Minstry of Health

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

SAFE MOTHERHOOD CONFERENCE

3rd National Safe Motherhood Conference

(23rd – 25th October 2023)

Theme: Reach every mother, reach every newborn.

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List of Abbreviations

ABCD: Abstinence, Be faithful, Condom use or else Death
AGYW: Adolescent Girls and Young Women
BA: Birth Asphyxia
BOU: Bank of Uganda
CSFSM: Corporate Society For Safe Motherhood
DHO: District Health Officer
DHIS: Demographic Health Information System
DHS: District Health Services
EmONC: Emergency Obstetric and Newborn Care
FBO: Faith Based Organizations
FP: Family Planning
H.E: His Eminence
HIV: Human Immuno Virus
HPV: Human Palinoma Virus
HC: Health Centre
HW: Health Workers
IPNMR: Institutional Peri Natal Mortality Rates
IPs: Implementing Partners
IUD: Inter Uterine Device
LMNS: Local Maternity and Neo natal Systems
MCH: Maternal and Child Health
MMR: Maternal Mortality Rate
MOGLSD: Ministry of Gender Labour and Social Development
MOH: Ministry of Health
MPDSR: Maternal and Perinatal Death Surveillance and Response
NASMEC: National Safe Motherhood Expert Committee
NGO: Non-Governmental Organization
NMS: National Medical Stores
PHC: Primary Health Care
PPH: Post-Partum Hemorrhage
PP FP: Post-Partum Family Planning
PS: Permanent Secretary
RNMCAH: Reproductive Newborn Maternal Child and Adolescent Health
RHH: Regional Referral Hospital
RHU: Reproductive Health Uganda
SDGs: Sustainable Development Goals
SRH: Sexual Reproductive Health
SRHR: Sexual Reproductive Health Rights
STI: Sexually Transmitted Infections
TBA: Traditional Birth Attendant
TCI: Transitioned Locations in Uganda
UBTS: Uganda Blood Transfusion Services
UDHS: Uganda Demographic Household Survey
UN: United Nations
UNFPA: United Nations Fund for Population
VHT: Village Health Team
WHO: World Health Organization

Background

Preamble - About the Safe Motherhood Conference

The previous 2nd National Safe-Motherhood conference in 2022 was held with discussions around health systems set a ground for discussions to advance efforts onto achieving health indicators, provided an opportunity for all stakeholders to plan and implement activities from the collaborative learning activity.

The 3rd National Safe Motherhood conference held 23rd to 25th October 2023 will proceed the regional and national discussions to review and act on the recommendations of the 2022 conference.

Safe Motherhood Conference Agenda

The agenda for the National Safe Motherhood conference was designed to provide a comprehensive and engaging experience for attendees, with a mix of expert speakers, interactive sessions, and opportunities for networking and collaboration.

DAY ONE: 23rd OCTOBER 2023

Opening Ceremony

Guests were invited to take their seats at 9:00 am. Dr. JP Bagala welcomes participants to the 3rd National Safe Motherhood Conference. Gratitude is expressed to the partners and organizing committee that sets out to reduce maternal and perinatal deaths. In accordance with the theme, the conference commenced.

Overview- Session Chair - Prof. Frank Karahuza

Points that the third National Safe Motherhood conference focuses on what we have done and what we are going to do next to reduce maternal deaths that have seen a 30% reduction in Maternal Deaths but new born deaths remain a sticking point.

Gratitude to Government and development partners, the private sector actors to make this happen. The session leadership team of NASMEC lead by Dr. Olaro that brings the players to discuss and perform. He then thanks to the conference organizing committee.

Finally, he notes that the conference was going to show case. Over 400 abstracts were received and selected close to 200 abstracts for poster and presentation demonstrating the commitment to the plight of women and children.

Conference theme and objectives:

- To disseminate good standards of practice and enable Shared learning among frontline health workers and leaders of safe motherhood in Uganda.
- To discuss the missed opportunities facing approaches towards reaching every mother and newborn
- To establish the prevailing impact from the exiting investments in family planning towards improving maternal and newborn health – health and economic outcomes.

Conference sub-themes

1. Family Planning
2. Leadership and Governance
3. Social behavior change and advocacy
4. Emergency Obstetric and Newborn care
5. Health investing and financing
6. Adolescent Health
7. Quality of care
8. Maternal perinatal death surveillance and response
9. Local Maternity and neo natal Responses

10. RMNCAH Supply Chain (Essential Medicines Equipment and commodities)
11. Local Maternity and Neo natal Systems.

The conference was then opened and the next speaker was invited.

What was agreed upon at the previous Safe Motherhood Conference? - Dr. Anorld Mowonge

The previous Safe Motherhood Conference resolutions were presented under the following themes:

i) Service delivery:
Strengthen referral systems at district and regional level. Last mile delivery of life saving health services for mother and newborns.

ii) Health workforce:
- Capacity building
- Continuous mechanisms for capacity building.

iii) Health Information Systems
A mid-term review was done and Data, smart phone, digitize the babies' matrix, consumption and utilization of blood shall continue to be lobbied for. Partners have supported printing of tools. The portal is functional the Safe Mama app has the guidelines and can be accessed on the smart phone. Digitizing the HMIS system is underway.

iv) Infrastructure and access to essential Medicine, supplies blood and equipment
- Financing for Maternal Care
- Progress made and practical actions that shall be taken
- Equipment repair tracking
- Digital blood tracking
- 81 maternity units built across the country
- Hoima and Arua to have fully fledged blood banks
- Parliamentary engagement s to increase allocations

v) Leadership accountability and governance
- Cooperation through District and Local Government and MOH for accountability through LMNS 15 are in place and 5 are set up
- Partnerships and collaborations with other service providers like UBTS and NMS – Moroto and Kabale have centers.

vi) Community Engagement
- Close relationships
- Partners and corporate society

The PS of Ministry of Health was welcomed to the conference. Sponsors, partners were recognized.

Nationwide Emergency Obstetric Newborn Care (EmONC) Needs Assessment – Prof. John Charles Okiria.

Pointed out the purpose of the assessment to conduct the Emergency Obstetric and Newborn Care (EmONC) needs assessment for services in Uganda. Detailed Health facility selection to take part and showed the road map leading to the launch by the Permanent Secretary.

Availability, utilization and needs of the EmONC services in Uganda formed the basis of the presentation. 17 regional facilities 163, HCIV 222 HC III provided sample to give a total of 804 facilities. Each district was to have 6 facilities. A road map was developed and included other partners made available the resources for the activity and a phased approach was adopted. The timeline took longer than the allocated 45 days.

The core content of the presentation awaits validated results that can be owned but the stakeholders. The assessment was done by staff with prior knowledge of the facilities and issues and they were trained. The information was both scientific and reliable. The HCIIs that took part were purely out of anticipation that their deliveries would be validated.

The national module was used to collect that data: GPS coordinates of the facility, capacity, infrastructure and communication; Human Resources - staffing patterns and services, staffing situation in the last 24 hours; Equipment and supplies for delivery of the services; Facility guest summaries for the last 12 months; EmNOC functions and services – how facilities function on the service spectrum; Case reviews – women who received Post Abortion Care (PAC); Reviews of new born complications with difficulty breathing at birth.

Progress Module were harmonized and housed at a command centre from the field. Pre testing, training and recruitment of research assistants, Data collection and data analysis and data cleaning is wait after consideration including Pre-term deliveries, HC IIs that took part in the assessment and more to give a correct picture.

The EmONC assessment was scientifically undertaken with Midwives in practice at selected locations. Further harmonization of data to inform the final report was underway placing the report at 97% complete and awaiting validation of results.

Pre-Safe Motherhood Conference

Adolescence and youth conference happened under Dr. Racheal Bayegera that had over 300 young people with MOGLSD and a statement from the conference presented by Namayanja Chibat Youth coordinator.

