



# PUBLIC HEALTH & ENVIRONMENT BULLETIN

DIRECTORATE OF PUBLIC HEALTH AND ENVIRONMENT

## EDITORIAL TEAM

**Daniel Ayen Okello**

Director Public Health & Environment

**Najib Lukoya Bateganya**

Deputy Director Public Health & Environment

**Sarah Zalwango**

Manager Medical Services

**Christopher Oundo**

Supervisor Medical Services

**Alex Ndyabakira**

Epidemiologist

**Elizabeth Katana**

Epidemiologist

Dear Reader,

Happy New year 2021!

Congratulations upon concluding the game changing year in public health (2020)

We welcome you to issue 3, volume 1 of the KCCA-Public Health and Environment Bulletin. The aim of this Bulletin is to document and communicate the works, achievements, and key challenges with regards to Kampala's Public Health, Environment and other related events. The end goal is to disseminate this information to the policy makers, health professionals, the public, implementing partners and all stakeholders.

In this issue, we are excited to share with you a wide variety of articles focusing on Kampala's health and environment including: COVID-19 highlights and other PHEs, timely testing for Presumptive TB, participation of HIV clients in developing client-retention interventions, Maternal and New-born health care services, KCCA and Bloomberg's Partnership on road safety and Gender Based Violence.

While thanking you, we invite you to share with us your ideas and feedback. Yes, we are excited to hear from you and ready to extend our Bulletin family. For further information with regards to anything in this bulletin please contact any of us: [andyabakira@kcca.go.ug](mailto:andyabakira@kcca.go.ug), [ekatana@kcca.go.ug](mailto:ekatana@kcca.go.ug)

Enjoy your reading!!

Thank you.

## IN THIS ISSUE

02

HIV CLIENT-RETENTION INTERVENTIONS

07

KCCA & BLOOMBERG'S PARTNERSHIP ON ROAD SAFETY

04

MATERNAL AND NEW-BORN HEALTH SERVICES

08

GENDER BASED VIOLENCE

## COVID-19 outbreak highlights, December 2020

Authors: \*Alex Ndyabakira<sup>1,2</sup>, Elizabeth Katana<sup>1,2</sup>, Cathbert Tumusiime<sup>1</sup>, Daniel A. Okello<sup>1</sup>

Institution: <sup>1</sup>Directorate of Public Health and Environment, Kampala Capital City Authority, Kampala, Uganda

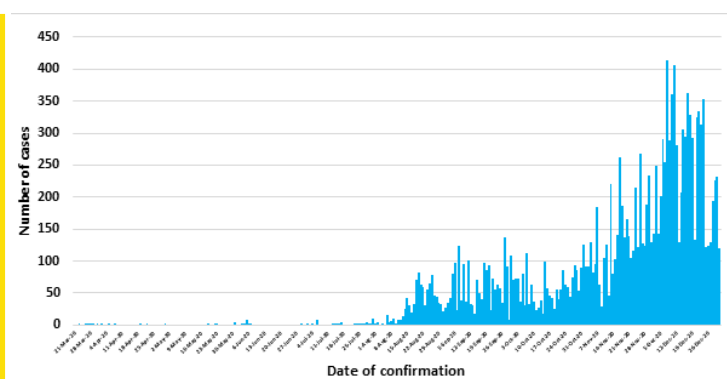
<sup>2</sup>Uganda Public Health Fellowship Program, Ministry of Health, Kampala, Uganda

\*Correspondence: andyabakira@kcca.go.ug

Globally, COVID-19 continues to affect countries, with almost 80 million confirmed cases, and more than 1.7 million deaths. The COVID-19 outbreak response has encountered challenges with many countries that had apparent success in suppressing initial outbreaks, are seeing a rise in infections and reporting new waves with reinstitution of lockdowns, some countries are struggling to flatten the curves, and there have been reports of a new variant strain in some countries including the United Kingdom, South Africa and Nigeria.

As of December 31, 2020, there was a cumulative total of 35,507 COVID-19 confirmed cases from 135/136 districts in Uganda. 96% of the cases were locally transmitted while 4% were imported cases. Cumulative deaths due to COVID-19 were 285 with a Case Fatality Rate of 0.82%. By November 2020, the COVID-19 epidemic in Uganda was in phase four (4) with intense and widespread community transmission in nearly all the districts. By mid-December 2020, Uganda was reporting a weekly average of 3,600 confirmed cases from 85 districts.

Kampala city continues to report the highest number of confirmed COVID-19 cases dominated by alerts and persons testing for travel purposes. Since March 2020, the COVID-19 task force at the Kampala Capital City Authority (KCCA) has developed and strengthened key interventions including; 1) organizing the city response into key pillars that included co-ordination and leadership, surveillance, case management, laboratory, risk communication, and social mobilisation, logistics and strategic information 2) setting up of an Emergency Operations Centre (EOC) with a toll-free call centre (0800 990000). By August 2020 the task force and response strategies were expanded to cover the Greater Kampala Metropolitan Area (GKMA) districts of Mukono and Wakiso.



Kampala curve as of December 31, 2020

The situation remains challenging requiring a Joint effort and mobilization by the public and all the stakeholders to achieve effective control of the COVID-19 epidemic. As we await the vaccine in mid-2021 expected to cover 20% of the population, we encourage the public to strongly comply with the preventive measures including consistent and proper face mask use, social distancing, and practise of good hand hygiene.

Important to note is that the COVID-19 pandemic was not the only emergency the world dealt with in 2020, this pandemic was just one of the many public health emergencies globally. In 2020, The World Health Organisation responded to more than 60 health emergencies including:

- A large measles outbreak in the Democratic Republic of Congo (DRC) with 380,766 confirmed cases and more than 7,018 deaths, early 2019 to August 24, 2020
- Measles in Mexico with more than 1,300 probable cases, April 2020
- Yellow fever in Gabon and Togo, June 2020
- An 18-month struggle that ended the world's second-largest Ebola outbreak in the Democratic Republic of Congo (DRC), with 3,481 cases, 2,299 of them died, June 2020
- A devastating blast in Beirut, Lebanon, causing at least 204 deaths, 6,500 injuries and leaving an estimated 300,000 people homeless, August 2020
- WHO Africa region declared wild polio-free, August 2020
- Flooding in Sudan with about 100 deaths and over 50 injuries, destroying more than 50,000 homes, September 2020
- A major outbreak of Chikungunya in Chad with over 27,500 cases, September 2020
- Storms in Philippines and Viet Nam, damaging thousands of homes and agriculture, November 2020
- Mystery illness cluster in India possibly due to a neurotoxin with more than 500 people hospitalized and one death, December 2020

## Improving Community - Health facility teams' coordination for Timely testing of presumptive TB cases in Nakawa division - Kampala City

Authors: \*Herbert Kisamba<sup>1</sup>, Harriet Komujuni<sup>1</sup>, Hajjarah Nanteza<sup>2</sup>, Disan Lukanga<sup>1</sup>, Daniel A. Okello<sup>3</sup>, Angella Kigonya<sup>1</sup>, Abel Nkolo<sup>1</sup>

Institutions: <sup>1</sup>USAID Defeat TB project,

<sup>2</sup>Reach out Mbuya community Health initiative (ROM),

<sup>3</sup>Directorate of Public Health and Environment, Kampala Capital City Authority

\*Correspondence: hkisamba@defeat-tb.urc-chs.com

### Background.

Tuberculosis (TB) disease is caused by a bacterium and is diagnosed through bacteriological confirmatory testing and clinical evaluation of Presumptive TB cases. Presumptive TB case refers to a patient who presents with symptoms or signs suggestive of TB.

Several diagnostic options including, sputum smear, urine TB Lipoarabinomannan (LAM) and chest X-ray can be used to detect TB. However according to World Health Organization (WHO) one third of the TB patients still go undetected and in Uganda more 30% of the TB cases go undetected either because of missed opportunities during care at health facilities or failure to access information and diagnostic services by the community.

USAID Defeat TB project has since September 2017 been working with Ministry of Health and the Directorate of Health and Environment at Kampala Capital City Authority (KCCA) to improve TB case finding in Kampala city.

The support by Defeat TB includes interventions at national and subnational levels including the community level. As one of the approaches for community level TB control, Defeat TB project sub granted 3 Civil Society organizations (CSOs) in 3 urban divisions in Kampala city -Kawempe Homecare (KHC) in Kawempe division, Reach out Mbuya community Health initiative (ROM) in Nakawa division and National women living with HIV in Uganda (NACWOLA) in Makindye division to implement community TB control activities. While executing their roles, CSOs noticed a delay in testing of presumptive TB patients identified through community interventions with some, missing the testing.

