NEWBORN CARE IN UGANDA:
High Impact Innovations for Scale Up
Symposium Objectives

- Provide updates and contextualize the Sustainable Developmental Goals (SDG) agenda for maternal and newborn health in Uganda.
- Provide key technical updates and country case studies on achieving impact at scale for Maternal and Newborn Health (MNH).
- Sharing Uganda’s experience of research and implementation of MNH; what are the key lessons learnt?
- Share lessons in implementing maternal and newborn health policies and programs in Uganda.
- Derive key recommendations on what will be needed for Uganda to achieve impact at scale based on available evidence.
The second annual Uganda Maternal and Newborn Symposium held on October 19, 2016 in Kampala came at a strategic time of one year after the end of the Millennium Development Goals (MDGs) and one year into the Sustainable Development Goals (SDGs) era.

The SDGs have more ambitious health goals and targets as packaged under SDG Three (3) than what the MDGs had. Specifically for mothers and children, the global agenda calls for reducing maternal mortality to a global average of under 70/100000 live births and ending all preventable deaths for newborns and children. The symposium, under the theme “Maternal and newborn care in Uganda: High impact innovations for scale up” focused on sharing experiences in implementing high impact interventions at scale for maternal and newborn health in Uganda.

Scalable Innovations will be critical as we embark on the post MDG era if we are to do things differently.

The conference extensively addressed local issues. The rich and insightful discussions that emerged are very important towards steering the process of learning from implementation, adapting, planning and decision making for better MNCH outcomes.

Notwithstanding, such discussions also complement the global goals agenda which is already well known.

Unique to this year’s conference was the presence of distinguished scholars with vast expertise in the largely successful HIV response. Professors Fred Wabwire-Mangen and David Serwadda’s keynote addresses were invaluable to the Maternal and Newborn fraternity as they came with many lessons from three decades of successfully mitigating the HIV/AIDS pandemic.

One of the key messages from one of the HIV/AIDs experts was: “We are not going to get more money necessarily focusing on newborn; it is a question of how we are going to package, develop the advocacy, create this an emergency and human rights issue, to be able to tap into the resources that are already available……. Make the case that this is not a situation that can be ignored. Embarrass everybody for not doing anything.”
It was observed that HIV/AIDS, malaria and TB has built capacity, yet HIV/AIDS deaths (42,000) are just less than half of maternal, newborn and stillbirth deaths (85,000) in Uganda. Participants severally called on government and donors to embrace local capacity building especially by embedding into national programs and projects implementation research by academia to ensure learning and adaptation for scale up of high impact interventions.

Also hot on the discussion floor was the issue of the new Community Health Extension Workers (CHEWs) policy and strategy in Uganda. This controversial subject elicited lots of feelings, emotions and valuable discussion. Overall, it was agreed that this is an opportunity for Uganda but with lots of challenges and requires careful consideration in terms coverage, cost and sustainability.

The need for strong leadership, champions, advocates and partnerships if we are to make progress in saving every mother, every baby and every child was reiterated. Politicians are also very critical for this to happen and the role of the private sector here cannot be under estimated, according to the symposium participants.

It was observed that quality of care is still key and requires investment especially for effective care at and around the time of birth. Calls for investment in the health care system in terms of skilled health workers, medical supplies, and equipment, among other things were re-echoed.

Symposium participants noted that despite the many feasible and affordable innovations that have been tested countrywide, only few have been scaled up. Participants decried the syndrome of piloting and never scaling up any of these interventions. In short, the key messages that emerged from the robust conference discussions were:

- Strong leadership and governance is required for success.
- Advocacy for more investment in maternal and newborn health needs to be strengthened.
- Partnerships and collaborations are critical; not forgetting the private sector.
- We need to harness the power of voices (families, communities, and media) to cause change.
- Bridging the gap between service delivery and the community through the CHEWS/CHWs is essential.
- Integration of Maternal and Newborn Care into HIV/AIDS.
- Scale up of feasible, affordable interventions.
Every day, 16 mothers and 107 babies die in Uganda! It is estimated that improving quality of care at birth for mothers will lead to a 40% and 26% reduction in both maternal and child mortality in the country. Improving quality of care at birth will produce a triple return on investment, saving mothers and newborns and preventing stillbirths. It is therefore very critical that every pregnant woman and newborn has access to and receives good quality care and life-saving interventions around the time of birth. There is also need to scale up feasible cost effective interventions with a focus on use of data and measurement to inform action at the subnational and local levels. We are in the first year of the global goals era laden with very ambitious targets that call for re-engineering and coming up with innovations to improve health systems performance in order to attain the “unfinished business” of the Millennium Development Goals period.