Key issues:

- Less involvement of the boy child in ending teenage pregnancy
- Limited responsive services for young people
- High risk behaviors that expose young people
- Social determinants of health causing teenage pregnancy
- Exploitation and exposure by communities they hail from.

She then invites young people representative to present a communique.

Communique: Namayanja Chibat - Youth Pre-Safe Motherhood Conference 2023
Objectives of the Youth Pre-Safe Motherhood Conference 2023 were to:

i. Evaluate progress on recommendations from the 2nd Safe Motherhood Conference.
ii. Share the performance of the National Adolescent Health Program.
iii. Share experiences and learnings on sexual and reproductive health (SRH) and Gender-Based Violence (GBV) by community-based adolescent health actors.
iv. Mobilize national and district adolescent health leadership to commit to sustainable initiatives for advancing adolescent and school health.

Key Issues Noted:

- Less involvement of the boy child as allies of change to end teenage unintended pregnancies.
- Insufficient SRH information for all adolescents and young people across the country.
- Limited responsive services for adolescents and young people
- Gate keepers e.g. parents and teachers have insufficient information on SRHR
- Limited involvement of parents in education provision and information in regards to SRHR
- High risk behaviors amongst youth exposing them to STIs teenage pregnancy etc.
- Social determinants of health as a key influence
- Girls being exploited, leading to teenage pregnancy.

Resolutions by young people

- Fast-track a multi-sectoral response to address social, economic, and environmental determinants of teenage pregnancy.
- Prioritize health information dissemination and life skills development in schools
- Implement a robust performance management and accountability systems for government, stakeholders and partners.
- Utilize various platforms to scale up age appropriate and culturally sensitive reproductive health education translation in play.
- Strengthen multisector collaboration and response to end teenage pregnancies
- Strength capacity building at all levels including community workers to improve and support adolescent services
- Introduce and incorporate mindset change programs through leveraging on existing structures at community level to empower and inform adolescents and young people on SRHR.
- Fast track the operationalization of implement guidelines and frameworks on adolescent and school health.
- Strengthen school health programs to improve information sharing and health services in schools.
- Improved access to information for both in school and out of school adolescents and young people so as not to leave any one behind.
- The progress on these issues we identified will be presented in the next conference as young people intend to work on them collectively.

Commitments:
Young people commit to working collaboratively with government ministries, CSOs, Faith-Based Organizations, Youth Groups and movements, Development Partners, and UN Agencies to end teenage pregnancy and provide quality SRH services to every adolescent in Uganda. Our collective efforts will make a lasting impact on the future of our nation. Together, we can create a healthier, more prosperous, and

empowered generation. Endorsed by the Youth Pre-Safe Motherhood Conference 2023. Jackie Katana from an Interfaith NGO – then invites religious leaders and FBOs.

Speech by His Eminence Deputy Mufti of Uganda Muslim Supreme Council

H.E observed protocol, stressed the that there was shared concern for better health and wellbeing for mothers and children and was grateful for in the invitation of the faith based leadership. Gratitude was expressed at the opportunity to be at the conference and commended the status of Uganda's effort to progress toward achieving sustainable goals.

Commended the successes registered by Uganda on Maternal and Perinatal deaths and sought to be part of the effort to accelerate the strides taken to meet targets. Called for addressing high teenage pregnancies, high HIV prevalence among adolescence and the unmet family planning needs.

Called for religious leaderships' involvement in the Sharpened Plan 2 and committed to respond to the areas of concern as follows: Cadres of health for promotions; Provides services through health facilities and media that can be used to disseminate important information.

Gratitude is conveyed to development partners and players for the support to improve outcomes for mothers, women and children. Pledged his continuous support to collaborate and coordinate to and respond to areas of areas of concern through the Ministry of Health through structures and events for uptake and utilization of services and to challenge the practices that ensure male engagement to understand and participate in the inter generation design. He affirmed the inter religious councils' participation in policy formulation and capacity building to reproductive and maternal newborn child and adolescent health processes and called on the ministry to develop a capacity building plan and harmonized M&E framework to monitor and evaluate the Sharpened plan 2 for improved participation, universal health coverage for a safe, healthy and positive living in the services and address the challenges that affected health for all.

Data Driven Response - Dr. Richard Mugahi

The report on "Bridging health system gaps for better maternal and perinatal outcomes" is presented. He observed protocol and thanked the PS for gracing the event as the conference begun. In summary he presents the 7th edition of the national MPDSR report.

General objective:

Document the data- driven healthcare system response to improve maternal and perinatal care outcomes.

Specific objectives:

- To describe the magnitude and trends of maternal and perinatal mortality.
- To describe the causes and avoidable factors associated with maternal and perinatal deaths.
- To provide accountability in form of data-driven response and investments towards reduction of maternal and perinatal deaths.
- To document best practices in form of success stories and case studies on MPDSR implementation for scale
- To assess progress towards implementation FY 2021/2022 recommendations.
- To assess progress toward implementation of targets
- To present accountability of results.

Key achievements:

- National level achievements – National MPDSR meetings
- Sub national level – establishment of LMNS
- Regional dissemination of MPDSR report
- Conducted regional dialogue and Doctors dialogue
- Service delivery level: Upgrade 81 health facilities and additional 369 facilities
- Adolescent friendly facilities and services offered at service level
- Coordinating referral from islands
- Developed an In-service training package for neonatal care.
- Initiated and Cmoc sites conducting high risk clinics proper risk identification
- Community level – Mapped TBAs to refer mothers to care
- Roll out of family connect program
- Medicines and supplies -training HCW to manage preterm deaths
- PAP framework with partners
- HR structure for implementation
- NASMEC secretariat
- Sub-national level trainings
- Oriented HW on provision of adolescent health
- SAFE motherhood
- Rotary pledge to deliver 300 tricycle ambulances
- Additional donations from partners, Stanbic Bank, Bank of Uganda.

Key findings:

- Trends in Institutional Perinatal Mortality rate per 1000 births
- IPWE region between FY 21/22 and FY22/23
- Institutional Perinatal Mortality by District
- Trends in perinatal deaths notifications

- Perinatal deaths reviewed and reported
- Causes of deaths
- Decision to incision interval among perinatal deaths delivered thorough C/S
- Perinatal Deaths reviewed by birth weight
- Patograph use among mothers of the reviewed perinatal deaths by health facility level
- Avoidable factors under delay 3 – Delay to provide care
- Trends in institutional maternal mortality
- MMR by district
- Institutional MM by age category
- Maternal Deaths reviewed by district
- Institutional Maternal Mortality by health facility level for the last 3 years.
- Deep dive of avoidable factors under delay 3
- Recommendations and focus areas (10)
- Key takeaways: Leading causes of death are unchanged, HC have improved but limited progress in addressing challenges.

Panel Discussion: What their organizations are going to do to ensure they improve the indicators.

1) **Grace Kiwanuka:** UHF and private sector is more than 90% PNFP in your role as UHF making the private sector accountable. What is your plan of action?

How the private sector provides support given as a federation bringing together pillars of the sector but match the pillars of the government led intervention. This is done through training? Noted challenges around Patograph use reluctance, Transportation to referred care from facility and address delays or the myriad of reasons why they do not move, Increased C- section in private sector. HR 10 cities, working with data and DHIS 2 to leap-frog into a system to get data from facility into DHIS 2, Quality of deliveries worrying with the Association of Obstetrics and Gynecologists to get in to mentorships with smaller facilities and what we are seeing in the data and how it can be addressed. Lastly, the self-assessment for quality. Asked how do we strengthen the self-assessment and the instruments and equipment through a payment plan?

2) **M/s Sarah Mwaku** – BOU safe motherhood champions at the Bank represent the Corporate Society of Safe Motherhood. What has been your contribution, where do you like to see safe motherhood and what do you like to see us achieve?