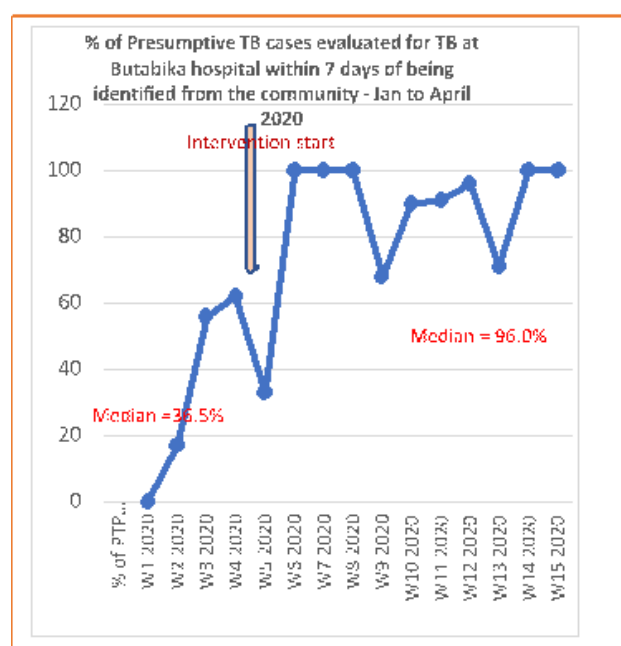
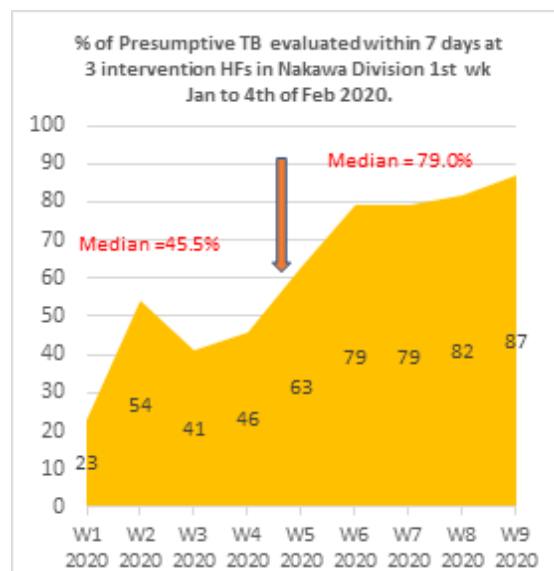
## Interventions.

In Feb 2020, TB care data analysis was done in Nakawa division to fully understand the underlying reasons for delay and non-evaluation of some Presumptive TB patients. The analysis indicated that; sputum samples collected by the community linkage facilitators (CLFs) were inadequate and thus rejected by labs. In addition, some presumptive TB patients could not access health facilities while some were delayed, and TB testing services were not consistently available at some health facilities.

Interventions were executed to address the noted gaps while monitoring the proportions of presumptive TB cases identified through community activities that were evaluated for TB within 7 days. A joint team of ROM staff and health facility TB focal persons within Nakawa division reoriented the CLF on the sputum sample collection procedures to avoid sample rejection at the laboratories, Lab personnel were coopted on the community TB outreach teams to support sputum sample collection and bi-weekly meetings were held between ROM staff, /CLFs, health facilities in charges and or TB focal persons to review progress and address any barriers.

## Results.

The proportion of presumptive TB cases identified through community interventions that were evaluated within 7 days of being presumptive TB cases increased from 23% at the 3 intervention HFs (0% at Butabika hospital) prior to the intervention to 87% by the end of week 5 into the intervention (2nd week of March 2020) and remained high thereafter. The number of identified TB case also raised during the intervention period compared to the preintervention period.



## Conclusion.

Improved coordination between the community TB providers and the health facility teams promotes timely access to TB diagnosis among presumptive TB cases through addressing barriers to TB testing.

## Exploring the participation of HIV clients in developing client-retention interventions in Kampala City Council Authority and Suburbs

Authors: \*Henry Magala<sup>1</sup>, Miisa Nanyingi<sup>2</sup>

Institutions: <sup>1</sup>AIDS Healthcare Foundation-Uganda Cares

<sup>2</sup>Uganda Martyrs University

## Summary

Participation of people living with HIV/AIDS in the development of client-retention interventions guarantees effectiveness of the interventions. It empowers beneficiaries to initiate, implement and monitor performance of their own retention interventions. Unfortunately, many HIV service providers do not practically support participation. This could be because of the costs involved in engendering participation.

In addition, participation apparently disempowers service providers from taking the lead in developing the retention interventions. The expert-driven medical system and stigma further undermine participation.

Hence, many retention interventions are top-down and not very appropriate for HIV clients. This could explain why globally only 20-40% of HIV clients are retained on treatment despite the many retention interventions. The study aimed at contributing to the third goal of UNAIDS, attaining 90% viral suppression. Effective retention interventions facilitate drug adherence leading to viral suppression. The study was informed by Arnstein's model of citizen participation. It was a qualitative study conducted in Kampala Capital City Authority and Wakiso District from August to December 2017. It involved 15 FGDs and 6 key informants from six HIV service providers that included civil society organizations, public and private health facilities. The study had four objectives namely: First, to find out the existing HIV client-retention interventions. Second, to find out the level of awareness and experience of HIV clients regarding retention interventions. Third, to find out the level of participation by HIV clients and Fourth, to find out factors determining participation of HIV clients in developing retention interventions. The results of the study were: Twelve retention interventions were found to be in use. However, participation of HIV clients in developing retention interventions as alternative intervention to retain HIV clients was not known. HIV clients were aware of the retention interventions but most of their experience was in implementing and not initiation. Wherever HIV clients participated, it was at a token level. Stigma and the operational environment of HIV clients were major factors influencing participation. In conclusion, participation of HIV clients in developing retention interventions was influenced by the recognition that participation is a necessity, prevalence of stigma and environment where HIV clients are served. The service environment also influenced stigma which reinforced absence of participation. The study recommends adoption of the principles of beneficiary participation, affirmative action for HIV clients in developing retention interventions, evaluation of non-discrimination policy for HIV clients being led by Ministry of Gender Labour and Social Development and scaling up media campaign against stigmatization of HIV clients. Future research on effectiveness of retention interventions developed by HIV clients would be required.

## Introduction

The study focused on exploring participation of HIV clients in developing interventions which facilitate retention of HIV clients in the care and treatment program. Participation of HIV clients delivers retention interventions which are owned and acceptable to the initiators. Therefore, such interventions enhance retention of HIV clients in care and treatment.

Retention of HIV clients is very important because HIV is a chronic disease. Once started on treatment, there must be continuity to benefit from the intended health outcomes like viral suppression.

Achieving 90% viral suppression is one of the UNAIDS 2020 targets. Falling out of treatment program leads to drug resistance, morbidity and eventually death. It is scientifically known that retention contributes to HIV prevention since HIV clients on medication are less infectious by 96%. Participation of people living with HIV clients is affected by stigma and the environment in which the clients are served. The attitude of health service providers was noted as one of the components of this environment which determines participation. Additionally, health service providers often decide the package of retention intervention for clients. According to Kranzer et al (2012) retention interventions for HIV clients are developed in high income countries and transferred to Sub-Saharan countries where health systems are poorly developed. Many of such interventions do not fit into local context and therefore not very appropriate. Appropriate retention interventions according to Kranzer et al (2012) require participation of the beneficiaries. This makes them acceptable and accessible. Uganda has traditionally followed the medical approach of service delivery where professional health workers entirely determine the content of medical service and not patients. This could account for gaps in participation of HIV clients in developing retention interventions. Therefore, the study attempts to explore the existing retention interventions and level of awareness and experience of the retention interventions by HIV clients, the stages of participation by HIV clients in developing retention interventions and the most important factors that determine participation of HIV clients in Uganda.

## Methods

The study was conducted in Kampala Capital City Authority and Wakiso District. It was specifically conducted in the divisions of Kawempe, Rubaga, Nakawa, Kampala Central and Lweza located in Kyadondo South Constituency, Wakiso District. The participants were drawn from TASO Mulago, Mildmay, Rubaga Hospital, Kawaala HCIII, Kisenyi HCIV and Child AIDS Fund. The study was descriptive and based on the grounded theory by Glaser and Straus (1967). According to the theory, analysis of the textual data is done to generate themes which form results of the study and the theory which forms the conclusion to the study. The study involved 15 focus group discussions which were categorized under the age groups 18-24 years and 25-49 years. There were 113 participants in FGDs. In addition, the study involved Heads of HIV programs as key informants. Participants provided varied opinion and experience related to the study objectives.

## Results

The study revealed 12 retention interventions for HIV clients namely: client follow up, health education, experience sharing by HIV clients, psychosocial activities, community pharmacy, client or service differentiation, treatment supporters, treatment buddies, medical monitoring of clients, referral system, income generating activities, and the family-centred model. Participation of HIV clients in developing retention was never mentioned by either HIV clients or key informants. The level of participation by HIV clients was token and hardly



making decisions on retention issues. Under token participation, involvement developing retention intervention was found to be low, devoid of leadership role and ability to influence decisions. Factors affecting participation of HIV clients were noted to be both internal and external to HIV clients. The major internal factors cited were stigma and availability of time to participate. The major external factor was the environment where clients are served. The environment included attitude of health workers reflected in the relationship with HIV clients.

