



Evidence brief:

A review on progress in improving maternal, child and adolescent health in Uganda

Countdown to 2030
Women's Children's & Adolescent's Health



Makerere University Centre of Excellence
for Maternal Newborn and Child Health (MNCH)
"A hub for information, research, capacity building and collaborations"





1. Introduction

The Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (EWEC Global Strategy) has three objectives: survive (end preventable deaths); thrive (ensure health and well-being); and transform (expand enabling environments) [1]. These objectives are aligned with 17 targets within nine of the sustainable development goals (SDGs), including SDG 3 on health [1]. Recognizing the holistic approach, the EWEC Global Strategy prioritizes meeting the needs of the most disadvantaged and marginalized women, children and adolescents [1]. To address the wide-ranging determinants of health, the strategy recognises the need to focus on reducing inequities, strengthening fragile health systems and fostering multisectoral approaches [1].

To improve maternal, child and adolescent health, Uganda revised its 2013 RMNCAH Sharpened Plan into the Investment Case (IC) for RMNCAH Sharpened Plan for Uganda 2016/17-2019/20 (herein IC). The IC aimed to redirect efforts towards accelerating universal coverage progress to end preventable maternal, newborn, child, and adolescent deaths in Uganda and promote general well-being and function. The IC's main thrust was to address major health system bottlenecks to enable the scale-up of high-impact interventions. The IC focused on five strategic shifts and the delivery of a priority intervention package at all health system levels. The shifts included:

- a) Emphasizing evidence-based high impact solutions;
- b) Increasing access for high burden populations;
- c) Geographical focusing/sequencing;
- d) Addressing the broader multi-sectoral context; and,
- e) Ensuring mutual accountability for RMNCAH outcomes.

In this evidence briefs report, we present findings on the review of the Uganda's progress in improving maternal, child and adolescents' health. The findings are part of the endline review for Uganda's RMNCAH investment case [2]. The end-line review was completed through three complementary approaches – desk review, secondary data analysis and primary qualitative data collection [2].

¹ World Health Organization. Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030. Available from: https://www.everywomaneverychild.org/wp-content/uploads/2016/11/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf

² Ministry of Health [Uganda]. Endline review of the Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan in Uganda, 2015/16 - 2019/20. 2020;

2. Findings

Institutional maternal mortality and stillbirth rates experienced declines, especially maternal mortality. However, these data need to be validated by in-depth studies of maternity/birth registers as underreporting tends to be a common problem. The number of reported maternal deaths in the DHIS2 was 1092 in 2019, down from 1337 in 2017 and 1169 in 2018. However, the number of audited maternal deaths reported for the same years were 1065, 885 and 1480 for 2017-2019. In 2019 the number of audited deaths was well above the reported maternal deaths.

Further assessment showed that often in districts the number of reported audited maternal deaths exceeded the number of maternal deaths reported. It is not clear if those non-reported deaths refer to community deaths that are audited or other factors influencing this discrepancy. If we use the maximum value for each district year (either reported or audited number) maternal mortality has not changed since 2017 (except a dip in 2018) and was 146 per 100,000 live births.

Based on the DHIS2 reported maternal deaths only the institutional maternal mortality ratio has been declining from 126 in 2016 to 103 in 2018 and 91 per 100,000 deliveries in 2019. In 2015/16 maternal mortality appears to have been considerably higher (181 in 2016). The decline was observed in both the high and low/intermediate priority district groups. Figure 1 also shows that maternal mortality is much higher in the high priority/burden districts than in the other districts. This is likely due to the presence of referral hospitals in the larger population districts which tend to report larger maternal deaths.

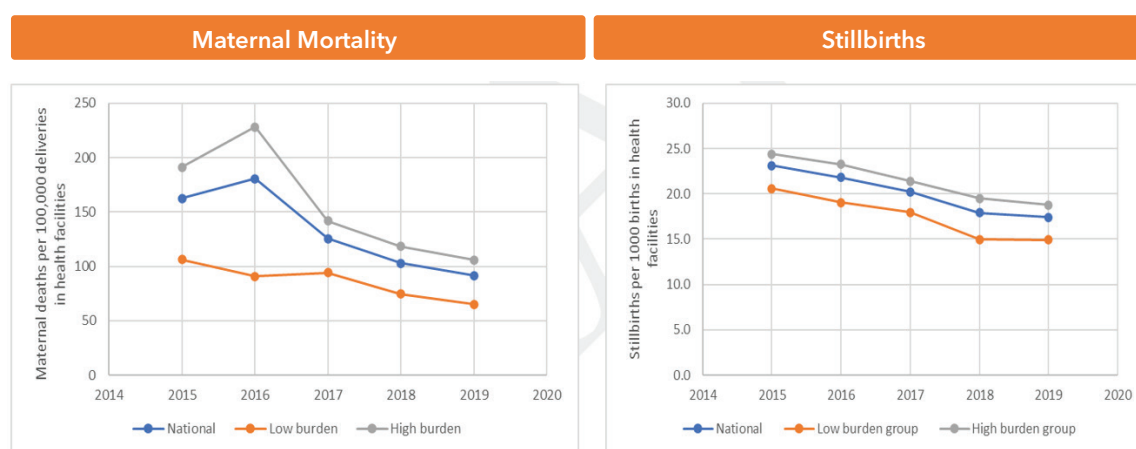


Figure 1 : Institutional maternal mortality and Stillbirth per 100,000 and 1,000 live births in health facilities respectively, by low/intermediate and high district priority group, based on reported maternal deaths, HMIS 2015-2019

The overall stillbirth rate was 17.4 per 1,000 births in health facilities in 2019 (Figure 1). This presented a decline since 2016 when 21.8 per 1,000 were either macerated or fresh stillbirth. The target of the sharpened plan for 2020 was 12 per 1,000. The high burden group of districts have higher mortality than the lower/ intermediate burden group of districts, but in 2019 the gap was reduced. Fresh stillbirth rates are used as an indicator of the quality of care at the delivery time and constitute about half of all stillbirths in Uganda. The fresh stillbirth rate also declined gradually from 11.0 to 8.7 per 1,000 births between 2016 and 2019.

