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The Annual Maternal and Perinatal Death Surveillance and Response (MPDSR) Report FY 2018/19 highlighted a reduction in institutional maternal mortality ratio from 108 to 92 per 100,000 deliveries in Uganda

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On 13th February 2020, the Ministry of Health, Reproductive and Infant Health Division with support from National Maternal Perinatal Death Surveillance and Response (MPDSR) Stake-holders, Non-Government Organisations (NGOs), Civil Society Organisations (CSOs), and Development partners disseminated the Annual MPDSR Report for Financial Year (FY) 2018/19 at Hotel Africana, Kampala.

This dissemination meeting was aimed at documenting progress on the implementation of MPDSR during the FY 2018/19 and stimulating actions among stakeholders at different levels. Specific objectives of this national meeting included; sharing updates on efforts in implementation of MPDSR, sharing lessons learnt and good practices, and making recommendations and action plans to improve maternal and perinatal health for year 2019/2020. This meeting was attended by representatives from World Health Organisation (WHO), United Nations Children's Fund (UNICEF) , United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), different Ugandan ministries, NGOs, CSOs, policy makers, academia, and researchers among others. Presentations about work on surveillance and response to improve maternal and perinatal health outcomes were made by different partners.

Key highlights of the MPDSR report FY 2018/19 included;

A relative reduction in the institutional maternal mortality ratio from 108 per 100,000 to 92 per 100,000 deliveries and an overall eduction in the Institutional perinatal mortality rate from 29.1 to 23.6 per 1,000 live births in FY 2018/19.

This report also highlighted leading causes of maternal deaths as; obstetric haemorrhage (46%), infections (13%), and hypertensive disorders in pregnancy (11%) while, birth asphyxia (47%), septicaemia (11%), and prematurity (8%) accounted for majority of perinatal deaths.

Delays in mothers seeking care, lack of blood products, supplies and consumables, lack of partner support and skills gaps among health workers in provision of emergency obstetric and new-born care services (EMONC) were the major avoidable factors that contributed to these maternal and perinatal death events.

The report noted that the reductions in mortality were a result of increased skilled birth attendance, supportive supervision, facility based trainings, onsite health provider mentorships, and Continuous Medical Education (CMEs) with technical assistance from Ministry of Health and its Partners.
Presentation of the MPDSR report triggered meaningful discussions among stakeholders and generated key actionable recommendations to improve maternal and new born quality of care.

Among these included; equipping health workers with practical skills in emergency obstetric and new-born care service delivery, intensifying interventions to prevent and manage complications such as; post-partum haemorrhage, hypertensive disorders in pregnancy, birth asphyxia, and prematurity. Functionalizing HC IVs and Hospitals, with a focus on new-born care units and lastly improving functionality of MPDSR committees at the various levels including data capture and utilization.