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Magnitude and Consequences of Maternal, neo-natal and child health (MNCH) & Family Planning (FP) Service Congestion in KCCA Public Health Facilities

Findings from a Rapid Assessment of Utilization and Capacity at Kawaala and Kisenyi Health Centre IVs

February 2022

Together we can transform Kampala city

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1. BACKGROUND & MOTIVATION

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This rapid assessment aimed to validate and update common understandings about service congestion in Kampala's public facilities

Prior to the study, widespread impressions included:

- **Public facilities are overcrowded with clients** *(see photo at right).*
- **This congestion undermines service quality, client satisfaction, and health worker morale. Specific harms include:**
  - Rushed consultations
  - Early discharges
  - Stockouts of drugs and supplies
  - Long wait times
  - Staff burnout
- **These realities are often taken for granted, but little work has been done to quantify service congestion or characterize its effects.**

Triage area at Kisenyi HC IV

Photo credit: Mugisha Michael

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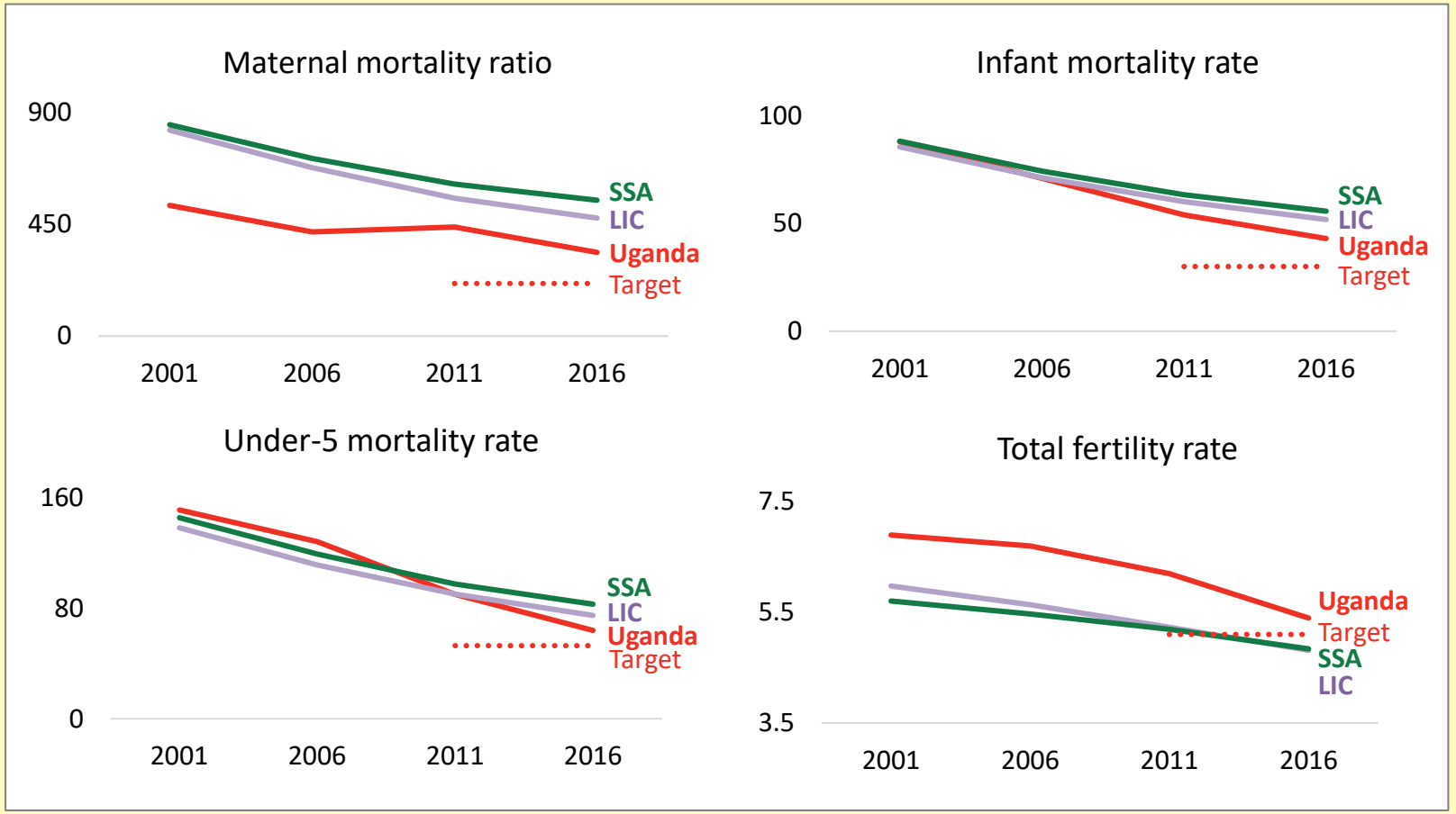
Uganda has outperformed regional and income peers on some MNCH outcomes but still falls short of its own targets

