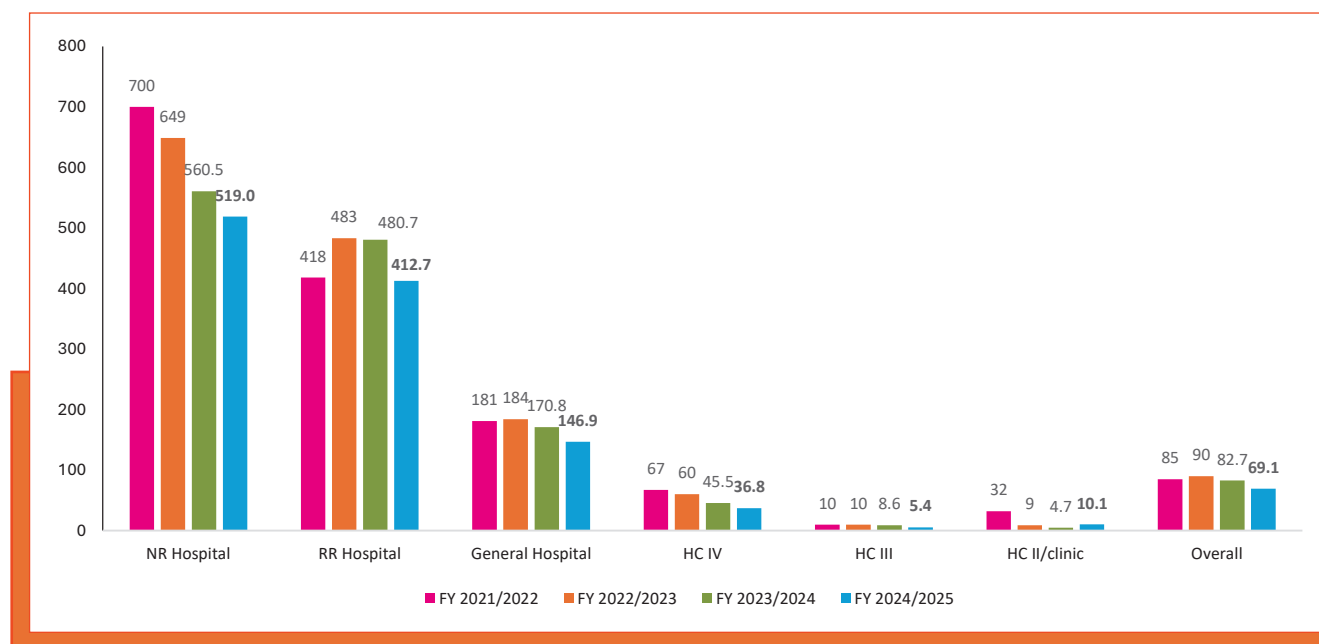
In FY2024/25, 82 districts (56.2%) reviewed¹ more than 95% of their reported maternal deaths, reflecting strong accountability. However, 13 districts (8.9%) reviewed fewer than 65%, with six districts (Bukedea, Butebo, Isingiro, Nakasongola, Namisindwa and Soroti) failing to review any of their reported maternal deaths. In addition, 23 districts did not report any maternal deaths, raising concerns about underreporting.

The respective DHOs and ADHO-MCHN, working with LMNS platforms, should follow up to confirm whether these districts indeed had no maternal death. Where death occurred, they should ensure that they are promptly audited.

Strengthening the use of weekly dashboards and ensuring that action plans are drawn and followed up will be key to sustaining accountability and driving corrective action.

3.3.8 Trends in institutional maternal mortality ratio reported by health facility level

Figure 35: Trends in institutional maternal mortality ratio reported by health facility level



Over the last 4 financial years (FY2021/22 to FY2024/25), the overall IMMR reduced from 85 to 69.1 per 100,000 deliveries. There was a 26% reduction in IMMR at NRH. The health centre II/clinics still had the least contribution to IMMR.

The high IMMRs in referral hospitals reflect the late arrival of complicated cases, overwhelming patient loads, and limited readiness for emergency obstetric care. By contrast, lower-level facilities show declining IMMRs, suggesting that improvements in service delivery, referral management and functionality of emergency ambulance services.

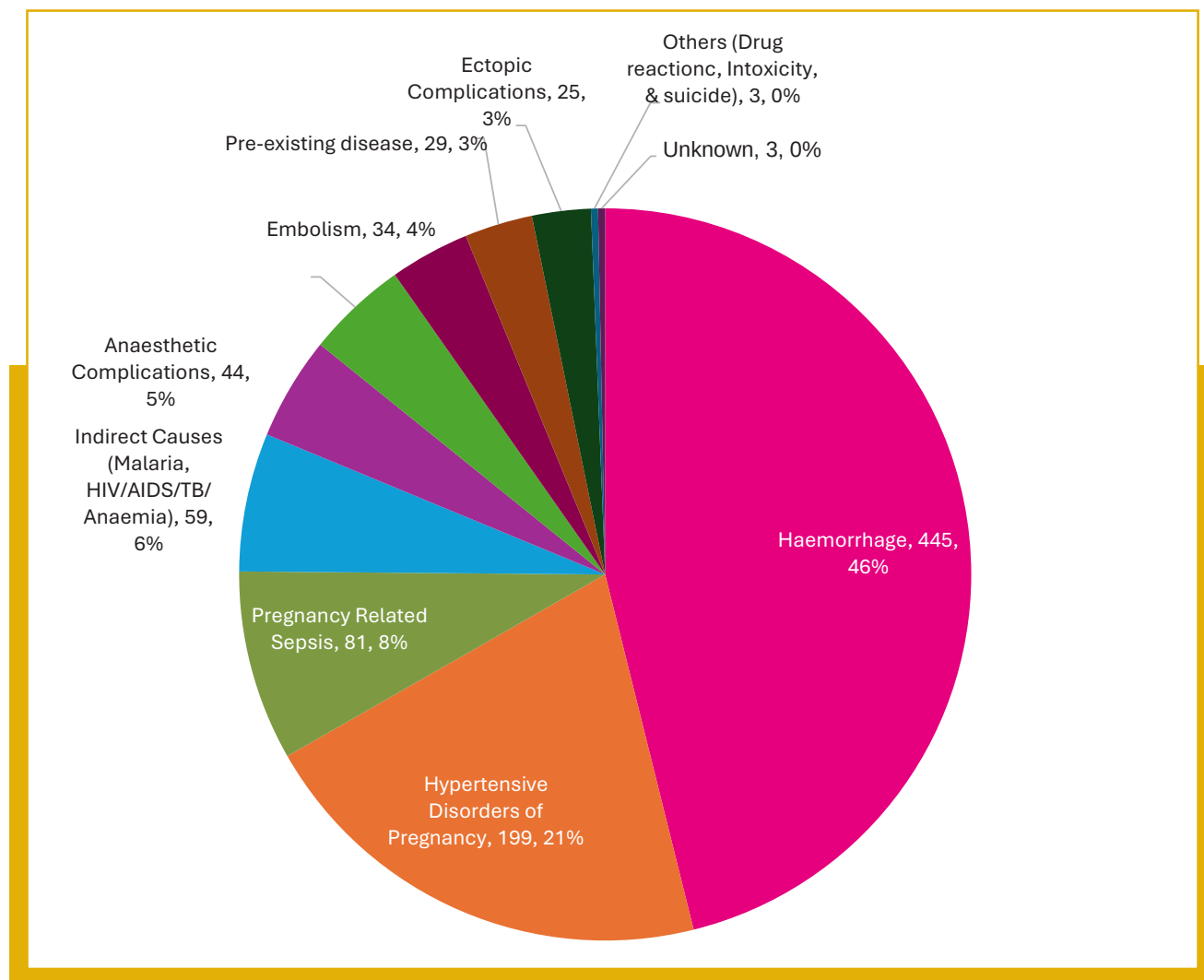
Efforts should focus on strengthening referral hospitals through timely access to emergency

1. A Maternal death is considered to be reviewed when the health facility MPDSR committee reviews it, documents on the review form, and the review form is captured in the DHIS2.

obstetric care, improved triage, and reliable blood supply, while consolidating gains at lower-level facilities through continued capacity building to further reduce delays and prevent avoidable referrals.

3.3.9 Causes of maternal deaths

Figure 36: Cause of maternal deaths, FY2024/25



Haemorrhage was the dominant cause of maternal deaths, accounting for nearly half of all reported cases, followed by hypertensive disorders of pregnancy and indirect causes such as malaria, anaemia, and HIV/AIDS. This picture has not changed compared to previous financial years.

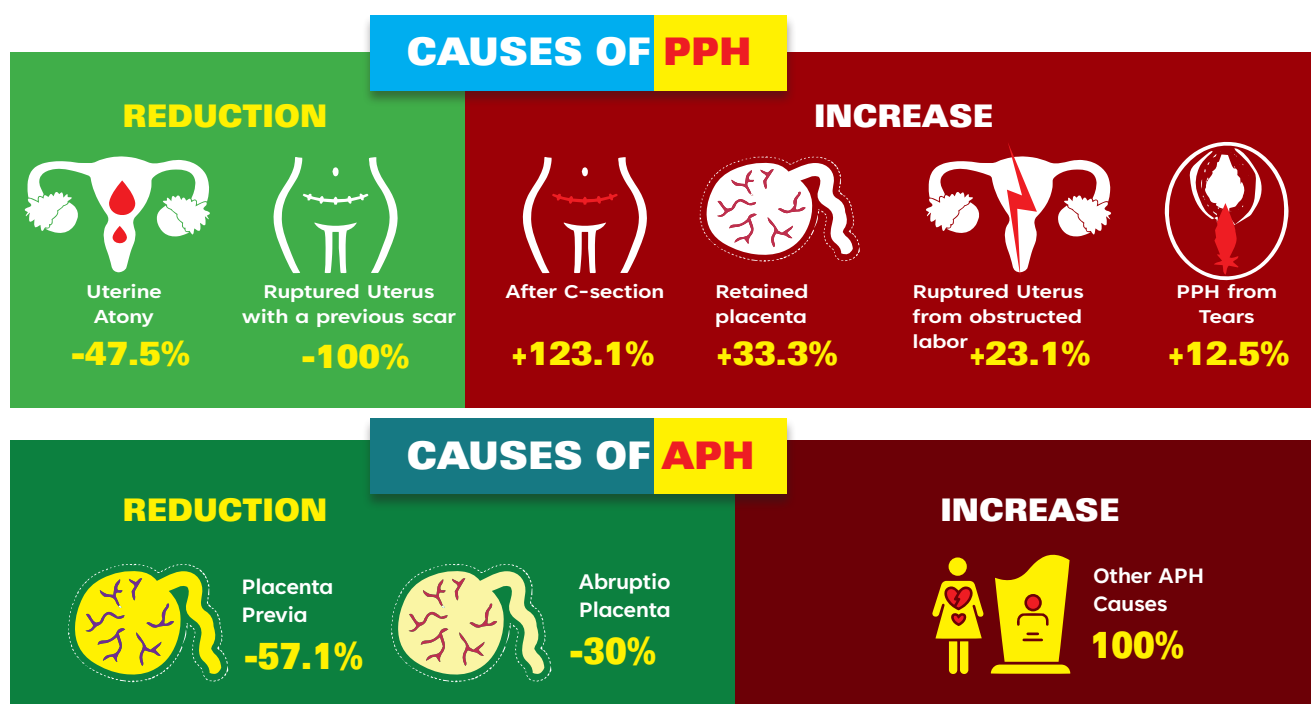
3.3.10 Deep-dive analysis of maternal deaths due to haemorrhage in the last two financial years

Table 31: Deep-dive analysis of maternal deaths due to haemorrhage in the last two financial years

Obstetric Haemorrhage	Type	FY2023/24 [n=521]		FY2024/25 [n=445]		Relative % change
		#	%	#	%	
PPH [80%]	Uterine atony	112	21%	50	11%	-47.5%
	PPH from tears	81	16%	81	18%	12.5%
	PPH after C- section	70	13%	130	29%	123.1%
	Ruptured uterus - obstructed labor	69	13%	73	16%	23.1%
	Retained Placenta	31	6%	34	8%	33.3%
	Ruptured uterus with previous scar	26	5%	1	0%	-100.0%
	Other	26	5%	22	5%	0.0%
APH [20%]	Abruptio Placentae	54	10%	32	7%	-30.0%
	Placenta praevia	37	7%	13	3%	-57.1%
	Other	7	1%	9	2%	100.0%

Over the last two financial years, there was almost a 50% reduction of PPH related maternal deaths from uterine atony and APH causes. Maternal deaths from PPH after caesarean section more than doubled.

Health facilities must strengthen caesarean section safety, enhance perioperative monitoring, and secure timely blood transfusion to curb this risk.



3.3.11 Causes of death by region

Table 32: Causes of maternal death by region, FY2024/25

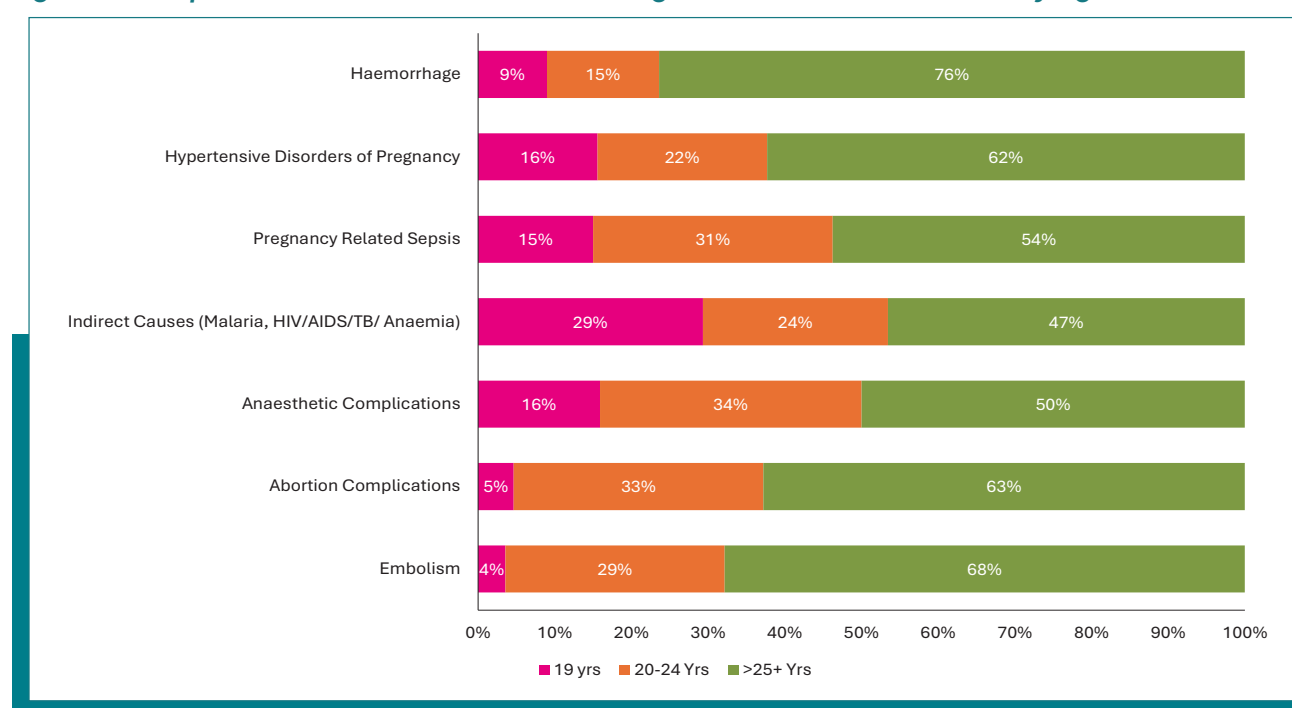
Region	Haemorrhage	Hypertensive Disorders of Pregnancy	Pregnancy Related Sepsis	Indirect Causes (Malaria, HIV/AIDS /TB/ Anaemia)	Anaesthetic Complications	Abortion Complications	Pre-existing disease	Embolism	Ectopic Complications
Acholi	44%	13%	6%	11%	6%	7%	9%	3%	1%
Ankole	44%	23%	4%	2%	4%	12%	8%	2%	2%
Bugisu	36%	20%	17%	5%	0%	6%	3%	2%	9%
Bukedi	59%	9%	3%	6%	6%	0%	3%	6%	0%
Bunyoro	43%	17%	11%	10%	8%	3%	2%	2%	2%
Busoga	60%	16%	1%	4%	1%	7%	1%	6%	4%
Kampala	31%	39%	8%	4%	6%	2%	4%	5%	1%
Karamoja	63%	8%	8%	4%	0%	8%	8%	0%	0%
Kigezi	39%	17%	4%	4%	17%	0%	4%	13%	0%
Lango	43%	12%	10%	24%	0%	7%	3%	0%	0%
North Buganda	53%	18%	9%	3%	6%	3%	2%	1%	5%
South Buganda	48%	21%	10%	3%	5%	6%	2%	3%	1%
Teso	53%	26%	5%	5%	0%	5%	0%	0%	5%
Tooro	47%	18%	11%	7%	6%	1%	4%	3%	1%
West Nile	54%	18%	13%	2%	5%	2%	2%	2%	4%
National	46%	21%	8%	6%	5%	4%	4%	3%	3%

Haemorrhage remains the leading cause of maternal deaths in nearly all regions, except Kampala where hypertensive disorders predominate. Regional variations exist: pregnancy sepsis (17%) and ectopic complications (9%) in Bugisu; indirect causes (24%) in Lango; anaesthetic complications (17%) and embolism (13%) in Kigezi; and abortion complications (12%) in Ankole.

These patterns highlight both national system-wide gaps and region-specific vulnerabilities. Sustained national efforts on haemorrhage control are essential, while Bugisu requires stronger infection prevention, Lango better Indirect Causes (Malaria, HIV/AIDS/TB/ Anaemia) management, and Kampala and Teso enhanced hypertension screening and emergency response.

3.3.12 Maternal deaths by age category

Figure 37: Proportional Contribution of the Leading Causes of Maternal death by Age FY2024/25



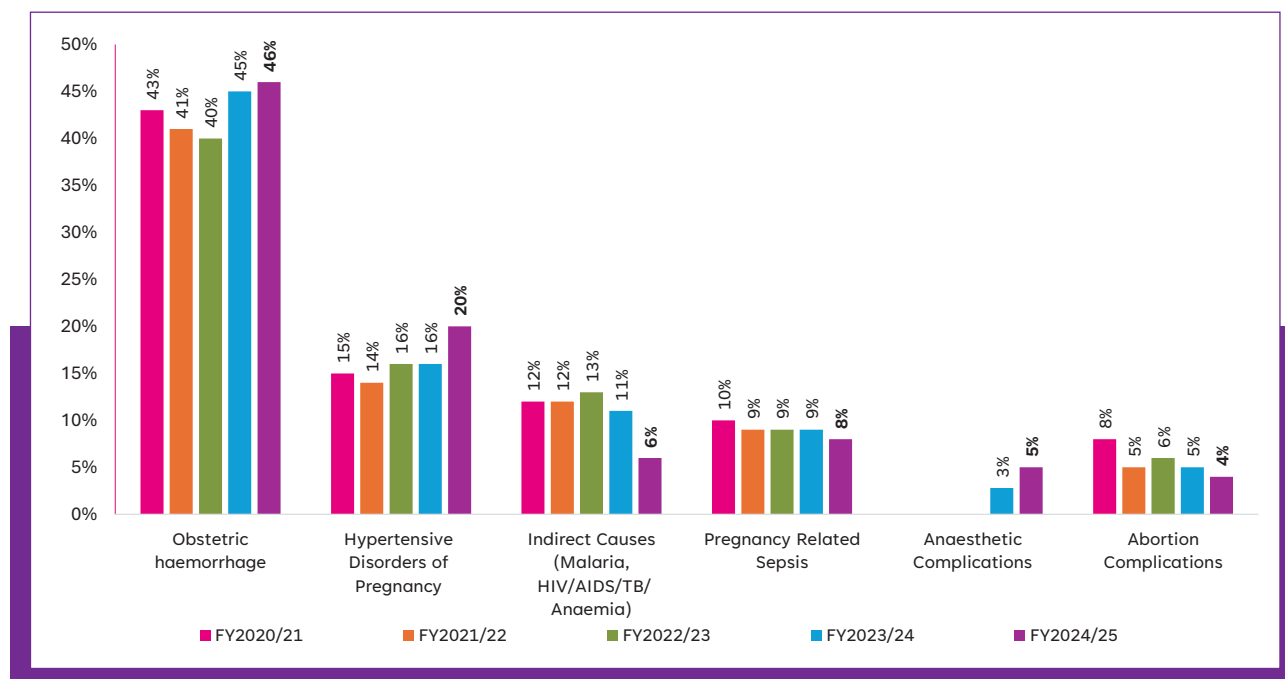
Most maternal deaths from haemorrhage (76%), hypertensive disorders (62%), and indirect causes (47%) occurred in women aged 25 years and above. Adolescents below 19 years were more affected by indirect causes (29%) and sepsis (16%), while abortion complications were highest among women aged 20–24 years (33%).