### Conclusion

Participation of HIV clients in developing retention interventions is determined by three main factors namely: recognition that participation of HIV clients in developing retention is also an intervention, stigma and environment where clients are served.

### Recommendations

HIV service providers should develop a participation framework and engender contribution of HIV clients in developing retention interventions. Civil society organizations should enhance advocacy campaign against stigmatization and discrimination of HIV clients which affect their participation. Additional research on effectiveness of retention interventions developed by HIV clients should be carried out. Ministry of Gender Labour and Social Development should evaluate policy on non-discrimination of HIV clients and address the gaps.

## A baseline health facility assessment reveals the capacity levels and gaps of private health facilities to provide Maternal and Newborn health care services in Kampala

Authors: \*Andrew Magunda<sup>1,2</sup>, Henry Kaula<sup>1,2</sup>, Yvonne Mugerwa<sup>1,2</sup>, Sam Ononge<sup>1,2</sup>, Daniel A. Okello<sup>3</sup>, Sarah Zalwango<sup>3</sup>

Institutions: <sup>1</sup>Population Services International, Kampala, Uganda

<sup>2</sup>Kampala Slum Maternal and Newborn Health (MaNe) Project, Directorate of Public Health and Environment, Kampala, Uganda

<sup>3</sup>Directorate of Public Health and Environment, Kampala Capital City Authority, Kampala, Uganda

\*Correspondence: amagunda@psiug.org; hkaula@psiug.org; ymugerwa@psiug.org;

### Summary

We present findings from a quantitative cross-sectional survey with 56 Private For Profit (PFPs) health facilities providing delivery and newborn care services in Lubaga and Makindye divisions in Kampala. The key results were; Majority of PFPs (94.6%) have midwives and 51.8% have doctors. All assessed PFPs (100%) offer normal deliveries but only 19.6% of these can conduct caesarean section deliveries, regarding client volumes, majority of PFPs (71.4%) deliver less than 20 mothers in 3 months and the same number of deliveries is recorded by majority of PFPs (44.6%) in 12 months, results also show that majority of PFPs use other motor vehicles for referral transportation and only 10.7% of PFPs have motor vehicle ambulances to transport referred clients to other facilities, In terms of labor and delivery Management, while all PFPs assessed had gloves (100%), sufficient lighting (94.6%), and means of ventilation(94.6%), and functional toilets and

curtains for privacy(98.2%), majority (>50%) don't have required labor and delivery guidelines, Looking at performance on Basic Emergency Obstetric and Newborn Care services, results showed that only 32.1% PFPs perform newborn resuscitation using a bag and a mask, 44.4% perform removal of retained products and only 3.6% perform assisted vacuum delivery, concerning evidence based Care, whereas 91.0% of PFPs routinely practice active management of thirds stage labor and 75% routinely use partographs to monitor labor, few perform breech delivery (17.9%), give special or intensive care to a preterm or low birth weight baby (12.5%), conduct maternal death reviews (5.4%) and perinatal death reviews (3.6%). The findings affirm that to a large extent, PFPs have gaps in provision of BEMONC services, and in using partographs to monitor labor. Furthermore, to a large extent PFPs don't do maternal and perinatal death notifications and reviews, and lack MNH guidelines, protocols and tools. We recommend continuous mentorship of health service providers in PFPs in provision of Basic Emergency Obstetric and Newborn Care (BEMOC), the value of evidence-based care especially maternal and perinatal death notifications, and on job mentorships on the use of partographs. We also recommend that the different health partners working in the Greater Kampala Metropolitan should support PFPs to acquire key MNH guidelines, protocols and data tools. To improve general service availability and referral practices, PFPs should be encouraged to utilize the new KCCA digital emergency transportation system as a way of enhancing travel from referring to receiving facilities.

### Background

The United States Agency for International Development (USAID) is supporting the Kampala Slum Maternal and Newborn (MaNe) Health project, a partnership initiative between Population Services International (PSI) and Kampala Capital City Authority (KCCA). The project is testing innovations to improve the provision of quality of care for better maternal and newborn health (MNH) outcomes in urban slum settings of Lubaga and Makindye divisions of Kampala.

The project conducted a baseline assessment in 125 health facilities located in and around slums of Makindye and Lubaga divisions to determine the current capacity of private health facilities that provide MNH care services and establish gaps in provision of MNH care services that can be fixed by MaNe project activities. The assessment was conducted for a period of two months collecting service data for the last 3 months and last 12 months to ascertain the client load of facilities that provide MNH services.

### Methods:

A quantitative cross-sectional survey design using a standard facility assessment tool adopted from the USAID Saving Mothers Giving Life (SMGL) project was used involving all health facilities which provide MNH services in Lubaga and Makindye divisions. Using data from the health facility census conducted by KCCA in 2017, a total of 125 health facilities within or close to slums in the two divisions were purposively

in the two divisions were purposively selected from the 444 health facilities and 5 public facilities offering MNH services in Makindye and Lubaga divisions. A total of 15 enumerators who were post graduate students at Makerere University Department of Obstetrics and Gynecology collected the data for a period of two weeks, using the electronic Open Data Kit (ODK), and supervised by the MaNe project staff. Data was downloaded in excel and exported to SPSS for analysis. Analysis and results presented in this article are based on 56 PFP health facilities which provided delivery and newborn care services for a period of one year (May 2018 - April 2019). Data was disaggregated by division and status of use of the PFP medical doctors. Pearson Chi-Square tests were run at 5 % level of confidence to determine the statistical differences among the disaggregation groups for the different variables analyzed.

## Results:

**Staffing and training at PFPs:** 94.6% of PFPs have midwives and 51.8% have doctors. There is a significant statistical difference in the number of doctors, clinical officers and registered nurses employed by PFPs with doctors and those without doctors. PFPs with doctors employ more staff of the above categories compared to PFPs without doctors. There are PFPs (5.4%) which deliver mothers without any midwife among their staff. Majority of these are PFPs without doctors although the difference in the proportions of PFPs of the two categories is not statistically significant. Only 25% of PFPs have at least one staff trained in maternal death reviews and 26.8% of PFPs have at least one staff trained in perinatal death reviews. All PFPs assessed (100%) offer normal deliveries but only 19.6% of these can conduct caesarean section deliveries (Figure 1)

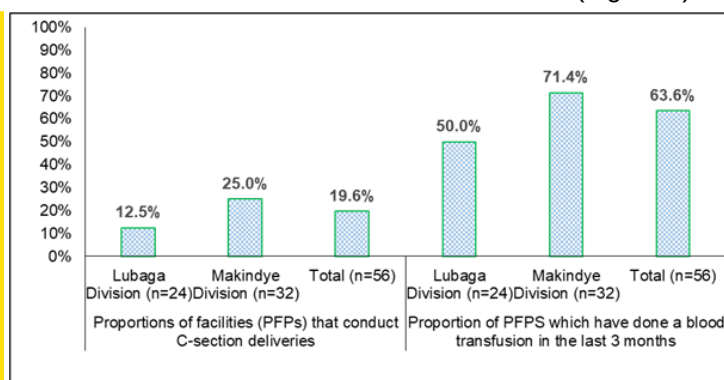


Figure 1: C-section Deliveries and Blood Transfusion

**Antenatal Care (ANC) Visits, deliveries and postnatal care (PNC) Attendances:** Results on the volumes of clients for ANC, deliveries and PNC show that majority of PFPs (71.4%) deliver less than 20 mothers in 3 months and the same number of deliveries is recorded by majority of PFPs (44.6%) in the 12 months period. Only 1.8% of PFPs which offer delivery services didn't register any delivery in the last 12 months. In a period of 3 months, on average PFPs get 23 mothers for the 1st ANC visit, 11 mothers for the 4th ANC visit and 13 mothers for PNC visits. This implies that majority of mothers don't complete the 4 ANC visits and don't turn up for PNC.

**Facility Capacity and Infrastructure:** On average, PFPs have a total of 8 beds. Out of these, 3 are dedicated to sick antenatal mothers, 1 for laboring women and 2 for post-partum mothers. Overall, majority of PFPs have electricity (96.4%) and water (94.6%), with piped water as the main water source (94.3%). However, only 40.7% have backup generators, and functioning toilets designated for client use (98.2%). All facilities without electricity, water, designated toilets and backup generators are PFPs without doctors.

**Communication and Referral transportation:** The findings from the assessment show that majority of PFPs (94.4%) have facility owned cell phones for making referral communications but only 55.4% of the communications made (calls) are paid for by the facility while 44.6% of the communications are paid for by facility staff. Majority of PFPs use other motor vehicles for referral transportation with only 10.7% of PFPs having motor vehicle ambulances to transport referred clients to other facilities, and 5.4% of the facilities using motorcycles to transport referred clients to referral facilities.