Graph 1: Key MNCH indicator performance over time



Sources: MOH 2020a, UBOS and ICF 2018, World Bank 2021

Notes: Maternal mortality expressed in deaths per 100,000 live births; infant and under-5 mortality in deaths per 1,000 live births, and fertility in births per woman aged 15–49.

Abbreviations: LIC = low-income country; SSA = sub-Saharan Africa (only includes IBRD and IDA borrowers)

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Low coverage of key services hinders further progress nationally; coverage is often better, but still lagging, in urban areas like Kampala

Indicator	Kampala	Uganda	National target
ANC 4th visit	68% (2020/21)	42% (2019/20)	48% (2019/20)
Skilled birth attendance	96% (2020/21)	74% (2019/20)	90% (2019/20)
PNC within 2 days of delivery	78% (2020/21)	54% (2019/20)	90% (2019/20)
Fully immunized by 1 year	80% (2020/21)	82% (2019/20)	95% (2019/20)
Under-5 vitamin A 2nd dose	30% (2020/21)	21% (2019/20)	66% (2019/20)
Modern contraceptive prevalence (share of currently married women)	65% (2016)	35%* (2016)	50% (2019/20)

Sources: KCCA 2020, 2021; MOH 2020a; Otim 2020; UBOS and ICF 2018

Note: * mCPR among sexually active unmarried women was 47% in 2016.

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There are few government-managed health facilities to meet growing service demand in urban areas, such as Kampala