The shows age-related variations, with older women contributing the largest share of haemorrhage and hypertensive disorders, while younger women and adolescents are more affected by abortion-related and infection-related causes.

Programs should strengthen haemorrhage and hypertension management for women over 25 years, while prioritising safe abortion care, infection prevention, and indirect cause management among adolescents and younger women.

3.3.13 Leading causes of maternal deaths over the last five years

Figure 38: Leading causes of maternal deaths over the last five years

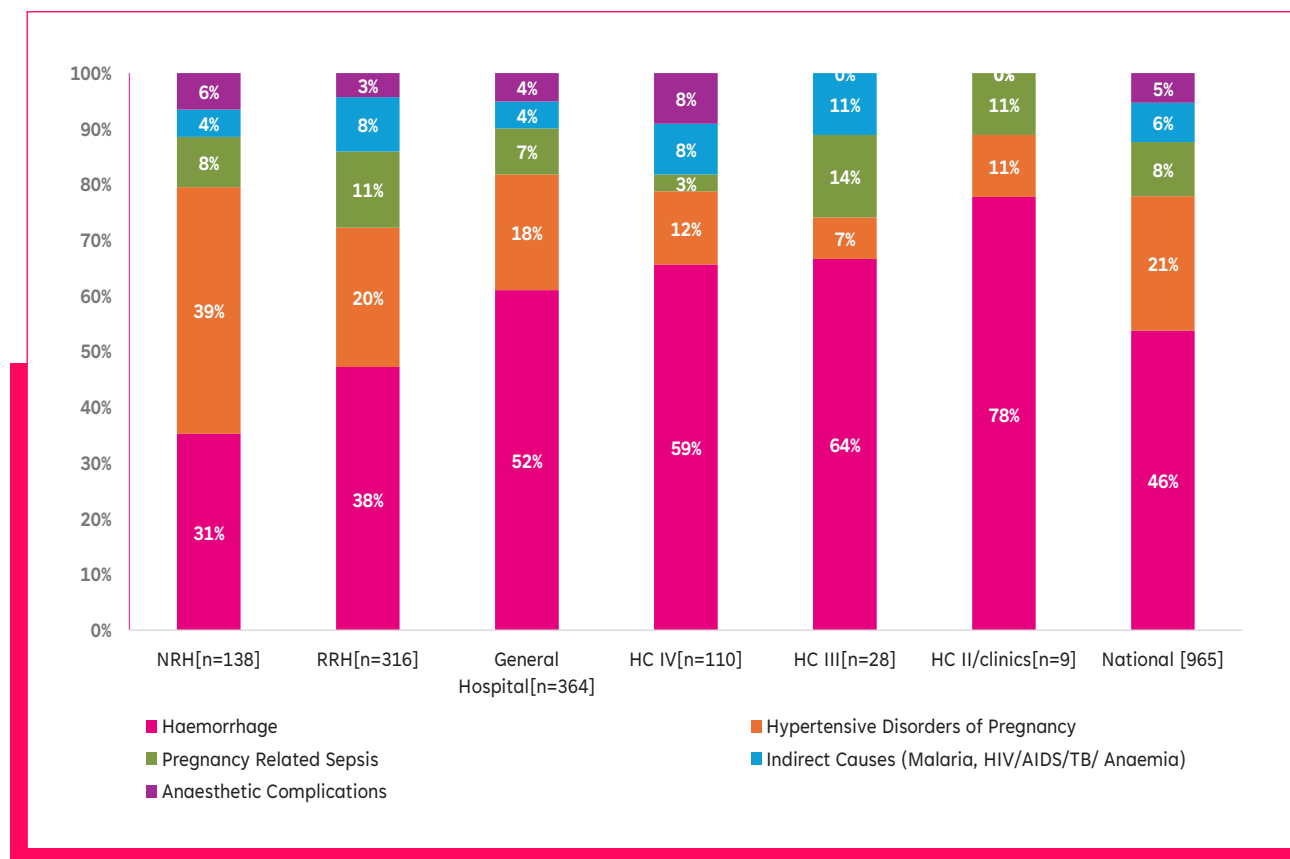


Over the past five years, obstetric haemorrhage has remained the leading cause of maternal deaths (40–46%), while hypertensive disorders steadily rose from 15% to 20%, overtaking indirect causes as the second leading cause. Indirect causes remained among the top three, while new risks such as anaesthetic complications emerged in the last two years.

These trends call for sustained haemorrhage prevention and management interventions, stronger hypertension screening and management, and vigilance for emerging perioperative risks.

3.3.14 Leading causes of maternal deaths by level of care, FY2024/25

Figure 39: Proportional Contribution of the Leading Causes of Maternal death by Level FY2024/25



In FY2024/25, haemorrhage remained the leading cause of maternal deaths across all facility levels, contributing the highest share in lower-level facilities (HC II–III). Hypertensive disorders were more prominent in HC IVs and hospitals, while sepsis and indirect causes were concentrated in regional hospitals and HC IIIs. Anaesthetic complications, though smaller in proportion, were reported at higher-level facilities.

These patterns align with the national trend over the past five years, where haemorrhage consistently led, hypertensive disorders steadily rose to become the second leading cause, and indirect causes remained in the top three. The emergence of anaesthetic complications in higher-level facilities underscores perioperative risks linked to increasing caesarean deliveries.

Interventions should sustain focus on haemorrhage control at all levels, scale up hypertension detection and emergency management at HC IVs and hospitals, strengthen infection prevention at regional facilities, and address perioperative safety where caesarean section volumes are high.

3.3.15 Breakdown of Indirect causes of maternal deaths by Age

Table 33: Breakdown of Indirect causes of maternal deaths by Age

Age Group	Malaria		Severe Anaemia		HIV/AIDS		Other		Overall	
	FY23/24	FY24/25	FY23/24	FY24/25	FY23/24	FY24/25	FY23/24	FY24/25	FY23/24	FY24/25
<19 yrs	17 (13%)	14(24%)	10(8%)	1(2%)	0%	1(2%)	0%	1(2%)	27 (21%)	17(29%)
20-24 yrs	20(16%)	8(13%)	3(2%)	3(5%)	7(6%)	2(3%)	2(2%)	1(2%)	32(25%)	14(24%)
> 25 yrs	27(21%)	11(19%)	15(12%)	7(12%)	9(7%)	7(12%)	10(8%)	3(5%)	61(48%)	27(47%)
Missing	3(2%)	0%	2(2%)	0%	0%	0%	1(1%)	0%	0.05	0%
Grand Total	67(53%)	33(56%)	30(24%)	11(19%)	16(13%)	10(17%)	13(10%)	5(9%)	126(100%)	58(100%)

Overall, maternal deaths from indirect causes declined from 126 in FY2023/24 to 58 in FY2024/25. Malaria remained the leading contributor, highest among mothers under 19 years (24% in FY2024/25). Severe anaemia and HIV/AIDS were most prevalent among mothers aged ≥25 years, while the burden of indirect causes was consistently lower in the 20–24 age group.

3.3.16 Characteristics of maternal deaths reported / reviewed

Table 34: Characteristics of maternal deaths reported/reviewed for the past three financial years

Item	FY2022/23 (n=1137)		FY2023/24 (n=1159)		FY2024/25 (n=965)	
	Number	%	Number	%	Number	%
Age Group						
<19 yrs	121	10.6%	129	11.1%	117	12%
20-24 yrs	223	19.6%	255	22.0%	204	21%
>=25 yrs	684	60.2%	724	62.5%	644	67%
Missing Age	109	9.6%	51	4.4%	0	0.0%
Parity at death						
Para 0+1	-	-	-	-	85	8.8%
Para 1	221	19.4%	435	37.5%	200	20.7%
Para 2-4	496	43.6%	435	37.5%	461	47.8%
Para 5-6	219	19.3%	156	13.5%	160	16.6%
Para 7+	167	14.7%	87	7.5%	48	5.0%
Missing data	35	3.1%	87	7.5%	11	1.1%
Referral status to the facility where the death occurred						
Referred	698	61.4%	658	56.8%	349	36.2%
Not Referred	366	32.2%	501	43.2%	608	63.0%
Missing data	73	6.4%	0	0%	8	1%
Duration of stay (between time of admission and time of death)						
<1 hr	819	72.0%	184	15.9%	246	25.5%

Item	FY2022/23 (n=1137)		FY2023/24 (n=1159)		FY2024/25 (n=965)	
	Number	%	Number	%	Number	%
1-5 hrs	216	19.0%	334	28.8%	201	20.8%
6-24 hrs	28	2.5%	473	40.8%	379	39.3%
> 24 hrs	1	0.1%	46	4.0%	138	14.3%
Missing data	73	6.4%	122	10.5%	0	0.0%
Mode of delivery						
Vaginal de- livery	344	30.3%	418	36.1%	383	39.7%
Assisted vagi- nal delivery	4	0.4%	16	1.4%	14	1.5%
<i>Caesarean</i> section	444	39.1%	430	37.1%	346	35.9%
Unknown/ Missing	107	9.4%	79	6.8%	15	1.6%
Undelivered	238	20.9%	216	18.6%	207	21.5%
Investigations done during Antenatal care of this pregnancy: Hepatitis B testing						
Yes	126	11.1%	207	17.9%	166	17.2%
No	171	15.0%	124	10.7%	104	10.8%
Unknown/ Missing	840	73.9%	828	71.4%	695	72.0%
Urinalysis-Protein/Sugar/casts						
Yes	137	12.0%	150	12.9%	149	15.4%
No	173	15.2%	143	12.3%	120	12.4%
Unknown/ Missing	827	72.7%	866	74.7%	696	72.0%
HIV testing						
Yes	590	51.9%	554	48%	470	49%
Test result positive	54	9.2%	35	6%	49	10%
Test result negative	536	90.8%	519	94%	358	76%
No	26	2.3%	33	3%	19	2%
Unknown/ Missing	521	45.8%	572	49%	476	49%
Syphilis testing						
Yes	400	35.2%	391	33.7%	354	37%
Test result positive	22	5.5%	12	3.1%	286	80.8%
Test result negative	366	91.5%	379	96.9%	10	2.8%
No	26	2.3%	75	6.5%	39	4.0%
Unknown/ Missing	673	59.2%	693	59.8%	572	59.0%
Haemoglobin testing						
Yes	132	11.6%	148	13%	139	14%

Item	FY2022/23 (n=1137)		FY2023/24 (n=1159)		FY2024/25 (n=965)	
	Number	%	Number	%	Number	%
No	177	15.6%	146	13%	118	12%
Unknown/ Missing	828	72.8%	865	75%	708	73%

During the past two financial years, most maternal deaths occurred among para 2–4 mothers, rising from 37.5% to 47.8%, suggesting missed risks in women often not prioritized at ANC/IRR clinics. Deaths among non-referred mothers increased to 63%, with a sharp rise in those staying in facilities over 24 hours (4% to 14.3%), pointing to gaps in inpatient monitoring.

3.3.17 Avoidable factors

Table 35: Regional trends in avoidable factors

Region	FY2023/24				FY2024/25			
	Total Maternal Reviews	Percentage Contribution			Total Maternal Reviews	Percentage Contribution		
		Delay 1	Delay 2	Delay 3		Delay 1	Delay 2	Delay 3
Acholi	46	48%	28%	65%	70	37%	14%	73%
Ankole	77	47%	30%	62%	52	67%	15%	50%
Bugisu	82	39%	26%	62%	64	42%	9%	42%
Bukedi	49	73%	53%	73%	32	53%	22%	72%
Bunyoro	79	51%	29%	71%	63	52%	11%	56%
Busoga	122	56%	39%	70%	90	64%	12%	78%
Kampala	181	57%	36%	52%	152	48%	5%	56%
Karamoja	34	68%	53%	53%	24	75%	17%	63%
Kigezi	36	64%	31%	64%	24	54%	4%	50%
Lango	60	53%	37%	62%	58	48%	14%	59%
North Buganda	107	60%	40%	55%	101	50%	14%	42%
South Buganda	94	51%	29%	53%	88	55%	15%	58%
Teso	49	76%	45%	61%	19	63%	16%	63%
Tooro	65	51%	23%	69%	72	57%	15%	54%
West Nile	78	50%	42%	68%	56	61%	11%	63%
Grand Total	1159	55%	35%	62%	965	53%	12%	58%

Between FY2023/24 and FY2024/25, Delay 2 reduced significantly in Kampala, Kigezi, and Bugisu. Delay 1 remained common in Karamoja and Teso, while Delay 3 continued to dominate in regions such as Busoga, Acholi, and West Nile.

Actions should focus on reducing Delay 3 through improved theatre functionality, blood availability, and timely emergency response. The approaches that lowered Delay 2 in Kampala, Kigezi, and Bugisu can be adapted in other regions, while interventions to address Delay 1 should remain a priority in Karamoja and Teso.

3.3.18 Deep dive of avoidable factors under delay 3

Figure 40: Deep dive of avoidable factors under delay 3

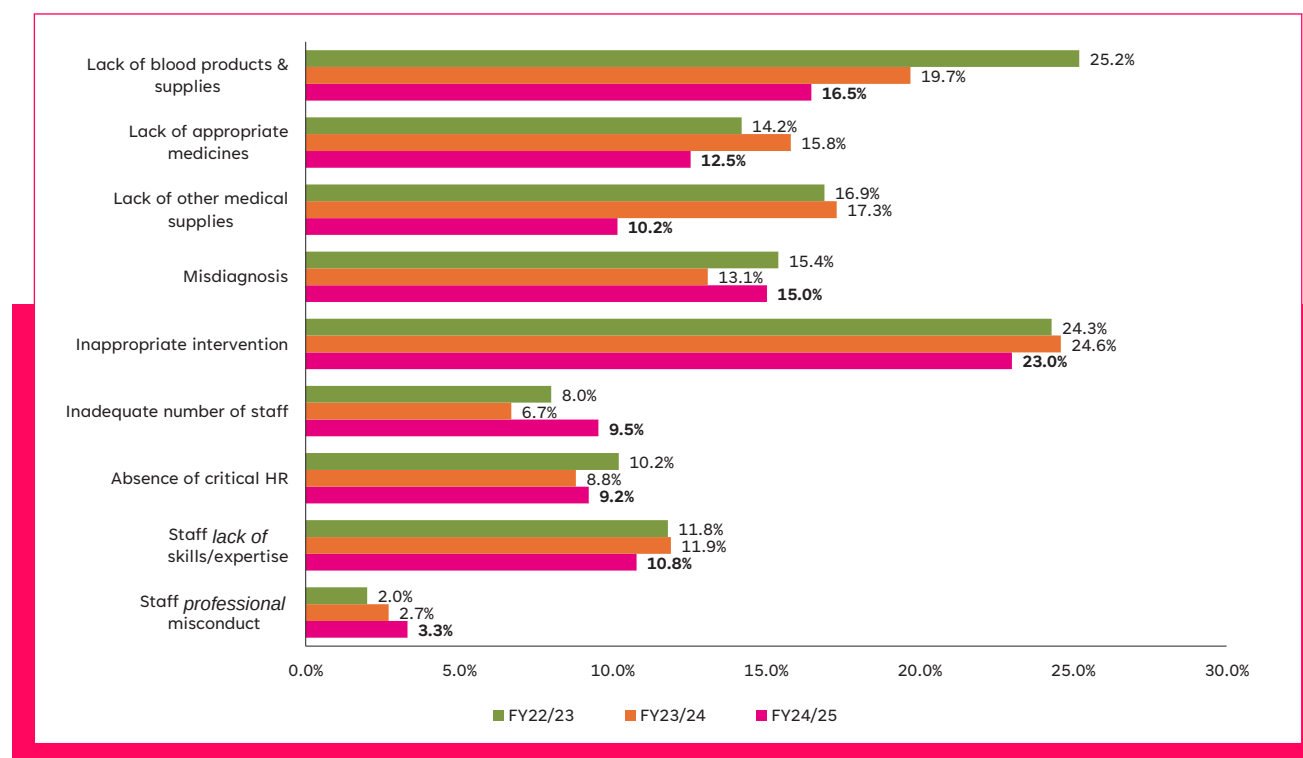


Table 36: Unpacking delay 3 by region

Region	Staff professional misconduct	Staff lack of skills/expertise	Absence of critical HR	Inadequate number of staff	Inappropriate intervention	Misdiagnosis	Lack of other medical supplies	Lack of appropriate medicines	Lack of blood products & supplies
Acholi	4%	11%	4%	16%	37%	23%	9%	13%	23%
Ankole	0%	12%	6%	12%	19%	13%	8%	10%	13%
Bugisu	2%	8%	3%	3%	16%	16%	5%	8%	6%
Bukedi	3%	9%	16%	22%	28%	22%	9%	16%	25%
Bunyoro	0%	3%	14%	5%	11%	13%	14%	13%	13%
Busoga	2%	16%	19%	11%	37%	17%	14%	17%	30%
Kampala	7%	11%	12%	7%	16%	15%	13%	14%	11%
Karamoja	17%	17%	13%	21%	8%	8%	13%	21%	17%
Kigezi	9%	13%	13%	17%	35%	17%	13%	26%	9%
Lango	2%	19%	2%	12%	31%	10%	7%	9%	16%
North Buganda	1%	11%	6%	7%	15%	12%	7%	9%	18%
South Buganda	1%	8%	9%	3%	25%	16%	10%	14%	16%
Teso	11%	11%	5%	5%	26%	11%	21%	16%	37%
Tooro	1%	6%	11%	13%	18%	14%	7%	11%	11%
West Nile	5%	13%	4%	11%	34%	16%	11%	9%	18%
National	3%	11%	9%	10%	23%	15%	10%	13%	16%

The most significant challenges facing healthcare delivery nationally are inadequate staffing and inappropriate medical interventions, reported at 23% and 15% respectively among the reviewed maternal deaths. These issues are more prominent in the Acholi, Busoga, and Kigezi regions, where over a third of maternal death reviewed reported having inadequate number of staff. Furthermore, lack of blood products and supplies is a pronounced problem in the Teso region (37%) and is also a major concern in Bukedi (25%) and Busoga (30%).

Karamoja reported the highest rates of staff professional misconduct (17%) while regions like Bunyoro and South Buganda report much lower levels of staff skill deficits. The absence of critical HR resources is most prominent in Bukedi (16%) and Busoga (19%), while Bugisu and South Buganda reported lower rate (3%). Misdiagnosis is a consistently reported problem across most regions, hovering near the national average of 15%.



3.4 INSTITUTIONAL PERINATAL DEATHS

3.4.1 National trends in Institutional Perinatal Mortality Rates (per 1000 births)

Figure 41: Trends in Institutional Perinatal Mortality rates (per 1000 births) in Uganda (FY 16/17- FY24/25)



The institutional perinatal mortality rate decreased by 24% over the past five years, from 20.2 per 1,000 total births in FY2020/21 to 15.4 in FY2024/25. During the same period, fresh stillbirths

declined by 31% (7.7 to 5.3 per 1,000), macerated stillbirths by 22% (7.5 to 5.8 per 1,000), and early neonatal deaths by 14% (5.0 to 4.3 per 1,000).

These reductions reflect system-wide improvements, including functional high-risk clinics at CEmONC sites, newborn units, operational HC IVs, improved quality of care in ANC, and enhanced neonatal training.