BOU has supported 9 health facilities. The model is to build a unit, provide medical equipment and plant trees. The initiatives were done by the society for safe motherhood. She then invited individuals and companies to step forward and aim to raise 6 billion Uganda Shillings in support of the Corporate Society for Safe Motherhood.

3) **Winnie Annie Nimwesigwa** President of Presidents Rotary is major donor of 10,000 USD. Why is rotary interested? Where do you see your work in Isigiro? 10 million dollars to Rotary International donations from global grants and Uganda is one of the top five. This has not been achieved.

Build on the technical expertise of MOH and WHO then the tax exemptions for tricycle ambulances to provide exceptions amounting to 2 million dollars. In future rotary seeks to scale up over 2 million dollars implemented in Uganda through rotary international conferences from which funding for MCH in Uganda and Tanzania. Invited members to join rotary to make bigger impact.

End of Panel session.

Remarks by the Permanent Secretary – Ministry of Health - Dr. Diana Atwine

Professor Kaharuza - Chair to the next session. Recognized the women MP for Mbarara as a champion of safe motherhood and the Director Clinical Services Dr. Olaro, the Directors of National and Regional Hospitals are and all the representatives and all observed protocol then welcomed all to the meeting. He then invites PS MOH to give remarks.

In her opening remarks the PS MOH Dr. Diana Atwine welcomes all to the packed conference room of participants selected to help us galvanize the information, resolution and commitment of each of the nearly 550 participants. The PS then brings apologies from the Honorable Minister of Health who was hosting the First Lady of the Republic of Burundi. Front-line health workers were appreciated for the outputs shared and statistics of halving the maternal mortality ratio was mostly attributed to their efforts.

She then expresses gratitude to the partners behind maternal health. (Development, Implementation and Private sector partners) promising to address the audience from the heart, rather than from a written speech. Registered appreciation to the special teams of women. The corporate society for safe motherhood who have contributed out of pocket, encouraged and identified the health workers, the team at the MOH and the maternity and newborn teams.

The gathering around the theme: "to reach every mother and reach every newborn." means the whole world. Every mother and child matter to us. No woman should die while giving birth. As we seek to improve Maternal and newborn deaths and the contribution made by 22% of the adolescents lost to death and 12 % of the girls are 19 years and below. She called to incorporate Hemoglobin testing with the essential tests that are done in antenatal. All the efforts can slip back if we do not stay on track to reduce mortality if we are complacent. The need to recommit and double effort in reengagement to achieve higher records.

The TBAs have been trained and the call to move on when we have increased access with 411 HC IIIs. The access is available over 800 HC IV and iii are equipped and TBAs will be unacceptable. She called for the media to highlight the practices that are not right. Ethics of practice including switching off phones by professionals.

She called up for professionals to demonstrate what they do. Supervisors must hold other accountable to ensure that people have clear duties and tasks fulfilled. Speaking up for those that want to work and cut out absenteeism. Called upon all to deal with it.

Monitoring intrapartum cases and the team priorities that are funded. The priorities need to be channeled to areas that make a difference. The focus would be to Digitize, led in community sensitization, addressing staffing challenges and involve multi-sector players.

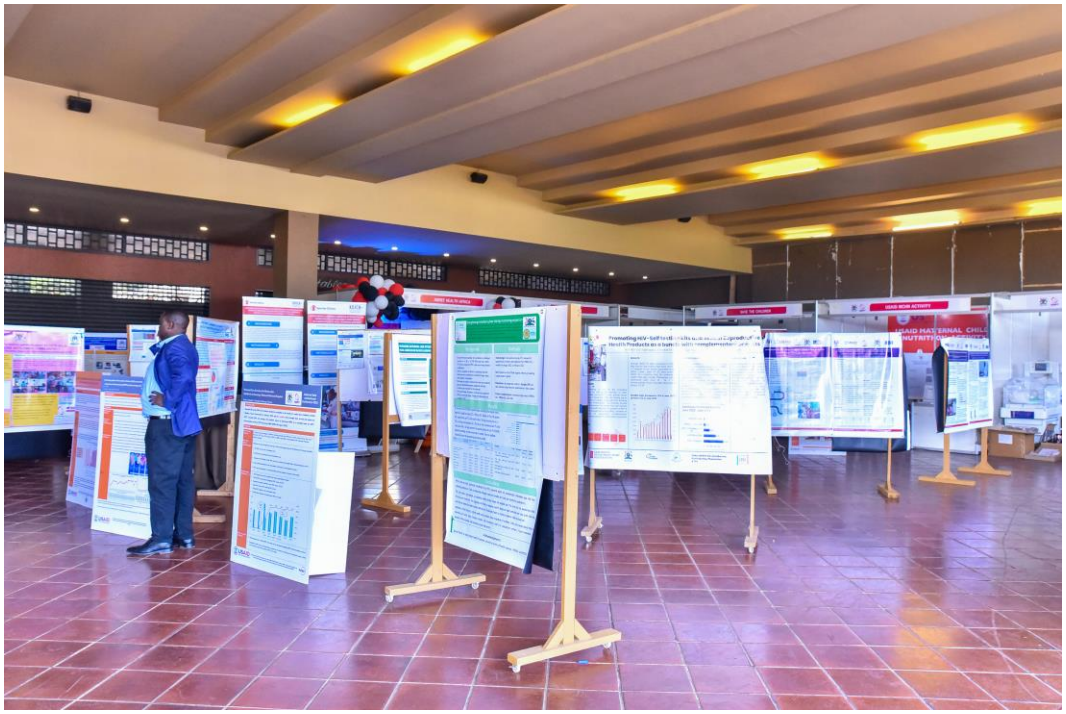
Lastly, she noted that an informed population is an empowered one. There is a big calling to save life and serve humanity that sets us apart. The conference was officially opened on behalf of the Minister of Health.

DAY ONE: AFTERNOON BREAKOUT SESSIONS.

Scientific committee brief Dr. Richard Mwesigwa and Dr. Richard Mugahi.

The guidelines for the abstracts provided by the scientific committee were: word limit 300; the structure or considerations were: Introduction/Objective; Methods; Results; Conclusion/Discussion submitted in Microsoft word.

Safe motherhood conference abstracts on display.



Total abstracts received by scientific committee	**456**
Approved for oral presentation	86
Approved for poster presentation	82
Total	**168**
Rejected Submissions	288 (63.2%)

What was expected in the submitted abstracts

1	Reason for writing	What is the importance of the research? Why would a reader be interested in the larger work?
2	Problem	What problem does this work attempt to solve? SMART objective
3	Methodology	Include specific models or approaches used in the larger study. Participants involved Study area
4	Results	Include specific data that indicates the results of the project
5	Implications	How does this work add to the body of knowledge on the topic? Are there any practical or theoretical applications from your findings or implications for future research?

Conference abstracts were presented in difference conference breakaways rooms. Maternal health, Newborn and infant health, MPDSR and Family Planning. A wrap of the sessions was done in each room. See appendix

DAY TWO MORNING: 24th OCTOBER 2023

Opening prayer was led then Dr. Ononge Sam Makerere University Kampala Department of Obstetrics and Gynecology. The chair thanked the organizing team for a successful previous day. Thanked participants for early turn out for day two.

Recap of day-one was led by Dr. Jackie: New babies' notification is still at 63.4 and then reviews is at 43.1. She notes that we still have a lot to do. Much as we are doing all the notification and reviews the translation of recommendation in to actions required coming up with actionable recommendations to take home. The most avoidable factors were: inappropriate intervention together with miss diagnosis. What this tells is that in all our meetings every Thursday the commonest issue is knowledge gap. Noted the effort to bridge the knowledge gap with webinars, meetings, designation of guidelines frameworks across the country but still sees this knowledge gap standing out. She re-echoed the challenge to address knowledge gaps in managing patients.