2.2. Child health

2.2.1. Major causes of outpatient and admission in children

The DHIS2 data continue to show the predominance of maternal, newborn and child health with outpatient and admission data. In 2018/19 nearly 10 million visits of children under five years were reported for outpatient care, corresponding with more than 1 visit per child per year. Malaria and upper respiratory infections were by far the most common causes (>50% of all visits), followed by diarrhoea, pneumonia and skin diseases. Children under 5 comprised 44% of all hospital admission in 2018/19, with malaria, pneumonia, and diarrheal diseases as leading diagnoses. The leading causes of death among under-fives in hospitals were malaria, other neonatal conditions, prematurity, pneumonia, and anaemia in 2017/18 and 2019/20.

2.2.2. Nutrition status of children and women in Uganda

Overall, every 1 in 10 children in Uganda is born with low birth weight (Figure 2). The National low birth weight increased from 4.4% in 2018/2019 to 8.5% 2019/2020, with rural areas having the highest percentage from 5.5% in 2018/2019 to 8.9% in 2019/ 2020 and urban increased from 2.6% in 2018/2019 to 7.4% in 2019/2020. Regionally the central region has the highest standing at 10.8% from 4.0% in 2018/2019 followed by the northern region from 4.9% to 9.7%, eastern increased from 3.7% to 8.1 and western having the least children born with low birth weight at 5.4% from 4.8% (Figure 2).

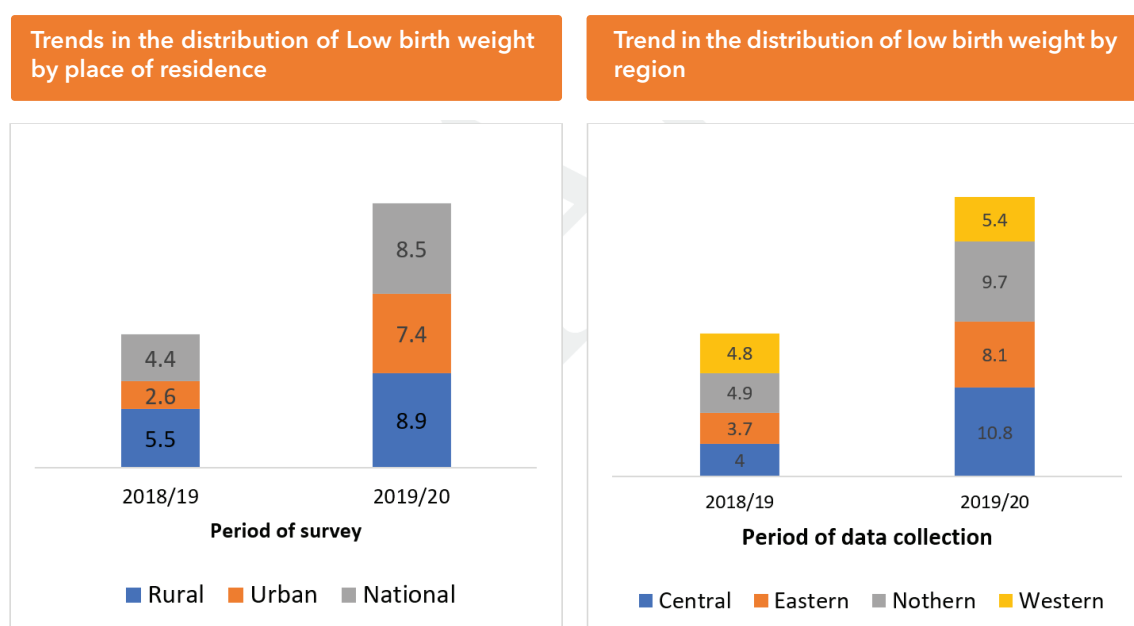


Figure 2 : Low birth weight among newborns in Uganda

Source : Uganda Living Standards Measurement Surveys

Stunting rates reduced nationally from 33.8% to 25%, 2009/10 to 2019/2020 respectively. Regionally western had the highest stunting rates standing at 33.1% and northern had the lowest standing at 22.7% while eastern and central had 23.8% and 24.3% respectively (Figure 3).

Distribution of stunting by place of residence and region

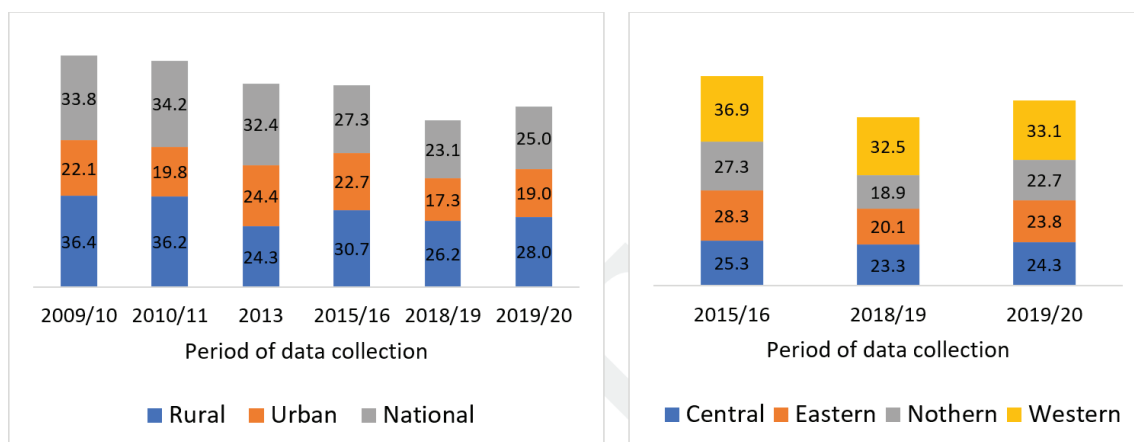


Figure 3 : Stunting among children 6 to 59 months in Uganda

Source : Uganda Living Standards Measurement Surveys

2.2.3. Anaemia in children and women of reproductive age group

Nationally, childhood anaemia increased from 30.4% to 44.3% among children under five years. Thus every 4 in 10 children 6-59 months are anaemic with the east (57.5%) and the northern region (51%) having the highest rates in the country (figure 4). Nationwide, anaemia in women of reproductive age is worsening, increasing from 15.4% in 2018/19 to 25.8% in 2019/20. Thus 3 in every 10 women of reproductive age are anaemic with rural regions having more anaemic women at 25.8% than urban areas (24.9%). Regionally it is highest in the East at 33.6% and lowest in the North at 19.2% (Figure 5).