3.4.2 Institutional Perinatal Mortality Rate by Region

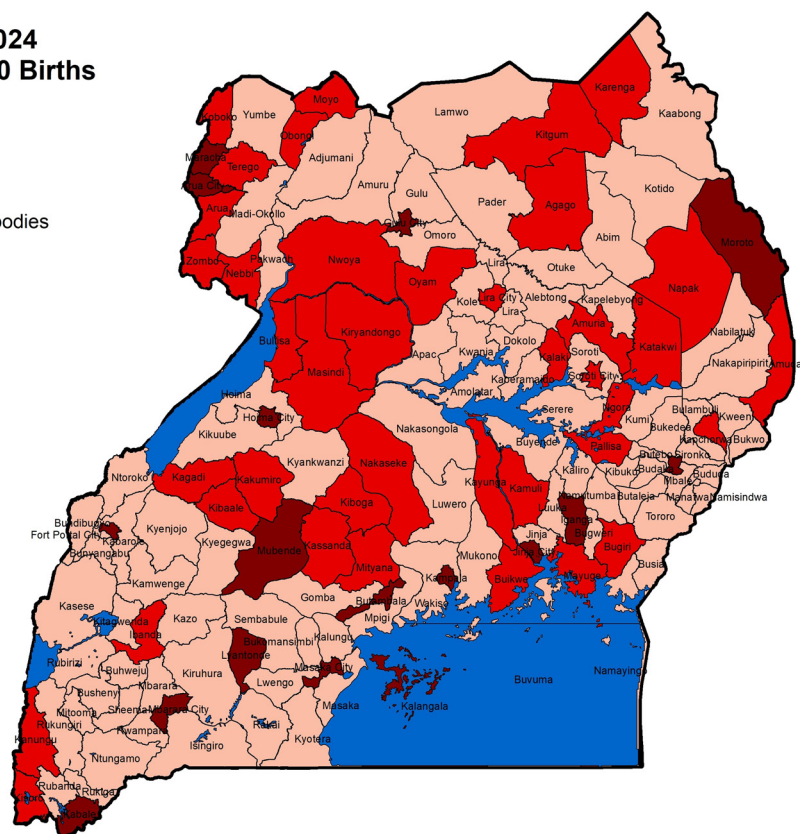
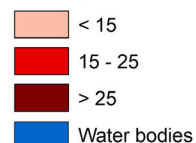
Table 37: Regional trends in Institutional Perinatal Mortality Rate

Region	Total Births			MSB/1000 Births			FSB/1000 Births			ENND/1000 Live Births			IPMR/1000 births			%Diff. in IPMR
	FY 2022/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25	
Acholi	64,129	66,792	69,767	7.3	8.4	6.9	6.1	5.6	5.8	7.4	7.5	7.6	20.8	21.3	20.3	-4.91
Ankole	114,088	121,593	133,870	5.4	5.2	3.9	5.4	4.6	4.2	2.3	3.3	1.7	13.1	13.1	9.8	-25.07
Bugisu	92,823	93,750	101,151	5.5	5.1	3.9	5.0	5.3	4.1	1.3	1.2	2.2	11.8	11.6	10.1	-12.56
Bukedi	84,427	91,846	93,361	4.0	4.1	4.2	4.5	4.6	5.4	2.5	2.4	1.5	10.9	11.0	11.1	1.27
Bunyoro	84,253	87,963	94,860	9.0	8.1	6.1	10.2	8.8	6.7	5.7	5.9	4.7	24.9	22.7	17.4	-23.42
Busoga	124,731	131,260	147,960	7.0	7.1	6.7	7.0	6.7	5.2	5.4	4.9	4.0	19.2	18.6	15.9	-14.43
Kampala	89,845	87,240	86,069	11.2	10.2	11.6	8.8	7.7	8.0	18.6	18.2	16.0	38.2	35.8	35.3	-1.44
Karamoja	34,963	40,599	43,124	3.6	3.3	3.4	6.5	6.3	6.3	4.0	4.5	6.1	14.1	14.1	15.7	11.34
Kigezi	53,911	55,432	57,678	5.4	5.1	4.8	4.4	3.7	4.3	5.2	6.4	5.2	14.8	15.2	14.2	-6.35
Lango	74,782	86,639	91,089	5.3	4.7	4.8	5.6	5.0	4.7	4.1	3.0	2.8	15.0	12.7	12.3	-3.01
North Buganda	146,767	152,764	162,203	7.2	7.1	7.7	7.9	6.6	6.7	3.4	3.2	3.7	18.4	16.9	18.0	6.67
South Buganda	141,233	145,774	160,255	6.7	6.6	6.7	6.7	5.7	5.1	4.3	4.0	4.3	17.6	16.2	16.0	-1.28
Teso	73,733	80,787	82,350	6.0	5.1	4.7	5.6	4.9	4.6	3.4	3.3	6.1	14.9	13.3	15.4	15.59
Tooro	121,567	118,672	124,868	5.3	4.5	4.4	5.1	4.1	3.9	3.5	2.4	2.4	13.9	11.0	10.7	-2.66
West Nile	112,505	120,815	131,965	6.8	6.8	5.3	6.1	5.8	5.1	5.3	3.9	3.4	18.1	16.4	13.7	-16.32
National	1,413,757	1,481,926	1,580,570	6.5	6.2	5.8	6.4	5.7	5.3	4.9	4.6	4.3	17.8	16.5	15.4	-6.79

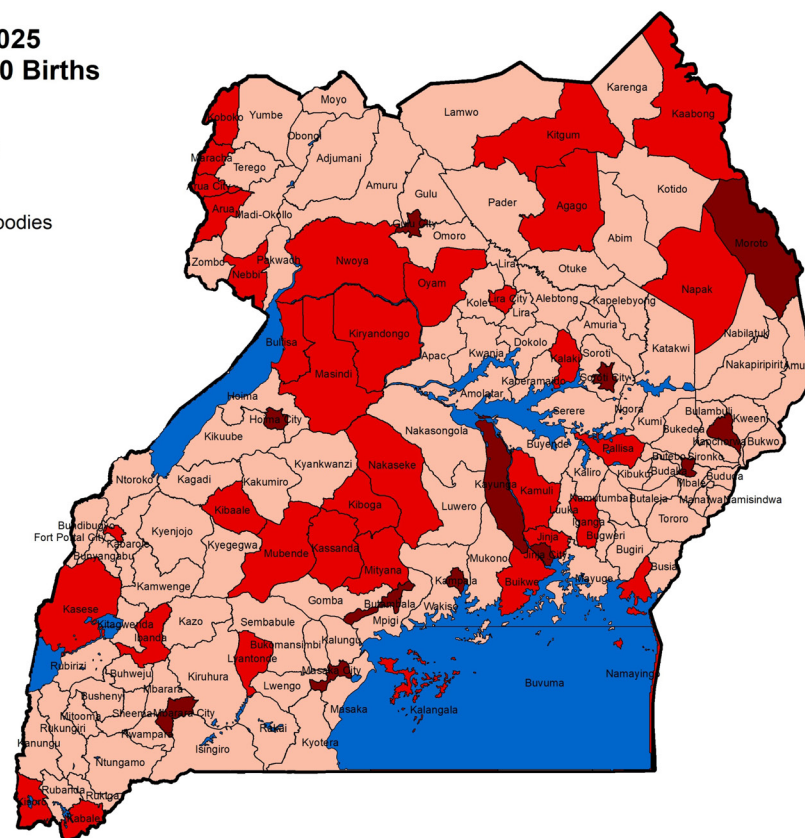
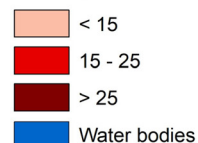
While the national IPMR declined from 17.8 to 15.4, regional disparities persist. Ankole, Bunyoro, West Nile, Busoga, and Bugisu registered major reductions, while Teso, Karamoja, North Buganda, and Bukedi reversed, with Teso showing the major rise driven by fresh stillbirths. These trends highlight the need for region-specific strategies targeting intrapartum care and immediate newborn survival.

Figure 42: Institutional Perinatal Mortality Rate by district - FY 24/25

Legend
FY 2023/2024
IPMR|1,000 Births

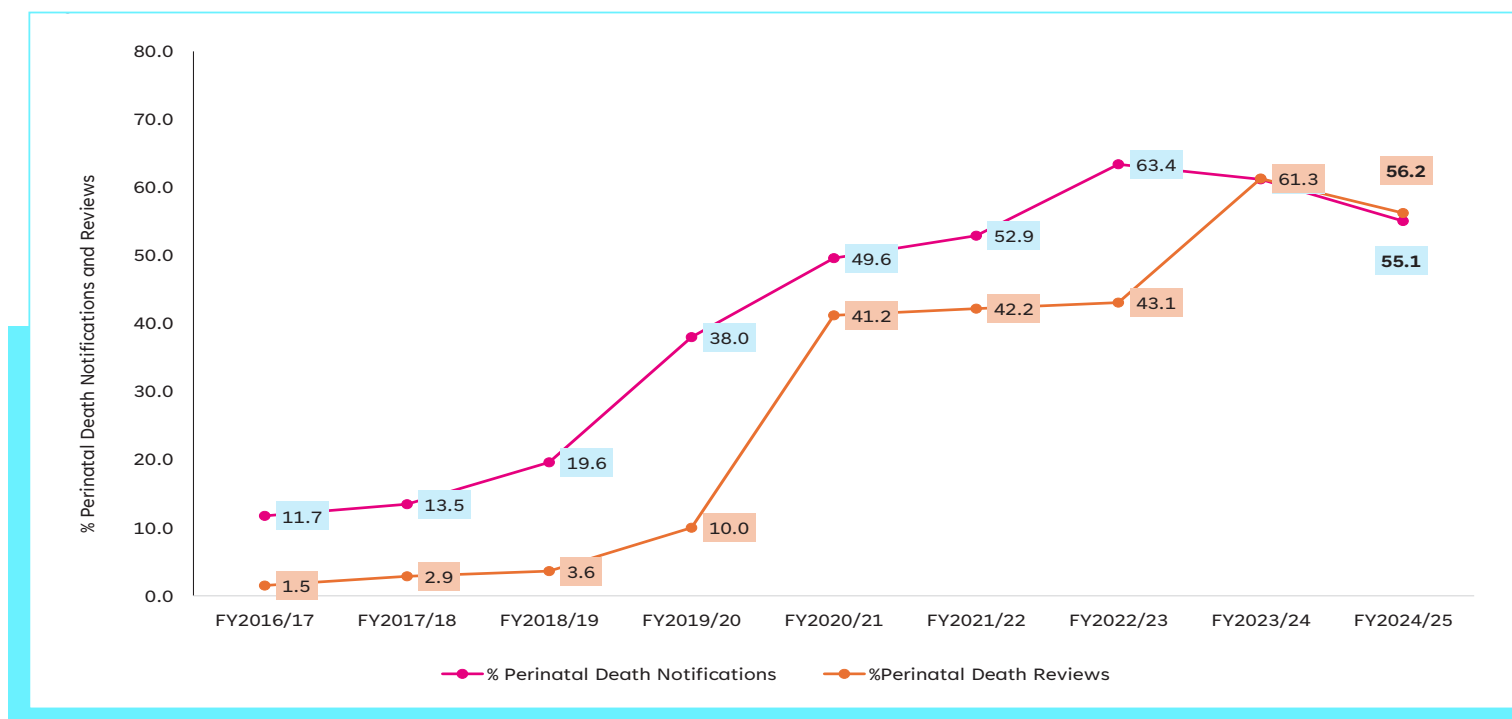


Legend
FY 2024/2025
IPMR|1,000 Births



Compared to FY2023/24, there is a slight reduction in districts with very high rates, indicating gradual improvement in newborn care and referral management. However, persistently high rates in several districts highlight continued challenges in quality of intrapartum and immediate newborn care, requiring strengthened surveillance and targeted interventions.

Figure 43: Trends in National Perinatal death notifications and reviews from FY 16/17 to FY 24/25



In the last two years, both perinatal death notifications and reviews have declined, with notifications dropping from 63.4% in FY2022/23 to 56.2% in FY2024/25 and reviews from 61.3% to 55.0%. Positively, most notified deaths are now being reviewed.

Sustaining high performance in both requires renewed accountability and consistent follow-up across all levels of the health system.

Table 38: Regional trends in Institutional perinatal deaths review rates

Region	Total Perinatal Deaths			Perinatal death Notification (%)			Perinatal death Review rate (%)			% Diff Perinatal Death Notification	% Diff Perinatal Death Review
	FY 22/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25		
Acholi	1332	1424	1417	73.4	94.2	82.43	68.8	86.4	78.69	-12.5	-8.9
Ankole	1489	1591	1315	87.6	55.3	63.19	67.4	73.7	73.16	14.3	-0.8
Bugisu	1094	1085	1024	95.1	109.5	52.83	47.3	74.7	57.23	-51.7	-23.4
Bukedi	920	1012	1039	41.2	80.7	63.43	36.3	68.4	57.27	-21.4	-16.3
Bunyoro	2095	2000	1649	53.5	50.9	63.92	13.1	39.9	54.03	25.6	35.6
Busoga	2396	2442	2352	46.9	64.0	47.58	17.3	79.0	59.06	-25.7	-25.2
Kampala	3436	3127	3014	86.8	25.1	19.53	70.1	65.0	43.60	-22.2	-32.9
Karamoja	493	571	680	45.0	95.6	89.85	61.9	80.7	79.12	-6.0	-2.0
Kigezi	800	841	841	87.5	102.1	88.82	79.1	99.8	84.54	-13.0	-15.3
Lango	1119	1103	1120	64.5	97.8	66.16	72.1	96.0	71.61	-32.4	-25.4
North Buganda	2703	2580	2919	57.0	52.1	53.96	22.6	37.4	50.36	3.7	34.8
South Buganda	2489	2362	2566	51.7	35.7	42.83	16.4	25.6	36.67	19.9	43.4
Teso	1102	1077	1270	51.3	75.9	49.13	55.5	68.8	32.76	-35.2	-52.4
Tooro	1690	1301	1342	58.7	48.9	56.04	23.9	44.5	54.69	14.6	22.9
West Nile	2041	1983	1807	50.2	64.4	71.83	59.1	55.9	67.79	11.5	21.2
National	25199	24499	24355	63.4	61.2	55.02	43.1	61.3	56.19	-10.1	-8.3

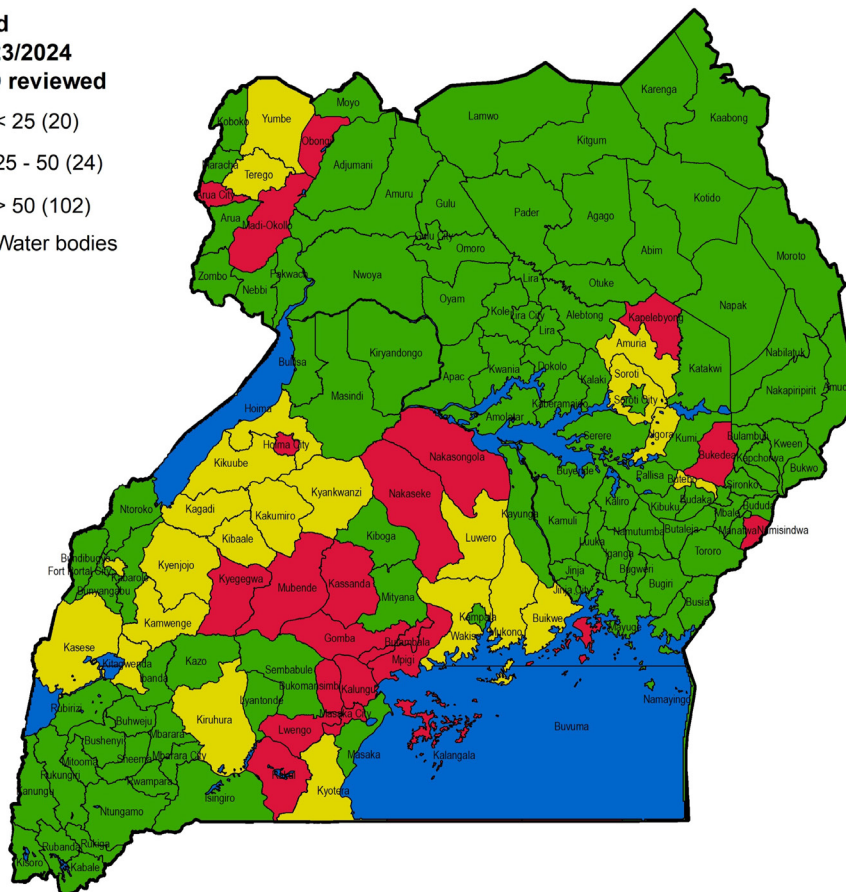
PDN/ PDR (%)



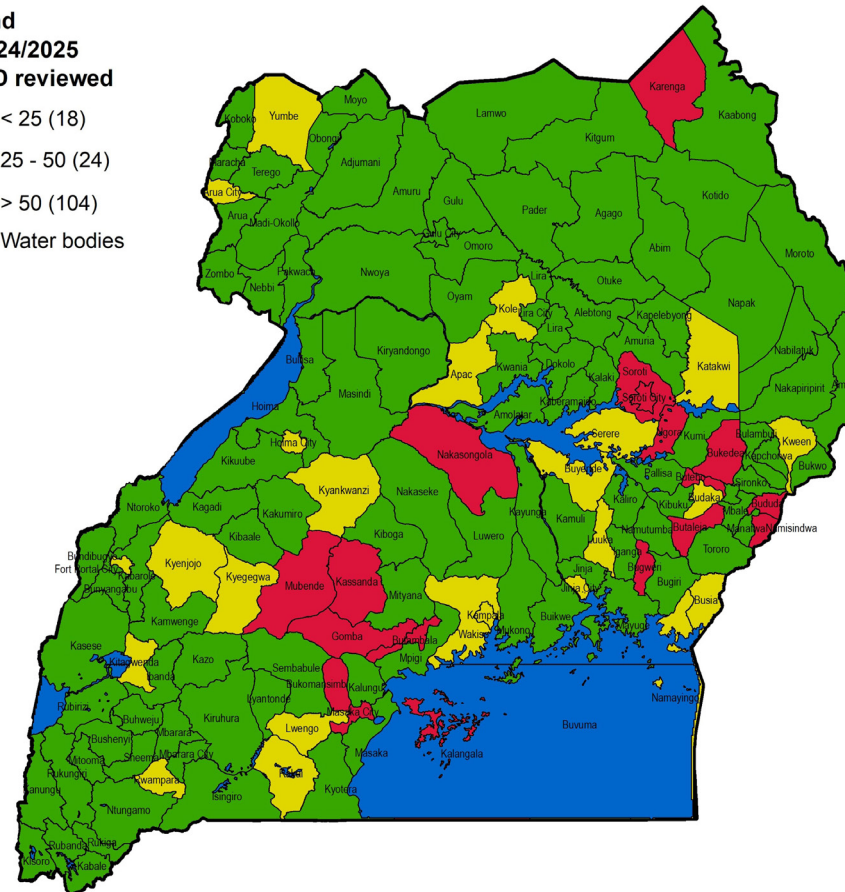
Overall, more than two-thirds of regions met the national target of >50% for perinatal death notification and review. However, four regions (Kampala, Busoga, South Buganda, and Teso) fell short on notification, while three regions (Kampala, South Buganda, and Tooro) fell short on review. Enforce mandatory perinatal death audits with quarterly reporting, provide targeted support to lagging regions, and strengthen accountability to ensure every notified death is reviewed.