**Service availability and general referral:** The assessment findings revealed that majority of PFPs (94.6%) are open 24 hours and 7 days a week and these offer obstetric and neonatal care. All PFPs which don't operate 24/7 are from the category of PFPs without doctors. In relation to referral of maternal complications, majority of PFPs (29.2%) in Lubaga division refer to Lubaga and Mengo Hospitals. In Makindye division, majority of PFPs (62.5%) refer to Nsambya and Kawempe Hospitals (18.8%). For neonatal complications, majority of PFPs (29.2%) in Lubaga division refer to Lubaga and Mengo Hospitals. In Makindye division, majority of PFPs (56.5%) refer to Nsambya and Kawempe Hospitals (21.9%). Majority of PFPs (92.9%) reported that the roads to the referral sites for maternal complications and neonatal complications are paved. On average it takes less than 20 minutes to travel from the referring to the receiving facilities.

**Essential drugs and Supplies:** In relation to availability of marker drugs, results show that all facilities have Dexamethasone, 96.4% have Oxytocin, 94.6% have folic acid and 96.9% have Nifedipine. Only 19.6% had pethidine, 23.5% had calcium gluconate and 32.1% had Betamethasone. Calcium gluconate was more available in PFPs with doctors compared to PFPs without doctors. Majority of the delays in delivery of drugs and supplies in PFPs are due to financial problems (38.2%) and administrative difficulties (20.0%)

**Labour and delivery Management:** All PFPs assessed had gloves (100%), 94.6% had sufficient lighting, 94.6% had means of ventilation, 98.2% had functional toilets and curtains for privacy and 94.6% had waiting areas for visitors. However, majority of facilities (>50%) did not have the required labour and delivery guidelines. More PFPs with doctors have Eclampsia –Pre-eclampsia management guidelines compared to PFPs without doctors. There is no significant statistical difference in availability of other labour and delivery

guidelines in the PFPs with doctors and those without doctors. It is also important to note that Oxygen cylinders, Ultrasound scans, Doptone, Uristix, Partographs and Newborn resuscitation tables are all more available in PFPs with doctors compared to PFPs without doctors. On average, each PFP has only 2 complete delivery kits (Figure 2)

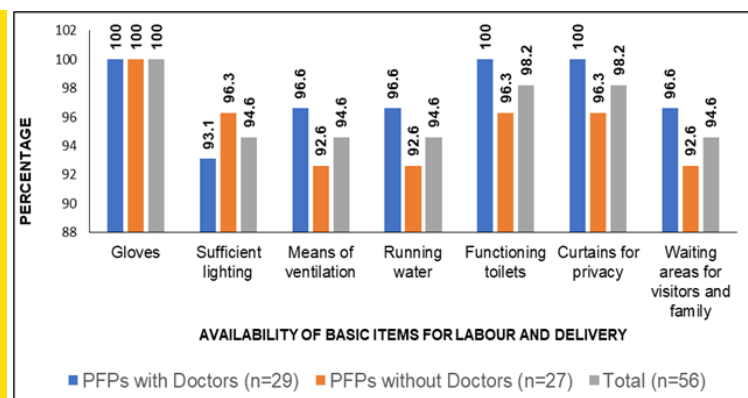


Figure 2: Availability of basic items for labour and delivery

**Facility data Management:** Only 3.6% of PFPs have all the required death notification forms and death review forms for maternal and perinatal deaths. There is no significant statistical difference in the availability of death review and notification forms in PFPs with doctors and those without doctors. Also, 23.2% of the PFPs did not have labour and delivery registers, 86.0% had complete and up-to-date registers, 37.5 % did not have ANC registers and 17.9% had ANC registers but not fully filled.

**Performance of BEMONC functions:** The assessment looked at how PFPs are performing on the Basic Emergency Obstetric and Newborn Care (BEMOC) signal functions. The results show that all facilities administer parenteral antibiotics and 85.7% of PFPs use misoprostol. Misoprostol is mainly used for management of postpartum hemorrhage (89.6%) and post abortion care (64.6%). Only 41.4% of PFPs use parenteral anticonvulsants and only 30.4% of PFPs perform manual removal of the placenta. It's not surprising that PFPs with doctors perform manual removal of the placenta more than those without doctors, 44.4% of facilities perform removal of retained products and only 3.6% perform assisted vacuum delivery. Only 32.1% perform newborn resuscitation using a bag and a mask.

**Evidence based Care:** Majority of PFPs (91.0%) routinely practice active management of third stage labour and 75% of PFPs routinely use partographs to monitor labour. Majority of PFPs (76.2%) which don't use partographs claim not to have blank partograph forms to use, while only 17.9% of PFPs perform breech delivery and only 12.5% give special or intensive care to a preterm or low birth weight baby. Results further disclosed that only 5.4% of PFPs conduct maternal death reviews and 3.6% conduct perinatal death reviews (Figure 3).

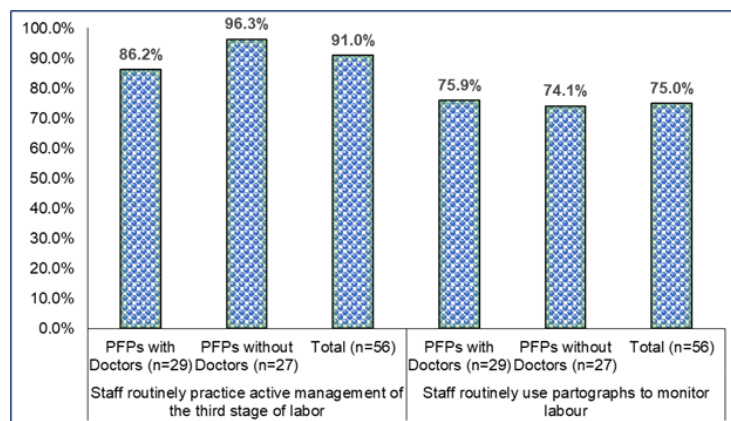


Figure 3: Routine Active Management of Third Stage Labour and Partograph use

**Antenatal and Postnatal Care:** Data on availability of key drugs, registrars and guidelines for ANC and PNC shows that out of 56 PFPs assessed, 39.2% don't have Fansidar, 70.4% don't have ANC clinical guidelines and 35.7% don't have ANC registers.

**Linkage to Community:** The assessment gathered data on how community health workers have been actively engaged in provision of MNH services. The results show that only 37.5% of PFPs work with maternal health Village Health Teams (VHTs). Majority of maternal VHTs are mainly used in community works (91.6%).

### Conclusions and Recommendations:

The findings of the study showed that there are gaps in service providers performing the BEMONC functions. There should be continuous mentorship of health service providers in PFPs on use of parenteral anticonvulsants, conducting assisted vacuum delivery, manual removal of the placenta, removal of retained products and newborn resuscitation.

Additionally, majority of PFPs don't have MNH guidelines and protocols. Some PFPs didn't have maternity registers. These PFPs should be supported to get these guidelines from MOH and other partners supporting MNH in Kampala City. With support from KCCA HMIS department, these PFPs should be availed with MOH Maternal registers (ANC, Maternity and PNC) and trained on use of these registers to collect quality data.

The results from the assessment showed gaps in using partographs in monitoring progress of labor due to lack of skills and lack of partograph forms. The Maternal health service providers in PFPs should have on job mentorships on the use of partographs and they should be availed with partograph forms which they can photocopy when their stock levels go down.

Majority of the PFPs don't do maternal and perinatal death notifications and reviews. Each PFP should assign one health worker the role of making maternal and perinatal death notifications to the MPDR committee in the division to come and do the audits/reviews.



## Speeding and Road Safety: KCCA partners with the Bloomberg Philanthropies Initiative for Global Road Safety (BIGRS)

Authors: \*Leah Kahunde<sup>1</sup>, Elizabeth Katana<sup>2,3</sup>, Daniel A. Okello<sup>3</sup>

Institutions: <sup>1</sup>Bloomberg Philanthropies Initiative for Global Road Safety (BIGRS), Kampala, Uganda

<sup>2</sup>Uganda Public Health Fellowship Program, Ministry of Health, Kampala,

<sup>3</sup>Directorate of Public Health and Environment, Kampala Capital City Authority, Kampala Uganda

\*Correspondence: leah.kahunde@bigrs.org

According to the World Health Organization, road traffic injuries are the eighth leading cause of death worldwide and the leading cause of death for people aged between 5 and 29 years. Each year, road traffic crashes kill over 1.35 million people and injure up to 50 million more around the world.

Over 90% of the world's deaths on the roads occur in low-income and middle-income countries, which have less than half of the world's vehicles and sadly, many of these deaths are preventable. In Uganda, four of the 10 people killed in road crashes every day are pedestrians, according to the 2019 Police Annual Crime Report. The report indicates a 0.4% increase from 2018 and of the 3880 that died in road crashes in 2019, 600 (15.5%) were children.

As part of efforts to curb this trend, the Kampala Capital City Authority (KCCA) entered a six-year partnership with the Bloomberg Philanthropies Initiative for Global Road Safety (BIGRS) in July 2020. BIGRS is a multi-country programme that aims to reduce road crash fatalities and injuries, supported by Bloomberg Philanthropies.