Anaemia among children 6 to 59 months in Uganda

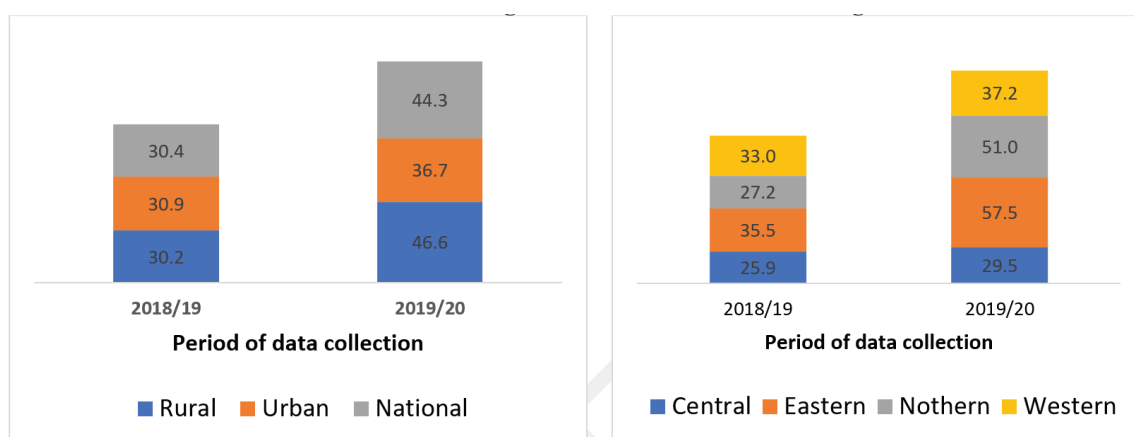


Figure 4 : Anaemia among children and women of reproductive age group

Source : Uganda Living Standards Measurement Surveys

Anaemia among women of 15 to 49 years in Uganda

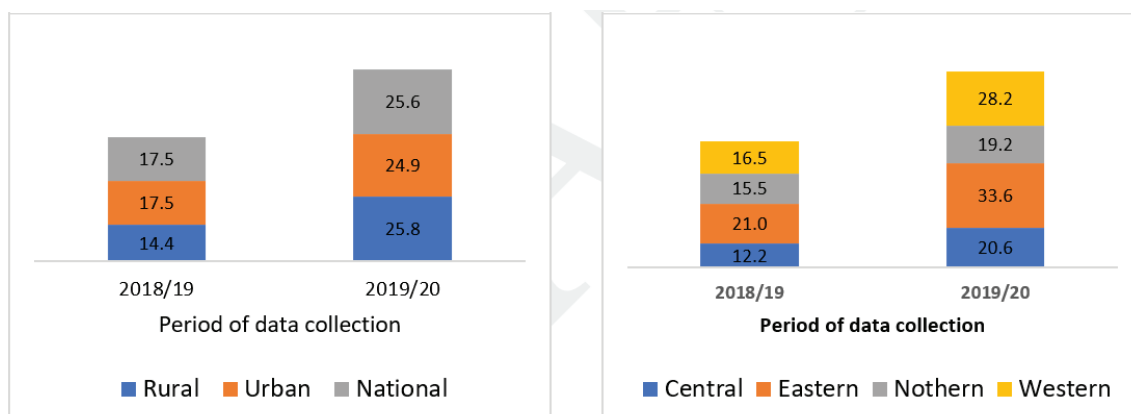


Figure 5 : Anaemia among children and women of reproductive age group

Source : Uganda Living Standards Measurement Surveys

2.3. Malaria

The MIS 2018/19 showed a major decline in the percent of children 0-59 months with parasitemia since the previous MIS 2014/15: from 19% to 9%. There were major differences between the regions of Uganda. Karamoja, West Nile and Busoga all had parasitemia above 20%, Lango and Acholi between 10% and 20% and less than 10% in all others. These results are according to blood slide with microscopy. The rapid diagnostic test was positive for 16.9% of children in 2018/19, compared to 29.9% in MIS 2014/15. The use of ITN remained at 60% of children under 5 according to the MIS 2018/9. This was no increase since 2014/15 and lower than a decade earlier (74% in the MIS 2009).

The percent of children with fever in the last 2 weeks was 26% in UMIS 2018/19, down from 33% in UDHS 2016 and 31% in UMIS 2014/15. Most children with fever were taken to a health facility (87%), as in previous surveys. The percent of children who were taken for diagnosis and treatment the same or the next day was 57% in the UDHS 2018/19, up from 48% in the UDHS 2016. Of the under-fives with fever, 62% received antimalarials and ACT was the most common treatment (88%) as in 2016 and 2014/15. The overall percent of children with fever who received ACT declined from 63% in the UDHS 2016 to 55% in the UMIS 2018/19, which was well short of the indicator target of 85%. The indicator however is not precise enough. Only confirmed cases should be treated with ACT and a decline in confirmed cases among children with fever would translate into a decline in the percent of children with fever who are treated with ACT. Therefore, this indicator's data cannot be interpreted as a decline in ACT use for malaria in children.

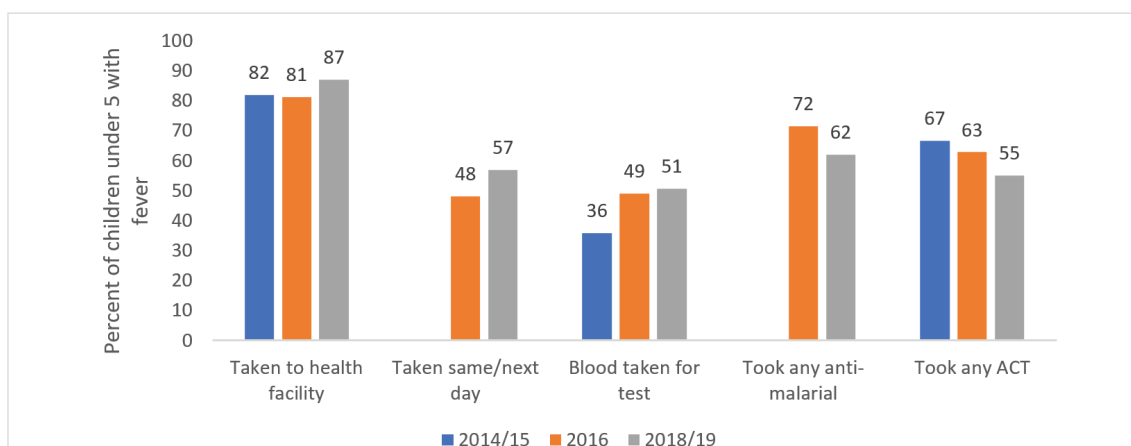


Figure 6 : Treatment patterns for malaria among children under 5 years with fever in the last two weeks as reported by the mother, UMIS 2014/15, UDHS 2016, UMIS 2018/19.

