Rapid Response Brief

Date: March 2026

What can research evidence tell us about: Interventions that can be implemented to reduce the perinatal mortality burden in health facilities in Mukono

Key messages

- The high incidence of perinatal mortality in health facilities is largely driven by intrapartum complications, infections, respiratory disorders, low birth weight, prematurity, and maternal sickness.
- Antepartum interventions focus on risk factor identification for the prevention of fresh stillbirths.
- Intrapartum interventions focus on labor monitoring and effective labor management for the safe delivery of babies to prevent macerated stillbirths and early neonatal deaths.
- To reduce the burden of perinatal deaths in Mukono, it is crucial to improve the quality of antenatal care, promote timely and consistent maternal and foetal monitoring, and emphasize adherence to care around delivery practices during delivery.

Where did this Rapid Response come from?

This document was created in response to a specific question from a policymaker in Uganda.

It was prepared by the Center for Rapid Evidence Synthesis (ACRES), at the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative

✚ Included:

- **Key findings** from research
- **Considerations about the relevance** of this research for policy decisions in Uganda

✕ Not included:

- Recommendations
- Detailed descriptions

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Short summary

Background

Mukono district reportedly continues to experience a substantial burden of perinatal deaths despite official statistics suggesting rates close to global targets (less than 12 deaths per 1000 births). The District Health Information System (DHIS2) shows that in 2025, the perinatal mortality rate in Mukono was 11 deaths per 1000 births. However, policymakers report that these figures underestimate the true burden of perinatal deaths occurring within the district health facilities. Therefore, they are interested in the interventions that can be implemented to reduce the perinatal death rate in health facilities

Rapid Response Question: What interventions can be implemented to reduce the perinatal mortality burden in health facilities?

Findings

Evidence suggests that the perinatal mortality rate in health facilities ranges from 10 to 38.8 deaths per 1000 births. Within this burden, the stillbirth rates range from 10 to 38.8 deaths per 1000 deliveries, while early neonatal death rates range from 12 to 36.4 deaths per 1000 livebirths. These deaths are largely associated with intrapartum complications, infections, respiratory disorders, low birth weight, prematurity, and maternal sickness. These risk factors can be addressed by antepartum interventions, which enable the early risk identification, and intrapartum interventions, which focus on effective labor monitoring and management for safe childbirth. Intrapartum interventions include strengthening antenatal care, folic-acid supplementation, foetal monitoring during pregnancy, adopting the safe childbirth checklist, and data strengthening. Intrapartum interventions include timely and consistent labor monitoring, adherence to care around delivery (CAD) practices, and vaccination of newborns.

Conclusion

Evidence suggests that the perinatal death rate in health facilities is largely driven by factors such as intrapartum complications, infections, respiratory disorders, low birth weight, prematurity, and maternal sickness. Therefore, to achieve significant reductions in the burden of perinatal mortality in Mukono district, it is crucial to target these risk factors. This mainly entails improving the quality of antenatal care, increasing awareness about risk factors among pregnant women, empowering health workers to perform timely and consistent maternal and foetal monitoring, and emphasizing adherence to the eight care around delivery (CAD) practices across the different health facilities.

Background

Perinatal deaths include both stillbirths and early neonatal deaths. A stillbirth is an intrauterine death of a foetus occurring at or after 24 completed weeks of gestation[1], and an early neonatal death is the death of a newborn occurring within seven days after birth [2-4]. Stillbirths can occur before labor (antepartum), during labor (intrapartum), or after labor (macerated)[5]. The estimated perinatal mortality rate in Eastern Africa is high at 33.1 per 1000 births[6]. Meanwhile, the District Health Information System (DHIS2) in Uganda indicates that the 2025 perinatal mortality rate in Mukono (11 per 1000 total births) was close to national and global targets (less than 10 deaths per 1000 births).

However, the district health decision-makers in Mukono report that the true incidence of perinatal deaths is possibly higher than what is being reported, and they are interested in options that can be implemented to reduce this burden. However, the underlying causes of the perinatal deaths are unclear, risking the implementation of less effective interventions. This may lead to even more babies dying and unnecessary resource wastage. Therefore, we summarise the available evidence on the interventions that can be implemented during the antepartum and intrapartum period in district health facilities to reduce perinatal deaths.