This third phase of BIGRS builds on the success and impact of Bloomberg Philanthropies' more than 10 years of investment in road safety, which has saved up to an estimated 312,000 lives and prevented up to 11.5 million injuries since 2007. BIGRS phase 3 will run from 2020 to 2025 and aims to bring the lives saved total up to 600,000 and prevent up to 22 million injuries in low- and middle-income countries.

Kampala joins the other priority cities in this phase including Accra, Addis Ababa, Bengaluru, Bogota, Buenos Aires, Guadalajara, Hanoi, Ho Chi Minh City, Kumasi, Mumbai, New Delhi, Sao Paulo, Salvador and Recife, with more expected to follow.

On this project/partnership, KCCA is working with other stakeholders in road safety including The Directorate of Traffic at the Uganda Police, Makerere University School of Public Health and, the Ministry of Works and Transport.

The project will focus on these areas; enforcing road safety laws on (speeding, drink driving, motorcycle helmets, and seat belts), designing and building safer roads, managing speed effectively, implementing transportation systems

to make urban mobility safer, promoting safe driving and, building public support to road safety through mass communication campaigns and use of data from high-quality monitoring and evaluation systems for policy and planning.

### Speeding and Road Safety

Phase 3 of BIGRS places special focus on speeding which is at the core of the road traffic injury problem.

The road safety risk relating to speed is associated with behavioural and non-behavioural factors, including road infrastructure or design, and vehicle safety elements. Speeding increases the likelihood of crash involvement, crash severity, and injury severity because of a transfer of kinetic energy when things collide. Excessive speeding means to travel faster than the prescribed speed limit while Inappropriate speeding means to travel too fast for the prevailing conditions, which could be within the prescribed speed limit. With regards to road safety, speeding can therefore be considered as traveling at both excessive and inappropriate speeds.

There is evidence that pedestrians have a 90% chance of survival when struck by a car traveling at 30 km/h or below, but less than 50% chance of surviving an impact at 45 km/h, and would have almost no chance of surviving an impact should a vehicle be traveling at 80 km/h. Excess and/or inappropriate speeding account for a high proportion of injury and death that result from road crashes, in addition to reducing the reaction time a driver could stop a vehicle and avoid a crash.

The Ministry of Works and Transport Traffic and Road Safety (Speed Limits) Regulations, 2004 guides 50km/h as the acceptable speed limit in Uganda's urban areas, trading centers and, other built-up areas including Kampala capital city. However, being both a residential and commercial city, it is more practical to have and enforce speed limits according to the environment within which the respective roads exist.

It is therefore important that ardent and deliberate effort is geared towards behavioral change advocacy, revamped enforcement strategies, better road designs, and post-crash management in a bid to contribute to the global goal of halving traffic deaths by 2030, recently announced by the United Nations as the Second Decade for Road Safety commencing in 2021.

For more information please visit:

[www.bloomberg.org/program/public-health/road-safety/](http://www.bloomberg.org/program/public-health/road-safety/)

Zebra crossings are commonly used on pedestrian crossings controlled by traffic signals or lights and pedestrians will only have priority when the lights show green to them. There is low coverage of zebra crossings with signal systems on the Kampala roads resulting in challenges related to their use on high speedroads, roads with high volumes of traffic or with heavy flow of pedestrians.

(continued on next page)



Ensuring safety of pedestrians in Kampala city is of priority value to KCCA and BIGRS partnership.



*Image: City Lead Eng. Jacob Byamukama and team adding a zebra crossing to a city road, 2020.*

### World Day of Remembrance for Road Traffic Victims, November 15, 2020, 3<sup>rd</sup> Sunday in November - Every Year



#### This Year: Sunday, November 21, 2021

On November 15, 2020, Kampala City joined the rest of the world in commemorating the World Day of Remembrance for Road Traffic Victims at the Uganda Youth Aid Nursery and Primary School Mbuya. This day was started by a British road crash victim charity, Road Peace, in 1993 and was adopted by the United Nations General Assembly in 2005.

This day is commemorated to remember the many millions killed and injured in the world's roads, together with their families, friends and many others who are also affected. It is also in this day on which we thank the emergency services and reflect on the tremendous burden and cost of this continuing daily disaster to families, communities and countries, and on ways to halt it. A dedicated website

([worlddayofremembrance.org](http://worlddayofremembrance.org)) was launched to make the day more widely known and to link countries through sharing common objectives and the remembrance of people killed and injured in crashes.

### Ending Gender Based Violence: We need to focus on prevention.

Authors: \*Ofwono Opondo, John Paul Opus

Institution: Reach Out Mbuya Community Health Initiative (ROM), Kampala, Uganda

\*Correspondence: [oofwono@reachoutmbuya.org](mailto:oofwono@reachoutmbuya.org) and [jpopus@reachoutmbuya.org](mailto:jpopus@reachoutmbuya.org)

#### Background

Gender Based Violence (GBV) is defined as harmful acts directed at an individual based on their gender. It is rooted in gender inequality, abuse of power and harmful norms. Women and girls are more affected by GBV than men and boys. The most predominant forms of violence against women and girls include domestic, sexual and psychological violence.

According to an analysis made by the World Bank and its partners, worldwide, almost one third (30%) of women who have been in a relationship report having experienced some form of physical and/or sexual violence by their intimate partner in their lifetime. Additionally, as many as 38% of murders of women are committed by a male intimate partner.

In Uganda violence against women and girls has reportedly increased with the COVID 19 pandemic. There has been an increase in GBV cases as the country instituted lockdowns and stay at home restrictions to prevent the spread of COVID-19. Some of these cases have already claimed lives of Ugandans even before COVID-19 does so as reported by Uganda's ministry of gender, labor and social development.

In homes, domestic violence is cited whenever families spend more time together with the perpetrators such as relatives including uncles, biological fathers etc. This was instigated more by the "stay home campaign" seen as a necessary evil during the COVID-19 response. This isolation shattered support networks including community-based network of the local council, school's administration support etc., making it far more difficult for victims to get help. This has caused higher levels of family instabilities as well as damaged the emotional, physical and mental status of the victims.

Reach Out Mbuya (ROM) conducts surveillance, for violence against women and girls in the areas of Kampala in addition to other services including HIV/AIDS (related services, Orphan and Vulnerable Children (OVC) related services, grandmothers' program and Non-communicable disease services.

#### Approaches and interventions

In January–March 2020 Reach Out Mbuya (ROM) recorded 345 GBV cases compared to 65 cases recorded between October – December 2019 at the different ROM sites of Mbuya, Banda and Kinawataka. ROM is using the holistic approach of care to ably identify the victims and help affected families achieve peace in their homes as follows.

The journey of ending violence against women and girls begins with prevention. Having well-grounded community structures that support to root out the structural causes of violence, early sensitization of the community plus involvement of men and boys is pivotal in this fight. Multiple interventions at different levels individual, community, institutional, legal, and policy are also needed. We also still need to address the CBV cases we have in our community. Public awareness and increased political will and resources towards fighting GBV are also key.

For couples Living with HIV/AIDS one of the common challenges they face is non-disclosure even amongst the married. Disclosing one's status to a sexual partner means talking honestly about one's HIV serostatus. Disclosure has been shown to result in better adherence to therapy, elimination of stigma, good clinical outcomes and reduction in the risk of HIV transmission among couples and reduce incidences of GBV. (It's only for people living with HIV failing to disclose their HIV status of fear of the outcome).

ROM has continued to work closely with partners like Center for Health, Human Rights and Development (CEHURD), International Justice Mission, the Uganda Local Council at all levels where some cases have been referred. ROM has experienced some challenges in managing GBV cases more so during the COVID 19 crisis. Some of the partners where ROM has been referring cases withdrew because of the lock down. In others, the victims withdrew cases from police or legal office, most defilement and rape cases were dropped since the clients could not pay for medical examination because they lacked money, instead choose to settle the cases in community through settlements.

Despite these challenges, ROM has come up with interventions to ensure the continuity of service delivery to the victims of Gender Based Violence. Through locally mobilizing funds to support our clients with medical examinations in cases of rape and defilement. ROM also plans to rollout GBV screening in all program areas.

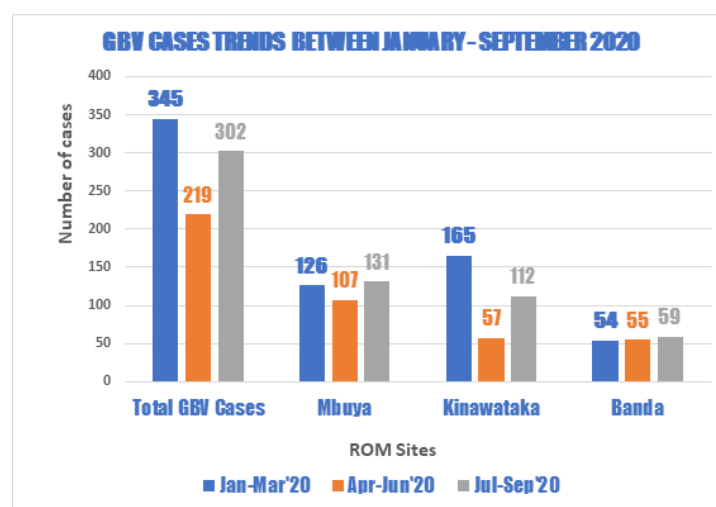
## Results

In the areas of Mbuya, Kinawataka and Banda, 372 cases were recorded in 2018, 288 cases for 2019, while as of October 2020, an almost triple number of 915 cases had been recorded for the year 2020 as shown in graph 2. This is because of the different interventions put in place to identify and record those cases. These interventions include screening all our clients who come at the facilities, GBV screening at house hold level and lastly screening young people at every activity. In addition to that, the GBV cases increased during the COVID 19 as opposed to the previous years.