2.4. HIV

Less than one percent (0.5%) of Ugandan children (ages 0-14 years) were living with HIV in the UPHIA 2016/17. Based on parents' reports, adjusted for ARVs detected in children's blood, only 56.3% of children diagnosed with HIV in UPHIA had been previously diagnosed and more than half of children (54.3%) who living with HIV were not on ART. The lowest viral load suppression level (39.3%) found in any subpopulation (by age group) examined in UPHIA 2016-2017 was



3. Pre-pregnancy and adolescent indicators

3.1. Unmet need for family planning

The PMA surveys reported slightly higher unmet need (35% in 2015 and 31% in 2016), which declined to 30% in 2017 and 26% in 2018. This is better than the Sharpened Plan's target, which mysteriously stood at 29%, an increase of unmet need compared to the baseline. The national data from the annual PMA 2020 surveys shows that modern contraceptive use among women 15-49 years increased between 2015 and 2018 from 30% to 36%. This however fell well short of the target of 42% (Figure 7). In PMA 2016, injectable methods were the lead method among married contraceptive users (64%) but in the PMA 2018, this proportion had declined to 46%. Implants, a long-acting method, increased from 16% to 27% of users.

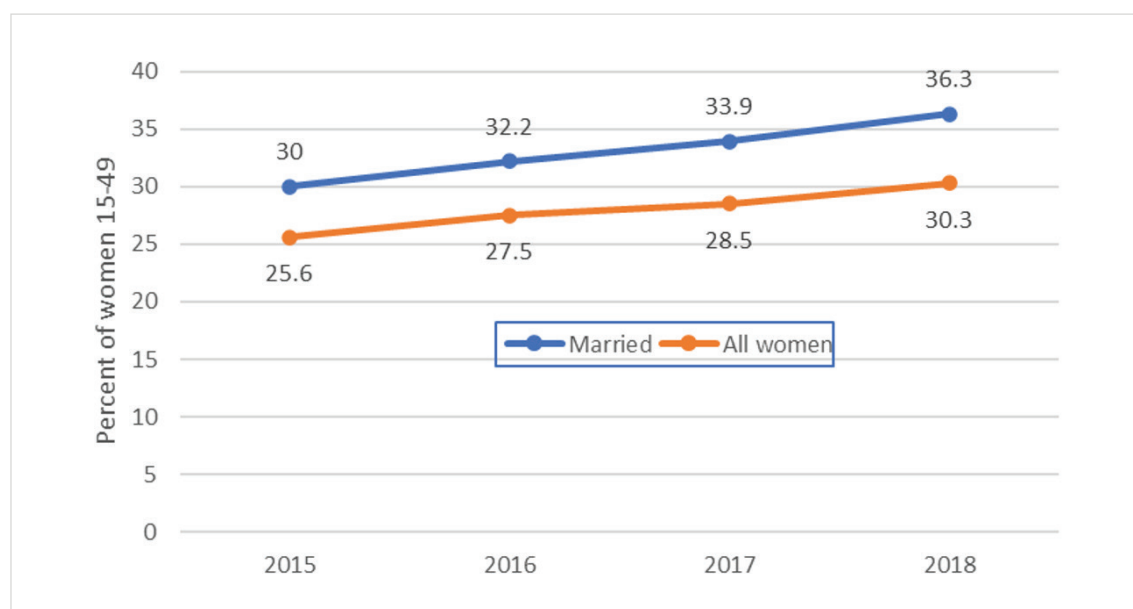


Figure 7 : Modern use of modern contraception among current married and all women 15-49 years

Source : source: annual PMA surveys

3.2. Teenage pregnancy

In the UDHS 2016, 43% of girls were married by the age of 18. The median age at first marriage of 19.4 years. In the PMA2020 survey in 2018, the median at first marriage for rural girls was 19.0 years and for urban girls 20.6 years. Teenage childbearing remains common in Uganda with more than a quarter of girls 15-19 years who have given birth or are pregnant at the time of the survey (Figure 8). The indicator used is the percent of girls 15-19 years pregnant at the time of the survey or have given birth. Uganda has a high level of adolescent pregnancy and there was no major decline. In the 2018 PMA survey round 28.8% of adolescents were pregnant or had ever given birth, compared to 27.0% in 2017 and 31.1% in 2016 (Figure 8).

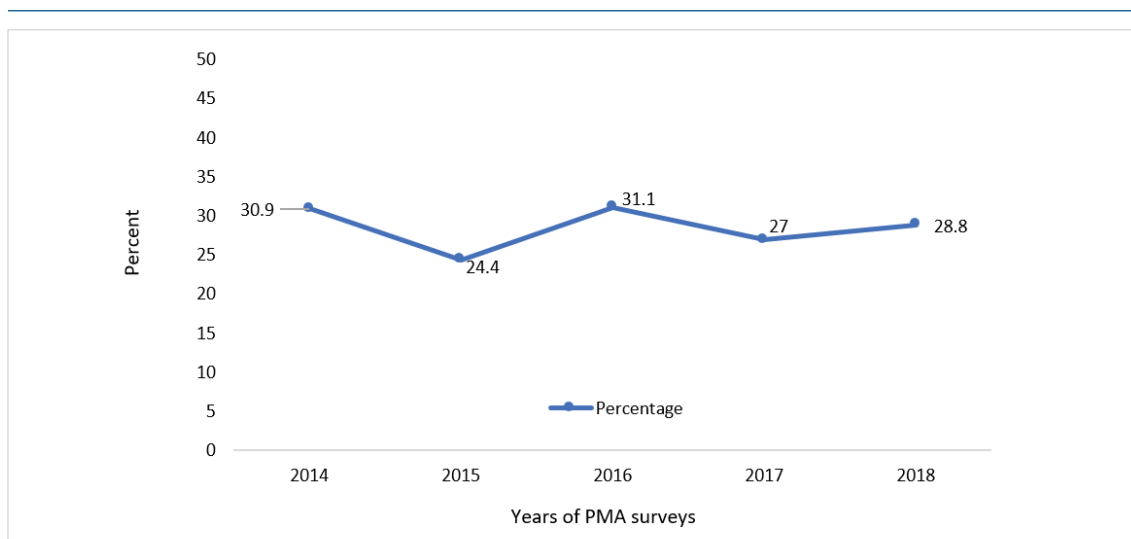


Figure 8 : Teenage childbearing: girls 15-19 who are pregnant or have given birth, PMA (age-adjusted for comparative purposes)

4. Pregnancy and birth

4.1. Antenatal care

Virtually all women in Uganda attend ANC at least once. In the UDHS 2016, 97.3% made at least one ANC visit with little variation between the regions and the median month of pregnancy for the first visit was 4.7 months: 29.1% attended before 4 months. In the UMIS 2018/19 a small increase was observed (31.7%). The DHIS2 data for 2016-2019 (2015 had poor data and was excluded) show lower coverage at 18-19% during 2016-2018, but a small increase to 21.6% in 2019 (Figure 9). The difference between the survey and the facility HMIS data may partly be related to different cut-offs (4 months of pregnancy, 12-16 weeks in HMIS) and misreporting of pregnancy duration by the women or the health worker (Figure 9).