Figure 44: Maps showing comparison in Institutional perinatal deaths review rates by district

	< 25 (20)
	25 - 50 (24)
	> 50 (102)
	Water bodies



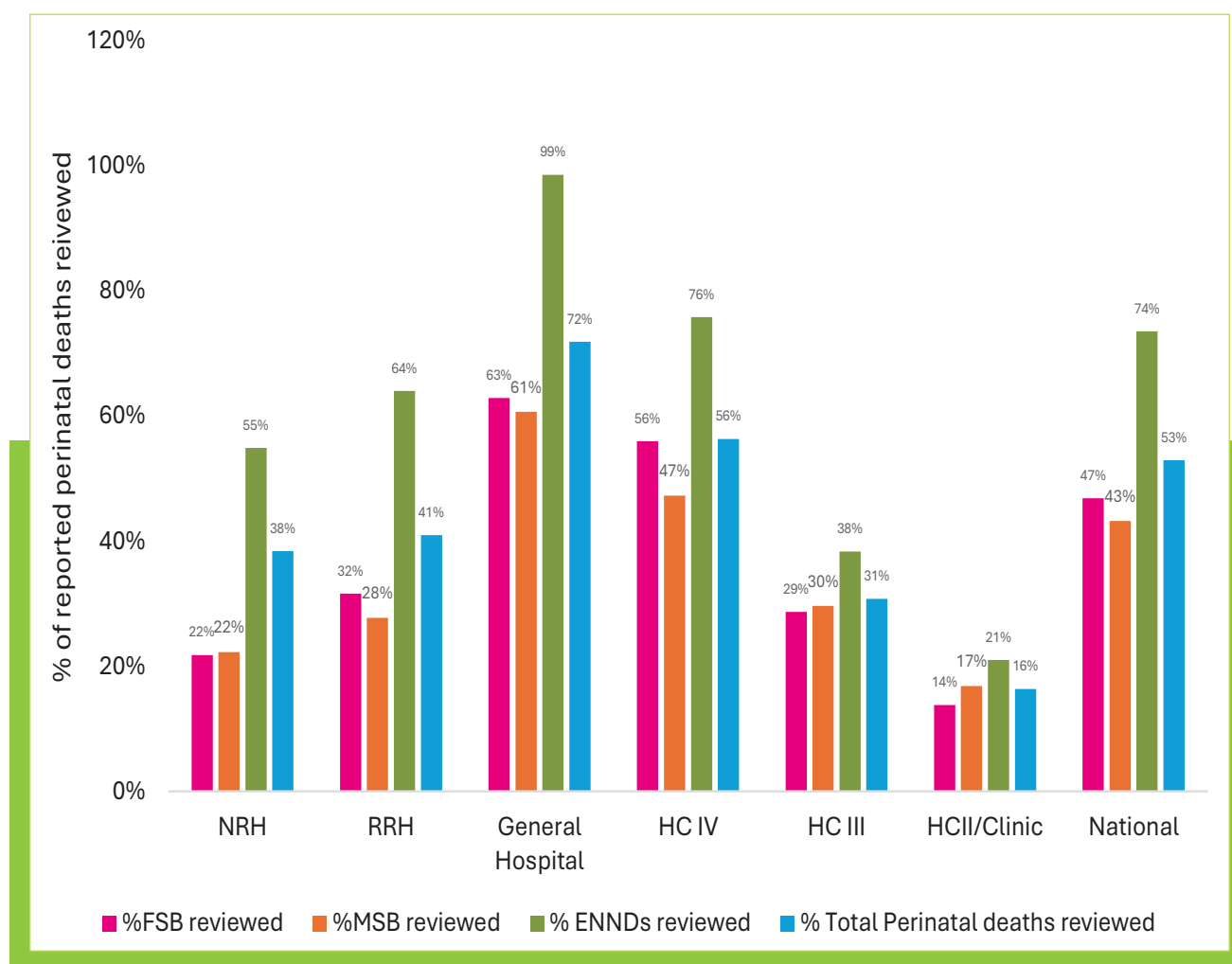
	< 25 (18)
	25 - 50 (24)
	> 50 (104)
	Water bodies



Overall, 104 districts (71%) reviewed ²more than 50% of reported perinatal deaths, showing progress in MPDSR implementation. However, 18 districts had review rates below 25%, including six districts Butebo, Kassanda, Nakasongola, Bukomansimbi, Gomba, and Soroti that did not conduct any reviews.

3.4.4 Perinatal death review rates by type and level of care, FY2024/25

Figure 45: Perinatal death review rates by type and level of care, FY2024/25



Reviews were highest for early neonatal deaths (74%) compared to fresh stillbirths (47%) and macerated stillbirths (43%) across all levels of care, showing a stronger focus on causes of death in the neonatal period to improve neonatal outcomes.

2. A Perinatal death is considered to be reviewed when the health facility MPDSR committee reviews it, documents on the review form, and the review form is captured in the DHIS2.

3.4.5 Characteristics of the perinatal deaths reviewed

Birth weight

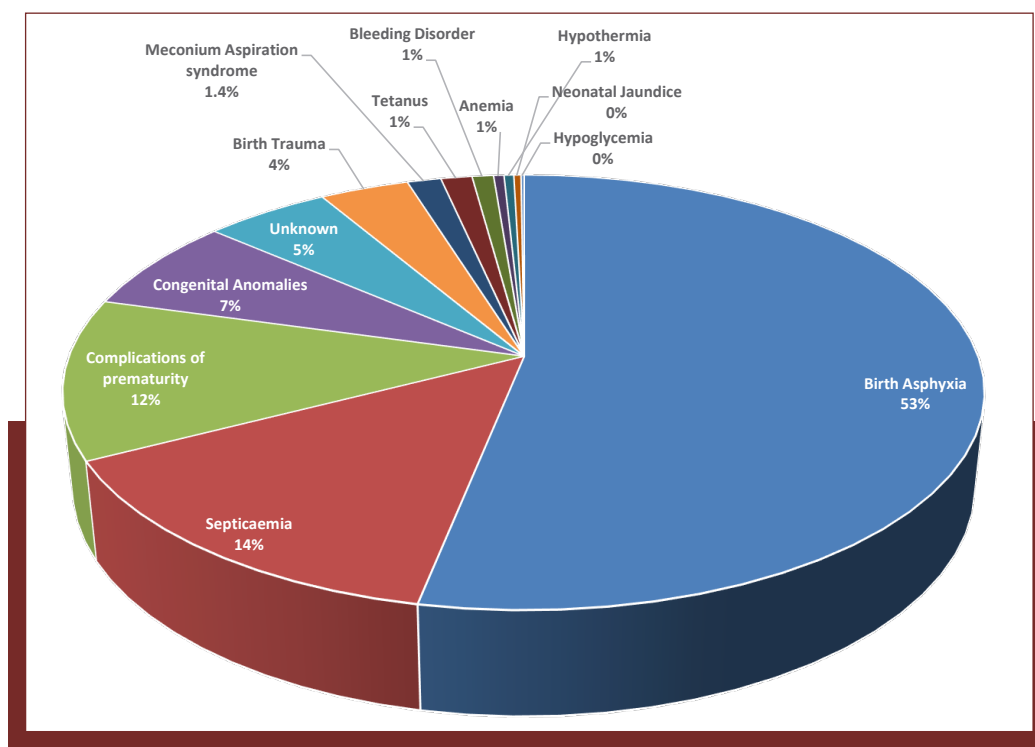
Table 39: Categorisation of perinatal deaths by type and by birth weight

Type of perinatal death	Fresh Still Birth	Macerated still Birth	Neonatal Death	Unclassified	Total
<1000g	4%	6%	6%	5%	5%
1000-1499g	6%	11%	17%	10%	12%
1500-2499g	19%	30%	25%	18%	24%
2500-3499g	49%	36%	38%	35%	41%
>=3500	18%	12%	11%	12%	13%
Missing Weight	4%	4%	3%	20%	5%
Total (N)	3929	3973	5001	852	13755

Sixty seven percent of the fresh still birth were of weight above 2.5kg, implying gaps in intrapartum care.

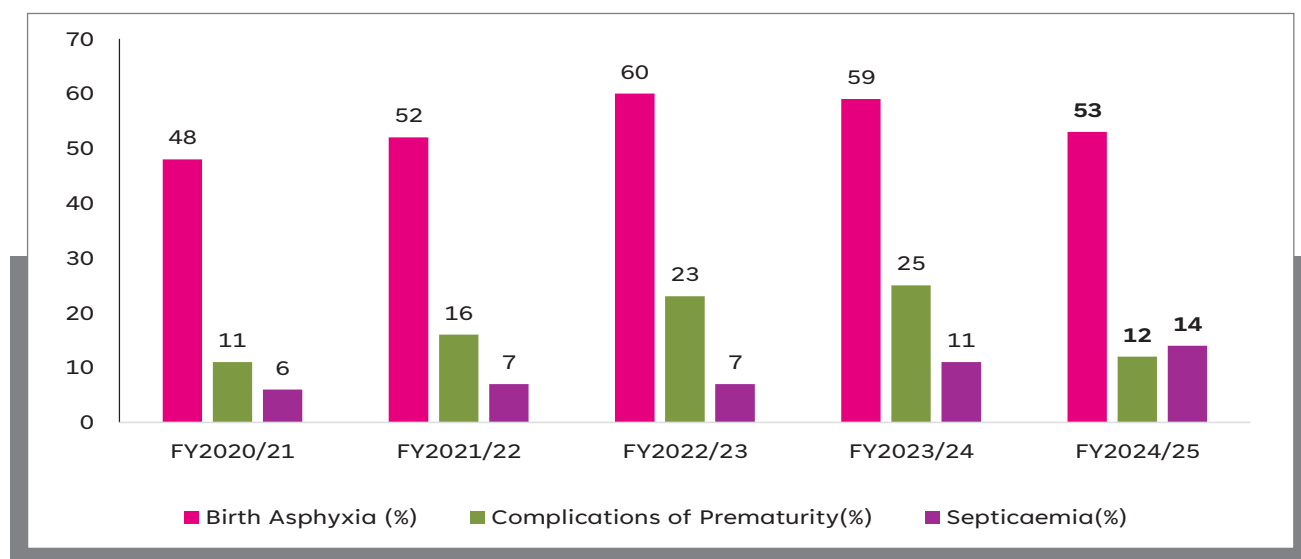
3.4.6 Causes of perinatal deaths

Figure 46: Causes of perinatal deaths, FY2024/25



Among the 5,001 reviewed early neonatal deaths in FY2024/25, birth asphyxia (53%), septicaemia (14%), and prematurity complications (12%) were the leading causes, accounting for nearly 80% of all deaths. Targeted interventions to address these three causes should remain the priority for reducing neonatal mortality. However, the resurgence of neonatal tetanus (1%) requires improvement in administration of Td.

Figure 47: Trends in causes of perinatal deaths



Birth asphyxia remains the leading cause of perinatal deaths across all reporting years, showing a slight decline in FY2024/25. Deaths due to complications of prematurity also decreased, while those attributed to septicaemia have continued to rise over the past two years.

The continued dominance of birth asphyxia points to ongoing gaps in labour monitoring and timely newborn resuscitation. The reduction in deaths linked to prematurity reflects efforts in care for preterm and low-birth-weight babies, while the rise in septicaemia suggests weaknesses in infection prevention and postnatal care practices.

Improve intrapartum monitoring and emergency response during delivery, strengthen infection prevention and control measures in maternity and neonatal units, and enhance care for preterm babies through well-equipped newborn corners and continuous follow-up.

3.4.7 Maternal characteristics of the perinatal deaths reviewed

(i) Age, parity, and type of pregnancy

Table 40: Maternal characteristics of perinatal deaths

Type of Perinatal death	Maternal age				Mother's parity				ANC contacts						Type of pregnancy	
	<19	20-24	25-34	35+	1	2-4	5-6	7+	0	1-3	4	5-7	8	8+	Multiple	Singleton
Fresh Still Birth	27%	30%	30%	30%	25%	31%	32%	34%	40%	30%	29%	33%	29%	24%	25%	29%
Macerated still Birth	27%	29%	30%	35%	28%	28%	33%	30%	15%	32%	33%	28%	30%	31%	19%	30%
Neonatal Death	40%	36%	34%	28%	41%	35%	29%	30%	40%	32%	33%	34%	37%	35%	51%	34%
Unclassified	6%	6%	6%	6%	6%	6%	6%	6%	5%	6%	5%	5%	5%	10%	6%	6%
Grand total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Fresh and macerated stillbirths occurred across all age groups, while neonatal deaths were slightly more common among older mothers. Most mothers had 2–4 previous births and attended fewer than four ANC visits. The majority of perinatal deaths were from singleton pregnancies.

The spread of deaths across all maternal profiles shows that both antenatal and intrapartum factors contribute to stillbirths and neonatal deaths. Limited ANC attendance reduced opportunities to detect risks early, while the high number of fresh stillbirths points to delays or poor care during labour. Neonatal deaths among mothers with some ANC follow-up suggest weaknesses in newborn care and follow-up after delivery.

Improve ANC attendance and quality, strengthen labour monitoring to reduce fresh stillbirths, and enhance immediate newborn care and follow-up to prevent early neonatal deaths.

(ii) ANC interventions

Figure 48: HB Testing and level of anaemia during ANC for mothers with reviewed perinatal deaths

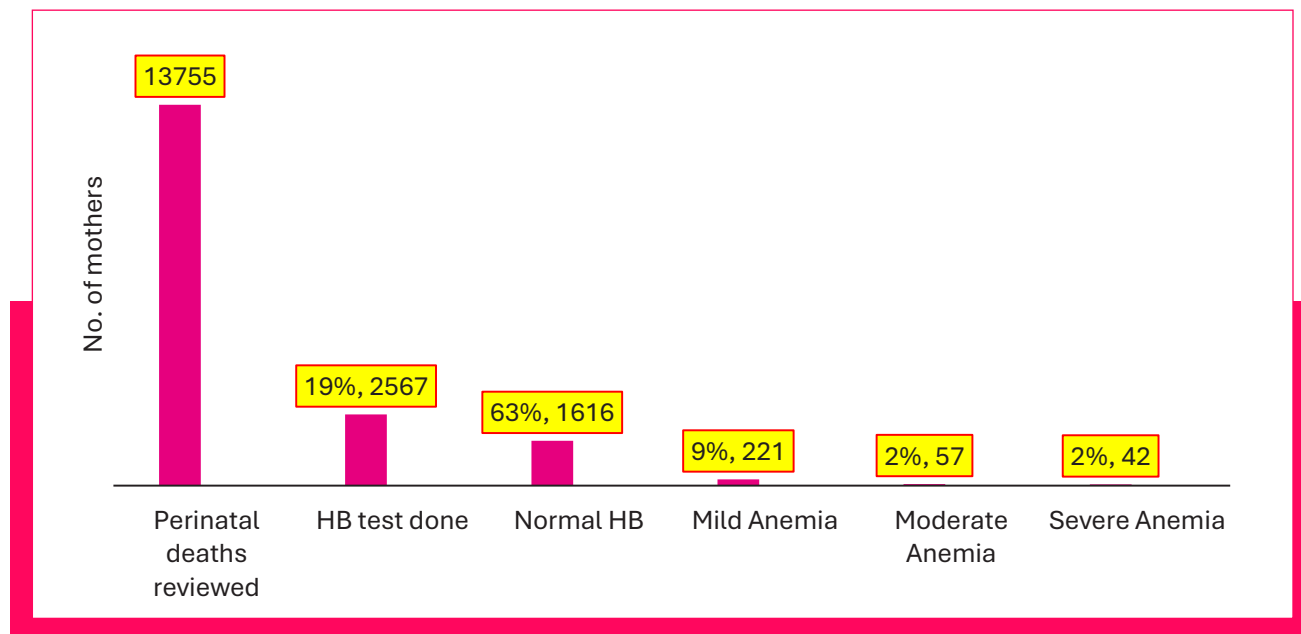


Figure 49: Trends in HB testing

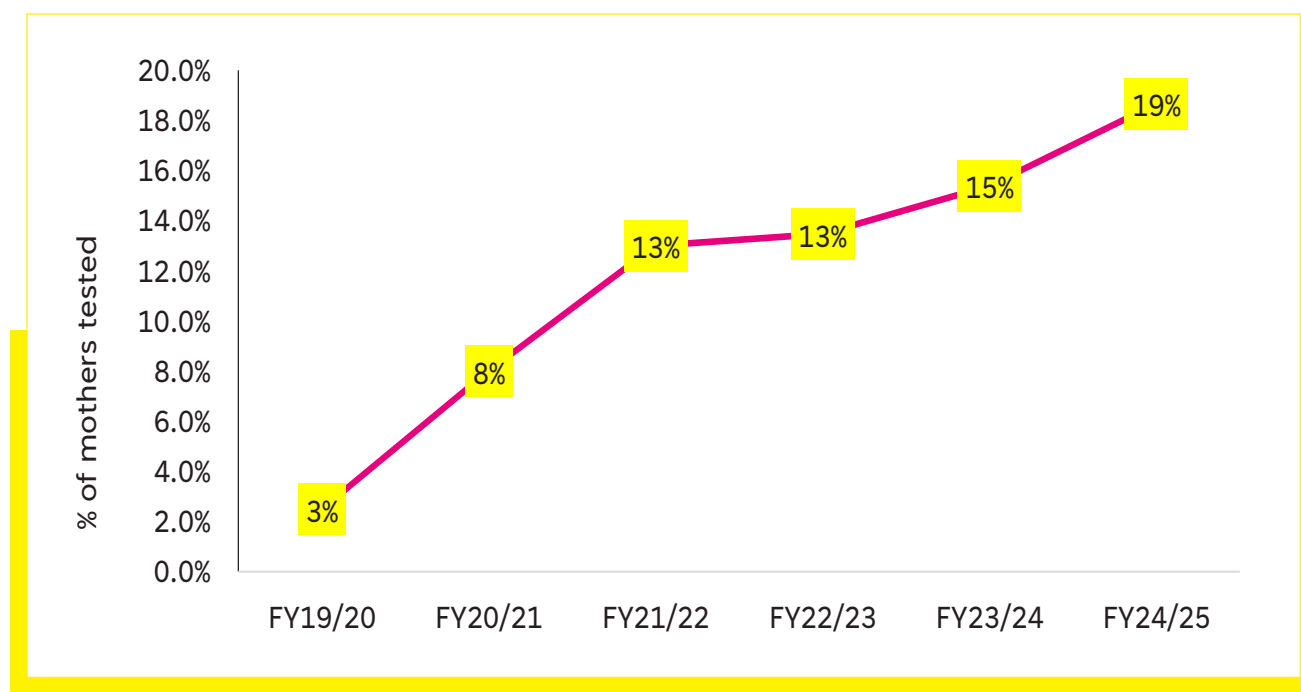
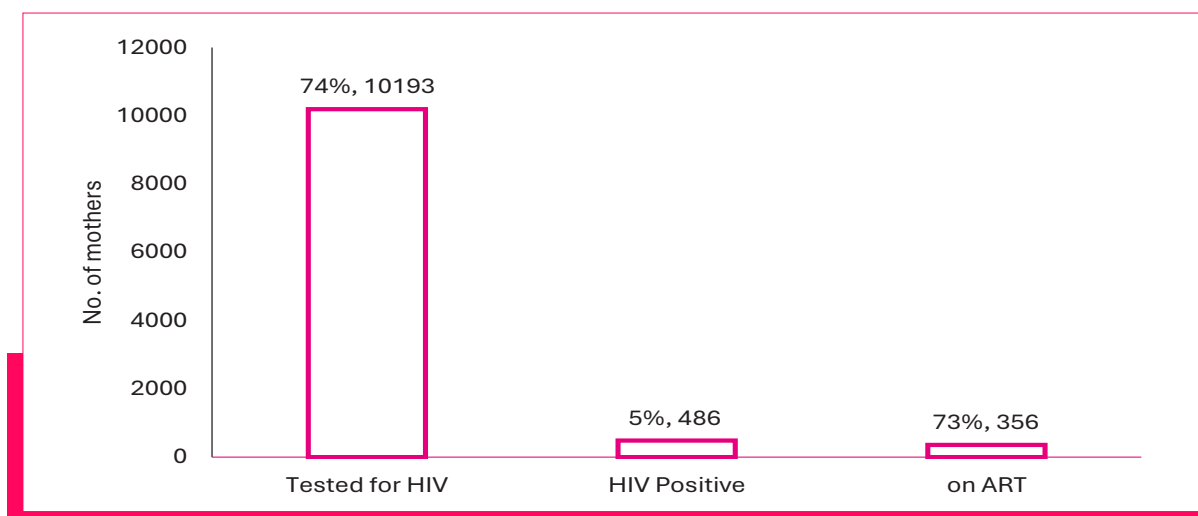
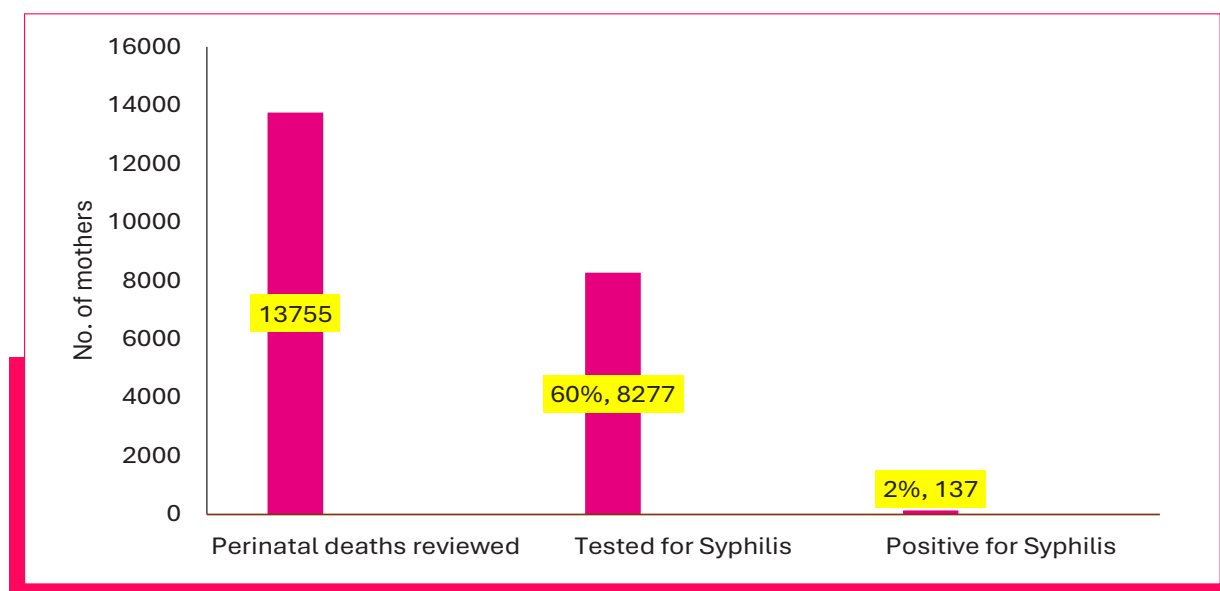


Figure 50: Maternal HIV Testing Cascade



Among the mothers who experienced the 13,755 perinatal deaths reviewed, the HIV testing cascade reveals that 10,193 (74%) were tested for HIV. Among those tested, 486 (5%) were identified as HIV-positive. However, a significant gap in the care continuum was observed at the treatment initiation stage, as only 356 of these HIV-positive mothers (73%) were documented as being on Antiretroviral Therapy (ART).