Once again the Makerere University School of Public Health (MakSPH) under the auspices of the Centre of Excellence for Maternal and Newborn Research organized the symposium with support from Save the Children. Other official partners included the Uganda Pediatric Association, the Association of Obstetricians and Gynecologists of Uganda and the Ministry of Health.

The 2016 Uganda Maternal and Newborn Health symposium aimed at galvanizing government and partner efforts around scaling up effective interventions geared towards impacting on the poor MNCH statistics.

In Uganda, maternal and neonatal mortality rates are still high at 438/100000 and 23/1000 live births respectively. This translates to about 6000 maternal deaths and 39,000 newborn deaths annually (in total 85,000 deaths around the time of death).
UNFPA Country Assistant Representative
Dr Edison Muhwezi

We are here to affirm our partnership with the School of Public Health and the Government of Uganda. The core of our work is the woman. We want to empower the women and ensure she gets the services. Because of the dwindling resources, we see that the issue of cost effective interventions is very critical. The population is becoming bigger but resources are dwindling or even stagnating. So we now need to focus on high impact interventions and bring them to scale. To do this, we need collective effort at the community level, health facility level, from the politicians, the civil society, and the academicians. We cannot succeed until we have a multidimensional approach. It’s our pleasure as UNFPA and on behalf of development partners to pledge our support especially to this centre of excellence. It is a great innovation and it requires a lot of support from all of us. We shall work with them and the Government of Uganda to work on the unfinished business from the millennium development goals regarding the mother and the baby.

Commissioner for National Disease Control at MoH
Dr Patrick Tumusiime

“Improving quality of care at birth will produce a triple return on investment, saving mothers and newborns and preventing stillbirths. It is therefore very critical that every pregnant woman and newborn has access to and receives good quality care and life-saving interventions around the time of birth. The Government of Uganda embraces all innovative approaches which operate within the framework of national guidelines for disease prevention and control. I take this opportunity to thank Makerere School of Public Health for the numerous international collaborations that have generated a lot of knowledge aimed at improving the lives of Ugandans.”
In Uganda, there are a total of 85,000 deaths a year during pregnancy and around the time of birth with maternal deaths accounting for 6000 fatalities, 40,000 stillbirths and 39,000 newborn deaths. Strategies to address maternal and newborn mortality need to be strengthened in order to address this gap. Many in country studies have shown positive results in the use of Community Health Worker (CHW) based strategies. CHWs can improve Maternal and Newborn health moderately, especially in terms of impacting knowledge, leading behavior change and demand creation. Also, CHWs have a moderate impact on health facility deliveries but a marked impact on birth preparedness. Therefore, a multi-pronged approach with the necessary support is needed with CHWs if they are to be deployed. There also needs to be multiple stakeholder engagement.

What Community Health Worker Strategies Work in Uganda – Evidence from Field Trials

Associate Prof. Peter Waiswa

In Uganda, there are a total of 85,000 deaths a year during pregnancy and around the time of birth with maternal deaths accounting for 6000 fatalities, 40,000 stillbirths and 39,000 newborn deaths. Strategies to address maternal and newborn mortality need to be strengthened in order to address this gap. Many in country studies have shown positive results in the use of Community Health Worker (CHW) based strategies. CHWs can improve Maternal and Newborn health moderately, especially in terms of impacting knowledge, leading behavior change and demand creation. Also, CHWs have a moderate impact on health facility deliveries but a marked impact on birth preparedness. Therefore, a multi-pronged approach with the necessary support is needed with CHWs if they are to be deployed. There also needs to be multiple stakeholder engagement.