Rapid Response question: What interventions can be implemented to reduce the perinatal mortality burden in district health facilities?

How this Rapid Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research.

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Summary of findings

The current reporting system, DHIS 2, provides data on the incidence of stillbirths and early neonatal deaths. However, it does not clarify the factors contributing to this burden. For effective reduction in the burden of perinatal mortality, it is important to understand the risk/ causal factors associated with the rising burden of these deaths

Burden of perinatal deaths

Evidence suggests that the incidence of perinatal deaths in health facilities ranges from 10 to 38.8 deaths per 1000 total births [7,8]. Within this overall burden, the stillbirth rate ranges from 10 to 38.8 deaths per 1000 deliveries [9,10], while the early neonatal death rate ranges from 12 to 36.4 deaths per 1000 live births [8,11,12]. Mukono is big and heterogeneous, meaning the risk/ causal factors of perinatal deaths are many and different across the health facilities. Nevertheless, evidence shows that the leading causes of perinatal deaths are intrapartum complications[13], infections[14], respiratory and cardiovascular disorders[13,14], low birth weight[13], prematurity[13,14] and maternal sickness[15].

Other factors in Mukono that may indirectly contribute to the incidence of perinatal deaths include socio-economic factors, such as low education, low income levels[13,16], inadequate infrastructure[17], inadequate information[17] and a long distance from the health facility[18]. In addition to these, health facility factors, including long waiting times, a shortage of staff, inadequate medical supplies, and equipment, also contribute to this burden. Therefore, interventions that target the identification and early management of these factors can significantly lower the burden of perinatal mortality.

Interventions to reduce the burden of perinatal deaths

This review focused on antepartum and intrapartum interventions that target and address maternal and foetal risk factors before labor, during labor and delivery, and immediately after birth. Antepartum interventions include strengthening antenatal care, folic-acid supplementation, the Safer Baby Bundle (SBB), adopting the modified WHO Safe Childbirth Checklist, and data strengthening. Intrapartum interventions include timely and consistent labor monitoring, care during delivery, and vaccination of newborns.

Antepartum interventions

These are preventative measures taken before labor to identify high-risk pregnancies and monitor maternal health and foetal development[19]. They are helpful for reducing the risk of fresh stillbirths.

a) **Strengthening the quality of antenatal care (ANC)**

ANC is the healthcare, support, and education given to pregnant women from conception until delivery to ensure that the mother and baby are healthy[20]. It involves the provision of 9 services:

1. Weight measurement
2. Blood pressure measurements
3. Urine assessment
4. Blood assessments
5. Education on signs of pregnancy complications
6. Education on where to go in case of complications
7. Iron supplements or information on where to get them
8. Provision of parasitic medication
9. Tetanus vaccination

Evidence indicates that women who do not attend ANC constitute a large number of those who experience a stillbirth[21,22]. It also suggests that the effectiveness of ANC is higher when it is of high quality (receiving 8 out of the above 9 services) and is delivered promptly[21].

Effectiveness: Evidence from rural Uganda indicates that attending at least 4 ANC visits reduces the odds of a stillbirth by 50%[23]. This is consistent with results from Ghana, which show a 51% reduction in the likelihood of a stillbirth. Additionally, evidence from Ghana shows that high-quality ANC reduces these chances by 45%[21], while in Ethiopia, higher quality ANC reduces the odds of an antepartum stillbirth by almost 81%[24].

b) The Safer Baby Bundle (SBB)

This is an intervention designed to educate pregnant women and health workers on how to reduce the risk of a stillbirth. Mukono can adopt an SBB approach similar to Ethiopia, which focused on providing healthcare workers with education and resources on 5 key areas: improving detection and management of foetal growth restriction; effective monitoring of foetal heart rate; improving awareness and care for women with decreased foetal movement; raising awareness of the maternal safe sleeping position (side-sleeping); and improving decision-making around timing of birth[25].

- **Detection of foetal growth restriction**

  Foetal Growth Restriction (FGR) is a pregnancy complication where the foetus fails to meet its growth potential[26]. Screening for FGR risk factors is done during ANC visits and documented using an FGR algorithm[25]. It is done between 24 to 38 weeks of gestation[25], using symphysis-fundal height (SFH) (distance from the pubic joint to the top of the uterus)[25,26], sonographic foetal weight estimation[26], or an ultrasound[26,27].