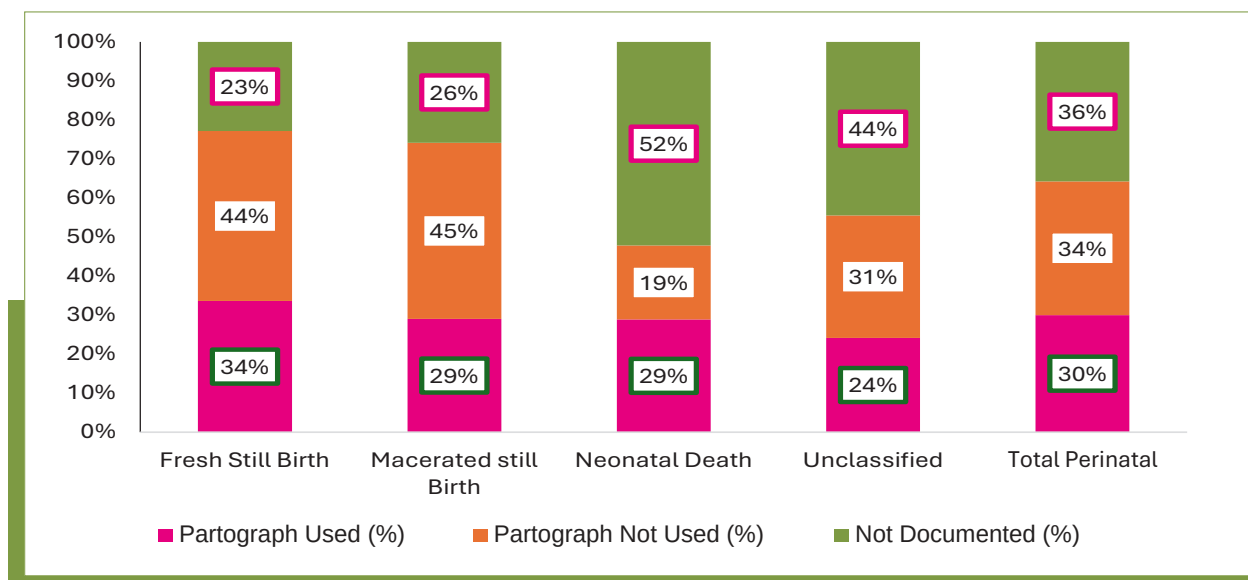
Figure 51: Syphilis testing and results, FY2024/25



A total of 13,755 mothers were assessed for syphilis testing cascade. The data reflects a critical gap in screening coverage, as only 8,277 mothers (60%) were tested for syphilis. This indicates that two out of every five mothers in this cohort did not receive syphilis screening. Among the mothers who were tested, 137 (approximately 2% of those tested) were identified as syphilis positive. While this positivity rate may appear relatively low, it represents 137 preventable cases where congenital syphilis could have contributed to perinatal mortality.

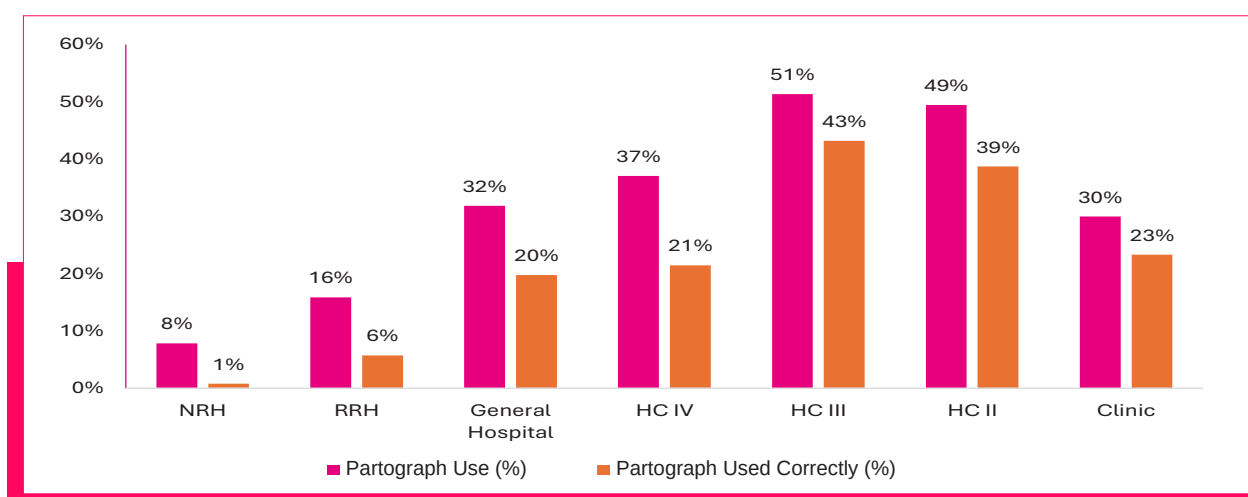
(iii) Partograph use among mothers of the reviewed perinatal deaths

Figure 52: Overall Partograph Use by Type of Perinatal Deaths, FY2024/25



Partograph use was low across all perinatal deaths, with only one-third of fresh stillbirths (34%) and neonatal deaths (29%) documented. Over half of neonatal deaths (52%) had no record at all, showing a documentation gap that limits case learning. Priority should be around strengthening record-keeping/documentation and enforcing partograph use during labour.

Figure 53: Partograph Use by Level of Facility, FY2024/25

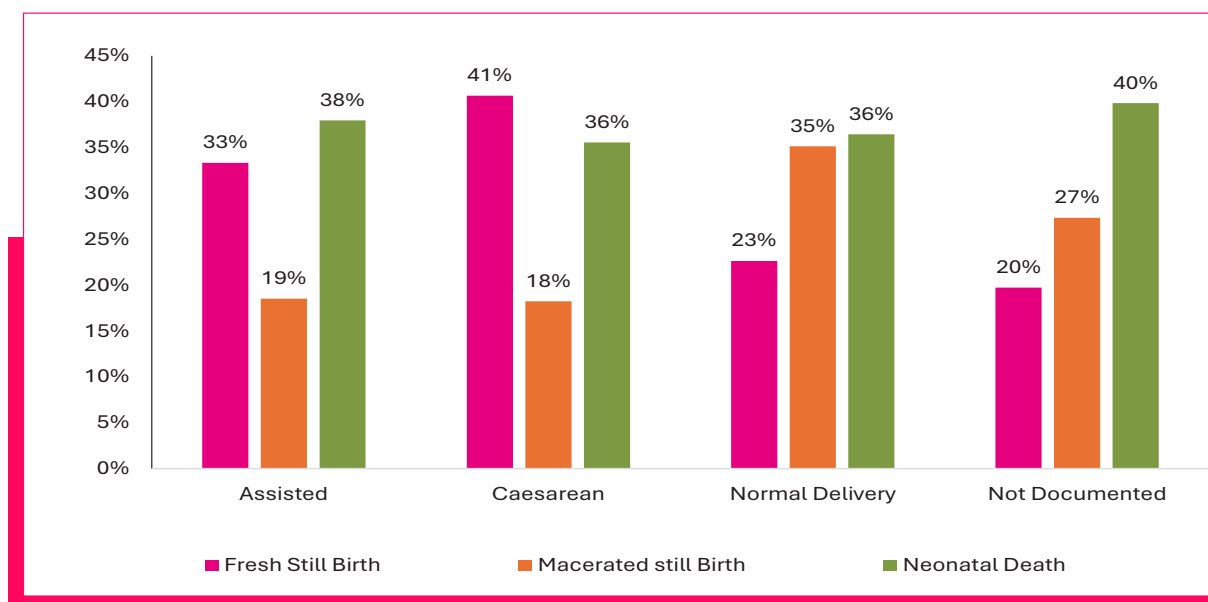


Referral hospitals had the lowest partograph use (NRH 8%, RRH 16%), while HC III (51%) and HC II (49%) reported the highest. However, correct use remained below 45% even in these facilities. This picture points at both skills gap, few midwives at these facilities, and poor-quality referrals. Improving partograph adherence in referral hospitals and ensuring correct use across all levels should be prioritized as part of quality-of-care improvement.

(iv) Complications during Pregnancy

Mode of delivery

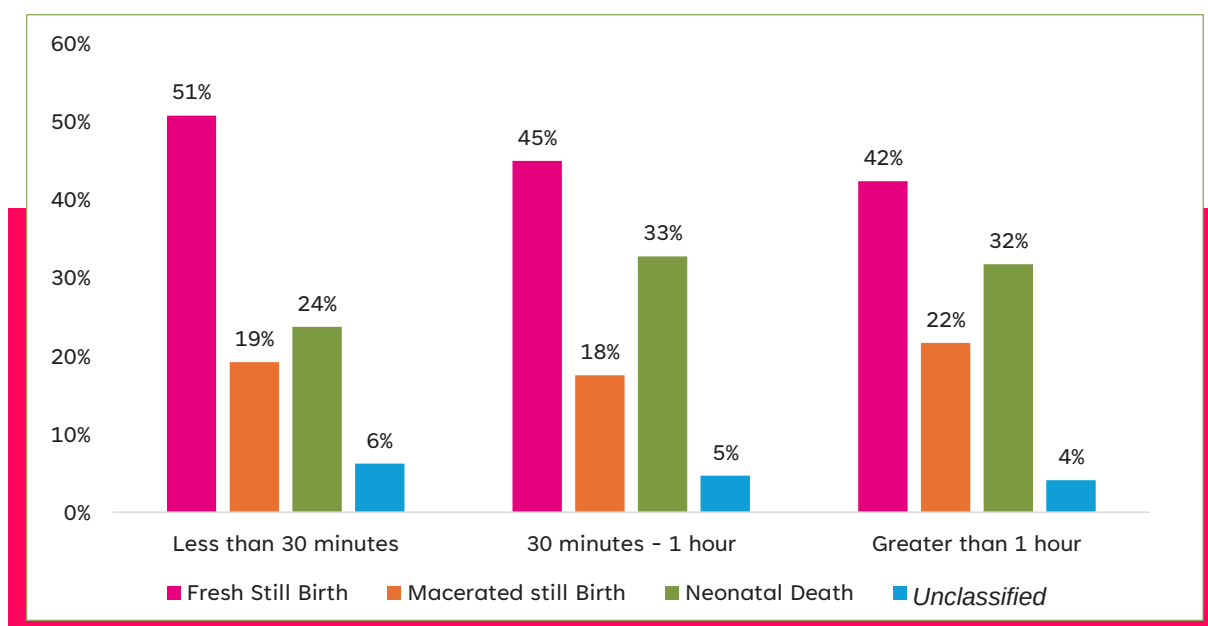
Figure 54: Percentage of Perinatal Deaths by Mode of Delivery, FY2024/25



Caesarean section contributed the highest share of fresh stillbirths (41%), while normal delivery accounted for most macerated stillbirths (35%). Strengthening surgical safety and intrapartum monitoring during both vaginal and operative deliveries is critical for reducing these outcomes.

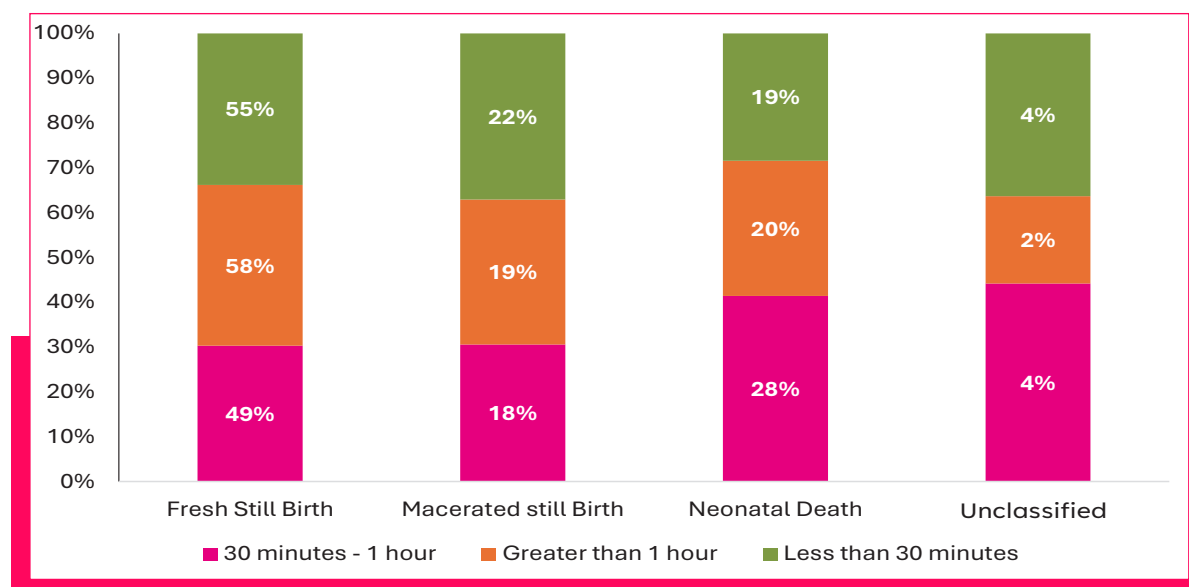
(v) Decision to incision interval

Figure 55: Percentage of Decision to Incision Interval, FY2024/25



Across all categories, more than two-thirds of caesarean cases lacked documentation (66–86%), while only 10–14% of fresh stillbirths were operated within 30–60 minutes. This reflects both poor documentation and delays in surgical response, highlighting the need for stricter monitoring of decision-to-incision timelines.

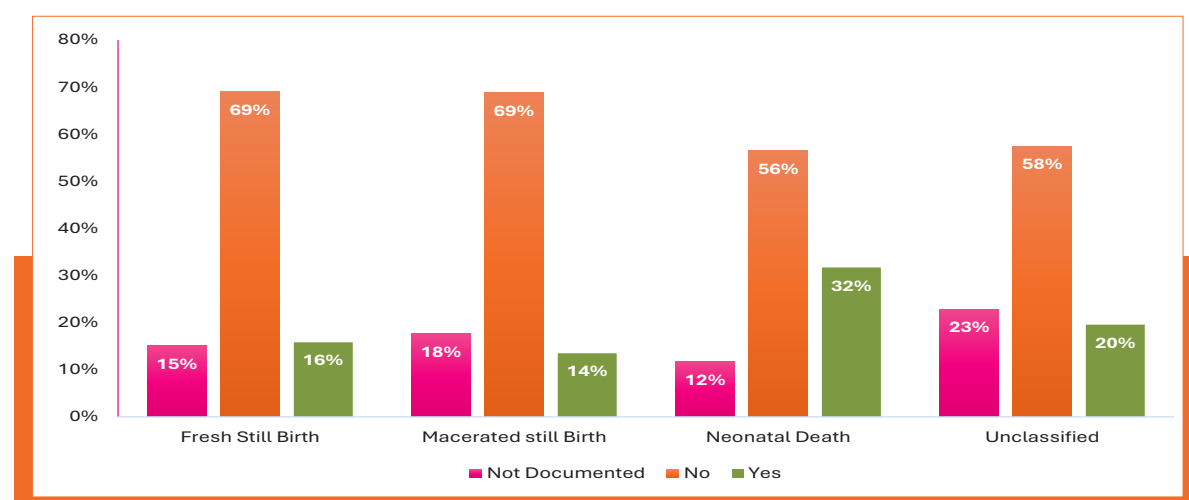
Figure 56: Percentage of Perinatal deaths by Referral Status and time of death, FY2024/25 [n=432]



Where referral intervals were recorded, 49% fresh stillbirths reached higher-level care within 30–60 minutes, demonstrating that functional referral pathways exist.

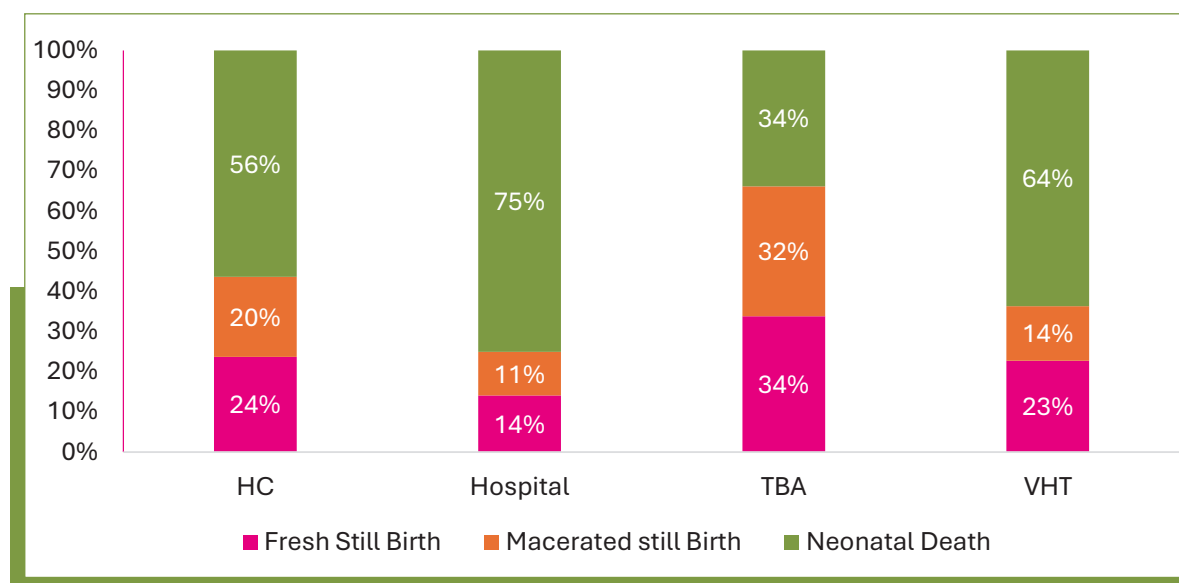
(vi) Referral status

Figure 57: Percentage of Referrals, FY2024/25



One-third of neonatal deaths occurred among referred cases. This underscores the need to strengthen stabilization and monitoring during transfer to improve survival rates.

Figure 58: Referral source, FY2024/25 (%)



Majority of the neonatal deaths originated from health centres. Referrals from health centres were high among neonatal deaths, accounting for about twice the share of stillbirth referrals

3.4.8 Avoidable/modifiable factors

Table 41: Regional comparison in avoidable/modifiable factors between FY2023/24 and FY2024/25

Region	FY2023/24				FY2024/25			
	Total Reviews	Percentage Contribution			Total Reviews	Percentage Contribution		
		Delay 1	Delay 2	Delay 3		Delay 1	Delay 2	Delay 3
Acholi	1,230	46.0%	27.0%	32.0%	1,115	43.3%	26.5%	35.2%
Ankole	1,173	44.0%	29.0%	14.0%	996	41.1%	26.3%	20.1%
Bugisu	811	43.0%	34.0%	19.0%	589	47.5%	39.7%	21.1%
Bukedi	692	62.0%	57.0%	20.0%	598	67.7%	59.5%	29.3%
Bunyoro	797	51.0%	38.0%	25.0%	892	53.4%	38.3%	28.7%
Busoga	1,928	55.0%	36.0%	24.0%	1,391	51.1%	31.1%	22.0%
Kampala	2,032	35.0%	28.0%	19.0%	1,326	18.4%	9.0%	12.8%
Karamoja	461	57.0%	43.0%	27.0%	539	56.4%	41.6%	33.2%
Kigezi	839	41.0%	26.0%	24.0%	711	43.9%	24.3%	20.5%
Lango	1,059	42.0%	26.0%	24.0%	804	41.0%	28.0%	32.1%
North Buganda	964	46.0%	34.0%	16.0%	1,471	41.8%	27.8%	17.8%
South Buganda	604	42.0%	27.0%	18.0%	942	45.2%	29.3%	24.1%
Teso	741	59.0%	35.0%	23.0%	417	60.0%	38.6%	23.3%
Tooro	579	49.0%	33.0%	18.0%	734	37.9%	26.8%	26.4%
West Nile	1,109	47.0%	22.0%	31.0%	1,230	48.0%	29.5%	31.3%
Grand Total	15,019	47.0%	32.0%	22.0%	13,755	44.4%	29.6%	24.5%

Nationally, Delay 1 reduced by 6%, Delay 2 by 8%, while Delay 3 rose by 11%. Regionally, Bukedi and Teso remained affected by Delay 1, while Acholi, Lango, Karamoja, and Tooro registered increases in Delay 3. Kampala showed the highest reduction across all delays.