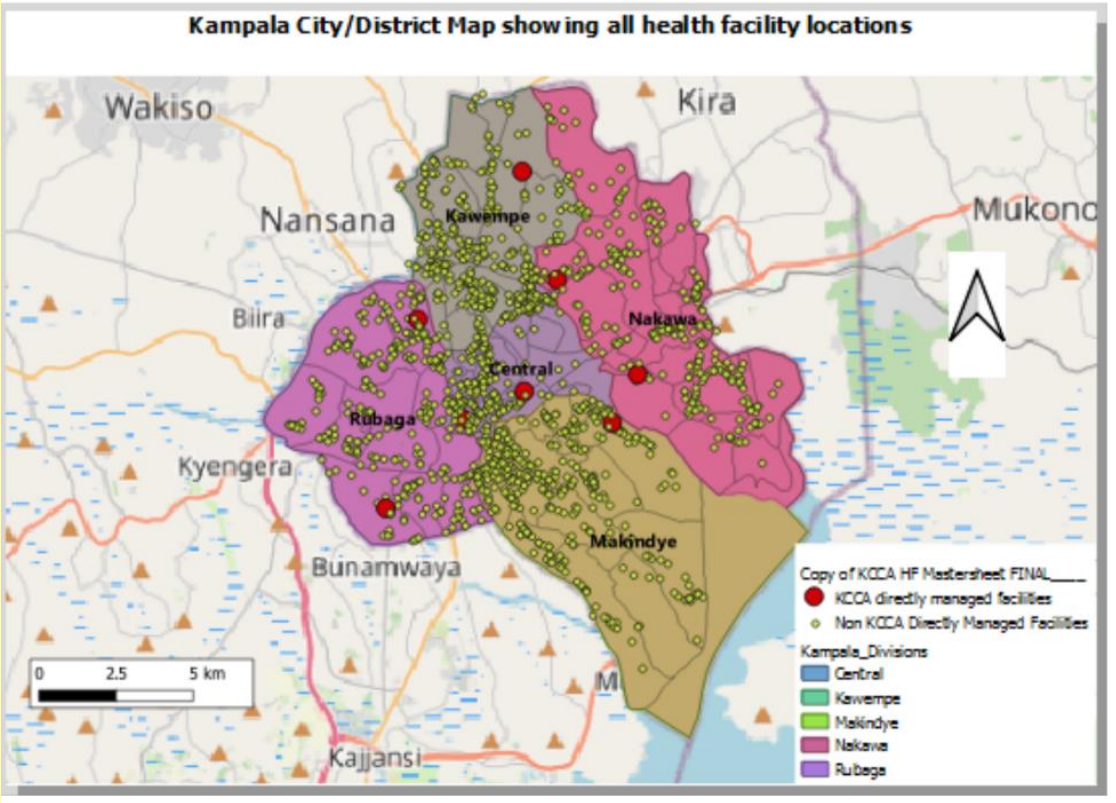

Image Source: KCCA Directorate of Public Health & Environment

- **Kampala has only 26 publicly-managed health facilities for a population of about 5 million people (residents plus daily commuters)** (KCCA 2021).
- **The Kampala Capital City Authority (KCCA) only manages 8 of these facilities** *(see map at left)*, **whose combined catchment population is less than a half million** (KCCA 2021)**. MOH manages all other facilities.**
- **21 of the public facilities, including 7 managed by the KCCA, offer MNCH and FP services** *(see table on next slide).*

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Private facilities can make important contributions to achieving universal health coverage (UHC) and other public health goals

Facility counts by management in Kampala

Facility management	# (and %) of facilities	# offering MNCH and FP services
KCCA	8 (< 1%)	7
MOH	18 (1%)	14
PNFP	61 (4%)	41
Private (other)	1,410 (94%)	844
Totals	**1,497 (100%)**	**906**

Source: KCCA 2019, 2021

Abbreviations: KCCA = Kampala Capital City Authority; MOH = Ministry of Health; PNFP = private not-for-profit

- **Nationally, private facilities handle 21% of deliveries, 39% of modern contraceptives, and 57% of childhood illness services.**
- **Their role is even greater in Kampala: 36% of deliveries, 73% of modern contraceptives, and 82% of childhood illness services** (UBOS and ICF 2018; Montagu and Chakraborty 2021).
- **98% of Kampala's health facilities are privately managed; of those, the majority offer MNCH and FP services** *(see table at right).*
- **With the few publicly-managed facilities in Kampala so overburdened, there is growing interest in exploring ways for the government to purchase health services from private facilities.**

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However, many in Kampala cannot easily access services from private facilities without assistance

- **Clients face a range of financial, logistical, informational, and social barriers to accessing services** (Morgan et al. 2017; Atusiimire et al. 2019).
- **The government remains committed to providing free services in public facilities.**
- **In contrast, private facilities charge user fees, which most city residents cannot afford, and very few households have health insurance.**
- **Consequently, demand for services remains concentrated at public facilities.**
- **Prior efforts to connect poor clients with private facilities via vouchers demonstrated that involving the private sector can improve access to high-quality maternal health services at a reasonable cost. But these initiatives were unsustainable due to their reliance on donor funding** (Bua et al. 2015; Jordanwood et al. 2021).

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KCCA and ThinkWell assessed MNCH and FP service congestion to inform design of a new public-private purchasing model

The rapid assessment sought to answer three key questions:

- How congested are MNCH and FP services in the selected facilities?
- To the extent there is congestion and what drives it?
- How does congestion affect access and service quality?

Assessment findings are meant to inform ongoing policy discussions regarding the following:

- Should KCCA purchase services from private providers?
- If so, which services should be prioritized?
- What benefits might be expected from decongesting KCCA-managed facilities?

The study launched in November 2020 and preliminary findings were presented to the KCCA in March 2021. Focus group discussions were conducted in April 2021 to validate and unpack the findings.

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2. ASSESSMENT DESIGN

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Setting for the rapid assessment: Kawaala Health Center IV and Kisenyi Health Center IV

These facilities were selected due to high volumes and large catchment populations relative to other KCCA facilities (KCCA 2020).

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Summary of the rapid assessment design

Design aspect	Details	
Setting	Two purposively selected KCCA-managed facilities: Kawaala Health Center (HC) IV & Kisenyi HC IV*	
Methodology	Mixed-methods, combining quantitative analysis of facility capacity versus utilization and qualitative analysis of facility staff members' knowledge, attitudes, and behaviors regarding clients and service congestion and its consequences. Quantitative data collection and key informant interviews were conducted in parallel, followed by focus group discussions after preliminary analysis.	
Services	Antenatal care (ANC), labour and delivery (L&D), post-natal care (PNC), and family planning (FP)	
Data sources**	Utilization:	District health information system (DHIS2) and facility registers for visits; key informant interviews with facility personnel for delivery-related bed occupancy
	Capacity:	Clinical guidelines; key informant interviews with facility personnel
	Consequences:	Key informant interviews and focus group discussions with facility personnel
Time period	Monthly capacity-utilization comparisons for fiscal years (FYs) 2018/19 and 2019/20† **Note:** Uganda's first COVID-19 lockdown occurred during the second half of FY 2019/20 Data validation and interviews conducted on site during December 2020 and January 2021 Focus group discussions were held in April 2021 following review of preliminary findings	

* HC (Health Centre) IVs are the service delivery level below district hospitals, with a target population of 100,000 people. HC IVs are supposed to have operating theatre, in-patient services, and laboratory services, and they serve as referral facilities for the HC IIs and HC IIIs under its jurisdiction. HC IVs are staffed by nurse aides, qualified nurses, clinical officers and doctors (MOH 2014).