SFH is measured in centimetres using a non-elastic metric tape after the pregnant woman has emptied her bladder[28], while foetal weight estimation is done based on various combinations of 4 biometric indices: head circumference, biparietal diameter, abdominal circumference, and femur length[26]. High-risk women receive serial ultrasound scans every 2 to 4 weeks, with estimated foetal weight plotted on a graph at each ANC visit[25,28].

- **Detection of decreased foetal movement**

Regular foetal movement is an indication that the foetus is well. It is expected between 16 and 24 weeks of gestation, right up to the time of delivery. During ANC visits, women are encouraged to report concerns of decreased foetal movement by 28 weeks, so that the necessary investigations are done, including risk factor screening for stillbirth, medical history review, and foetal heart rate[25].

- **Effective foetal heart monitoring**

Monitoring of foetal heart rate can be done using monitoring devices available at the facilities, and once there is suspected or under-detected FGR, an ultrasound can be used for confirmatory purposes.

- **Maternal side-sleeping**

Evidence shows that a mother sleeping on her side, from 28 weeks of pregnancy, can reduce the risk of a stillbirth by 50% compared to her sleeping on the back[28]. This is because lying on the back can strain major blood vessels, reducing blood and oxygen supply to the foetus[28]. Pregnant women are advised to sleep on their side and to maintain the position during all sleep periods, including naps, at night, and after waking up[25,28].

They are also advised not to worry if they wake up lying on their backs, but rather to turn back onto their side and continue sleeping. To improve awareness, brochures on side sleeping and decreased foetal movement can be translated into the local language and pinned on health facility notice boards or distributed to pregnant women during their routine ANC visits[25].

- **Timing of birth decision-making**

Decisions about when to deliver are made jointly by the pregnant woman and healthcare workers, considering risk factors, gestational age, and findings from investigations. Although a baby's growth and development continues up to about 39 to 40 weeks of gestation, the timing of birth may vary depending on the possibility of complications. Pregnant women without complications are encouraged to deliver close to their due date and allow for labor to begin naturally. On the other hand, those whose babies are unwell or are at risk of stillbirth may be advised to consider labour induction or delivery by caesarean section[28].

Effectiveness: Evidence shows that the Safer Baby Bundle lowers the likelihood of a stillbirth by 24.8% and that of an early neonatal death by 19.9%[25]. Evidence also shows that the detection of impaired blood flow in foetal umbilical vessels using ultrasound monitoring may lower the risk of perinatal mortality by almost half (42%) [27].

c) Iron-folic acid supplementation.

The World Health Organisation recommends iron-folic acid supplementation as part of ANC to reduce the risk of maternal anaemia and low birth weight. The capsules contain 30 to 60mg of iron and 0.4mg of folic acid, and are to be taken daily as early as possible after conception[29].

Effectiveness: Evidence from Tanzania shows that iron-folic acid supplementation lowers the risk of perinatal mortality by 24%[30], while in Ethiopia, it lowers the risk by 56%[31].

d) Adoption of the modified WHO Safe Childbirth Checklist

This checklist focuses on the identification of mothers at risk of preterm labor for prompt management. Mothers found to be at risk are given antenatal corticosteroids[32], such as dexamethasone, to support foetal lung development[33], or referred early to another health facility [32] for better management. The checklist can be integrated as part of the ANC services.

Effectiveness: There is currently no evidence specifically reporting on the effect of the modified safe childbirth checklist on perinatal mortality. Nevertheless, if included as part of a quality improvement package, the risk of perinatal mortality reduces by 33%[32]. Evidence on the effectiveness of dexamethasone is mixed. In some settings, evidence shows a 12% reduction in the risk of perinatal mortality[33], while in other settings, it shows a 30% increase in the risk of early neonatal mortality[34].

e) Data strengthening

In addition to strengthening the quality of antenatal care, it is important to strengthen the data systems within and across the health facilities in the district. This may include regular review and standardisation of indicator definitions, such as birthweight, Apgar scores, and birth and discharge status, to support the identification of newborns at high risk of death. It may also include the provision of essential measuring equipment to support the monitoring of mothers and their babies, along with reviewing the completeness and accuracy of data on stillbirths and early neonatal deaths[32].