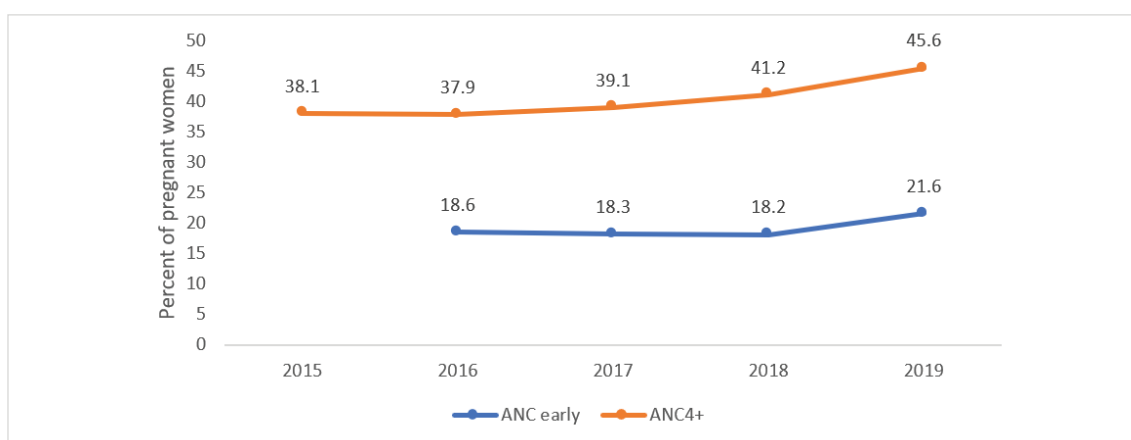


Figure 9 : Early ANC and ANC 4 or more visits coverage, Uganda, 2015-2019, based on HMIS data.

¹ The survey data refer to the 5-year period before each survey for the ANC indicators.

In the UMIS 2018/19, 57% of women reported 4 or more ANC visits than 60% of women in the UDHS 2016. The HMIS data show lower coverage with 38% in 2015 and 2016 and then a gradual increase to 46% in 2019 (Figure 9). It is very well possible that the HMIS data are more accurate than the survey, where women may overreport the number of visits during pregnancy, which has been observed in several countries.

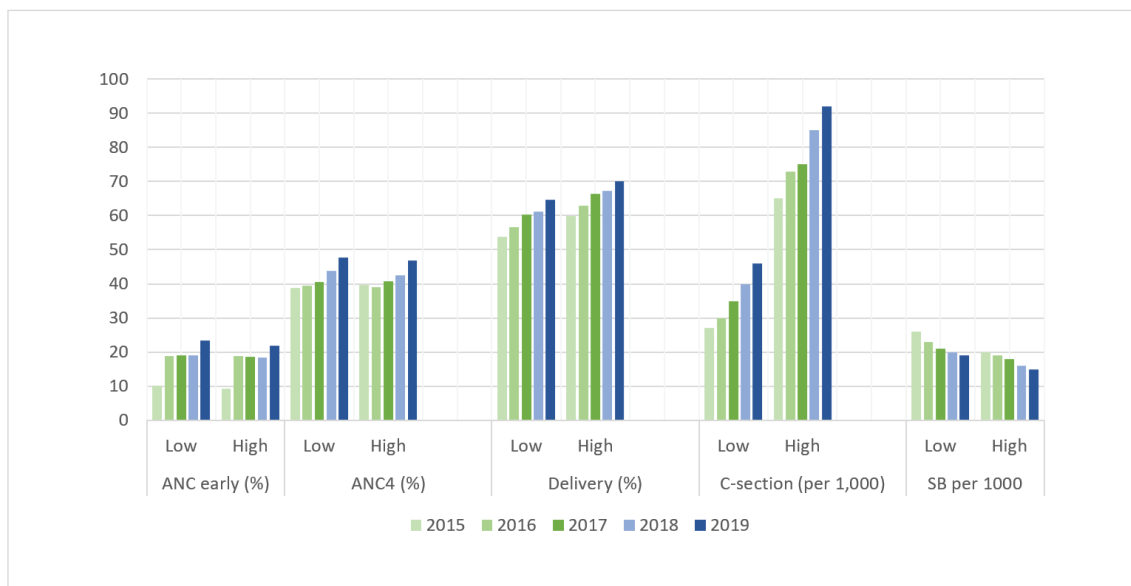


Figure 10 : Selected indicators (ANC early attendance, ANC 4 or more visits, institutional delivery (per 100 deliveries), C-section rates (per 1,000 deliveries) and stillbirths (per 1,000 births) by low/intermediate and high district priority group, HMIS data, 2015-2019

The coverage of intermittent preventive therapy (IPT) with 2 doses of SP for malaria prevention increased considerably in the most recent survey, from 49% in UMIS 2014/15, 46% in the UDHS 2016 to 72% in the UMIS 2018/19 (all figures for the two years preceding the survey). Also, IPT3 increased strongly to 41% in 2018/19 from 17% in 2016. This increase is also observed in the HMIS data from 54% to 66% during 2016-2019 (Figure 11).