The Community Health Extension Workers Strategy

Dr Christopher Oleke

The Ministry of Health (MoH) has developed a Community Health Extension Workers (CHEWs) policy and strategy to replace the Health Centre II (HC II) level of service provision. The plan is to shift HCII staff to HC III level. MoH is proposing 2 people per parish as CHEWs as of 2016/17. CHEWs are meant to be a paid cadre with basic literacy skills, elected by community members to receive a 9 months training unlike CHWs who are volunteers and undergo a 5 day training. Their potential role will include health promotion, drug distribution and will link communities to health facilities. Use of CHEWs can be a cost effective means of reducing maternal and neonatal mortality. Under the new strategy, two people are to be chosen per parish and trained as CHEWs. Training of the CHEWs is to commence in the 2016/17 financial year. The total number of CHEWs to train is 15,000. About 50 percent of the current VHTs qualify to join the CHEWs.
We found that in most of the countries the use of community health workers could be cost effective if you are able to reduce neonatal mortality by as little as 1 per 1000 live births, your programme will be cost effective. Use of community health workers can be a cost effective means of reducing maternal and neonatal mortality however careful consideration should be given to the following: Package (multiple vs single); Incentives (Paid vs volunteers); Coverage (Number of CHW’s and supervision); and support from formal system.

Learning from the MDGS
Prof. Fred Wabwire-Mangen

MDGs were a global development agenda that increased awareness, increased efforts by many donors and led to some successful targeted interventions (malaria, HIV/AIDS, measles). There was no consensus on how progress would be measured and not all goals had clear numerical targets. The one-size-fits-all approach was inappropriate for countries at different levels of development. What can we do differently to achieve SDG 3?

- Focus on care during labor, birth and day after birth.
- Prioritize high coverage of high impact interventions.
- Quality of care matters.
- Achieve universal coverage and equity.
- Harness the power of parents, families and communities.
- Measurement, oversight and accountability.
- Action for all: involvement of stakeholders.

SDGs are giving direction for women and children’s health. We need to commit to changing the quality of care in health facilities. There are new guidelines passed by WHO for Maternal and Newborn health to guide the global community over the next 13 years. Uganda has committed internationally to ensure that comprehensive Emergency Obstetric and Newborn Care (EmONC) increases from 70% to 100% in hospitals and from 17% to 50% in health centers. There is need to ensure commitment to bridge the gap in the unmet need for family planning from 40% to 20%, increase Antenatal Care (ANC) from 42% to 75% with a strong emphasis on Prevention of Mother to Child Transmission (PMTCT). The overall aim is to halve facility deaths of mothers and newborns in five years in countries enrolled into global coalition of governments, implementation partners and funding agencies. There are eight quality standards: Evidence based care, Health information system, referral, communication, respect, emotional support, and competent motivated staff for EmONC and enabling physical environment. Details can be found on the following link: http://www.who.int/maternal_child_adolescent/documents/improving_maternal-newborn-care-
With a well-designed, funded and implemented project, reduction of MMR is very possible in LMICs. Systems can be rebuilt rapidly to deliver services. Dedication and hard work is required from the frontline health care workers. Regular use of data for decision making is paramount. Government of Uganda has used lessons from the pilot to review the sharpened plan and develop the new investment case for RMNCH. Upgrade of Health Centre (HC) III and HC IVs can increase access to obstetric services. Instituting Neonatal Intensive Care Units increases access to care of the sick newborn. Active and sustained engagement of district and community leaders is vital for quality services.

JHPIEGO used a "Low dose, High frequency" training approach to train health workers to save lives at birth. The training was completely focused on short periods for training health workers in saving lives at birth project. The trainers were from the Health sub-district, so it was easy to integrate them into the schedule of the facility. A team based approach which limited disruption, provided interactive learning and ongoing practice, was good and this emphasized onsite teamwork. Focus of the training was on helping babies breath, and helping mothers survive (birth asphyxia and post-partum hemorrhage). Key features included use of a single day training at a time, use of interactive simulators and twining training which was critical training in the first golden minute after giving birth. Some lessons learnt included a culture of change apparent even with untrained providers improving performance for some care tasks. Facility and simulation based training are feasible and result in gains in provider performance and health outcomes.
The USAID-ASSIST project in 15 districts in Northern Uganda was set to strengthen the health system from national to sub-national level and to avoid preventable maternal and child deaths. The project priorities at birth include:

- Identification and management of obstetric complications, use of medical technologies for difficult labor and newborn resuscitation.

Approaches used to achieve this include:

- Facility level interventions by supporting QI teams to develop improvement aims based on RMNCH and Coach and mentor teams in implementing improvement.
- Supporting network of facilities to set up mechanisms for shared learning.
- Setting up mechanisms for shared learning-exchange visits and peer to peer learning sessions.
- Building capacity at district, regional and national level.
- Community engagement.