Effectiveness: There is currently no evidence specifically reporting on the effect of data strengthening on perinatal mortality. However, if included as part of a quality improvement package, the risk of perinatal mortality reduces by 33%[32].

Intrapartum interventions

Intrapartum interventions are procedures or measures taken during labor and delivery to ensure the safety of the mother and foetus and to reduce the chances of a stillbirth or newborn death. They cover the period between 37 and 42 weeks of pregnancy, during delivery, and immediately after birth[35]. They are useful for reducing the risk of macerated stillbirths and early neonatal mortality.

1. **During labor**

    a) **Timely and consistent labor monitoring**

    Intrapartum interventions during labor include regular monitoring of labor, foetal heart rate, uterine contractions, maternal pulse, maternal blood pressure, temperature, and vaginal assessment[36]. For these interventions to be effective, they need to be done in a timely and consistent manner. Evidence defines optimum timing as monitoring of labor, foetal heart rate, uterine contractions, and maternal pulse every 30 minutes, and vaginal assessment, maternal blood pressure monitoring, and temperature measurements every 4 hours[36].

    Effectiveness: Evidence indicates that the receipt of timely care increases the chances of foetal survival by over 2-fold[36].

2. **During delivery and immediately after delivery**

    a) **Care around delivery (CAD) practices**

    These encompass 8 intrapartum (5) and post-partum (3) components. Intrapartum care practices include ensuring clean hands, a clean cord, a clean cord tie, a clean delivery surface, and a clean blade[37]. Hygiene can be achieved through hand washing with soap, sanitizer, or the use of 4% chlorhexidine gel for umbilical cord care[38]. Postpartum care practices immediately after delivery include skin-to-skin practices, early initiation of breastfeeding, and delayed bathing until 6 hours after birth[37].

    Effectiveness: Practice of all 8 CAD components reduces the risk of an early neonatal death by 19%[37]. Evidence also shows that the use of chlorhexidine gel for umbilical cord care may reduce the risk of newborn mortality by 35%[34], skin-to-skin contact between the mother and baby may reduce this risk by 27%[34], while the early initiation of breastfeeding (within 1 hour) may reduce the likelihood of an early neonatal death (by 78%)[31]. Additionally, through breast milk, some antibodies are transferred from the mother to the newborn for protection against diseases that may increase their risk of death[39].

    b) **Vaccination of newborns**

    Newborns are very vulnerable to infectious diseases because of their underdeveloped immune systems[39]. Therefore, early vaccination can boost their immunity against infections. In Sub-

Saharan Africa, the common vaccines recommended at birth include the BCG vaccine and the hepatitis B birth vaccine (HBV). The BCG vaccine protects newborns against tuberculosis, especially in tuberculosis-endemic settings[40], while the HBV vaccine protects newborns from the Hepatitis B virus, which is associated with acute or chronic infection[39].

Effectiveness: Evidence indicates that vaccinating newborns reduces the risk of early neonatal mortality by 77%[31]. Particularly, early administration of BCG lowers the likelihood of all-cause newborn death by over 30%[34,40], while the administration of HBV vaccine at birth may reduce the risk of newborn infection by 73%[39].

Conclusion

Evidence suggests that the perinatal death rate in health facilities is largely driven by factors such as intrapartum complications, infections, respiratory disorders, low birth weight, prematurity, and maternal sickness. Interventions that target risk factors in the perinatal period include antepartum interventions, which are useful in preventing fresh stillbirths, and intrapartum interventions, which are useful in preventing macerated stillbirths and early neonatal deaths. Antepartum interventions focus on the identification of factors that increase the risk of perinatal deaths and early decision-making for their management. Intrapartum interventions focus on labor monitoring and effective labor management for the safe delivery of babies. In Mukono, improving the quality of antenatal care, ensuring timely and consistent maternal and foetal monitoring, and emphasizing the 8 CAD practices during delivery can significantly reduce the perinatal mortality rate across health facilities in the district.

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ACRES' collaborators:

Regional East African Community Health Policy Initiative

EVIPnet

Glossary

of terms used in this report: 01 sure rapid response guides 2011 11.pdf (cochrane.org)

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Conflicts of interest

None known.

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