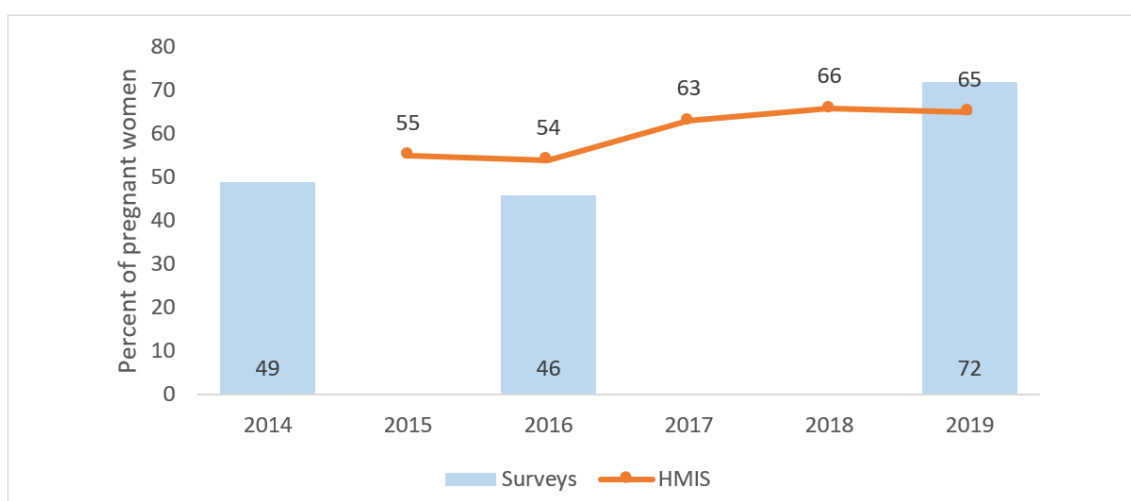


Figure 11 : IPT2 coverage among pregnant women, DHS and MIS surveys, and HMIS data, 2014-2019.

HIV positive pregnant women not on ART should receive ARVs for the elimination of mother to child transmissions and their treatment. In the Uganda PHIA survey in 2016, among HIV-positive mothers who gave birth in the 12 months before the survey, 72.9% were already on ART before pregnancy. Among all HIV-positive women who gave birth in the 12 months preceding the survey, 95.3% reported use of ART during pregnancy, which indicated high coverage of ART provision for PMTCT. The HMIS data showed that 88% of pregnant women newly received ART during pregnancy, delivery or postpartum in 2016. This did not increase in 2018/19 (91% in annual health systems performance report; 83% in 2019 HMIS), falling short of the 95% target.

4.2. Delivery care

The percent of deliveries in health facilities increased steadily over time according to the HMIS data. In 2016 57.5% of deliveries occurred in health facilities and in 2019 this was 66.9%. The most common place of delivery was HC III (39% of deliveries in health facilities), followed by general hospitals (19%), HC IV (17%) and HC II (13%) – which per MoH policy is not recommended. About one in 11 deliveries took place in regional or national referral hospitals.

C-section is not part of the M&E framework of the Sharpened Plan. It is however a very useful indicator of emergency obstetric care. The percent of deliveries by C-section is increasing in Uganda, especially in 2018 and 2019. In 2016 6.2% of deliveries were by C-section, in 2019 8.0%. The health system section of the M&E plan includes further indicators of emergency obstetric and newborn care. These data show an increase in the percent of HC IV offering C-section from 70% in 2016/17 and 78% in 2017/18 to 81% in 2018/19 (Figure 12).

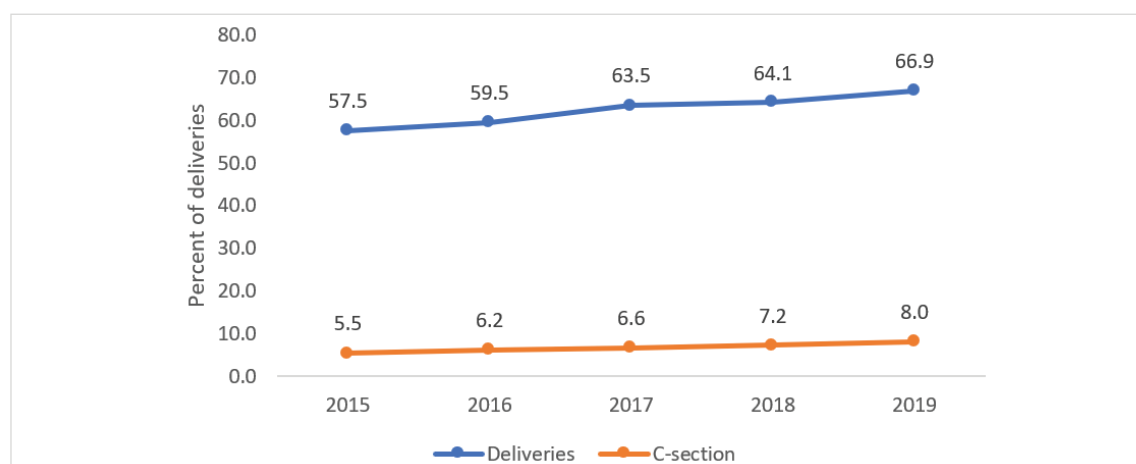


Figure 12 : Percent of deliveries in health facilities and percent by C-section among all deliveries, Uganda, HMIS 2015-2019.

4.3. Postnatal care

The Sharpened Plan's two indicators (postnatal care for mothers within 48 hours and newborns within 48 hours) do not have an exact equivalent in the HMIS system. The indicators are postnatal care within 6 hours and within 6 days. The percent receiving postnatal care with 6 hours is very high and exceeding the target. In 2016 it was 61%, increasing to 78% in 2017, 84% in 2018 and 94% in 2019. Most of these women will still be in the health facilities where they delivered, but it appears a significant part of women goes to a health facility within 6 hours after a home delivery, if these HMIS data are correct. The percentage of visiting health facilities after 6 days is increasing but still low at 30% in 2019, up from 13% in 2016.

Almost all mothers who were HIV positive received ARVs. According to the UPHIA 95% of women used ARVs during the last pregnancy in the last 12 months. The HMIS data suggested that all eligible women accessed ARVs.

4.4. Quality of care

The proportion of HC IV with comprehensive EmNOC was only 47% due to the lower availability of blood transfusions. C-sections were available in 81% of HC IV. The other two indicators, availability of essential commodities and unmet need for contraception did not meet their targets. We also assessed the coverage and quality trends for 11 interventions using a summary measure (Figure 13). An index can provide a general overview of the differences between regions and the overall trend. Using the Countdown example of the RMNCH composite coverage index, a combined index was computed, including 11 maternal and child health indicators and indicates the regional situation. The DHIS2-based MNCH coverage index combines the following indicators, all derived from DHIS2: ANC visit before 12 weeks, ANC 4 visits, IPT2, institutional delivery, C-section (with 15% as the maximum, equaling 100% coverage), stillbirth rate as a proxy for the quality of intrapartum care (with 30 or higher per 1000 births as 0% coverage and 0 per 1000 as 100%), early initiation of breastfeeding (within 24 hours), postnatal care within 6 hours, penta3 vaccination, measles and PCV3 vaccination (unweighted), all based on the DHIS data for 2016–2019. All indicators were given equal weight in the index.