Private health facilities account for 45% and 44% of the health providers are in the private sector. The private sector contributes 60% of the child health visits and 14% of deliveries and 40% of the private sector providers offer reproductive health and maternal health services. The Programme for Accessible health Communication and Education (PACE) has used social franchising under the ProFam Social Franchise operating in a network of 207 clinics in 5 regions focused on reproductive health, family planning, cervical cancer screening, HIV/AIDS, maternal health care and other reproductive health issues. Interventions for this franchise include:

- Training of health care workers in managing causes of maternal death (Postpartum Hemorrhage (PPH), Infections,
The Uganda Reproductive Voucher Project (URHVP) project is a 4 year project from 2015 to 2018 running with support from World Bank and UNFPA. URHVP focuses on safe delivery through use of maternal health vouchers to address key drivers of maternal and perinatal mortality. In the short term, the vouchers provide and immediate result of increasing demand and access to delivery services. In the long term, they addresses the supply and demand sides and policy challenges that may limit the equitable access and use of maternal services. Lessons learned from this approach include:

- Providing coaching and mentorship which includes face-to-face mentorship with health workers and also the involvement of peer mentors.
- Assessed quality by EMONC QI tool,
- Conducted hospital placements in busy labor wards and neonatal nurseries and generated demand.

Lessons learned:
- Franchising of maternal health services in private facilities is feasible and improves quality.
- There is strong commitment by health workers to improve quality.
- There needs to be considerable resources invested in data management and quality improvement.
- There’s a need for financing packages and options for private health facilities to address sustainability; through linkage to National Health Insurance, Vouchers to reach more women and Community Based Insurance health schemes.

The Uganda Voucher Scheme and Other Results Based Financing Initiatives

Dr. Bateesa Carole Sekimpi

The Uganda Reproductive Voucher Project (URHVP) project is a 4 year project from 2015 to 2018 running with support from World Bank and UNFPA. URHVP focuses on safe delivery through use of maternal health vouchers to address key drivers of maternal and perinatal mortality. In the short term, the vouchers provide and immediate result of increasing demand and access to delivery services. In the long term, they addresses the supply and demand sides and policy challenges that may limit the equitable access and use of maternal services. Lessons learned from this approach include:

- There needs to be consistent engagement of the leadership at district level especially for public health facilities including the Chief Administrative Officer, District Heath Officer, Sub-county chief and the in-charge of the health facility so as to build quality of the services.
- It is important to agree in advance on how much income from re-imbursements will be utilized to improve service delivery in the health facility.
- Staff should be involved through a committee in planning and prioritizing the use of service income.
Unfortunately, I don’t think there is going to be any more money in the health sector moving forward than there has been over the last 10 years. So it’s a question of mobilising, creating the urgency and the importance of newborn. We are not going to get more money necessarily focusing on newborn, it is a question of how we are going to package, develop the advocacy, create this as an emergency, human rights issue, to be able to tap into the resources that are already available. Let me tell you, in order to get the money required for HIV, there was a group called ACT UP; they would stand on the tables, bang the tables telling ministers of Health 'we need money for drugs now.' It was unbelievable. That is what actually created the money for research and treatment. It is advocacy and the ability to get attention; that’s what we need to get from HIV to the newborn agenda. HIV meetings were not moral talks, it was action now. That is how we got money and HIV on every body’s agenda. The politicians were not very interested in talking about HIV/AIDS issues. So I think the [MNH] data is appalling and that should scandalise anybody. We need to create advocacy around this.

Newborn Care Research Priorities for Uganda

Dr Frank Kaharuza

The Uganda research agenda largely focuses on the demand, supply and health system factors as key priorities for the research in the country. The priority questions included both global and local areas of focus. Of the top 15 research questions, 80% (12/15) were in the delivery domain while 13.3% (2/15) were in the development domain and only 6.7% (1/15) was in the group “other” that comprised of epidemiological questions, socio-economical suggestions. The leading questions in the delivery domain focused on effective use of partographs, improvement in health worker skills and use of models such as peer groups to improve care. Among the top 15 questions, nine (60%) questions were focused on integrated care, while four (26.7%) questions addressed intrapartum care. Only two (13.3%) of the questions focused on newborn sepsis.
Innovations: Augmented Infant Resuscitator (AIR)

Dr. Santorino Data

There are 1.8 million deaths from birth asphyxia each year. Most of them can be saved if birth attendants have the right skills and equipment to give newborns timely and effective ventilation. The Augmented Infant Resuscitator (AIR) is a device that improves newborn resuscitation. The device monitors ventilation quality and provides real-time objective feedback and actionable cues to users. This enables them to maintain skills and build their confidence and readiness to act. The Intervention group so far has achieved effective ventilation 40% faster than the control group and were 16 seconds faster. Further, the intervention group maintains effective ventilation 58% longer than the control group.