Summary key messages:

- Conference objectives were presented
- Presentation on 2022 resolutions and strides pointed to 64 % functioning of Health Centre IVs
- EMoC Progress report was at 94% awaiting validation of findings
- MPDSR report was presented. The one for last year is to be released. IMMR was at 90.3 IPNMR (Institutional Perinatal 17.8 per total births, maternal notifications and reviews 17.1 New born death notifications and reviews need to translate into actionable recommendations for action. Most avoidable factor was misdiagnosis and inappropriate interventions at 43%. Bridging knowledge gap.
- Bank of Uganda and Rotary international presentation. The theme for BOU was: "Maternal and child care for a healthy society" and pointed out the donations to health centers and plans for next year.
- PS presentation take home: "If you are not ready to work please resign and go keep your cows. Absenteeism and presentism were not acceptable especially after salary enhancement." The media was called on to promote positive reports of Ministry of Health.
- Breakout sessions were well attended and full to capacity, participation: Family planning, Maternal and New-Born Health. The marginalized group presentation of the Batwa may feature. MPDSR provided sharing and resolutions.

KEY NOTE ADDRESS: Prof. Joy Loy via zoom

Professor. Joy Loy, Director for global foundation for child births. Director of MD Centre, has published over 320 peer reviewed papers and books and written policy statements. She lived in and worked in East Africa grew up in Northern Uganda and was born in Karamoja. She has worked in West Africa, South Africa, including being a Lecturer and Neonatologist in Ghana, she shifted to Public Health and Global estimation work at WHO collaboration Centre in Atlanta from 1998 to 2001 and then went into child health London UK. She completed Master's in public health at Helmen University Atlanta and PhD. and for 10 years she has been the Director of global evidence for saving new born life birth. She was then invited to address the meeting.

The Journey or race is for new born survival to go faster to meet targets for women and babies. What do women want? To survive and their babies is to survive and the job is to make that a reality. Beyond the this her survival story has been the basis for every women and baby in Uganda. The role is to take data and make SDG half time sustainable goals. 300,000 women die in delivery, 400,000 babies die and the 2 million babies die in the last months of pregnancy, totaling to 9 million deaths for women and children annually, in Africa that represents 13 % of the world population. There is optimism for Uganda but there are still 26 000 still births and 32 000 child deaths annually. Advocacy needs to feature these numbers.

How can we go faster? More and more the voices need to come together to end preventable maternal mortality and joint targets reached with a cascade from lessons on HIV with district level implementation. Uganda has an accelerated Newborn Maternal plan. The biggest buys are in Pregnancy care and maternal care and critical

care to count still births. The single biggest impact for babies is new born care in facilities. These targets need to reach district level.

How can Uganda can set a NNMR of 12 or less by 2030. For Uganda to get to this. It needs to run quite as fast as the current rate. History shows that Uganda can go faster. USA and UK reached this in the 1980's. In SSA and Southern Asia. In some parts of Uganda NNMR are higher and community level interventions are critical. Uganda is generally in phase 3 which means neonatal care and then move to intensive care to ensure disability free care. China managed that in the same amount of time by focusing on infrastructure, investments and human resources for rebuilding well once, instead of rebuilding five times. India Bangladesh and Nepal were here 5 years ago and picking the gains of investments in neo-natal care.

An example for Uganda going fast. Akibua 100 Meter hurdle? How can we go faster? Start with the Baby Moderately new term with respiratory distress needing more than one intervention and more skilled health workers. Every child should be given a chance to conquer and make a case for neonatal care and resuscitation.

Health systems interventions:

- Kangaroo mother care found superior to incubators despite being seen as a poor country option and WHO has reported it to be the best care everywhere for every baby.
- What could be done at health centers is that we need both. Especially after level two and three and they need to be done together. Not as a substitute.
- What are the practical ingredients needed for neonatal care to work? Health systems change, Human resources, Implementation toolkit that allows Uganda to start and go faster. Policies, Leanings and Human Resources.

Case of Malawi: More support still needed and benchmarks can be used. Data can drive change in a case of hypothermia. People: Education ecosystem with skills labs and not just classroom care with up to 16 devices with biomedical technicians are part of the team and keep the devices and machines. Efficiency needed from good devices that will be efficient and cost effective. Investment = Major returns a case of Tanzania demonstrates an investment case in 147 districts demonstrated a major return on investment and within a few months the government invested to leverage funding and is making a difference. E.g. A national floor plan.

Ending remarks: She stressed the need to consider go-faster by thinking, of building better, building human resources, getting the equipment, how to do that together and hope to deliver for Uganda's new born.

Questions, Comments and Reactions

The commissioner then: invited reactions to Joy, invited two comments: Joy a has challenged on the lifecycle, implementation, investment, innovation gaps.

1) Impressed by lessons from Tanzania where the government took lead. Alignment to one plan that coordinates their commitment.
2) The suggestions by Loy are spot on. Getting the pieces implemented in totality not in isolation using the tenets of the health system. Accountability stood out – Dr. Walakira.

NASMEC Achievements:

What National Motherhood Experts Committee (NASMEC) has been able to achieve in the last year – Dr. Joseph Byamugisha and Dr. Tom to assist.

- Leadership structure was presented
- 8 sub-committees, thematic areas: Medical education and training, Quality of care and improvement and Research and development.
- Research and Development committee
- Research agenda

- New equipment for PPH
- Training on equipment and Trainer of Trainers
- Regional Champion support for advance readiness and preparedness
- Brochures for mothers and caregivers. Disseminated
- Reaching out to partners to support translation for end users
- Support in the revision of Uganda clinical guidelines
- Job aid on obstructed labor
- Support Gmoc training curriculum
- Committee: SAFE BIRTH and OBSTRUCTED LABOR: To reduce Man Postnatal mobility
- Respectful Maternity care

PET Professor. Annet

- Review Maternal deaths
- Addendum to the national guidelines
- How to disseminate the messages to the consumers through translation?
- Research agenda is ongoing
- Achievements of the awareness campaigns

Tom: Neonatal Sub-committee on behalf of the team lead

Achievements:

MPDSR 250 deaths weekly to respond to the this.

Originally composed to answer the question on why are children dying and co-opted stakeholders in the hospitals. Goals of the committee.

- To strengthen capacity of H/w
- Increase access to commodious essential to reduce PD and essential
- To train H/W to manage Newborns
- Reduce time to C section to acquire it

National Score card -Aziz Agaba: Uganda National Health Consumers Association

Voice of the citizen in the RAMNAH –N Discourse

- Objectives of the scorecard were shared
- Development of the scorecard process
- Populating the scorecard and how it works
- Presentation of indicators:

Service level indicators, >GREEN<
Policy Leadership and Governance, > RED <
Accountability and community engagement < YELLOW>
Civil society < YELLOW>

Recommendations:

- Increased advocacy by CSO and government to provide data for the same
- CSOs to participate in development of indicators and targets

Minister of Health. Hon Dr. Ruth Aceng remarks and official opening of the conference.
She commended the new sharpened five-year plan 2 and the potential it offers to collaborate to deliver improved indicators.

Cited the role of UN family by led by UNICEF for that stands with MOH to address the enduring challenges in the adolescent agenda.

She pointed out that the majority of mothers in Uganda produce in health facilities and quality of care continues to suffer quality of care and suffer lack of appropriate care to reduce MM cases and bring services to the people and reduce the need for excessive referrals.

UNICEF has seen positive changes come quicker where strong leadership and coordinated partnerships for stronger outcomes and drive system delivery.

Imperative to mobilize resources and communities to shared goals and encouraged achievements for of the health indicators as per SDGS. Called on all to share the conference outputs to make impacts in the health and the people of Uganda.

Address by CSOs representative- Seed Global Health.
Glad to be present when progress has been made but stressed the importance of uniting to achieve the extra to reach the end goal. Congratulated all on the progress and commended the efforts of the health workers.

Today's theme to reach every mother and every newborn with quality care the is befitting and to be able to reach every mother and new born. It shall take more than just numbers. With a population of health workers needs to be commensurate with the people and their numbers. The role of hard to access Health Workers we must guarantee access to highly skilled HWs to their locations and retention of HWs to those areas. Reminded the parliamentary committee to see that there is a highly motivated workforce in the entire country.