The relative reduction in Delay 1 and Delay 2 suggests improvement in community awareness, health care-seeking behaviour, and referral processes. However, the rising contribution of Delay 3 highlights weaknesses in intrapartum and facility-based care, particularly in high-burden regions.

Strengthen facility readiness to manage emergencies by ensuring 24/7 staffing, timely surgical response, and reliable supplies (blood, drugs, and equipment). Regions with persistently high Delay 1, such as Bukedi and Teso, should reinforce community engagement and birth preparedness programs. Regions showing increases in Delay 3, including Acholi, Lango, Karamoja, and Tooro, require targeted mentorship, clinical audits, and accountability frameworks to reduce intrapartum care delays.

Figure 59: Deep dive on delay 3 across the last two financial years

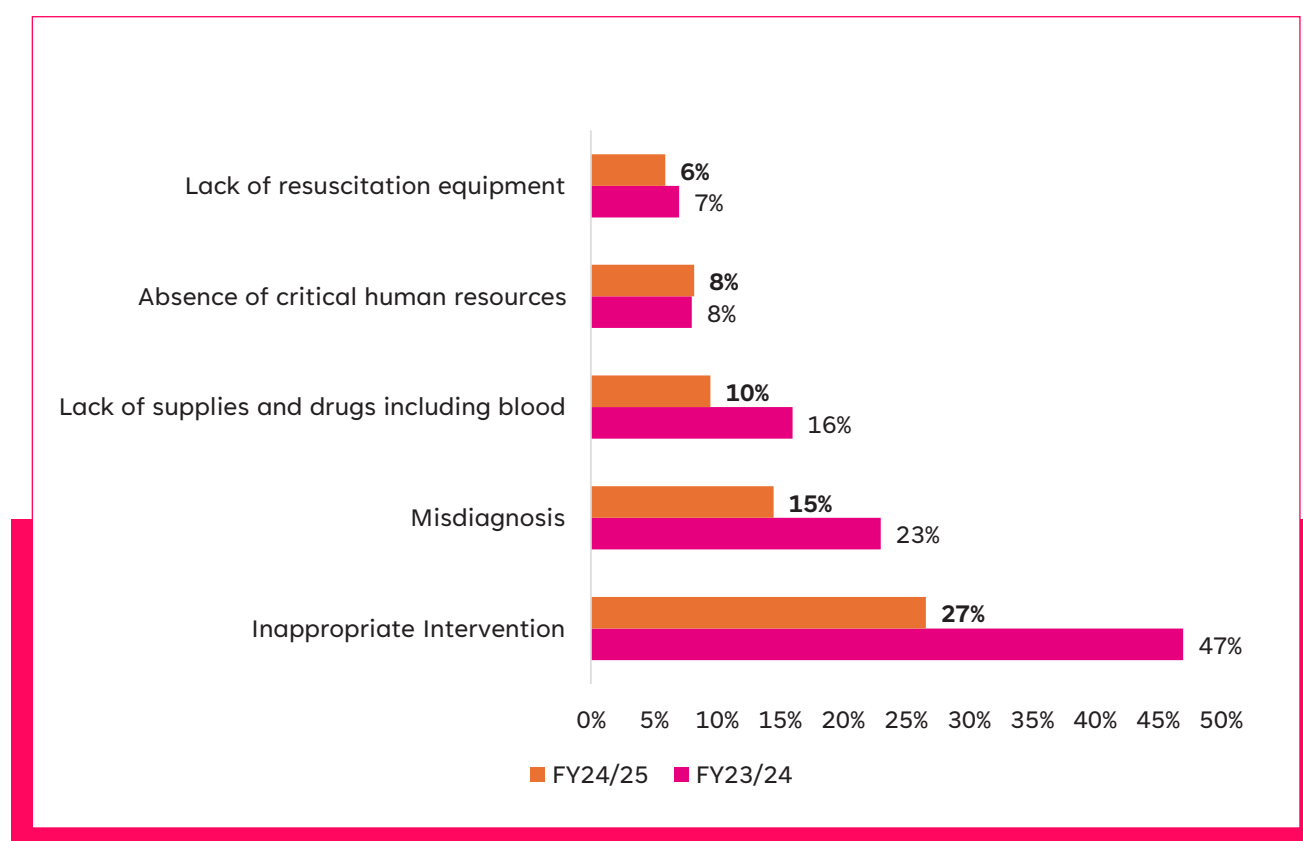


Table 42: Regional deep-dive on delay 3

Region	Inappropriate intervention	Misdiagnosis	Lack of supplies and drugs including blood	Absence of critical human resources	Lack of resuscitation equipment
Acholi	33.4%	18.4%	7.1%	8.2%	6.0%
Ankole	28.1%	18.5%	11.4%	8.0%	5.9%
Bugisu	30.2%	15.6%	9.8%	5.9%	6.8%
Bukedi	21.0%	14.0%	12.6%	11.9%	9.4%
Bunyoro	30.4%	11.5%	11.5%	11.1%	3.5%
Busoga	18.3%	10.9%	7.0%	6.6%	4.3%
Kampala	21.6%	13.6%	14.3%	7.7%	9.1%
Karamoja	26.3%	13.8%	9.1%	7.5%	7.5%
Kigezi	27.3%	16.9%	6.7%	6.7%	6.4%
Lango	30.8%	13.5%	10.2%	7.1%	5.0%
North Buganda	18.5%	12.4%	12.9%	11.5%	7.3%
South Buganda	19.5%	17.4%	9.6%	8.6%	5.2%
Teso	29.1%	15.6%	6.4%	10.6%	9.2%
Tooro	25.9%	17.1%	7.1%	6.8%	3.5%
West Nile	36.9%	13.0%	9.0%	7.2%	5.2%
Total	26.6%	14.5%	9.5%	8.2%	5.9%

Nationally, delay 3 was mainly driven by inappropriate interventions (27%) and misdiagnosis (15%), followed by gaps in supplies and drugs (10%), absence of critical staff (8%), and lack of resuscitation equipment (6%).

Regions such as West Nile, Acholi, and Bunyoro reported the highest contribution of inappropriate interventions, while Kampala and Bukedi recorded more challenges in supplies and HR. These patterns point to the need for strengthening clinical decision-making, timely resuscitation capacity, and consistent availability of essential supplies and equipment.

CHAPTER FOUR

RECOMMENDATIONS

INTRODUCTION

This chapter builds on the results and performance indicators presented in Chapter Three to provide concrete recommendations and their corresponding policy implications. The recommendations are structured along the continuum of care; maternal health, newborn health, child health, and system-level reforms and are further grouped under the themes of health system strengthening, workforce and capacity building, community engagement, and policy and governance. They are framed for implementation at national, regional, district, facility, and community levels to ensure accountability and accelerate progress towards Uganda's RMNCAH Sharpened Plan II and Sustainable Development Goal targets.



“From evidence to action this chapter turns data into direction, outlining concrete steps to strengthen Uganda’s RMNCAH response across all levels of care.”

Recommendations & Policy Implications (FY 2024/25)

Table 43: Recommendations & Policy Implications (FY 2024/25)

No.	Theme	Gap & Evidence (FY2024/25)	Recommendation	Responsible Institution(s)
1	CEmONC functionality at HC IVs	About 82.9% of public HC IVs offer both C-section and blood transfusion services.	- Implement a regional HC IV operationalisation plan with clear milestones to achieve 100% coverage. - Track HC IV operational status monthly through LMNS dashboards.	MoH/RCH Dept.; RRHs; LMNS platforms; DHOs; NMS; UBTS
2	Safe obstetric surgery and rational C-section use	1,788 C-sections performed at HC IIs/clinics (mostly PFP).	- Enforce regulatory accreditation of PFP facilities for obstetric surgery. - Strengthen district regulatory oversight and initiate PPP referral agreements. - Develop a minimum standards checklist for safe C-sections.	MoH/Quality Assurance & Regulatory; Professional Councils (UMDPC/UNMC/AHPC); DHOs; PNFP/PFP bureaus
		Increased maternal deaths due to PPH after C-section.	- Scale up ETOO training for medical officers performing obstetric surgery. - Strengthen mentorships in infection prevention, intraoperative safety, and post-operative monitoring of mothers. - Strengthen cross consultation during difficult obstetric operations.	MoH; MoES; AOGU; Training Institutions DHO, LMNS
3	Blood availability and transfusion	Haemorrhage case fatality rate (3.5%), driven by delayed blood transfusions and inadequate blood stock monitoring at facility level.	- Operationalise blood transfusion services in all CEmONC facilities. - Expand satellite blood banks at RRHs. - Activate a real-time blood application dashboard for available blood products. - Strengthen active stock monitoring of blood and blood products at all CEmONC facilities.	UBTS; RRHs; NMS; MoH/HIS; DHOs
4	Skilling of health workers for obstetric and newborn emergencies	High proportion of deaths linked to misdiagnosis and inappropriate interventions.	- Expand hands-on competence-based training and mentorship on emergency obstetric and newborn care, including anaesthesia. - Conduct quarterly simulation drills at RRHs and HC IVs.	MoH; SEC; DHOs; ADHO-MCHN

No.	Theme	Gap & Evidence (FY2024/25)	Recommendation	Responsible Institution(s)
5	ANC diagnostics and treatment modalities	HB screening 28% vs target 65%; ultrasound 28%; Hep B testing 58%; due to non-functional machines, reagent stockouts, and operator gaps.	- Repair and maintain HB and ultrasound equipment. - Establish framework contracts for reagents. - Integrate ultrasound and Hep B testing into routine ANC. - Train staff on use and maintenance of diagnostic equipment.	MoH/Lab, Health Infrastructure & RCH; NMS; RRHs (biomed); DHOs
		Syphilis treatment remains low (51–73%).	- Train health workers on same-day test-and-treat protocols. - Ensure consistent Benzathine Penicillin supply.	MoH/RCH & Pharmacy Div.; NMS; DHOs; VHTs
		Low male HIV testing.	- Intensify couple-focused ANC education and testing. - Link male testing to broader men's health services (HIV, NCD screening).	Health Facility In-charges; DHOs; ADHO-MCHN; CSOs
6	Postnatal care integration and continuity	PNC coverage remains low (36% at 6 days; 55% at 6 weeks) due to weak linkage with immunization services.	- Integrate PNC with immunization visits through combined mother-baby clinics. - Reinforce discharge-to-follow-up bundles (home visits by CHWs within 72 hrs, defaulter tracking). - Scale up digital reminders for postnatal follow-up.	Health Facility In-charges; DHOs; CHEWs, VHTs; Vaccinators
7	Postpartum and post-abortion family planning (FP)	iPPFP uptake at 2.2% nationally.	- Institutionalise iPPFP counselling and service delivery at all levels. - Strengthen integration of FP counselling during ANC, labour, and immediate postpartum. - Build capacity of health workers and ensure consistent FP commodity availability and provision.	MoH/RCH (FP); RRHs; GHs; PNFP/PFP; NMS
		Only 10.6% of post-abortion clients received PAFP.	- Institutionalise¹ PAFP counselling and services in all facilities. - Strengthen provider training and stock management for PAFP commodities.	MoH/RCH (FP); RRHs; GHs; PNFP/PFP; NMS

1. Institutionalization requires training of health workers, provision of supplies and equipment, provide standard guidelines and protocols, monitor and evaluate.

No.	Theme	Gap & Evidence (FY2024/25)	Recommendation	Responsible Institution(s)
8	Teenage maternal deaths (133 cases reported)	High proportion of deaths among adolescents, linked to early pregnancy, delayed ANC, and social vulnerability.	- Scale up the teenage pregnancy surveillance and response platforms under a multisectoral framework at subnational level. - Strengthen community-based prevention, reintegration, and empowerment programmes for adolescent mothers. - Facilitate cross-learning and knowledge exchange visits with districts that have achieved low teenage pregnancy rates for benchmarking.	MoH/RCH; MoES; MoGLSD; Local Govts; CSOs
9	Data for decision-making	Incomplete data for ANC and PNC across facilities.	- Build capacity of facility teams to use data for decision-making. - Strengthen LMNS data review platforms for accountability and follow-up.	Health Facility In-charges; DHOs
10	Leading causes of maternal and perinatal death	PPH, eclampsia, and PET remain the top causes of mortality.	- Scale up EMOTIVE, ETOO training, and facility readiness. - Intensify screening for hypertensive disorders and ensure stock availability. - Reinforce infection prevention and control (IPC) practices in all delivery and postnatal units.	MoH/RCH & Clinical Services; RRHs; DHO; Health Facility In-charge
		Birth asphyxia remains the leading cause of neonatal deaths, reflecting gaps in intrapartum monitoring and timely clinical decision-making.	- Strengthen intrapartum fetal monitoring and timely interventions to prevent birth asphyxia. - Improve newborn resuscitation readiness through competence-based mentorship and availability of functional equipment. - Integrate perinatal audits into routine MPDSR reviews with active participation of the obstetrics team.	
11	Emerging causes of newborn deaths	Sporadic cases of neonatal tetanus reported.	- Strengthen TT vaccination for teenage girls and mothers. - Reinforce infection prevention and control (IPC) practices in all delivery and postnatal units.	MoH/EPI; DHOs; Health Facilities
12	Integrated Child Health and Community Case Management	- Childhood illnesses such as pneumonia, diarrhoea, and malaria remain leading causes of under-five morbidity and mortality. - iCCM coverage varies widely across districts, with challenges in stock availability and supervision of VHTs.	- Sustain and scale up the iCCM initiative to improve early diagnosis and treatment of childhood illnesses at community level. - Strengthen supply chain management to ensure consistent availability of essential child health commodities. - Reinforce mentorship and supervision of CHWs to improve quality of community-level case management and timely referrals.	MoH/RCH; Pharmacy Department; DHOs; Partners; Local Governments

APPENDICES

APPENDIX I: CASE STUDIES AND SUCCESS STORIES

From Hesitation to Confidence: A Medical Officer's Journey to Saving Mothers in Kalungu

Key Issues: High maternal deaths from preventable causes; limited confidence and capacity of health workers to manage obstetric emergencies; need for both technical and soft skills in maternal health care.

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Maternal mortality in Kalungu remains a pressing concern, with many deaths stemming from preventable causes such as excessive bleeding after childbirth (postpartum haemorrhage), preeclampsia, and obstructed labour. Despite their dedication, frontline healthcare providers often face skills gaps and low confidence, feeling underequipped

when faced with emergencies that require surgical care.

To address these gaps, the Babies and Mothers Alive Foundation (BAMA), with support from the ELMA Foundation, organized an Essential Training in Operative Obstetrics (ETOO) to equip medical officers, clinical officers, and midwives with practical, life-saving skills, while emphasizing compassionate and respectful maternity care.

Isaac Muyanja, a medical officer at Villa Maria Hospital in Kalungu, exemplifies the transformative impact of this training. Before attending the ETOO course, Isaac often felt unprepared when faced with life-threatening maternal complications. The training introduced him to practical interventions such as managing postpartum haemorrhage using the E-MOTIVE bundle, applying novel technologies like the non-pneumatic anti-shock garment (NASG), performing difficult caesarean sections, repairing perineal and cervical tears, monitoring patients during and after surgery, and strengthening infection prevention practices. He also gained valuable exposure to psychosocial support and respectful maternity care: soft skills that are often overlooked yet critical in maternal health.

Back at Villa Maria, Isaac received onsite mentorship from the regional Senior Consultant obstetrician and immediately began applying his new skills with confidence and precision. He now responds swiftly and decisively to emergencies, ensuring mothers

receive timely, effective, and compassionate care. His renewed approach has improved maternal outcomes and inspired colleagues, creating a ripple effect of better care across the maternity unit. Reflecting on his experience, Isaac remarked: *“This wasn’t just a refresher; it was an awakening. I left feeling empowered, equipped, and renewed in purpose. I now have a stronger ability to save lives.”*

Achievements:

These efforts, including the Essential Training in Operative Obstetrics (ETOO) and other programs facilitated by the Babies and Mothers Alive Foundation (BAMA), have driven substantial, measurable progress. In the FY2024/25 period, across 38 focus health facilities in Masaka City and five scale-ups (Masaka, Bukomansimbi, Ssembabule, Lwengo, and Kalungu), the institutional maternal mortality ratio (IMMR) decreased by 20%, from 152 to 118 per 100,000 live births. This translates to 20 maternal lives saved out of 32,334 deliveries registered, indicating progress toward safer motherhood in the Greater Masaka region.

Collaborative Efforts:

This dramatic reduction in maternal mortality shows what can be achieved when partners come together around a common goal. Strategic implementation by the Babies and Mothers Alive Foundation, national technical leadership from the Ministry of Health, coordinated regional efforts through the Greater Masaka Local Maternity and Neonatal System, and vital stewardship from Local Governments created a strong alliance. Generously supported by ELMA Foundation and Babies and Mothers Alive USA, this partnership introduced a unified, team-based training approach that enhanced clinical capacity across the entire health system in Greater Masaka. This effort was strengthened by committed facility leaders who empowered providers like Isaac by providing necessary resources and fostering a culture of peer mentorship that sustains itself.

Next Steps:

To sustain these gains and build on this lifesaving momentum, BAMA will continue to partner with the Ministry of Health and the Greater Masaka Local Maternity and Neonatal System to champion the expansion of our maternal health mentor network. By empowering proven leaders like Isaac to pass their skills to peers and the next generation of experts, we will ensure every mother across the region has sustained access to safe and dignified care.



This wasn’t just a refresher; it was an awakening. I now have a stronger ability to save lives,” says Isaac Muyanja, Medical Officer, Villa Maria Hospital



Catalytic Support to Lower-Level Health Units: Reducing Severe Maternal Complications and Deaths at Mbale Regional Referral Hospital

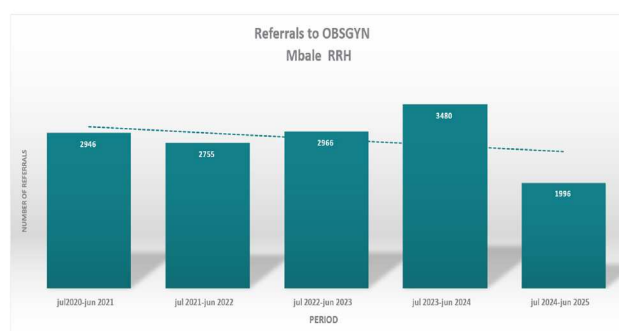
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4. Seed Global Health Uganda

to lower-level health units has shown that decentralized capacity-building, community engagement, and strengthened referral coordination can save lives and restore dignity in maternal and newborn health care.

TRENDS IN REFERRALS TO THE HOSPITAL OVER 5 YRS PERIOD-OBSGYN



Days out of stock and number of essential commodities reduced, less staff burn out

Coverage of ELMNS



Introduction and key issues: The Elgon LMNS covers a catchment population of 4.45 million across Bugisu, Bukedi, and Sebei sub-regions. With 127 HCII, 78 HCIII, 14 HCIV, and 7 hospitals feeding into Mbale Regional Referral Hospital (MRRH), it seeks to bridge the gaps between communities, frontline facilities, and the referral system. Catalytic support

In the lush green foothills of Mount Elgon, Mbale RRH has long stood as both a sanctuary and a last resort. For decades, ambulances and boda bodas brought mothers in distress: bleeding after childbirth, seizing with eclampsia, or obstructed in labor. They often arrived late too late. The corridors bore silent testimony to lives lost, not because help was absent, but because it was delayed.

In many Ugandan cultures, birth is a deeply social event, woven with rituals of kinship, hope, and continuity. Yet when complications arise, those rituals collide with the stark realities of health systems stretched beyond capacity. To the health workers at MRRH, every mother who arrived in extremis was not just a patient but a story interrupted an unfinished life, a community shaken.



The Elgon LMNS initiative was born from this recognition: that saving mothers requires shifting the locus of care from the referral hospital back into the community and its primary health facilities. Supported by Seed Global Health and partners, catalytic interventions began:



Figure: Simulation Drills at Bukwo General Hospital, Bukwo District

Simulation drills where midwives and doctors at Budaka, Butebo, Bukwo, Mulanda, and Bubulo practiced managing hemorrhage

or resuscitating newborns using the low dose high frequency model. These were not abstract exercises; they were rehearsals for life-saving moments.