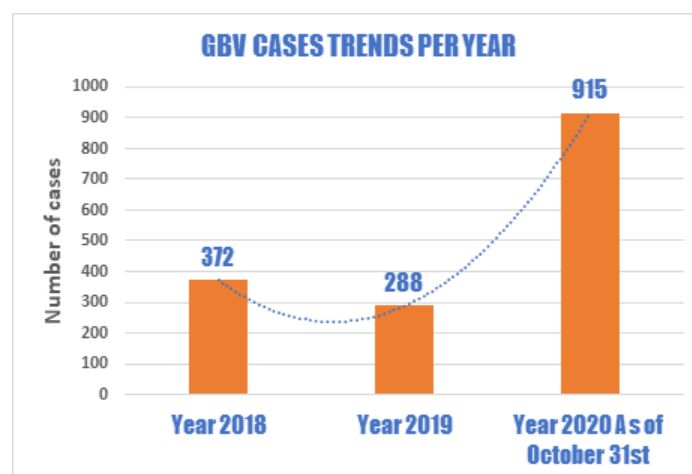
The overall number of cases was highest from January to March 2020, followed by July to September 2020, while a lower number was reported from April to June 2020 as shown in graph 1. The reduced number of cases between April and June 2020 could have resulted from the lockdown restrictions which hindered reporting and community response. The fewer cases

reported were due to limited movement of our team to the community and facilities to screen people for GBV and limited movement of our clients to the facilities to report the GBV cases. This does imply that the cases were not there but rather highlights the limitations.

In Mbuya, the number of cases was above 100 for all the three quarters, in Kinawataka more cases were reported in the first and third quarters, while in Banda almost equal numbers were reported in all the three quarters. Banda reported fewer cases because the community has mostly university students who had already gone back home. Therefore, the GBV numbers were few due to a reduced population.



**Graph 1:** Trend of GBV cases between January 2020 and September 2020, from Nakawa Division and 85% accounts for women and girls as victims of Gender Based violence.



**Graph 2:** The trend of Gender Based Violence over the three years.

## Ending Gender Based Violence: We need to focus on prevention.



November 25 was designated by the United Nations General Assembly as the International Day for the Elimination of Violence Against Women. The role of the day is to raise awareness of the fact that women around the world are subject to rape, domestic violence and other forms of violence; furthermore, one of the aims of the day is to highlight that the scale and true nature of the issue is often hidden.

For 2014, the official Theme framed by the UN Secretary-General's campaign UNiTE to End Violence against Women, was *Orange your Neighbourhood*. For 2018, the official theme was "Orange the World: #HearMeToo". For 2019 it was "Orange the World: Generation Equality Stands Against Rape" and for 2020 it was "Orange the World: Fund, Respond, Prevent, Collect!". Every year Uganda joins the rest of the world to commemorate the international day for the Elimination of Violence against Women on 25 November.

## Strengthening client-centred and respectful maternity and newborn care in public and private health facilities in Lubaga and Makindye divisions in Kampala city

Authors: \*Yvonne Mugerwa<sup>1,2</sup>, Dorothy Balaba<sup>1</sup>, Daniel A. Okello<sup>3</sup>, Sarah Zalwango<sup>3</sup>, Henry Kaula<sup>1,2</sup>, Andrew Magunda<sup>1,2</sup>, Sam Ononge<sup>1,2</sup>

Institutions: <sup>1</sup>Population Services International, Kampala, Uganda

<sup>2</sup>Kampala Slum Maternal and Newborn Health (MaNe) Project, Directorate of Public Health and Environment, Kampala, Uganda

<sup>3</sup>Directorate of Public Health and Environment, Kampala Capital City Authority, Kampala, Uganda

\*Correspondence: sononge@psiug.org; hkaula@psiug.org; ymugerwa@psiug.org;

### Introduction

There is growing evidence that disrespect and abuse of women during childbirth is a deterrent to women utilising maternity services especially in low- and middle-income countries (LMIC). Literature suggests that fear of disrespect and abuse may sometimes be a more powerful deterrent to the use of skilled birth care than geographical and financial obstacles [1,2]. For instance, In Uganda the current facility birth rate is at 73% but is 94% in urban settings like Kampala [3]. Despite this high rate of facility birth, a formative study conducted by Kampala Slums Maternal and Newborn Health (MaNe) project in 2019 showed several aspects of

disrespectful and ill-treatment of women at health facilities. Following the findings from this study, among the several interventions, MaNe project implemented several innovative approaches to address barriers to provision of quality MNH care in urban settings in Kampala city especially among the urban poor. One key specific intervention was to strengthen client-centered and respectful maternity and newborn care (RMNC) in public and private health facilities in Kampala city. Therefore, the objectives of this study were in line with this thought: 1) To assess client satisfaction among women who received antenatal, intrapartum (maternity) and postnatal services from public and private health facilities from the month of September using in-depth qualitative interviews, and 2) To determine and recognise/reward the best performing facility, departments, and health providers among selected public facilities using client feedback on receiving respectful maternity care.

### Methods

This was a mixed methods cross-section survey that utilised both qualitative (in-depth interviews) and quantitative methods of data collection. The data collection was carried out between October and November 2020, in Lubaga and Makindye divisions, the two MaNe project sites. Within this two divisions, 12 facilities were purposively selected because they had received training in RMNC. Four of them were public health facilities (table 1). The participants who visited private facilities answered to only objective 1 (participated in only qualitative in-depth interviews) while those that received services from public facilities answered both objectives 1&2.

The study included women who had used the selected services at the selected health facilities from the month of September 2020; were current residents of the slums of either of the two divisions; and women with contact phone numbers which were captured at the facility level registers (ANC, delivery & postnatal). The women were clients who received antenatal, intrapartum (maternity) and postnatal services from public and private health facilities. For childbirth experiences, we excluded women who had delivered stillbirth in period. We recruited 30 women for the qualitative interviews (Objective 1) as shown in table 1, and 257 women for the quantitative (Objective 2).

No.	Facility Name	ANC	Delivery	Postnatal	Total
1	Kisenyi HC IV*	0	1	1	2
2	Kisugu HC III*	2	2	2	6
3	Kitebi Health Centre HC III*	1	0	1	2
4	Kawaala Health Centre HC III*	2	2	1	5
5	Maria Theresa Domiciliary Clinic HC II	1	0	0	1
6	Pearl Medical Centre HC IV	0	0	1	1
7	Family Clinic Lusazze HC II	2	2	2	6
8	Joy Medical Centre HC III	0	1	0	1
9	Victoria maternity	1	1	1	3
10	Keah medical centre	1	0	0	1
11	St. Edward Clinic	0	0	1	1
12	Kisakye maternity home	0	1	0	1
	<b>Total</b>	<b>10</b>	<b>10</b>	<b>10</b>	<b>30</b>

**Table 1:** Selected public and private facilities that took part in the study and participants enrolled for the qualitative in-depth interviews

\*The public health facilities



Qualitative and quantitative questionnaires were adopted from tools produced in Heshima project in Kenya [4], focussing on key aspects of RMNC in the continuum of maternity care including rapport, confidentiality, preservation of dignity during care, privacy, right for information, consented care, solicitation of informal payments by health workers and any form of abuse. In addition, the tools had and questions on observed health care quality, satisfaction and future health care utilisation. The data collection also assessed the women's recollection of the health system issues that impacted on quality of care. For identification of health provider who deserved to be recognised and rewarded, we asked the study participant to give a name of one provider, whom she felt deserved recognition and a reward. Given that the survey was carried out during Covid19 period, a strict observation of Covid19 SOPs was done.

**Data management:** For qualitative interviews, data was transcribed and analysed manually using content and narrative analysis to identify patterns, themes, and relationships. Based on the understanding of the study expectations the team agreed on six themes including; 1) Satisfaction of clients and willingness to recommend the service to other users/clients; 2) General client experiences as they moved from home to access services and while in care; 3) Dignified care 4) Provision of information regarding the treatment /ailment by the providers; 5) Privacy and confidentiality; and 6) Asking for money or payment

Regarding quantitative data, data was entered into excel and later exported to Stata version 12 for analysis. Descriptive statistics were computed for the sociodemographic characteristics of the participants and presented as frequencies, percentages and means. The different dimensions of RMNC were analysed as a binary outcome (occurred or not) as reported by the woman. To compute the score for the department (ANC, childbirth and postnatal clinic) of the facility, the attributes of RMC were added with equal weights to create a composite score with maximum of 44 points for ANC, 58 points for childbirth and 51 points for postnatal clinic, generating average scores that were useful to identify the best performing department within the facility. The mean score for the facility was computed to compare the performance of the four public health facilities.