As seed global health collaborates with Ministries and partners to develop a resilient workforce. E.g. Mbale the low energy that the health workers and went beyond the call of duty to innovate recognition of outstanding performers monthly, In Lira training the community skills in midwifery and the pledges to go to the government hospital after getting quality care to the home and the simple activity has encouraged the mother to come to the facility. Innovations need to happened to elevate the quality of care for mothers and newborns.

The following recommendations are made:

- Invest in the health workforce in neonatal care,
- Priorities the wellbeing of health workers
- Fostering teamwork
- Champion patient care and in-service care
- Care for the care taker
- Ensure conducive work environment.

Conclusion: In her closing remarks she expressed gratitude to the organizers that brought the team to reaffirm their commitment to the cause of mothers and new-borns. We pledged to remain steadfast to supporting MOH to deliver Quality of care to all.

Remarks NASMEC Dr. Sam Ononge
Welcomed all to the conference, recognized to the role of the MOH and the minister for the achievements that have been reported from NNMR from 336 to 189 institutional deliveries increased from 70 to 90 / 100. Effort to attract the 10% to the facility.

NASMEC meetings are voluntary and review what has happened and align to the technical issues that can happen as a country to reduce MM and NNMR and with the support of the Ministry a lot more can be done to reduce Morbidity and Mortality of mothers with PPH accounting for 34% of MMR.

Achieving innovations like a drape calibrated to measure blood loss and asnamic acid is all the facilities to reduce MM by about 60%. This bundled approach of care of women to reduce MM.

Pledged to work with the MOH in the NASMEC webinar attended by hundreds to demonstrate practical good practices with mentorship and supervision and seek full participation in the local maternity networks providing coordination and preparation to manage cases of referral. Need MOH to support and supervise the local maternity networks to do better. He pledged to write as NASMEC and share what can be done tighter to deliver on the critical.

Highlights from the National MPDSR report 2022- 2023 Dr Mutumba Robert

Theme: A data driven response for better to Maternal Health The 7th Edition 2022-23 to bridge health systems gaps in perinatal and neonatal outcomes.

Mentioned the role of effective leadership and governance at MoH. Commended the partners MTN foundation, Stanbic Bank, Bank of Uganda that have supported the safe motherhood work in the country and shared the 81 HC upgraded and 369 HC to provide Adolescent Health Care services and praised Parliaments' role in increasing resource allocation to meet he SRH structure with health workers and cadres and implementation.

Concerning supplies: New RH commodities approved for PPH and Astemic acid for treatment of PPH.

Noted reduction in HC deliveries 1276 MMD reported in HMIS, IMMR has reduced from 108 Increase in IMMR for under 19 years and this is worrying.

Over seven years increase in MD notified from 34% to 94% and now health workers are not in fear of reporting

PPH and hypertensive disorders and pregnancy related sepsis and hemorrhage is the leading cause of deaths across the age groups over the years. Post-abortion sepsis remains common among the young mothers

Inappropriate interventions and lack of blood and blood products came through the report

Perinatal death reduction in Institutional births despite a 6 % reduction in Perinatal deaths. Lower IMMR is reducing and a 3.8 % reduction in IPMR. Improved perinatal deaths notification from 11%, 5 years ago to 64 % which might be the highest in the East African Region.

PDR 1.5 % to 43 % in seven years attributable to improved reporting. Birth Asphyxia continues to plague the PMR.

Recommendations and focus areas:

- Priority package for new born care
- Skilling health workers to help babies breathe
- Low cost interventions like Kangaroo baby care
- Training the service providers to bridged capacity gaps
- Rational use of blood and blood products: NCQY initiative to identify high risk mothers
- Points of care Labs at and anemic mothers are identified
- Use of the patogram to reduce decision to incision time to reduce from one hour
- Decentralized MPDSR and safe motherhood and empower LMNS to function and empower the countries EmoC assessment system
- Engage key stakeholder in Adolescent Responsive Health Services
- Facilities conform to WASH standards and implement maternal guidelines to prevent Sepsis

- Engage the parliament and get allocations for improved access to essential supplies.

The Sharpened Plan 2 - Dr. Jessica Nsungwa

Expressed gratitude to the effort to the sharpened plan and support to get Uganda on a promise renewed plan to get Uganda back on track to ensure the world bank loan and the implementing partners and CSOs that have supported the second Sharpened Plan.

Shift from the MDGs to the SGDs means a focus away from survival to thriving and transformation. The improvements form 2000 to date points to the work that needs to happen to maintain the new good results. Becoming goal keepers of the results and who are accelerators to attain the seven-year gap that lie ahead. The pockets of low mortality and persistent shifts from rural to urban deaths. The funding platforms have changed and the plan is unearthing the strategic shifts.

A priority package for Uganda allows a business plan that focuses on doing differently: The RMNCAAH shifts are:

1) Focusing where mortality is housed – Districts with the highest burden
    - Addressing graphic inequities
    - Regionalized universal coverage of EmNOC and QoC
    - Establish community delivery systems
    - Equity measures to inform
2) Populations highly burdened by disease, population group or location> Urban areas or occupation
    - Differentiated client based delivery for vulnerable populations
    - Targeted delivery for vulnerable populations including adolescents
    - Targeted delivery, community led or based channels
    - Engage private sector especially midwives
    - Surveillance on inequity
3) Scaling up evidence based high impact packages
    - Life stage and continuously over lifetime
    - Basal RMNCAH interventions plus:
        i. Care at birth and in the first week
        ii. ANC initiation in the 1st trimester
        iii. IMNCNCCM plus
        iv. Pre-term and inter conception
        v. Extended nurturing care
        vi. SBCC for RMNCAH
4) Multi sectoral approach.
    - Tackling underlying determinants of poor RMNCAH fate and non-fatal outcomes
    - Shift from facility catchment population planning
    - GBV /VAC
    - Primary and secondary health interventions
5) Mutual accountability. Commitments
    - Wider accountability engagement
    - Downward horizontal accountability
    - Tracking funding and resource commitments
    - RMNCAH accountability index and community scorecard

Thank you and closing remarks on the refurbished health units in the country MQ, a center of excellence MNB unit in Hoima and Mbale.

Annual MPDR report summary:
The highlights of the MPDR report:

- There was a reduction in MMDR from 108/1000 MMR
- Increase in deliveries 1,412,000 institutional deliveries 1,440, 000 representing a decline in facility deliveries last year.
- 51% met the financial year target of 70% MMR 34 districts had IMMR at 90% 2 districts = 13 % reported zero maternal deaths
- Highest Maternal deaths are among the 25 year olds representing 66 %
- Adolescents contributing 13 % of MM deaths
- Highest IMMR registered in Hoima, Mbale, Ntoroko, Gulu Kayunga, Fort Portal, Mbrara, Kisoro, Lira and Sororí. This coincided in some cases with the regional referral Hospital
- 90 districts did not report any MMR
- 45 of the districts reduced MM by 90%
- 16 % reviewed MMD.

Hon. Ayebare Margret Woman MP Mbarara invited Dr. Ayume - Chair of Parliamentary Health Committee

The Mbarara Woman MP invited Dr. Ayume who spoke next seeking a deeper look in to the statistics and what they mean to the floor of parliament. He pointed out Hon Margaret's long alignment with the safe motherhood agenda and the role that she plays in ensuring clear messages reach the population and the parliamentary committee on which she sits. Concluded with remarks that oversight and interface with midwives shows training with CMOK and BMOK perinatal deaths can be addressed by tracking and deploying incubators and scale up to invest in health center IVs. 70 % of mothers deliver in lover level units. Dr. Ayume then invited the Minister of Health to address the meeting.