Awareness campaigns concerts, blood drives, skits, even football matches that carried medical knowledge into the rhythm of everyday life, reshaping conversations about pregnancy and danger signs.

As confidence grew at lower-level facilities, something shifted. Mothers were no longer hurried along rough roads to Mbale in desperate condition. Stabilized, managed, and often saved near their homes, fewer reached the referral hospital on the brink of death

MPDSR reviews at Kibuku HCIV where each maternal death became a teaching session, its lessons guiding new practices.

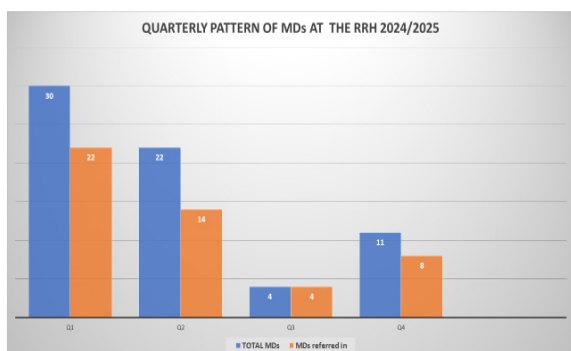
Results

- Reduced referrals: Facilities such as Budaka and Butebo now handle emergencies that once overwhelmed MRRH.
- Decline in maternal deaths: Data show

fewer women arriving in extremis at Mbale RRH, easing the burden on staff and resources.

- **Increased blood availability:** Over 50 units collected through community-driven campaigns blood as a shared resource of solidarity.
- **Knowledge and morale:** Health workers describe newfound confidence, less burnout, and stronger teamwork.
- **Community engagement:** Myths dismantled, IEC materials translated, and families encouraged to seek care early.

2024/2025 MDs DISTRIBUTION PATTERN AT RRH



These achievements reflect not just technical capacity but reconfigured relationships: between health workers and communities, between lower and higher levels of the system, and between global partners and local realities. Philosophically, they affirm that care is not only an act of treatment but also an ethic of presence of being ready, responsive, and responsible at the right time and place

Increased blood availability: Over 50 units of blood mobilized through LMNS-supported

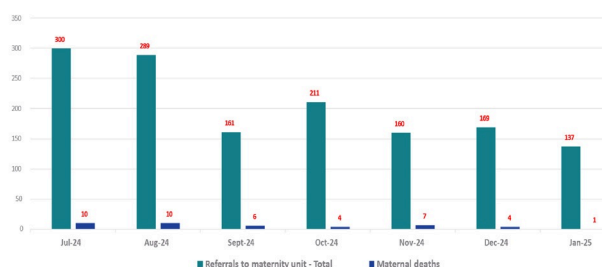
donation campaigns in PPH walks and PET activities. Delays in accessing blood are solved through transportation of blood to reach the facility instead of transporting the mother

Improved knowledge & morale: Health workers gained confidence in handling emergencies, reducing burnout and delays in care.



Community engagement: Myths were demystified, IEC materials translated into local languages, and awareness of maternal danger signs increased.

RELATIONSHIP BETWEEN REFERRALS INTO OBSGYN AND MDs



PET Awareness Concert



Next Steps:

- Scale up simulation drills to additional facilities.
- Expand awareness campaigns, including a PPH Walk in Mbale City and community health talks on an annual basis and conduct grand rounds and CMEs.
- Strengthen documentation of maternal outcomes and referral trends.
- Advocate for renewed logistical support, including replacement of the aging coordination vehicle.

“

Before, we feared emergencies because help was far away. Now, with the skills we have gained, we act quickly, save mothers here, and only refer when absolutely necessary.” – Koote Irene, Midwife, Butebo District

Against All Odds: A Couple's Journey Nurturing Preterm Twins in Bukomansimbi

Key Issues: Preterm births, challenges of rural access to maternal care, hospital-to-home follow-up support, and community-driven family empowerment.

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In the heart of Bukomansimbi, a rural area in South Buganda, Nalongo, a hardworking mother of three, was determined to complete her farming contract before giving birth. She ignored her labor pains and continued digging, hoping to earn money for her family. Unfortunately, she could not reach the health facility in time and delivered her first twin, a baby girl, just in front of her house. Panicked, her mother-in-law rushed to call for an ambulance. By the time Nalongo arrived at Butenga Health Centre IV, she had not yet

delivered her second baby. With the skilled hands of Cissy Namuddu, a BAMA mentor midwife, the second twin, a baby boy, was safely delivered. Both babies were premature, weighing only 1.0 kg and 0.9 kg for the first and second twin, respectively. They were immediately admitted to the Neonatal Intensive Care Unit (NICU) for specialized care.

Cissy enrolled Nalongo in the **Hospital to Home (H2H) program**, providing comprehensive education to her and her husband on caring for small and sick newborns, including recognition of danger signs, kangaroo mother care (KMC), and proper hygiene practices. She also offered lactation support and promoted exclusive breastfeeding. Yet the challenges were far from over. Shortly after discharge, the twins fell ill with diarrhea and malnutrition due to insufficient breast milk, forcing the exhausted couple to return to the health unit, fearful for their babies' lives. The twins were admitted, successfully managed, and the family was linked to Mr. John Ssekiwunga, a BAMA-trained H2H Ambassador, for post-discharge follow-up in the community.



On his first follow-up visit, John quickly recognized the family's vulnerability: they were living in a partially constructed house that exposed the premature twins to cold and illness. "I measured the babies' temperature; Babirye was 35.4 °C and Kato was 35.6 °C," John recalls. Realizing the danger sign of hypothermia, he sensitized the mother on keeping the babies warm and safe, including consistent practice of Kangaroo Mother Care.

"I took up this couple because I was touched," John recalls. "I had to do my level best and be there for the family." Together with other ambassadors, he conducted regular follow-ups, educated the couple on stress management, offered small business skills, and linked them to a Village Saving and Loans Association group to boost household income.

He conducted regular follow-up visits, educated the couple on stress management, and offered basic financial literacy and business skills. Furthermore, he linked them to a Village Savings and Loans Association group to help increase their household income and long-term resilience. He also mobilized fellow Village Health Teams and H2H Ambassadors, who pulled resources to complete the shelter and supplied mosquito nets, warm blankets, and other essentials to the couple.

Achievements:

Today, the once fragile twins are thriving. Nalongo shares, "My children are now big. I followed what John taught me, and my babies have gained weight. My husband is now proactive in helping me care for

the children, which I appreciate. All thanks to BAMA for the support through the H2H ambassadors who still visit us every month." The twins' survival is a testament to the power of skilled maternal care, community follow-up, and family empowerment.

Next Steps:

Building on proven successes, BAMA is scaling up its Hospital to Home (H2H) model across Health Centre IVs in Greater Masaka to reach more vulnerable newborns and their families. The expansion will train additional H2H Ambassadors and Village Health Teams for household follow-up, integrate digital tools with Community Health Extension Workers to improve communication and data use, and link families to economic support through Village Savings and Loan Associations. By partnering with the Ministry of Health and governments to embed H2H into national health strategies, BAMA ensures that every premature or vulnerable newborn receives continuous post-discharge care, enabling them not just to survive, but to thrive.



I thought I would lose my children when they became sick again. But with the visits and teachings from John and BAMA, my twins are alive and healthy today." Says Nalongo.

Functionalization of the Neonatal Intensive Care Unit (NICU) at Dokolo Health Centre IV: A Collaborative Milestone in Strengthening Newborn Care Services in Lango Sub-region



Authors:

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3. Dokolo Health Centre IV, Uganda
4. USAID G2G Lira Regional Referral Hospital

Background

Neonatal mortality remains a significant public health challenge in Uganda, with preterm birth complications, infections, and asphyxia contributing to high morbidity and mortality rates. The Lango sub-region has historically recorded some of the highest neonatal mortality rates due to limited access

to specialized newborn care services.

Dokolo Health Centre IV, a key lower-level referral facility, previously lacked a functional Neonatal Intensive Care Unit (NICU). As a result, many sick or preterm babies were referred to Lira Regional Referral Hospital (RRH), regardless of the severity of their condition. This practice increased transport-related risks, overwhelmed the referral system, and contributed to preventable deaths from birth asphyxia, prematurity, and neonatal sepsis.

As part of the Ministry of Health's efforts to decentralize and strengthen neonatal care, and building on successful national initiatives demonstrating the benefits of facility-based newborn care, Lira RRH in collaboration with Dokolo HC IV, USAID RHITES–North Lango, USAID G2G Lira RRH Activity, Seed Global Health, and the Lango LMNS embarked on functionalizing the NICU at Dokolo HC IV to improve neonatal survival at community level.

Problem Statement

Before 2023, Dokolo HC IV did not have a functional NICU. Sick and preterm newborns were referred to Lira RRH, often for manageable conditions, leading to:

- High neonatal mortality due to delayed care.
- Neonates needing thermal regulation, oxygen therapy, or specialized monitoring being managed in the maternity ward under suboptimal conditions.
- Overwhelming pressure on the Lira RRH NICU and referral system.
- Limited capacity at Dokolo HC IV for advanced newborn care.

Collaborative Efforts / Interventions

The functionalization of the NICU was achieved through a multi-partner collaboration involving Dokolo HC IV, Lira RRH, USAID RHITES–North Lango, USAID G2G Lira RRH, and the Lango LMNS.

In early 2023, a joint assessment team from Lira RRH and USAID RHITES–North Lango reviewed newborn care readiness across all CEmONC sites in Lango. A structured intervention plan was developed, focusing on infrastructure improvement, equipment support, and capacity building.



Key Interventions

1. Infrastructure and equipment support

- Renovation and allocation of a dedicated NICU room with proper ventilation and infection prevention measures.
- Installation of incubators, radiant warmers, oxygen systems, and monitoring tools.
- Renovation of the theatre and provision of

modern anaesthesia machines by USAID RHITES–North Lango.

2. Capacity building

- Training of Dokolo HC IV staff in newborn resuscitation, preterm care, essential newborn care, infection prevention, and monitoring protocols by the Lira RRH NICU team.

- Continuous mentorship, supportive supervision, and follow-up visits by Lira RRH NICU staff.
- Adoption of standard clinical protocols to reduce avoidable referrals and improve care quality.
- Strengthened use of newborn data registers and referral tracking tools.
- Integration of NICU indicators into routine HMIS reporting and performance reviews.

3. System strengthening and operational support

- Regular supply of essential consumables and technical guidance.

Achievements / Outcomes

Indicator	Before NICU Setup	After Functionalization
Neonatal mortality rate (institution-based)	20 per 1,000 live births	10 per 1,000 (64% reduction)
Referrals to Lira RRH (per month)	~15 babies	1–3 babies
Cases referred (excluding exceptions)	Majority of admissions	Only congenital anomalies, <600 g, or severe complications
Asphyxia case fatality rate	13% (Dokolo District)	5% (improved with IPC and care protocols)

Impact on Neonatal Health and Facility Dynamics

1. Lives saved locally: Institutional neonatal mortality reduced by about 64%, attributed to improved in-facility care, timely management, and adherence to resuscitation and IPC protocols.
2. Reduced referral burden: Monthly referrals to Lira RRH decreased by over 90%, with only complex cases requiring tertiary-level intervention being referred.
3. Improved morbidity outcomes: Enhanced infection prevention and strict adherence to clinical protocols led to faster stabilization and reduced complications.
4. Enhanced care quality: Facility staff are now proficient in neonatal resuscitation, thermal regulation, kangaroo mother care, and continuous monitoring, supported by regular mentorship from the Lira RRH NICU team.
5. Community confidence restored: The functionalization of the NICU has raised the quality of newborn care, reduced avoidable deaths, and restored community confidence in seeking care from Dokolo HC IV and neighbouring facilities.

Lessons Learned

- Establishing functional NCU services at lower-level facilities drastically reduces preventable neonatal deaths.
- Continuous mentorship and supportive supervision are essential for sustaining quality outcomes.
- Data-driven monitoring informs targeted interventions and efficient resource use.
- Collaboration between referral hospitals, local facilities, and partners accelerates success and scalability.

Recommendations

1. Scale-Up NCU functionalization: Expand NCU services across all CEmONC sites in the Lango sub-region through joint efforts between Lira RRH, MoH, and implementing partners.
2. Strengthen monitoring and data use: Utilize e-Afya and HMIS platforms for real-time tracking of neonatal outcomes and referral trends.
3. Sustain mentorship and supportive supervision: Maintain structured mentorship from Lira RRH to ensure continuous quality improvement.
4. Community engagement: Intensify sensitization to promote early care-seeking and trust in local neonatal services.
5. Ensure resource continuity: Maintain a steady supply of equipment, consumables, and trained staff to preserve and scale the NICU's success.



Testimonials

“Since the NICU began functioning, we have seen many more babies survive the first critical days,” shared the Maternity In-Charge, Dokolo HC IV.

“We now refer only the most complex cases; mothers are more confident and less anxious,” added the Dokolo HC IV NICU In-Charge.

“We rarely receive referrals from Dokolo District now only for complex conditions,” noted the NICU In-Charge, Lira RRH.



Radiant Warmer at Dokolo HC IV now functional

APPENDIX II: HEALTH CENTRE IVS NOT OFFERING BLOOD TRANSFUSION OR CONDUCTING CS, FY2024/25

Table A1: Health Centre IVs not offering blood transfusion or conducting CS, FY2024/25

No.	District	Health Facility	Offer Caesar- ean sections	Offer Blood Transfusion	Comment
	Amudat	Karita Health Centre IV	No	NO	Theatre not working
	Amuria	Wera Health Centre IV	No	NO	No Theatre
	Apac	Akokoro Health Centre IV	No	NO	Incomplete
	Arua	Bondo Health Centre IV	No	NO	No post-operative ward, Theatre complete
	Bududa	Bulucheke Health Centre IV	No	NO	Has no Theatre, and Dr's. House
	Buikwe	Ngogwe Health Centre IV	No	NO	Incomplete
	Bukedea	Kachumbala Health Centre IV	No	NO	Incomplete (No Theatre)
	Buliisa	Buliisa Health Centre IV	No	NO	Missing theatre equipment
	Buliisa	Biiso Health Centre IV	YES	NO	Blood fridge available, not accredited
	Kabale	Kakomo Health Centre IV	No	NO	Missing key equipment
	Kalaki	Kalaki Health Centre IV	No	NO	Incomplete (No Theatre)
	Kampala	Nsambya Police HC IV	No	NO	
	Kampala	Naguru Police Health Centre IV	No	NO	
	Kampala	Luzira Staff Clinic	YES	NO	
	Kamwenge	Bisozi Health Centre IV	YES	NO	No Theatre
	Kanungu	Rugyeyo Health Centre IV	No	NO	Human Resource gaps
	Kanungu	Mpungu Health Centre IV	No	NO	No theatre
	Kapchorwa	Kaserem Health Centre IV	YES	NO	No blood fridge
	Kasese	Nyabirongo Health Centre IV	YES	NO	No blood fridge
	Kassanda	Bukuya Health Centre IV	No	NO	Incomplete theatre
	Katakwi	Toroma Health Centre IV	No	NO	No theatre
	Kisoro	Busanza Health Centre IV	No	NO	Human Resource gaps
	Kumi	Kumi Health Centre IV	YES	NO	No blood fridge
	Kyegegwa	Mpara Health Centre IV	No	NO	No blood fridge
	Lira City	Ober Health Centre IV	No	NO	Incomplete Theatre
	Maracha	Maracha Health Centre IV	No	NO	Theatre Complete (Lacking Equipment)
	Mitooma	Bitereko Health Centre IV	No	NO	Has not yet started operations, No drugs
	Nakapiripirit	Namalu Health Centre IV	No	NO	Incomplete theatre
	Napak	Irimi Health Centre IV	No	NO	Incomplete theatre
	Ntoroko	Rwebisengo Health Centre IV	YES	NO	No blood fridge
	Pader	5th Military Division Health Centre IV	No	NO	
	Rukiga	Kamwezi Health Centre IV	YES	NO	No power
	Rukungiri	Rukungiri Health Centre IV	No	NO	No blood fridge
	Rukungiri	Buhunga Health Centre IV	YES	NO	No blood fridge
	Wakiso	Kira Health Centre IV	YES	NO	Incomplete theatre

APPENDIX III: DISTRICT DEEP-DIVES, FY2024/25

District	ANC 1 in 1st Trimester	ANC 4 coverage	ANC 8 coverage	Iron& Folic Acid at ANC 1 (%)	HB screening at ANC 1 (%)	Prev. of Diarrhoea (U5 at OPD)	Prev. of Pneumonia (U5 at OPD)	Prev. of Malaria (U5 at OPD)	ANC 1 received ITN	Total Maternal deaths	IMMR/ 100,000 Deliveries	MDR (%)	Total Perinatal death	IPMR/1000 BIRTH	FSB/1000 birth	MSB/1000 births	PD reviewed (%)
Abim	60%	72.6%	9.9%	74.2%	0.8%	10	4	39	73.7%	3	47.7	100%	44	7.0	3.5	2.4	102%
Adjumani	57%	74.3%	14.6%	74.4%	46.9%	13	10	18	79.2%	2	14.7	100%	135	10.0	3.6	4.7	75%
Agago	41%	51.5%	4.7%	85.6%	30.3%	8	2	55	72.3%	5	51.8	100%	154	16.0	3.3	6.4	94%
Alebtong	50%	57.9%	3.2%	79.8%	57.7%	7	6	56	75.3%	6	73.3	100%	47	5.9	3.2	1.8	79%
Amolatar	58%	79.1%	9.1%	83.1%	67.4%	8	12	30	67.9%	3	41.4	100%	66	9.1	4.0	3.6	82%
Amudat	38%	27.6%	1.3%	86.2%	20.9%	10	5	18	87.9%	4	98.8	100%	53	13.3	6.5	2.3	55%
Amuria	43%	48.5%	2.0%	69.0%	10.8%	4	2	33	66.9%	1	10.6	100%	77	8.1	4.2	3.0	110%
Amuru	27%	58.7%	2.0%	79.8%	35.5%	13	4	36	60.3%	3	44.8	100%	55	8.2	3.4	3.4	84%
Apac	53%	69.3%	6.0%	80.4%	51.9%	7	12	41	66.7%	3	36.6	67%	122	14.9	5.4	5.7	48%
Arua	23%	50.5%	1.6%	63.7%	7.7%	9	2	16	73.9%	1	23.0	100%	66	15.1	7.8	4.6	93%
Arua City	28%	51.5%	2.3%	55.6%	29.5%	8	1	17	69.8%	25	161.6	52%	386	24.7	10.4	10.6	32%
Budaka	47%	57.0%	2.8%	71.8%	18.0%	9	2	29	84.8%	2	15.2	100%	64	5.1	2.5	2.2	31%
Bududa	69%	89.8%	24.2%	92.1%	87.4%	9	12	6	98.4%	2	14.0	50%	84	5.9	2.1	1.2	20%
Bugiri	35%	52.6%	3.8%	64.5%	31.1%	11	5	11	76.8%	8	46.3	100%	216	12.2	5.0	4.4	60%
Bugweri	33%	51.6%	1.7%	83.2%	21.6%	8	3	50	77.9%	0	0.0		58	9.8	3.1	5.3	7%
Buhweju	60%	49.0%	2.4%	95.6%	65.7%	10	10	3	97.4%	1	21.2	100%	17	3.8	2.0	0.7	81%
Buikwe	30%	53.3%	2.1%	76.9%	30.3%	5	5	18	72.6%	10	63.3	80%	326	20.3	6.2	8.7	58%
Bukedea	42%	42.7%	2.6%	50.8%	9.3%	7	2	43	59.8%	2	22.4	0%	80	9.2	3.1	3.2	3%
Bukoman-simbi	39%	40.6%	3.5%	58.6%	30.5%	5	5	17	60.1%	2	39.9	50%	53	10.5	3.2	5.4	0%
Bukwo	57%	64.3%	4.5%	67.2%	44.4%	14	11	2	93.3%	2	37.2	100%	55	10.7	4.3	3.3	55%
Bulambuli	50%	41.8%	3.8%	70.5%	19.4%	11	10	19	78.7%	1	12.2	100%	52	6.5	3.1	2.2	54%
Buliisa	32%	45.6%	0.9%	56.9%	11.3%	9	7	38	63.9%	2	47.5	100%	75	17.8	6.4	7.6	84%
Bundibugyo	35%	73.6%	7.4%	69.4%	10.1%	10	11	17	83.0%	3	27.1	100%	78	7.1	3.8	2.3	99%
Bunyangabu	45%	53.1%	1.4%	73.4%	27.9%	9	5	6	86.6%	2	21.9	100%	37	4.1	1.3	1.2	84%
Bushenyi	68%	72.9%	4.6%	89.2%	62.3%	5	11	3	95.7%	12	93.3	92%	161	12.6	3.8	4.4	71%
Busia	37%	57.4%	2.3%	84.8%	31.0%	9	4	28	75.1%	10	56.0	80%	177	10.1	4.8	4.3	36%
Butaleja	33%	58.5%	1.1%	61.0%	27.5%	10	4	14	83.9%	3	27.5	67%	147	13.3	8.6	4.7	1%
Butambala	27%	32.4%	0.6%	60.9%	64.2%	4	4	9	85.8%	9	108.7	89%	264	31.9	13.2	11.3	6%