4G Augmented Infant Resuscitator

Why is this important?

- Every 30 seconds delay in establishing effective ventilation increases risk of death by 16%
- Self-confidence increases chances of ventilation success
- Emotional connection drives adoption and passion
- Objective time-stamped data will be a great tool for quality improvement efforts.
The media have an important role to play in improving maternal and newborn care since they can reach large and targeted audiences in short periods of time. Also, it is an avenue for disseminating information and messages with the aim of bridging the communication gap between policy makers, service providers and communities. There is therefore need to build the media capacity by: Equipping them with accurate information to report on maternal and newborn health; Enabling them to understand the scientific language health workers use; Enabling them to know the right people/sources to approach for information; and Helping them understand the misconceptions about maternal and newborn health.

I was awed at last year’s conference to learn that Uganda loses over 75,000 lives around the time of birth in form of maternal and newborn deaths and still births, many of which are preventable. I learned that studies here in Uganda and elsewhere have demonstrated that there are certain interventions that can be done within our context to save these lives. The question we should ponder on is whether we are all doing what we are supposed to do the end these preventable deaths. To my colleagues in academia what is the ultimate goal of our research? Do we conduct it with an aim of transforming society? Do we ever think beyond the academic journal articles and academic promotions?

As one philosopher [Peter Ferdinand Drucker] has already observed, “Today knowledge has power. It controls access to opportunity and advancement.” Now is the time for academic institutions such ours [Makerere] to see how to increase the uptake of our research by key stakeholders. This can only be done by putting in place sound knowledge translation plans for the research that we are conducting. When we do this, we shall then be in position to contribute to solving national and global challenges in the global goals era.
The recommendations that emerged from the discussion sessions at the symposium are as follows:

1) The leadership and governance in terms of maternal and newborn issues needs to be strengthened. Champions need to be identified.

2) Advocacy needs to be strengthened so as to act as a platform to increase the investment on maternal and newborn initiatives so as to meet the SDG targets.

3) Bridge the gap in service delivery between the community and health systems through the support of Village Health Teams and CHEWs.

4) Feasible, effective and affordable innovations should be scaled up countrywide.

5) We need to develop and promote integrated plans that deliver services along the continuum of care in a coordinated way. Maternal and newborn care should be integrated within HIV/AIDS programmes.

6) There is need to improve universal health care coverage in order to reach every girl, every woman and every newborn including the poorest.

7) Quality of care: Quality of care is still key and requires investment especially for effective care at birth.

8) We need strong leadership and champions so as to get buy in by the politicians and other stakeholders. There also needs to be more involvement of the private sector given their contribution to RMNCH.

9) There is great potential in citizens. We need to harness the power of the parents, families and communities to mobilize change.

10) There needs to be more involvement of the media in maternal and newborn initiatives to equip them with the right information and demystify the misconceptions about contentious issues.

Above all, in order to meet these targets, participants called upon stakeholders to focus on the following:

a) Strengthening leadership and governance in the area of maternal and newborn health. Champions need to be identified.

b) Embracing advocacy to act as a platform to increase the investment on maternal and newborn initiatives so as to meet the SDG targets.