Speech by the Minister of Health - Hon. Dr. Ruth Aceng
Observed protocol, applauded for the great work done to convene the safe motherhood pre-conference and appreciated all for the contributions toward improve MCH indicators citing that the 523/ 100,000 in 1991 to 189/100,000 live births in 2022. The target of 70/100,000 by 2030.

She noted that the reflections on the last three years have had on society. The limited number of challenges with skills and capacity. The hope is to get better and is commendable. The case stories from the health practices are true and painfully so. She called for calls for better pay despite enhancements more than in other sectors. She appealed to the audience to seek life calling for quality services with care and compassion.

She then cited the delicateness of the improvements and called for the health workers presence, are they loving, is the environment conducive, how is the cleanliness, comfortable, equipment and services are available. She was very categorical in pointing out that we got our FP messages wrong from the start. NASMEC needs to help with this. People link FP messages to commodities and not he actual FP. This is the time to correct the information. The commodities are the tool to support the planning and create demand for the messages, services and commodities and practices.

She pointed out contra indications in the data for instance that fertility rates were going up in Karamoja despite the interventions that were well meaning. Teenage pregnancies have stagnated for 20 years. She called for the need to get the population to reach the: "Why?" or rationale in the key messages. They need to be engaged in the dialogues that create answers that bring understanding.

The MOH is committed to continuous improvement process to guarantee quality healthcare, Access and upgrade of health care facilities at HC III and IV. Called for investments in diagnostics and clinical care, building capacity of HW, Support supervision and accountability. Resource mapping and monitor what each are doing to account to each other. WE have seen it work. The target of 70 and lower in MMR are attainable. The declaration of intervention in duplication, resources envelops and the accountability forum shall be instituted.

Community engagement and community communication shall be focused. Increased delivery is tagged to the safety and specialized health workers. We must support he National Health Insurance scheme bill needs support and everybody must contribute. People do not value what they do not pay for.

Launch of RNNCAAH investment case that needs to be refocused to the main strategy and enable reduction in maternal mortality in Uganda. Can Uganda distinguish all SDGs and standout? This is possible but the resourcing is required.

The ministry pledges stewardship and technical guidance and implementing of the sharpened plan 2. She was in appreciation of development partners, Implementing partners, private sector, NGOs and for the unwavering support for health sector and government. Call to strengthen supervision by leaders.

The minister called for dual employment arrangements to be revisited to ensure fair and equitable service delivery and declared the 3rd Safe motherhood conference officially opened: "For God and My country."

DAY TWO: 24th OCTOBER 2023 - AFTERNOON

Adolescent health - Dr. Sabrina Kitaka

Dr. Sabrina's presentation via zoom focused on: Young people's health; Schools; Parents roles; HIV; Why are adolescent girls and women left behind? and how to coordinate services that reach adolescents; including HPV vaccination.

She pointed out that platforms are now available and they can be increased but also know that we have challenges of internet connectivity and also lack of awareness. One example from the US, Bright future its opera 3 online training for providers. It's important to know that the services have to be administered by a provider within the health care network. There are so many sexually transmitted diseases and cartoons of genital warts, HIV, syphilis carries potent messages.

Citing that everyday 1 billion people get STIs and may have no immediate symptoms or minor symptoms with some cases may have serious reproductive conditions like causing infertility or later on causing mother to child transmission. Nearly 38 million people are living with HIV. Sadly, majority are in Sub-Saharan Africa so it's important for us to discuss and also be able to provide this information either face to face of digitally.

A young woman who has problems cannot access condom-use and health facilities need to consider digitalization. 3 key points: The facility which has providers, The community, and even the adolescents themselves. The key is to enhance provider capacity, incorporate health promotion and prevention as well as youth development, assure consenter confidentiality even when we are dealing with digitalized information. Assure access to vulnerable population. Engage them more and coordinate all these services together.

She had reviewed parts from the Lancet publication and it showed that open dialogue across generations is essential to the needs of children and adolescents. According to the data, adolescents who seldom access traditional health services could be easily reached through digital home platforms. An example is a U-report

which has been used by unsafe to develop calls and long-time data collection. However, she called for the need to be conscious because they are different based internet interventions that have challenges.

They are different actions required at every level. At the national level providing methods and tools, at the district level and the community level, acting has bridges for the district and national level making sure that they have supportive action and protection, as we digitalize revolution to adolescent section and reproductive health, we need providers even at the national level. We know that sexual and reproductive revolution health can become real but it needs a multisector approach and doing business unusual, digitalization is the way to go but do we know how many Ugandans can even access a mobile phone. Do we know how many Ugandans are competent on how to use digital platforms, there many prevention mechanisms for example for HIV she presented in 2016 but we know that HIV-PREP is available, condoms are available, circumcision is important but most importantly we must push for a power of hope and we appreciate all the adolescents who have continued to work with their spaces for example ask without shame is a digital platform that is confidential you can call them and ask what ever question you want.

Question:

How do we intend to bridge the gap between our desire of sexual and reproductive health regarding adolescents versus the society norms and believes? for example, a 16-year-old using a condom and contraception Vises society expectation.

Answer:

Sexuality education was launched, and the government has aligned the guidelines for implementation, the only thing missing is the signing. This would provide for suitable mechanisms to address the information gaps that account for adolescent missed opportunities.

Recall: Young people and adolescents make the revolution of HIV/STI prevention real through a multi-sectoral approach

Dr. Olive Comments.

Context has changed and the protective environment in which young people used to grow has changed and the new social economic and social challenges require a head on action. The take away is in the giving accurate information about their growth and development issues they face. To address the adolescent pregnancy issue, we need to state things accurately. We need to put in place a community willing to talk explicitly and raised the boy and girl child. IT requires continuous talk about how to prevent pregnancy prevention and get back to the (ABCD) Abstinence, Be faithful, Condom use or else Death.

Updates on the W.H.O labour care guide - Dr. Godfrey Mugyeni

Senior Lecturer at Mbarara University of Science and Technology

Qn Dr. Pande Steven: Emphasis on training with the new patograph. Did you explore other forms like coaching, mentoring and CMEs for cost effectiveness

The views are of the health workers of learning from someone who has just learnt and need to learn in a formal context rather than learn on job.

Qn Bahati Johnson: What does the Labour guide tell us to sure the problems of the old pato graph.

The health care providers' views provide perspective and need to be synthesized for a way forward

Comment: Dr. Drani DHO Ajumani: The old patograph does not give time for intervention in the old patograph. We need to support you to develop the tool to reduce the number of elective caesarian section.

Panel discussion:

Dr. Lilian Sekabembe

Health is a right for the entire population and if it is access remains a challenge. The focus of the panel of five experts to discuss quality SRH service to the last mile. Matters around self-care and its role in the SRH services available to the last mile. Self-care was defined as the ability of individuals, families and communities to

promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker.

Self-testing as an option Self literacy and individuals' behavior, since 2019 Self-care guidelines for contextualizing WHO self-care guidelines to fit in our system.

Dr. Richard Mugathi

Dr. Olive Sentumbwe

Since the publication from WHO in 2019 and guidelines in 2022 many countries have customized it? What is Self-care a huge priority across the globe today?

The SRH issues are a need and a burden for a large population in need in a continuum requiring an effective health system. The need to move faster means that the service cannot be provided by the system to increase access and toward the targets for universal health care and ensuring that we are including the various groups, we must now engage the individuals to participate in health care themselves in linkage with the health system and service providers as the issues are diverse.

The need is big so the need to engage the community, family, self and others to ensure we reach those the at need the services through self-care interventions. New evidence shows that the needs are beyond SRH needs.

How does WHO help Uganda to translate and contextualize these initiatives? There is need for the country to contextualize the guidelines and this is what happened with the guidance provided in the 2018-2019 guidelines and developed the areas Uganda wished to begin with. Post abortion care, Family planning, STIs and the Uganda adopted guidance needs to move to the process of approval.