## Results

As it shown in the flowchart below, the total number of women who visited the four public facilities in the month of September 2020 and whose records the team was able to get, was 1,617. Out of this number, 970 (60%) women had their phone numbers captured at the facilities, while the rest did not have their phone contact details. Out of those whose phone details were captured, 449 women were not reachable due to different reasons, while the team managed to reach to 521 (54%) that agreed for an interview. However, the study team was not able to reach 264 participants because either the phones were off despite several attempts, were not interested, spouse with the phone/not consenting for interview or failed to locate the residence.

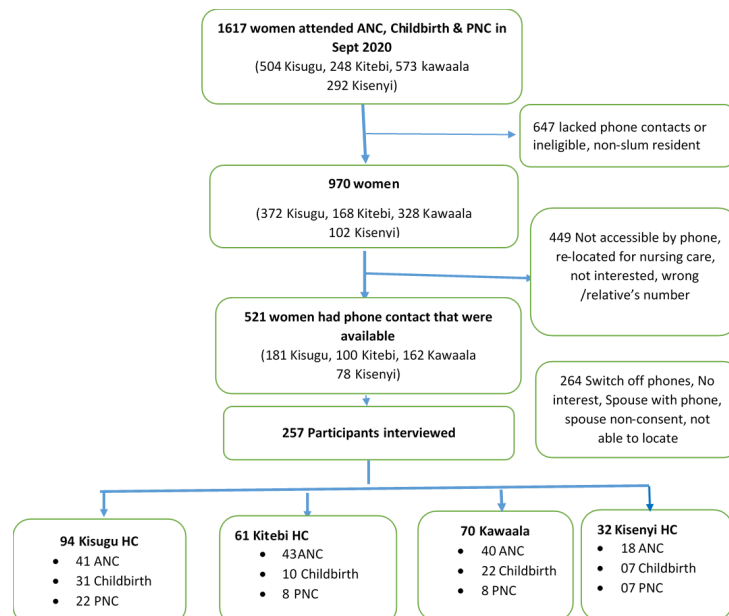


Figure 1: Flow chart show participants reached in the four public health facilities

## Qualitative findings on client satisfaction among women who received antenatal, intrapartum (maternity) and postnatal services from public and private health facilities

On satisfaction of clients and willingness to recommend the service to other users /clients, most of the women were not happy with the services they had received. This was the case for almost all the public facilities. The mothers were not satisfied with the services and didn't intend to go back next time or even refer other mothers to those facilities.

*"I felt so bad on the way I was treated because we go there when we are in sorry state, we don't need to bark at us, we don't to leave us au attended to, that event annoyed me and I can't forget it. A mother at Public health facility, Makindye*

*"personally I can't (go back) because of the way I was treated, I even had one of my neighbours who came and asked me because she knew I delivered from there, she was attending ANC from there whether she can get enough support from Kisenyi, I told her to go and see for herself but she was very hesitant"- A mother who received care at a public health facility*

For some mothers they have resigned to the fact that they still have to seek services at those facilities despite the poor attitudes and treatment received.

*"I used to deliver from Gayaza side, most of my children were delivered from that side and others in Mulago so this it's only this one that I delivered from this way because I just moved this way not long ago and I don't have any other hospital that I can comfortably say that that's my alternative for the moment Kisenyi is my only choice around here - Mother who received care at Public facility Makindye*

However, the women attending private health facilities report high level of satisfaction. In fact, the reverse held true the respondents were happy with the services even if it cost them some money.

*"I was very satisfied because the health workers are good, they chat with the patients, they are so caring, they even ask you whether you have eaten food, you can even send them to go and buy for you something from the shop"* - **A mother who received care at a private health facility, Lubaga**

On general client experiences while in health care facility, the respondents reported having received mixed experiences when they reached the facilities where they sought services. They reported having experienced good and welcoming reception at the private facility and a generally less welcoming reception at public facilities.

*"When we reached the facility they welcomed us, someone came and picked our things from the motorcycle, a lady came and took our language inside, they gave me a bed and the health worker came and made my bed, my mother went back home to attend to my siblings and the health worker remained there attending to me, my husband came and spent a night but the health workers kept checking on me, the health workers even prepared for me some tea at night"* - **A mother that gave birth at a private health facility, Lubaga**

*"When we reached (the facility) the nurse was in her room, my attendants knocked and the nurse came out (because I was very weak) and I knelt down; she asked 'is that one going to deliver from here, what has she been waiting for?', then one of my attendant responded 'nurse don't ask us first help us and show us where to go we will explain to you later, our patient is badly off'"* - **A mother that gave birth at public health facility, Makindye**

However, few clients that received services at public health facilities acknowledged that the health workers had received them well, though this seemed to happen in instances where the health workers already knew the mothers from past health care engagements.

*"On reaching there (the health facility) the nurse received me, I gave her my mother's card and she told me to get on bed and started examining me. She worked on me very well and didn't get problem with them because that's where I have been delivering all my children at Kawaala health Centre"* - **A mother that gave birth at public health facility in Makindye**

As regards dignified care and how clients are handled at the health facility, the study looked at how clients were handled during care at the facility for instance, how were they talked to? Was it with dignity? Were they shouted at or harassed? Were they asked to consent to be examined etc.? As pointed out earlier the mothers noted having experienced better dignified care at private facilities in comparison to public facilities. The women were ignored (left alone unattended),

while some received harsh treatment from the health providers.

*"Even if they found you crying because of the pain they could say don't shout for us, sit down and keep quiet, health workers were harsh you just see a health worker at a distance and imagine what she is going to abuse you. Their facial expression is not bad but what comes out of them is not good, they are rude"* - **A mother at a public health facility, Lubaga**

The respondents from the private facilities reported better experiences with the health workers as regards the care that they sought. The experience of being treated with dignity was mostly reported by mothers that sought care among private facilities

*"I think what I loved most was that at the time of delivery, the health workers weren't harsh on me because when you pregnant, people always tell you that the health workers are harsh, that they slap women but for me I didn't experience any of the sort even mere barking at me didn't happen"* - **Respondent at a private facility in Lubaga**

This experience could partly be explained by the fewer number of clients seen at the private facilities in comparison to public facilities. One respondent however was on side of health workers. She felt that the clients were treated in accordance to how they themselves approached the health workers. Although this should not be the case, from the respondents' narrations this practice seems to be present among health workers at public facilities.

*That (mistreatment) can only happen when you had a problem with the health worker, but if the relationship was good then I don't see why he/she treats you badly. Sometimes we mothers carry our bad behaviors to hospital, this prompts them to revenge in turn. For me I have never gotten any mistreatment from nurses* - **A mother at public health facility in Rubaga**

It was interesting to note that even in the midst of the poor undignified treatment that many respondents talked about, there were experiences of good and polite treatment from other staff in the same facility and even in the same unit. Many mothers seemed to have had better experiences during ANC but undesirable ones during childbirth (in labour wards).

*"so the other nurse also appeared after sometime and I asked her to check on me but she shouted at me that I shouldn't bother her because she told me to take tea and I ignored her and she went out quarrelling without even touching me.... I forced myself and walked to the reception where they normally sit and they were there, I asked them to come check on me because I felt it was time for me to deliver but that nurse who shouted at me for not replying, with a harsh tone ordered me to go back to the room.... after a few minutes another more polite nurse came and checked on me and told me the delivery time had reached, the other (harsh) nurse came also*

and continued to shout at me but colleague told her to stop until am done delivering and the she can say whatever she wanted" - **A mother at public facility in Makindye division**

As regards to right to information from providers regarding the ailment suffered or treatment received, the respondents were asked if they were provided information about their illness or education about how to take care of their babies. From their responses it was apparent that the health workers preferred to give information about how to take care of their children to new mothers. Once they realise that a mother had given birth before they do not even bother to try to educate them at all. This applied to both the private and public facilities.

"They didn't tell me that because they asked me how many children do you have, I told them I have two and this one is the third one so she thought I know how to feed baby and she just told me on 20th November 2020, come back here for examination"- **A mother at private facility in Makindye division**

"They usually do that (educating mothers) when it's your first born but for us who are veterans they don't. Even when you reach hospital health workers usually asks the number of children you have, and she doesn't give you much attention if it's not your first delivery" - **A mother at public facility in Lubaga division**

However, during ANC the respondents in some facilities noted that they were offered health education either as individuals or as groups

"They even teach us and they explain to us the meaning of the results they have found and they ask you if you have some pain experiences then they recommend the appropriate medicine for that"- **A mother at public facility in Lubaga division**

On privacy and confidentiality during clerking and examination, respondents generally felt that the facilities (public & private) offered privacy. To a great extent, they felt that their privacy and confidentiality were respected largely on account of the way the facilities were organized either by having a separate room or rooms separated by curtains.