c) Bridging the gap in service delivery between the community and health systems through the support of VHTs and CHEWs.
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<td>Arrival and registration</td>
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<td>8.30-8.40a.m</td>
<td>Opening remarks</td>
<td>Assoc Prof Peter Waiswa (MakSPH)</td>
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<td>Dr Sarah Naikoba (Save the Children )</td>
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<td>8.40-8.55 a.m</td>
<td>What works? Experiences from Implementation Research</td>
<td>Assoc Prof Peter Waiswa (MakSPH)</td>
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<td>8.55-9.10a.m</td>
<td>Cost of Community Health Workers in Maternal and newborn care: can we afford them?</td>
<td>Dr Elizabeth Ekirapa (MakSPH)</td>
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<td>9.10-9.25a.m</td>
<td>The Uganda VHT assessment: what lessons for tomorrow implementation?</td>
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<td>Maternal and Newborn care in the proposed Community Health Extension Workers in Uganda</td>
<td>Dr. Oleke Charles, Ministry of Health.</td>
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<td></td>
<td>Session Host: Dr. Ekrapa Elizabeth, Senior Lecturer, Makerere School of Public Health</td>
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<td>Key note address: Learning from the MDGs, what can we do differently to achieve the maternal, newborn and still birth SDG targets in Uganda?</td>
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<td>-The Centre of Excellence for Maternal and Newborn Health</td>
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<td>-Head of Department, HPPM</td>
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<td>-Save the Children- Dr Sarah Naikoba</td>
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<td>9.55-10.25 a.m</td>
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<td>Prof Fred Wabwire-Mangen</td>
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<td>10.25-11.00a.m</td>
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- Uganda Paediatric Association - Dr Rebecca Nantanda
- Association of Obstetricians and Gynecologists of Uganda - Dr Jolly Beyeza
- Ministry of Health - Assoc Prof Mbonye
- Guest of Honor - UNFPA

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<td>11.30-11.50 a.m</td>
<td><strong>Key note address:</strong> New WHO standards for quality of care at birth: strategy and guidelines</td>
<td>Dr. Olive Sentumbwe Mugisha</td>
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<td>11.50-12.05 p.m</td>
<td>Saving Mothers Giving Life (West and North)</td>
<td>Dr. Addy Ketitinwa</td>
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<td>JHPIEGO</td>
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<td>Hoima Regional Learning lab/ Save the Children</td>
<td>Dr. Ediamu Tom/Dr Richard Musoke</td>
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<td>URC Assist experiences improving quality of care at birth</td>
<td>Dr. Mirwais Rahimzai, University Research Co.</td>
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<td>1.05-1.15 p.m</td>
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<td>2.15-2.35 p.m</td>
<td><strong>Key note address:</strong> The Global Financing Facility (GFF) in Uganda</td>
<td>Dr Jesca Nsungwa</td>
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<td>2.35-2.50 p.m</td>
<td>The experience working with the private sector</td>
<td>Dr. Dorothy Balaba</td>
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<td>The Uganda voucher scheme and other Results Based Financing (RBF) initiatives in Uganda</td>
<td>Dr Carole Sekimpi (Marie Stopes)</td>
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<td>3.05-3.20 p.m</td>
<td>Can we integrate maternal and newborn care in PMTCT?</td>
<td>Dr Joshua Musinguzi-Prog Manager ACP/STD</td>
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<td>3.20-3.35 p.m</td>
<td>Discussion (Question and Answer)</td>
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**Session 2:** Improving Quality of care at birth for mothers and newborns – New Global strategy and experience from Ugandan regional models of care

Chair: Dr Dinah Nakiganda - Acting Assistant Commissioner, Reproductive Health

**Session 3:** Harnessing opportunities for Maternal and Newborn care in the Sustainable Development Goal era

Chair: Dr Romano Byaruhanga
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<td>Opportunities for integration of PMTCT and newborn care in Uganda</td>
<td>Dr Jolly Beyeza</td>
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<td>The Uganda Maternal &amp; Newborn research Agenda</td>
<td>Dr Frank Kaharuza</td>
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<td>Innovation: Augmented infant resuscitator RCT</td>
<td>Dr Data Santorino</td>
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<td>Poster/Innovations Exhibition</td>
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<td><strong>Session 5: Closing session: Recommendations, next steps and closure</strong></td>
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<td>5.30 – 5.45p.m</td>
<td>Recommendations and Next steps</td>
<td>Assoc Prof Peter Waisa</td>
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<td>5.45 -6.00p.m</td>
<td>Closing Remarks</td>
<td>Mr David Okello, Directorate Research and Graduate training</td>
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<td>6.00p.m</td>
<td>Tea/Departure</td>
<td>Hotel</td>
</tr>
</tbody>
</table>

**Symposium Organising Committee**

- **Chairperson:** Assoc. Prof. Peter Waiswa
- **Co-Chair:** Dr. Monica Okuga
- **Members:**
  - Makerere University School of Public Health
  - Lydia Kabwijamu
  - Doris Kwesiga
- **Save the Children**
  - Patricia Pirio
  - Mary Kinney
  - Kate Kerber

**World Vision**
- Esther Nasikye
- Ministry of Health
- Prof Anthony Mbonye
- Dr Makanga Livingstone

**Rapporteurs**
- Carol Kamya
- Juliet Nabirye

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