A systematic introduction of the guidelines is critical to the how the progress is measures and unrolled I nth ether various contexts. The working committees are in place and the partners are requiring a lot of advocacy for self-care within the current health system.

QN Winnie Bagonza- Midwife in Mukono Local Government
There is always difficulty getting the big picture into our context. How can we ensure that this guidance does not just stay on paper?

What does the actual integration of self-care mean for the integration in the system mean? Integration from contact, participation, coordination to integration in the HMIS.

Data, information share, voices of the health care providers collected to improve the advancement of self-care in the country. The need to disseminate the guidelines up to the health providers and to the clients and the need to strengthen the supply chain.

Fatiya Kiyange - CEHURD
Government must implement and mobilize domestic financing to sustain the initiative. Covid 19 response provided self - care services to perfect model districts in phases rather in a scattered way to permit measurement. A supportive health care system that must be bought into and supported to see the impacts. Self-care needs users to be the first targets if they are equipped. Building local evidence and leveraging lessons from other countries to review and provide for policies points to the fact that they are not explicitly there. The supportive legal environment and policy will be required.

Key stakeholders, special populations, other key populations but health workers are there any key stakeholders that must be considered and what their roles could be? Parliament is a stakeholder, and address the fears of abuse, Religious and cultural leaders, Professional councils and bodies/ Associations that reach out the care workers, CSOs, CBOs and international NGOs.

Professor Makumbi - SCPH MUK
Why integrate self-care be integrated into data and measurement? Our knowledge would be limited if we have limited information is without measurement. Empirical evidence must inform the logistics and finances needed. How will we capture the VHT to capture the data we need on community health and enable demographic health surveys to help capture the data that we do not get when we chose self-care.

Dr. Mugahi
Shared the vision for success with SHR in Uganda. The Fear of measuring especially wrong things. We need to measure those are well rather than those who are sick. The health workforce must prepare for the literacy of the patients and empower them to address this. The National self- care guidelines shall soon be disseminated and the quality improvement initiatives. The consumers of healthcare must be involved in the manufacture of health. The legal backing and multi sectorial platforms shall built in.

QN Lillian: In regard to self-care Covid 19 offered practices for self-care. What quality controls do we integrate to this?

Concerning hardships of tracking and data, what mitigation measures are being put in place to provide legitimate information?

Dr. Jackie then announced then led the breakout sessions for abstract presentations:

The full list of abstracts is detailed in the appendix

Day 3 of conference was scheduled to start at 8:00 am

End of Day 2

DAY THREE: 25th OCTOBER 2023

Highlights from the Kampala MCH Symposium Dr. Daniel Ayen Okello Director PH KCCA

12th October 2023 meeting to role play the improvement of indicators

He presents the background to Kampala's, Perinatal Deaths at the nearly 2300 health facilities in Kampala with about 10 % offering maternity services. Of the 2300 less than 1 % are public and conduct about 60 % of the deliveries. 48% of deaths are between 0 to 7 days.

Hope for him comes from the figures that 47 % of the deaths are preventable at community level. The public notes lack of supplies, community engagement, delays in seeking care and delays in reaching the right facility. Regrets the empty referral from one facility to another without improvements in care or even illness recognition.

Stakeholder commitments made: MOH, CSOs. Politicians, Private sector, Academia, RCC, Minister for Kampala, KCCA, Media.

The declarations made as a pure coincidence.

1) Upgrade facilities e.g. Kisenyi HC IV that conducts qbout 10,000 deliveries in a year
2) Competencies for HW in new born care needs to be looked into
3) Community engagement – Does the ANC card speak to the mother? Or the health worker
4) Media engagements – Tell them what is happening
5) Political interests - engage them as part of the community
6) Improved support supervision of the private sector for routine support supervision for MCH
7) 0.5 % of facilities are taking 60 % of the load in MCH. Need for strategic decongestion
8) Registration and qualification to have the right people in the right facilities.
9) Research and knowledge transfer of skills

QN: Harriet from UNICEF: What are the trends? Has Kampala always been like this?

4 years ago Perinatal deaths were growing from 15 to 70 % low numbers in the past were not being reported. Facilities in the city create referrals that are more severe and may result in mortality. Irrespective every life matters.

QN: Are there TBAs in the city and how to you reach them out?

A: Yes, the oldest was 88 years old and a study established why they are there and the issues were passed on, convenience, and when a mother is due to give birth, she calls her mother who tends to direct them to the other TBAs.

Institutionalization of self-care in Uganda - Dr. Roselyn Achola

State of self-care

Drivers of self-care: Health literacy, Healthcare professionals, Health care systems, Products and Medication, Technology

Vision of Self-care: Accelerated progress toward Universal Health coverage

Strengthen PHC multi-sector collaboration

Approaches to institutionalization of self-care

Best practices.

Selected Self-care priorities: Prevention and management of - FP, ANC, HIVS, STIs, Post-Abortion care, NCDs.

Maternal mortality- Dr. Roselyn Achola

The presentation focused on:

- Post-partum FP as a High Impact Practices (HIP)
- Targeted for unintended pregnancies
- Institutional deliveries at over 90% so we should offer the FP services as they leave
- Uptake of FP at National level has consistently remained low >
- Missed opportunities for PF information
- Challenges of PPFP
- Opportunities available
- Roadmap of scale-up and track implementation of PPFP
- Call to action.

Dr. Olive Sentumbwe commended Dr. Roselyn on the presentations and opened up for remarks and questions:

- Dr. Mugasa - Comment 6 months to 6 weeks within the framework needs to be considered among providers.

A) PP period is 6 weeks not 12 weeks. Let's not miss out PP FP at time of delivery

- Prof: Pius - Comment: congratulated Dr. Roselyn role of digital platforms and social media. How would this be done on the rural areas where digital. The use of the web and AI for health. Could she share more on this digital channels?

A) Dial 161 capability in whichever language will offer none smart phone and the young people can continue to use the plat forms

- Comment: Prof. Josephat noted undertones of self-care and fears to go into introduction of other aspects not accepted in the country and translate this into local languages?

A) WHO has supported the messages that shall be translated to ensure the messages reach the grassroots and information on self-care. Approval at MOH awaited

- Prof. Mirembe - PP FP needs to be well documented. Was asking if we have prepared the midwives for PP FP. Can the community efforts to communicate he benefits be integrated in to the community messages?

A) Nurses and Midwives competencies to be improved. Outreach services and community component is structured in. LNMS accountability mechanism is the approach for sustaining mentorships harmonized by coordinators to ensure that they are able PPFP to the scope and mentor all providers. PPIUD post C-section shall be taken to lower level facilities where 91% of women deliver to ensure the range of method mix is offered in the PP period.

- Should PP FP be incorporated into the ANC card and be documented?

A) Asterik in ANC card to be included to show decision to do PP FP and notifying the mother in labor.

- Comment: Male involvement in PP FP would mean integration to the range of service offerings.

A) Couple counseling, remote counselling integrated in the FP training manual.

- Commended self-care presentation: Quality control issue, self-aware, self-testing and self-management. How will tracking and reporting be done? How will those with disabilities cope with these? Promoting injector plane and Sayana press and request for it without pressure testing and weight.

A) Insulin and Sayana Press shall go hand in hand and the service providers need to provide information. Same methods are needed and MOH department shall share self-care guidelines and mechanisms for that are in place.

- Harriet: Had a chance to work with a PNFP hospital. Particularly faith based catholic hospitals, what is in plan to see that they are able to give the government prescribed FP information because the mostly emphasized methods are natural contraception methods? Can they care and refer patients to care?

A) Policy position from government on PNFPs, PFPs has provided guidance and let's follow the policy and offer the services. The lack of knowledge seems to affect and refer to the next facility to get eh service.

- **Qn:** Intern doctor in Bwere- Kasese: Interest on quality control with antimicrobial resistance and self-care seem to be at odds. Where is the line drawn between review before care or are we letting self-medication and self-care take precedence? How do we overcome wrong information from social media influencers who drive followings?