In 2019, the prioritized districts covered 61% of all women, children and adolescents currently not reached by the essential interventions, including 10% living in Wakiso and Kampala districts. The 51 priority districts have an estimated 50.5% of all live births, showing that districts' prioritisation indeed targets a larger proportion of non-reached women and children than no prioritization. The proportion of live births in Wakiso and Kampala is 10.7%, which corresponds with the 10% in need (no targeting).

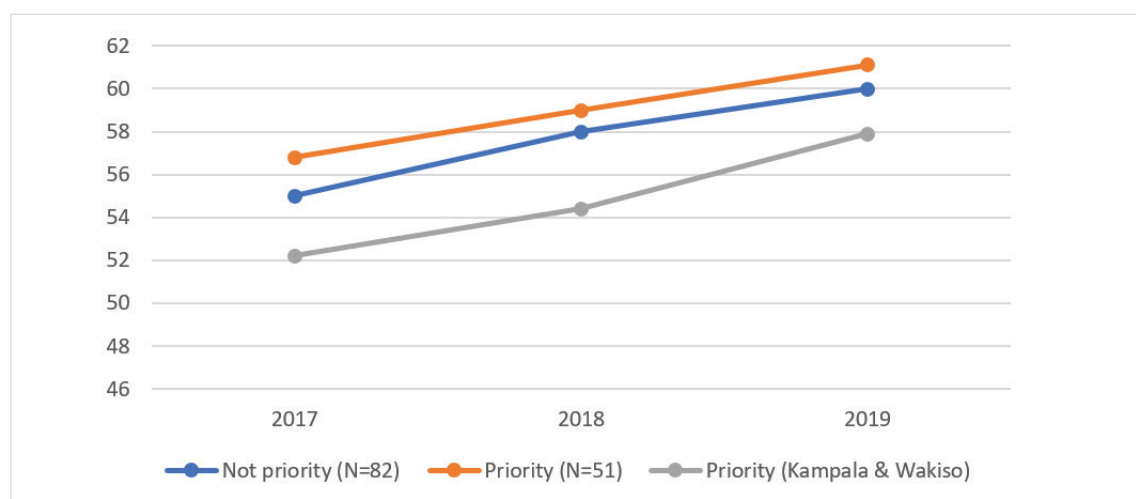


Figure 13 : RMNCH index based on 11 indicators by low/intermediate (81 districts), high district priority group (51 districts) and Kampala/Wakiso priority districts, HMIS data, 2017-19.

5. Neonatal and child health care

5.1. Summary of newborn performance indicators

There are three newborn and twelve child health indicators in the Sharpened Plan. Three indicators could not be measured (% cases of severe neonatal infection managed; % of districts implementing district-wide kangaroo mother care for low birthweight babies; % of facilities with IMCI trained clinicians) as they need better definitions or had no facility data.

In addition, two indicators of care-seeking behaviour for sick children are derived from household surveys and no new data are available: % children with ARI treated with antibiotics and % children under-5 that take ORT/Fluids for diarrhoea. That leaves 10 indicators on neonatal and child health for this review.

Table 1 : Child health and care indicators

Indicator	Baseline	Result	Progress	Target	Comment
Neonatal					
% of mothers initiating breastfeeding within 1 hour	66% (UDHS 2016) 79% (HMIS 2016)	91% (HMIS 2019)		80%	Target met for facility births;
Child					
% Districts with >80% full immunisation coverage	15% (HMIS 2016)	20.0% (HMIS 2016)		90%	Small increase but far from target
% children fully immunized	55% (UDHS 2016) 59% (HMIS 2016)	64.1% (HMIS 2019)		80%	Modest increase according to HMIS data
Prevalence of malaria in U5s	19% (UMIS 2014/5)	9.1% (UMIS 2018/9)		<25%	Prevalence based on microscopy
% Under-5 children that slept under LLINs	62% (UMIS 2014/5)	60.3% (UMIS 2018/9)		90%	No improvement
% children with fever treated with ACTs	67% (UMIS 2014/5) 63% (UDHS 2016)	55% (UMIS 2018/19)		85%	Derived from UMIS & UDHS published data; indicator should be confirmed malaria cases
% children with fever treated within 24 hours	48.1% (UDHS 2016)	56.9% (UMIS 2018/9)		80%	Progress but target much higher
% HIV+ children accessing ARVs	52% (source)	54% (UPHIA 2016/7)		90%	No data after 2017
% Under-5 that receive vitamin A supplementation	54%			80%	Still to be analysed
% cases of severe neonatal infection managed	No data	No data	No data		
% of districts implementing district-wide kangaroo mother care for low birthweight babies	No data	No data	No data		
% of facilities with IMCI trained clinicians	No data	No data	No data		

5.2. Breastfeeding initiation

Initiating breastfeeding with the first hour of life was reported by 66% of mothers in the UDHS 2016. The HMIS provides data on breastfeeding initiation which presumably refers to all babies born in health facilities. In 2016, 79% were breastfed within 1 hour. This increased to 85% in 2017, 89% in 2018 and 91% in 2019. Surprisingly, the HMIS data are considerably higher than the population rates from the DHS as one would expect that early breastfeeding in community births are higher than in facilities. This may need further investigation to make sure the HMIS is not over-reporting.

5.3. Immunization

The HMIS data on immunization show little change over time. The percent of children who received all vaccinations increased modestly from 59% in 2016 to 64% in 2019 (Figure 14). There was no increase in the coverage of the third dose of the pentavalent vaccine (89% in 2016 and 88% in 2019), but measles coverage increased from 76% to 81%. The UDHS 2016 showed lower coverage rates for penta3 than the HMIS 2016 (2015 data were not usable) (79%). In 2016, 20 of the 135 districts had full immunization coverage among infants above 80%. This increased to 21 in 2017 and 28 in 2018. In 2019, 27 districts had full coverage above 80% (20% of districts), which was well short of the target of 90% of districts.