District	ANC 1 in 1st Trimester	ANC 4 coverage	ANC 8 coverage	Iron & Folic Acid at ANC 1 (%)	HB screening at ANC 1 (%)	Prev. of Diarrhoea (U5 at OPD)	Prev. of Pneumonia (U5 at OPD)	Prev. of Malaria (U5 at OPD)	ANC 1 received ITN	Total Maternal deaths	IMMR/100,000 Deliveries	MDR (%)	Total Perinatal death	IPMR/1000 BIRTH	FSB/1000 birth	MSB/1000 births	PD reviewed (%)
Butebo	34%	32.1%	2.3%	72.9%	11.3%	10	5	47	81.3%	2	49.6	0%	42	10.6	5.0	4.0	0%
Buvuma	42%	36.5%	1.6%	88.1%	26.0%	9	10	26	73.1%	0	0.0		25	7.9	3.5	3.2	80%
Buyende	47%	69.3%	7.3%	83.6%	5.8%	9	4	51	73.8%	3	19.1	100%	59	3.8	1.6	1.6	42%
Dokolo	50%	67.2%	4.0%	87.3%	35.5%	6	9	46	78.8%	4	51.2	100%	69	8.8	3.7	2.9	75%
Fort Portal City	36%	73.1%	2.3%	87.5%	35.1%	5	3	3	58.0%	29	297.2	97%	195	21.4	6.5	11.9	47%
Gomba	30%	44.3%	0.7%	55.6%	21.7%	6	3	18	86.2%	1	23.1	100%	23	5.3	2.5	2.1	0%
Gulu	36%	49.4%	1.6%	86.4%	16.6%	10	2	45	87.7%	1	29.5	100%	28	8.4	1.8	2.7	82%
Gulu City	37%	74.5%	6.4%	84.3%	59.4%	7	3	14	57.5%	43	259.6	93%	597	37.8	9.7	11.6	73%
Hoima	38%	64.1%	1.0%	68.8%	17.6%	12	8	29	34.9%	0	0.0		20	3.3	1.5	1.2	70%
Hoima City	24%	48.7%	2.3%	61.6%	45.8%	6	3	14	51.2%	43	456.7	98%	511	55.2	19.4	15.7	32%
Ibanda	57%	76.4%	3.0%	87.3%	34.2%	5	7	26	82.6%	4	32.9	100%	197	16.2	5.8	6.8	92%
Iganga	45%	66.3%	4.3%	79.7%	25.4%	8	4	45	61.7%	16	73.1	94%	440	19.9	4.9	8.7	61%
Isingiro	39%	52.2%	2.3%	78.7%	12.5%	10	10	8	73.7%	2	9.3	0%	144	6.7	3.8	2.2	97%
Jinja	40%	45.7%	3.8%	74.6%	153.1%	15	11	40	70.0%	7	100.0	100%	129	18.8	7.7	7.7	76%
Jinja City	37%	72.1%	4.9%	74.2%	51.0%	7	4	14	71.7%	34	243.0	100%	529	37.1	13.2	15.6	47%
Kaabong	45%	40.0%	1.3%	82.2%	15.0%	16	8	35	88.1%	1	18.4	100%	92	16.9	6.4	2.8	100%
Kabale	53%	68.5%	3.9%	90.2%	55.4%	9	7	0	95.0%	9	75.4	100%	275	22.9	6.7	6.8	90%
Kabarole	37%	46.5%	4.9%	63.6%	24.6%	6	4	5	78.9%	0	0.0		20	4.2	1.0	2.3	75%
Kaberamaido	57%	53.1%	6.0%	60.0%	10.5%	8	3	38	67.4%	1	19.7	100%	66	12.9	5.1	4.1	61%
Kagadi	43%	54.1%	0.9%	63.3%	2.2%	6	3	30	73.4%	1	7.6	100%	147	11.3	5.6	4.1	56%
Kakumiro	34%	56.9%	1.2%	50.2%	15.1%	6	3	34	67.1%	2	12.1	100%	240	14.5	5.7	5.8	53%
Kalaki	30%	42.4%	2.1%	114.9%	33.7%	6	3	37	63.2%	2	53.4	100%	64	17.2	6.5	6.7	87%
Kalangala	54%	45.8%	1.9%	64.7%	44.4%	10	6	5	77.1%	1	72.4	100%	25	18.8	6.0	9.0	12%
Kaliro	43%	55.7%	3.4%	65.8%	26.5%	9	8	57	68.0%	0	0.0		47	5.5	1.6	3.3	61%
Kalungu	38%	47.4%	1.5%	64.1%	31.9%	7	6	12	87.7%	7	79.7	100%	124	14.1	6.0	4.8	85%
Kampala	27%	72.9%	5.8%	58.0%	31.2%	3	2	4	32.9%	169	198.7	90%	3037	35.3	8.0	11.6	44%
Kamuli	38%	56.7%	3.4%	63.0%	13.0%	8	12	50	75.1%	22	114.2	100%	406	21.2	4.2	9.5	86%
Kamwenge	38%	66.9%	4.5%	69.5%	15.2%	6	17	39	60.1%	4	27.2	100%	101	6.9	3.7	1.5	58%
Kanungu	47%	56.1%	3.2%	95.9%	24.5%	7	6	7	71.8%	8	82.9	88%	140	14.6	6.1	4.4	84%
Kapchorwa	34%	45.4%	2.9%	86.3%	31.8%	10	11	4	88.2%	6	94.5	100%	161	25.6	8.1	6.5	49%

District	ANC 1 in 1st Trimester	ANC 4 coverage	ANC 8 coverage	Iron& Folic Acid at ANC 1 (%)	HB screening at ANC 1 (%)	Prev. of Diarrhoea (U5 at OPD)	Prev. of Pneumonia (U5 at OPD)	Prev. of Malaria (U5 at OPD)	ANC 1 received ITN	Total Maternal deaths	IMMR/ 100,000 Deliveries	MDR (%)	Total Perinatal death	IPMR/1000 BIRTH	FSB/1000 birth	MSB/1000 births	PD reviewed (%)
Kapelebyong	24%	37.9%	4.4%	71.0%	2.1%	12	3	38	69.8%	0	0.0		40	10.8	3.0	4.0	55%
Karenga	42%	32.9%	0.5%	83.4%	17.4%	20	6	27	71.6%	0	0.0		31	12.7	4.5	4.5	23%
Kasese	26%	57.1%	4.1%	68.1%	20.1%	10	7	5	56.9%	26	87.5	100%	488	16.8	5.5	6.3	57%
Kassanda	35%	68.3%	5.0%	62.6%	17.7%	8	3	28	67.3%	0	0.0		247	20.8	7.1	10.3	0%
Katakwi	47%	56.9%	4.7%	77.3%	2.4%	7	7	37	66.2%	2	23.2	100%	128	14.9	6.9	5.8	35%
Kayunga	31%	50.9%	1.5%	60.8%	43.2%	7	4	35	69.3%	23	150.0	91%	407	26.7	8.1	9.4	59%
Kazo	55%	82.8%	4.4%	75.9%	18.5%	4	5	35	78.5%	1	14.9	100%	16	2.4	1.5	0.8	88%
Kibaale	37%	54.9%	2.6%	72.4%	8.8%	6	5	36	42.7%	0	0.0		162	22.2	9.2	6.5	66%
Kiboga	43%	65.1%	3.4%	73.4%	57.7%	5	10	13	77.4%	11	120.5	100%	142	15.5	5.0	6.0	92%
Kibuku	46%	53.8%	1.2%	58.4%	45.2%	6	2	57	75.1%	2	20.0	100%	44	4.5	2.0	2.2	86%
Kikuube	31%	74.7%	2.4%	87.5%	13.0%	11	13	41	67.1%	1	6.2	100%	86	5.3	2.0	2.5	69%
Kiruhura	49%	115.5%	0.9%	61.9%	12.3%	7	6	22	90.2%	1	9.0	100%	27	2.4	1.5	0.5	107%
Kiryandongo	35%	57.7%	1.9%	82.0%	19.8%	8	10	37	49.1%	11	93.1	100%	216	18.4	6.4	6.4	51%
Kisoro	32%	30.8%	1.4%	57.1%	22.8%	11	4	4	47.3%	7	64.5	71%	181	16.5	5.7	5.1	56%
Kitagwenda	47%	61.7%	3.1%	75.7%	12.8%	4	4	27	86.6%	0	0.0		13	2.1	0.5	1.3	38%
Kitgum	35%	55.2%	2.2%	89.2%	20.7%	7	6	41	71.6%	16	183.1	94%	218	24.8	8.2	9.1	80%
Koboko	43%	66.7%	5.7%	67.4%	33.7%	14	2	21	81.4%	5	53.2	100%	175	18.7	7.6	5.9	69%
Kole	55%	55.3%	5.1%	70.1%	36.1%	8	24	55	62.9%	1	10.7	100%	44	4.7	1.2	2.9	26%
Kotido	38%	59.9%	1.7%	70.3%	14.7%	19	6	33	77.5%	3	38.3	67%	113	14.6	8.0	3.1	67%
Kumi	43%	57.0%	1.3%	63.7%	16.0%	5	2	34	73.0%	6	56.4	83%	143	13.5	4.9	5.6	64%
Kwania	55%	75.6%	4.9%	70.9%	69.7%	6	16	45	70.1%	3	36.6	100%	94	11.3	5.8	4.4	52%
Kween	51%	54.5%	2.2%	73.3%	34.4%	13	5	6	87.7%	0	0.0		13	2.6	1.6	0.6	38%
Kyankwanzi	34%	49.9%	1.0%	61.4%	0.4%	5	8	34	74.7%	1	14.3	100%	65	9.3	3.9	5.0	28%
Kyegegwa	33%	59.8%	1.8%	69.6%	22.5%	6	11	35	62.3%	4	20.2	75%	150	7.6	3.3	2.8	41%
Kyenjojo	29%	44.9%	1.0%	69.0%	24.4%	6	16	30	83.4%	3	16.6	100%	225	12.4	4.4	6.2	40%
Kyotera	33%	48.0%	1.0%	76.3%	12.4%	6	7	16	75.9%	2	18.2	100%	122	11.1	4.5	5.7	72%
Lamwo	57%	64.1%	14.6%	92.8%	41.8%	11	8	43	55.4%	2	31.1	50%	87	13.6	4.5	4.4	82%
Lira	47%	50.5%	2.7%	66.0%	42.1%	9	7	55	74.2%	2	33.5	100%	34	5.6	2.6	2.0	71%
Lira City	40%	105.8%	5.9%	75.8%	52.9%	6	3	26	71.7%	29	220.7	100%	294	22.3	9.4	11.5	62%

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Luuka	37%	40.4%	2.8%	89.2%	14.7%	9	4	60	48.6%	0	0.0		29	5.3	2.5	2.4	31%
Luwero	32%	62.5%	1.6%	58.9%	52.3%	5	7	22	79.0%	16	61.2	81%	369	14.1	6.3	7.0	76%
Lwengo	40%	43.1%	2.8%	54.6%	13.7%	7	5	17	67.0%	0	0.0		80	9.4	4.0	4.2	43%
Lyantonde	37%	50.7%	2.0%	59.8%	5.7%	7	6	11	54.4%	3	56.6	100%	114	21.5	8.5	8.5	81%
Madi-Okollo	44%	63.3%	3.5%	71.9%	23.1%	13	7	16	78.9%	2	35.7	100%	47	8.4	3.0	2.7	93%
Manafwa	53%	57.0%	1.2%	72.5%	46.9%	7	4	39	96.6%	0	0.0		53	6.6	3.7	2.7	96%
Maracha	34%	56.2%	5.0%	91.2%	36.2%	12	7	19	73.7%	2	29.5	100%	129	19.0	5.6	4.3	97%
Masaka	69%	77.3%	3.2%	55.0%	31.8%	6	7	10	91.1%	1	29.5	100%	11	3.2	1.2	1.5	100%
Masaka City	38%	56.2%	4.4%	46.5%	25.2%	3	3	6	73.9%	40	306.3	93%	770	58.8	13.0	17.1	21%
Masindi	26%	55.3%	2.1%	59.6%	21.6%	10	2	22	56.1%	4	36.0	100%	192	17.9	6.8	7.7	86%
Mayuge	40%	53.3%	2.1%	70.1%	36.9%	8	4	38	60.2%	0	0.0		235	14.3	5.4	5.6	61%
Mbale	72%	82.5%	4.8%	72.7%	50.6%	7	9	29	85.7%	2	15.9	100%	47	3.8	1.2	1.5	91%
Mbale City	45%	81.9%	5.2%	74.4%	47.5%	6	4	19	81.9%	61	336.2	84%	472	26.0	10.8	11.5	62%
Mbarara	52%	48.7%	3.7%	98.1%	53.7%	6	12	11	92.6%	1	23.3	100%	28	6.5	1.6	3.7	107%
Mbarara City	32%	79.6%	4.4%	84.7%	46.7%	7	4	2	74.5%	29	181.7	90%	437	26.7	12.6	11.5	58%
Mitooma	59%	67.7%	3.4%	94.2%	34.7%	9	8	15	92.1%	0	0.0		11	1.5	1.1	0.1	91%
Mityana	31%	49.5%	2.2%	61.3%	16.9%	6	5	20	80.2%	15	110.7	93%	238	17.9	7.4	8.0	55%
Moroto	43%	54.3%	2.9%	80.5%	17.4%	10	10	25	78.4%	9	262.9	100%	165	48.4	12.0	5.9	77%
Moyo	63%	49.5%	9.7%	91.9%	60.2%	8	10	13	93.8%	2	61.0	100%	43	13.1	4.0	4.6	68%
Mpigi	35%	61.3%	1.0%	57.0%	33.9%	6	9	10	69.8%	8	71.7	88%	100	8.9	3.1	4.4	95%
Mubende	37%	59.0%	2.2%	72.1%	12.7%	3	1	10	47.3%	21	118.3	52%	446	24.8	11.0	9.0	3%
Mukono	24%	41.7%	1.2%	72.4%	25.9%	6	6	17	80.3%	17	65.6	94%	337	13.0	4.8	5.2	95%
Nabitalutuk	54%	72.7%	1.2%	88.2%	21.6%	9	5	54	93.5%	2	52.6	100%	32	8.6	4.5	2.1	69%
Nakapiripirit	47%	51.7%	3.3%	73.5%	14.4%	11	10	45	87.6%	1	24.8	100%	36	8.8	4.4	1.2	86%
Nakaseke	30%	51.9%	1.8%	76.5%	10.8%	3	2	12	76.7%	6	64.9	100%	218	23.6	9.4	10.2	60%
Nakasongola	29%	43.7%	1.4%	64.1%	35.1%	8	6	25	79.9%	2	28.6	0%	104	14.9	4.5	8.6	0%
Namayingo	38%	57.5%	3.3%	77.9%	23.8%	16	9	18	67.8%	1	12.9	100%	126	16.5	6.7	6.4	31%
Namisindwa	49%	54.5%	2.4%	80.9%	23.2%	7	5	24	91.8%	3	25.1	0%	41	3.5	2.0	1.4	2%
Namutumba	38%	46.0%	1.5%	81.0%	11.9%	14	11	25	85.4%	0	0.0		81	9.5	4.7	4.1	57%

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Napak	36%	49.9%	2.3%	77.8%	22.1%	8	8	39	83.3%	2	32.8	100%	111	18.4	6.3	6.6	95%
Nebbi	31%	74.2%	10.3%	69.4%	11.8%	9	5	23	72.6%	11	72.5	100%	298	19.4	5.1	9.3	94%
Ngora	32%	39.4%	1.4%	63.4%	8.4%	6	4	36	74.1%	3	46.2	100%	68	10.8	4.6	5.1	25%
Ntoroko	36%	45.5%	2.0%	46.7%	3.6%	12	4	12	80.9%	3	100.8	100%	30	10.1	4.0	4.4	83%
Ntungamo	41%	45.7%	2.1%	69.8%	11.6%	6	10	6	56.7%	6	32.4	83%	131	7.2	3.1	3.1	56%
Nwoya	33%	62.9%	4.2%	78.7%	24.8%	6	4	39	63.5%	2	29.9	100%	110	16.5	4.7	7.8	103%
Obongi	49%	52.5%	11.4%	78.2%	64.5%	14	13	6	91.1%	0	0.0		42	11.0	3.9	3.4	64%
Omoror	38%	62.8%	3.8%	86.3%	22.1%	7	3	49	64.3%	1	16.0	100%	79	12.9	4.7	4.3	58%
Otuke	55%	57.2%	3.2%	77.7%	45.3%	7	8	63	82.5%	0	0.0		38	8.4	2.6	2.6	95%
Oyam	49%	78.2%	7.5%	83.4%	80.9%	9	8	50	63.2%	8	43.2	100%	314	17.1	5.0	4.9	95%
Pader	46%	53.2%	3.2%	79.4%	30.9%	8	9	50	59.6%	2	31.6	100%	85	13.4	5.2	3.2	72%
Pakwach	38%	64.8%	2.9%	68.9%	18.5%	13	8	11	70.6%	1	13.7	100%	77	10.6	4.1	3.4	94%
Pallisa	59%	70.2%	8.7%	75.9%	46.3%	8	2	22	75.8%	5	32.7	60%	277	19.0	8.7	5.7	70%
Rakai	33%	39.6%	1.2%	81.2%	12.8%	6	11	11	78.2%	0	0.0		88	9.7	3.6	4.9	44%
Rubanda	45%	66.3%	5.1%	85.3%	42.3%	13	12	0	85.1%	1	12.0	100%	41	4.9	1.7	1.9	93%
Rubirizi	72%	70.8%	5.0%	84.7%	32.2%	6	7	24	93.5%	0	0.0		37	7.6	3.1	2.9	89%
Rukiga	50%	41.9%	3.1%	88.6%	39.3%	9	9	1	87.5%	0	0.0		29	10.0	3.1	4.1	103%
Rukungiri	47%	62.9%	1.7%	89.7%	50.2%	9	6	3	87.6%	2	14.4	100%	155	11.2	1.6	5.0	103%
Rwampara	55%	47.6%	1.4%	77.7%	46.2%	8	15	8	90.2%	0	0.0		8	2.2	0.8	0.8	38%
Sembabule	33%	41.5%	0.5%	64.5%	8.1%	9	3	22	92.1%	1	15.4	100%	62	9.5	4.2	4.5	94%
Serere	38%	40.6%	1.7%	65.3%	17.9%	6	4	40	68.1%	4	32.4	75%	44	3.6	1.7	1.4	39%
Sheema	57%	51.2%	3.4%	75.7%	43.8%	7	15	1	94.2%	2	19.3	100%	100	9.7	2.5	4.5	64%
Sironko	51%	52.9%	2.3%	69.3%	45.3%	9	6	18	83.0%	1	8.1	100%	48	3.9	1.4	2.4	88%
Soroti	36%	37.9%	2.0%	57.0%	12.6%	5	3	45	62.5%	1	17.2	0%	50	8.7	4.2	3.8	0%
Soroti City	38%	71.9%	2.3%	67.4%	25.2%	5	2	26	52.9%	23	294.3	9%	506	62.4	8.4	11.5	7%
Terego	52%	47.6%	2.7%	75.7%	29.2%	13	7	21	62.0%	4	49.9	100%	112	14.0	5.5	5.8	63%
Tororo	41%	56.5%	2.4%	78.7%	22.9%	12	8	6	72.4%	16	66.3	94%	289	12.1	5.4	5.0	96%
Wakiso	29%	30.4%	1.5%	57.1%	19.2%	5	3	9	59.2%	23	36.0	83%	727	11.3	3.5	6.0	33%
Yumbe	67%	52.3%	7.1%	90.7%	38.7%	15	4	18	72.8%	7	23.3	71%	185	6.2	2.3	2.0	46%
Zombo	32%	59.6%	4.4%	73.6%	19.8%	11	12	15	82.5%	8	88.3	100%	116	12.8	5.5	5.0	76%