A) Further messaging will be provided for clarifying self-care and self-medication and share new information kits. The drivers for self-care must be the health facility prescription and self-care shall help with the right information to manage in line with what was prescribed. Self-care shall not take away doctors work. Community, family and individual shall be empowered to prevent disease for lifestyle and nutrition.

- Challenge in the field is stocking out. What plan do you have to maintain sustainable supply? Many midwives do not document and appreciate the need to report and document?

A) Commodities through NMS to distribute to the las mile. The facility needs to request for what they need. Order for the commodities. Delays need to be addressed as complaints and interagency transfers can happen.

Key note: Dr. Rita Wadimba - Increased uptake of FP to increase safe motherhood - COP- USAID FPA.

Protocol was observed and sought to share what they are doing the FP space with pillar 1 for safe motherhood. She notes that safe motherhood and family planning are integral. The actions were linked to:

- Addressing provider bias especially in services for adolescents through the beyond bias model on why the health workers' personal beliefs affect the services provided to adolescents
- Data use requires that stock outs are documented and predict and plan for more accurate procurement and provide more commodities
- Embracing the high impact practices: The whole list of proven practices that are open for implementation at the duty stations and facilities.

Scientific Committee feedback on Abstract writing - Milton Musaba PhD

Call for abstracts was given as follows:

300 words, Structured and submitted in Microsoft word. Review criteria was provided. 400 abstracts were received. Total rejected were 63%. Details for rejection over ¾ did not follow simple criteria and shared dissertations. What is an abstract? What are the types of abstracts? What to include in a good abstract was explained?

Panel discussion: Local Maternity and Neo natal Systems
Dr. Nathan Lira RRH Director

Has 550 people offering innovations to reduce MMR.

Do differently? Sustain the LMNS and not let it burn out

Paul Okot Okello MoLG

Do differently? Nothing done wrong but there are opportunities to do revised staffing norms and priorities key staff to recruit MN staff. Can the attitudes, skills and knowledge. Safe Motherhood. Where are the fathers?

Dr. Katamba Allan Program Manager

He applauded the idea of local solutions and local data for informing interventions to save mothers. He likes to see deeper engagements with leadership at regional and district and facility level to take on the mantle to make coordination happen more seamlessly. He advised on expanded membership to have service delivery discussions and demand creation systems to come up with strategies to mitigate problems and take it to build capacity to make decisions and quality improvement in the work happening. A future with an inter LMNS coordination mechanism was envisaged. Finally, he called for institutionalize the LMNS and make it for all not just the willing only.

Dr. Racheal Nanzira

Noted the improvements in Kawempe hospital decongesting and referral from doctors and improved coordination. She envisaged a future that is data-driven mentorship with pathways to improve service delivery.

She advised on strengthening the referral and ambulance system, digital medical records, Regional dashboards, a referral tracker for all LNMS.

Safe Motherhood Conference Resolutions 2023 Dr. Arnold Muwonge
Draft resolutions were presented and would be fleshed out for adoption:

- There are 75 Fully functional HCIVs that shall be supported to deliver safe motherhood efforts
- New born care inititives and guidelines shall be adhered to
- Maternal (Identification and Management of risky pregnancies)
- New evidence; MNR among ADYW
- Strengthen community engagement and sensitization at RAMCAAH –AC
- Health financing shall be targeted and involve partners
- Capacity gaps shall be bridged
- Digitization of supplies monitoring systems
- HRH (Digital plat forms, HRH systems, Performance Management, Capacity building)
- Leadership and governance (LNMS and inter LMNSs learning, Accountability meetings)
- Use of data to inform decisions.

Awards: BOU to LNMS

Safe Motherhood awards 2023
Award handover by Dr. Olaro Charles

Tier one awards. Exemplary health workers contributing toward safe motherhood.

1. **Obstetrics and Gynecology (Winner)** Dr. Kusolo Isaac
2. **Midwives (Winner)** Atim Christine
3. **Pediatrician (Winner)** Dr. Engor Charles
4. **Laboratory (Winner)** Martha Ajilong
5. **Data analysts (Winner) MPDSR** Dr. Harono Brenda
6. **Mentors at facilities in safe motherhood (Winner)** Dr. Chebet Irene
7. **Adolescent health Peer educator winner (Winner)** Nanyondo Shakira
8. **(Arua) Life Saver award –** Keti Lamwaka

Tier two awards: Contribution by MOH selection for contribution of the awardees and organizations.

1) **STD and HIV control:** Award winner: TASO Uganda
2) **Family Planning:** Award winner: RHU
3) **Antenatal Care:** Award winner: Teso Safe Motherhood Project
4) **Obstetric Services:** Award winner: Mama Tulia Ministries
5) **Social Behavioral Change:** Award Winner: HEPS Uganda
6) **Best performing local Neonatal System:** Award Winner Elgon LNMS
7) **NASMEC sub-committee:** Award Winner: Safe birth Obstructed labour – Dr. Mugyeni
8) **Health facility Supporter/ Safe mother initiative:** Award BOU led by Sarah Mwaka
9) **Alternative Health care financing in Safe motherhood in corporate society**
   Award: Stanbic Bank - Diana

Tier three awards: Lifetime achievement award winners – Announced by Phiona Mado.

1) Prof. Mirembe Florence Maureen
2) Pius Okong
3) Dr. Samuel Kalisoke
4) Dr. Anthony Mugasa
5) Dr. Olive Sentumbwe
6) Ms Inid Mwebaza
7) Dr. Florence Ebanyat
8) Prof Byamugisha Josephat
9) Frank Kaharuza
10) Jessica Nsungwa.

Safe Motherhood Conference closing remarks - PS Dr. Diana Atwine

The short remarks made by the PS conveyed congratulation message to all those who contributed to the conference discussions and were committed to returning to do more. She sought to do more with limited resources Thanked the attendees who have committed to the discussion, believes that each one of us is committed and can make a change to safe motherhood then thanked the partners for the humbling experience in the trenches to get the services and infrastructure and facility visits and the need has been seen.

Shared plan with Health workers and DHOs to sustain monthly meetings for action orientation rather than lamentations. She committed to whatever we do that MCH will come first in whatever they are doing and noted the MOH commits to support you all, permission to call and watsup her to deal with service delivery improvement.

The commitment, resolutions and recommendations shall be fleshed out for the real work that has to be done. Next year's best local maternity shall be given a big reward and called for planning for this to happen. On behalf of MOH she stressed that we are committed to improving the statistics but called on the continued collaboration to attain the goals set out.

In conclusion she thanked the seniors, Prof. Okong, Mirembe, Bwamugisha and all who have continued to light the path without abdicating your duties and may God reward you. We called on the continued mentoring for young people despite the challenges and sought to talk with the hearts and minds can follow your spinning examples.

A photo moment with organizing committee was set up

Dr. Olaro Charles - Closing remarks

On behalf of the Director General of Health Services, Dr. Olaro expressed thanks to the organizers for this conference and noted that the key issues are the unfinished business. He sought to target at closing gaps including HC IVs getting functional data that drives us shows that there are HC with minimal performance.

He announces the next Safe Motherhood conference for next year slotted for 28th October 2024 preceded by the Adolescents' pre conference on 29 - 31st October 2024.

The conference was officially closed and participants were invited for lunch.

APPENDIX: KEY CONFERENCE ABSTRACTS

1. Revitalizing the rollout of the Paediatric Emergency Triage, Assessment and Treatment in Uganda with a rapid situation analysis. - Agnes Namagembe
2. Power of People-centered advocacy approaches- Akampurira Sarah
3. Improving Vital Signs Monitoring Documentation and Identifying Neonatal Early Warning Scores (NEWS) in Neonatal Intensive Care Unit (NICU) at Gulu Regional Referral Hospital. - Albert Okanya. and: Ingwai Susan
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