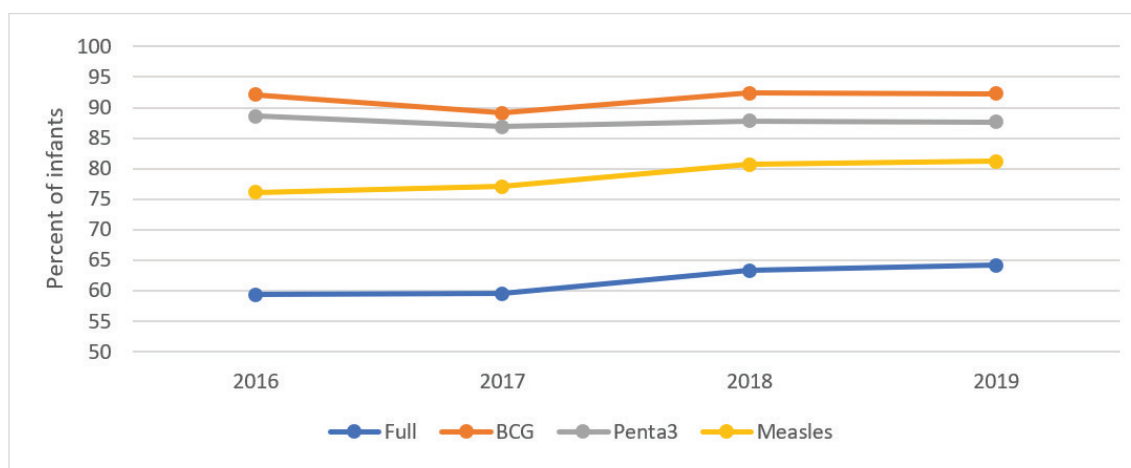


Figure 14 : Full immunization coverage and coverage with pentavalent 3rd dose, measles and BCG vaccinations in the first year of life, HMIS, 2016-2019.

6. Investment case implementation

6.1. Maternal, newborn and child health

- Reports reviewed elucidated several activities that have been implemented for neonatal care. For example, under the URMCHIP project, rapid assessment of neonatal care in health facilities is being conducted and training of essential staff and continuous mentorship and supervision of health workers.

²For the immunization coverage rates we used the reported number penta1 vaccinations as denominator, with an adjustment for unvaccinated children. See appendix for methodological details.

- The Ministry is scheduled to start placing health workers in centres of excellence in neonatal care for mentorship. Areas of focus identified include provision of essential equipment (baby warmers, incubators, chairs for kangaroo mother care and oxygen concentrators for newborn care); space for the provision of neonatal care services, essential drugs for management of newborn conditions; and knowledge and skills on the management of neonatal conditions among others.
- In addition, it's reported that 71 districts are implementing ICCM through VHTs in collaboration with public health facilities; towards the reduction of child morbidity and mortality due to malaria, pneumonia and diarrhoea supported by different partners [The URMCHIP project has supported ICCM supervision in 24 districts in FY 2019/20, although noting low levels of reporting on ICCM indicators in DHIS2; attributed to lack of remuneration and transport for the VHTs specifically bicycles; stock out of key commodities/drugs; lack of registers for accurate reporting; lack of other logistics which includes torches to facilitate their work when called at night, raincoats; lack of adequate human resource to supervise VHTs; and attrition of VHTs due to death, relocation, old age and loss of morale (URMCHIP Progress Report 2020). A case study on child health successes and failures (2020), reports that limited progress has been observed in child health.

6.2. Gender and equity

- The investment case tried to integrate gender and equity in its design, mostly through some of its shifts - for example, the shift that targeted high burden populations. Gender and equity overlaps were also noted with adolescent health.
- The national strategy to end child marriage and teenage pregnancy 2014/15-2019/2020 is being implemented. Additionally, the national integrated early childhood development policy action plan 2016-2021 has been developed. The Ministry is currently reviewing Adolescent health (ADH) in other policies and is to develop a national implementation plan. Training of 879 health workers on AFHS and SGBV; and mentorships for 56 health facilities in 22 districts (Karamoja and refugee-hosting districts) has been undertaken. 16 districts have been supported to establish coordination platforms with support from Danida and UK AID through UNFPA.
- With URMCHIP support, building health provider capacity for 1000 health workers and 400 health facilities HCIIIs and HCIVs responsiveness to ADH needs and challenges is planned for 40 high burdened districts. Under the Project, a training of 90 trainers (ToTs) for health workers was completed. Subsequently, 1200 community resource persons including VHTs and 1200 young peer mobilizers and 60 university health providers were to be trained in March 2020. This was put on hold due to the COVID-19 pandemic.
- The Ministry has also adapted the Information Education and Communication (IEC) guidelines and pretested ADH materials in selected districts. However, dissemination of the pre-tested materials has been delayed by the COVID-19 lockdown. Other critical activities that have been prioritized include community parents, teachers, and health provider dialogues, engagement of cultural and religious leaders, school outreaches during Bazaars especially in universities that have reported high risk and unhealthy practices. In February and March 2020, the Ministry had dialogue meetings with the kingdoms of Busoga, and Arua with over 300 people in each of the meetings. University bazaars were covered during which young people were mobilized and provided with appropriate reproductive health information. ADH, Maternal and Reproductive materials were reviewed and are due for printing. The engagement of media houses was submitted to procurement and is awaiting approval. Once contracted, the media houses will improve information dissemination.

Challenges

- By default, RMNCAH services are mostly utilized by the female gender. There is a limited engagement of men and boys in most of the interventions which are also skewed to the supply side.
- Generally, Gender/equity is as elusive as social accountability, and both can partly be explained by disproportionate focus on the supply side with limited community-facing and preventive interventions.

7. Conclusion

In terms of implementation experiences and reported RMNCAH outcomes, little difference was observed. The multisectoral link and broader non-health sector interventions have a direct and significant impact on RMNCAH outcomes. In implementing the investment case, the effect on non-health sector interventions has been both positive and detrimental to IC targets' achievement. The non-health sectoral issues continue to contribute to the burden for example progress was registered where non-health actors addressed malaria, nutrition and WASH. Most interventions were skewed to reactive and focus on addressing problems instead of balancing them out with investing in the potentially impactful prevention processes on the demand side. However, the broader macro policy landscape is getting better and enabling linkage, integration, and multisectoral partnership, such as the current NDP approach, OPM intersectoral meeting, and the new Community Health Strategy. These are significant windows of opportunity that should be fully utilized as they present.