"You go one by one into the examination room and when you a ready you don't come back you stay there and deliver" - **A mother at public facility in makindye division**

"Yes, there was enough privacy because it was inside a room with curtains and could only be accessed by health workers and at the time of my check up, we were only, two me and the nurse"- **A mother at a public facility in Lubaga division**

### Asking for inappropriate payment during care while at the facility outside normal payments

There were experiences of seeking inappropriate payments reported by the respondents at almost all public facilities, but it was not even mentioned at the private facilities. In some instances, the payments were not requested for directly but indirectly by withholding services or outright patient neglect.

"yes (they asked for) UGX 20,000 but we accept because we know there is nothing for free in this Uganda of ours... they get you in your time of need and you have no option but pay in fact if I had that money then I would have given it to them but that money is a lot" - **A mother at a public facility in Makindye division**

No, it (asking for money) didn't happen at all and we spent the whole day and nurse would come and check on me and my baby and asked have you eaten and breast fed the baby, she told me to start breast feeding the baby - **A mother at a public facility in Makindye division**

When money is asked directly from the clients, usually it is in the guise of buying the items to use such as gloves or medicines because it is common knowledge that the supplies at government facilities are never enough.

"The health worker told me about the buying of things within the hospital, I asked her (whether this applied to everything we needed), she told me yes, I also asked the total amount of money and she said UGX 60,000.... This was for ten pairs of gloves, Cotton and other things they use in the delivery process; she didn't give me any kind of list of those things so I don't know exactly what else she would be providing - **A mother at a public facility in Makindye division**

### Findings from assessing public health facilities for the best performing facility, and departments at the facilities.

A total of 257 women were interview. Out of these, 142 had visited the facilities for ANC, 70 for delivery while 45 had visited the facilities for PNC services. The table 4 below represents the numbers of women reached per department in each facility, their characteristics, and those reporting disrespect, and abuse during their visit to the facilities.

Characteristics	Overall (N=257)	ANC (n=142)	Childbirth (n=70)	Postnatal (n=45)
<b>Non-consented care before</b>				
physical exam	104/253 (41.1%)	61/140 (43.6%)	31/70 (44.3%)	12/43 (27.9%)
Private part examination	30/88 (34.1%)	3/4 (75%)	23/70 (32.9%)	4/14 (28.6%)
<b>Non-dignified care</b>				
Shouting/scolding	42/251 (16.7%)	14/136 (10.3%)	24/70 (34.3%)	4/45 (8.9%)
<b>Neglected</b>				
Ignored when needed help	20/248 (8.1%)	9/139 (6.5%)	9/68 (13.2%)	2/41 (4.9%)
Physical abuse	6/201 (3.0%)	2/131 (1.5%)	4/70 (5.7%)	-
Staff was verbally aggressive	15/152 (9.9%)	8/42 (19.1%)	5/70 (7.1%)	2/40 (5%)
<b>Inappropriate demand for payment</b>				
Staff asked for a bribe	164/245 (66.9%)	117/132 (88.6%)	4/69 (5.8%)	43/44 (97.7%)
Threatened not take if had no supplies	17/68 (25%)		17/68 (25%)	-
Detention in facility for failure to pay				
<b>Health facility system perceived challenges</b>				
Clinic crowded	150/256 (58.6%)	102/141 (72.3%)	34/70 (48.6%)	14/45 (31.1%)
Inadequate staff	144/251 (57.4%)	74/138 (53.6%)	45/70 (64.3%)	25/43 (58.1%)
Dirty environment	4/255 (1.6%)	1/140 (0.7%)	3/70 (4.3%)	0 (0%)
Inaccessible water	113/230 (49.1%)	75/119 (63.0%)	33/67 (49.3%)	5/44 (11.36%)
Not offered tea to drink while in labour	37/69 (53.6%)	-	37/69 (53.6%)	-
Inaccessible toilets	21/234 (9.0%)	11/123 (8.2%)	7/68 (10.3%)	3/43 (7.0%)
Inadequate equipment & supplies	105/250 (42%)	73/136 (53.7%)	26/69 (37.7%)	6/45 (13.3%)
Not linked to childbirth registration	25/68 (36.8%)		25/68 (36.8%)	-

(continued on next page)



**Table 2:** Occurrence of disrespect and abuse during antenatal care, childbirth, and postnatal care (immunisation) among participants from four public health facilities in Kampala, Uganda.

Table 2 above shows different forms of disrespect and abuse as reported by the clients who received care at the four public health facilities. The most reported forms of disrespect and abuses across the continuum of care were; Failure of the health providers to introduce themselves to the clients (54.6%), no consent sought before physical examination (41.1%) and vaginal examination (34.1%), failure to educate women on food to eat (56.6%) and feed their babies (42.0%). Health workers soliciting for a bribe was reported in 88.6% and making threats in 59.7%. The respondents reported crowded health facilities (58.6%) with inadequate staff (57%). However, the facilities performed well on cleanliness. Almost one in two women had no access to water, more in the antenatal and childbirth clients.

Characteristics	Overall (N=257)	ANC (n=142)	Childbirth (n=70)	Postnatal (n=45)
Likely to use the facility in future	236/255 (92.6%)	134/140 (95.7%)	60/70 (85.7%)	42/45 (93.3%)
Recommends other women	245/254 (96.5%)	136/139 (97.8%)	66/70 (94.4%)	43/45 (95.6%)
Computed mean score for facility & Dept (sd)				
Health facility (TBN*_01)	73.6%	73.0% ± 4.4	71.5% ± 9.8	82.3% ± 7.7
Health facility (TBN*_02)	60.5%	59.2% ± 7.9	61.8% ± 5.7	66.8% ± 11.9
Health facility (TBN*_03)	65.0%	55.3% ± 10.0	66.5% ± 16.5	81.0% ± 10.6
Health facility (TBN*_04)	69.2%	59.6% ± 11.7	74.4% ± 8.8	84.1% ± 9.7

\*TBN: to be named

**Table 3:** Client's acceptability of the facility and average scores for facility based on the positive respectful maternity care

On table 3, almost all women expressed that they will in future utilize the facility for the services (92.6%) and recommend other women (96.5%).

The recognition and award of the health facility had not yet happened, and we opted to keep the names of the facilities anonymous till the function is conducted. This also applies for the recognition of the individual health provider. The best performing facility is TBN\_01 with score of 73.6%, meanwhile across all the facilities, postnatal departments excelled.

### Assessing and recognizing the best performing individual within the public facility

Clients were also asked to name individual health providers who had provided outstanding services to them in the month of Septembers, 2020. This was based on the experience the women had with the health providers when they visited the facilities and specifically, the different departments within the facility that they visited. Table 4 below shows the names of health providers whom the women felt should be recognised for their exemplary care.

Best MNH providers per facility	Freq
Kisenyi HC IV	
Masowo_Kis01	3
Masowo_Kis02	3
Masowo_Kis03	3
Kitebi HC III	
Masowo_Kit01	7
Masowo_Kit02	5
Kawaala HC IV	
Masowo_Kaw01	5
Masowo_Kaw02	2
Kisugu HC III	
Masowo_Kisu01	3
Masowo_Kisu02	2
Masowo_Kisu02	2

## Conclusion

1. MNCH services at public health facilities are perceived by mothers as less satisfactory with several of them feeling that health providers are harsh to them, not respectful and not treating them in dignified manner.
2. Private facilities were generally perceived as providing good services and several mothers will recommend or seek care from them in future.
3. Privacy and confidentiality in both public and private facilities was acceptable to the mothers.

## Way forward

1. The results of the findings shall be disseminated to health facilities with the hope that respective providers will undertake reflection and suggest action to improve quality of MNH services.
2. The reward and recognition of the health facilities, departments and individual is hoped to motivate health providers to be more accountable in their actions and promote provision of RMC
3. As a program, MaNe will repeat this survey to evaluate the changes that have occurred using a similar methodology.

## References

1. Azhar, Z., O. Oyebode, and H. Masud, Disrespect and abuse during childbirth in district Gujrat, Pakistan: A quest for respectful maternity care. PLoS One, 2018. 13(7): p. e0200318.
2. Denny, E., Respectful maternity care needs to be the standard for all women worldwide. BJOG, 2018. 125 (8): p. 943.
3. Uganda Bureau of Statistics - UBOS and ICF, Uganda Demographic and Health Survey 2016. 2018, UBOS and ICF: Kampala, Uganda.
4. Heshima:, CLIENT PROVIDER INTERACTION and CASE NARRATIVE GUIDE: Promoting dignified and respectful care during childbirth in Kenya. Population Council : Translating Evidence into action.

## Acknowledgements



**MAKERERE UNIVERSITY**  
COLLEGE OF HEALTH SCIENCES  
SCHOOL OF PUBLIC HEALTH



**USAID**  
FROM THE AMERICAN PEOPLE



Please visit the KCCA COVID-19 Response Hub  
<https://coronavirus-response-19-ctf-kcca-gisservices.hub.arcgis.com/>