**For more details on data sources, see Appendix 1.

†Fiscal years run from July of the lead year through June of the outer year.

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Estimating capacity and congestion

- Facility capacity was defined for each service based on data and assumptions for:
  - Personnel
  - Time spent per visit
  - Hours worked per day
  - 30 days of operation per month

- A service was considered congested if utilization exceeded estimated capacity, based on time norms for staff (and beds for labour and delivery services)

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3. FINDINGS

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Profiles of Kawaala & Kisenyi HC IVs

- **As in all publicly managed facilities, all services are supposed to be free to clients.**
- **Kawaala was upgraded from HC III to HC IV during FY 2018/19.**
- **80% of clients at Kisenyi come from outside its catchment area compared to 20% at Kawaala.**
- **Both facilities added beds during the period covered by the study.**
- **The triage spaces in both facilities are overcrowded because they are also where staff provide health education to mothers.**

Selected facility attributes (FY 2019/20)

	Kawaala HC IV	Kisenyi HC IV
Catchment pop.	54,367	104,347
Doctors	2	2
Nurses/Midwives	15	25
Operating theatre	1	1
Triage spaces	1	1
Consultation rooms	1	1

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Monthly facility capacity for MNCH and FP services

- **For ANC, L&D, PNC, and FP services, the capacity for human resources was estimated based on the number of midwives assigned to those services and health workers' estimates of the amount of time a midwife needs to spend with each client to deliver a high-quality service.**
- **For L&D, physical capacity was also estimated based on the number of beds in each facility, assuming an average of six hours of bed use per delivery.**
- **FP counseling is typically delivered to groups of clients, so the time estimates used for capacity calculations were based on the average time required for individual consultations and method provision following group counseling.**

Monthly capacity by service

Service	Kawaala HC IV	Kisenyi HC IV
ANC midwives	1	2
ANC capacity (# of visits)	960	1,920
L&D beds	2018/19: 12 2019/20: 23	45
L&D capacity (bed days)	2018/19: 360 2019/20: 690	1,350
L&D midwives	8	14
L&D capacity (# of births)	320	560
PNC midwives	1	2
PNC capacity (# of visits)	480	960
FP midwives	1	1
FP (# of visits)	480	480

Note: capacity computations are shown on the next slide.

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Computations for service-specific capacity

Service unit(s)	Monthly capacity per midwife or bed	Kawaala HC IV monthly capacity	Kisenyi HC IV monthly capacity
ANC: visits	$\frac{30\ days}{month} \times \frac{8\ hours}{day} \times \frac{1\ visit}{0.25\ hours} = \frac{960\ visits}{month}\ per\ midwife$	1 midwife → 960 visits	2 midwives → 1,920 visits
L&D: bed days, births	$\frac{30\ bed\ days}{month}\ per\ bed$ $\frac{30\ days}{month} \times \frac{8\ hours}{day} \times \frac{1\ birth}{6\ hours} = \frac{40\ births}{month} per\ midwife$	2018/19: 12 beds → 360 bed days 2019/20: 23 beds → 690 bed days 8 midwives → 320 births	45 beds → 1,350 bed days 14 midwives → 560 births
PNC: visits	$\frac{30\ days}{month} \times \frac{8\ hours}{day} \times \frac{1\ visit}{0.5\ hours} = \frac{480\ visits}{month}\ per\ midwife$	1 midwife → 480 visits	2 midwives → 960 visits
FP: visits	$\frac{30\ days}{month} \times \frac{8\ hours}{day} \times \frac{1\ visit}{0.5\ hours} = \frac{480\ visits}{month}\ per\ midwife$	1 midwife → 480 visits	1 midwife → 480 visits

Assumptions and sources:

- For ANC, PNC, and FP services, the capacity norms of 1 visit per 0.25 hours, per 0.5 hours, and per 0.5 hours, respectively, were based on the average of estimates provided by midwives during key informant interviews.
- For deliveries, monthly capacity was assumed to be 30 bed days per bed and 1 birth per 6 hours for midwives, based on bed capacity data in the DHIS-2 and estimates provided by midwives during key informant interviews.

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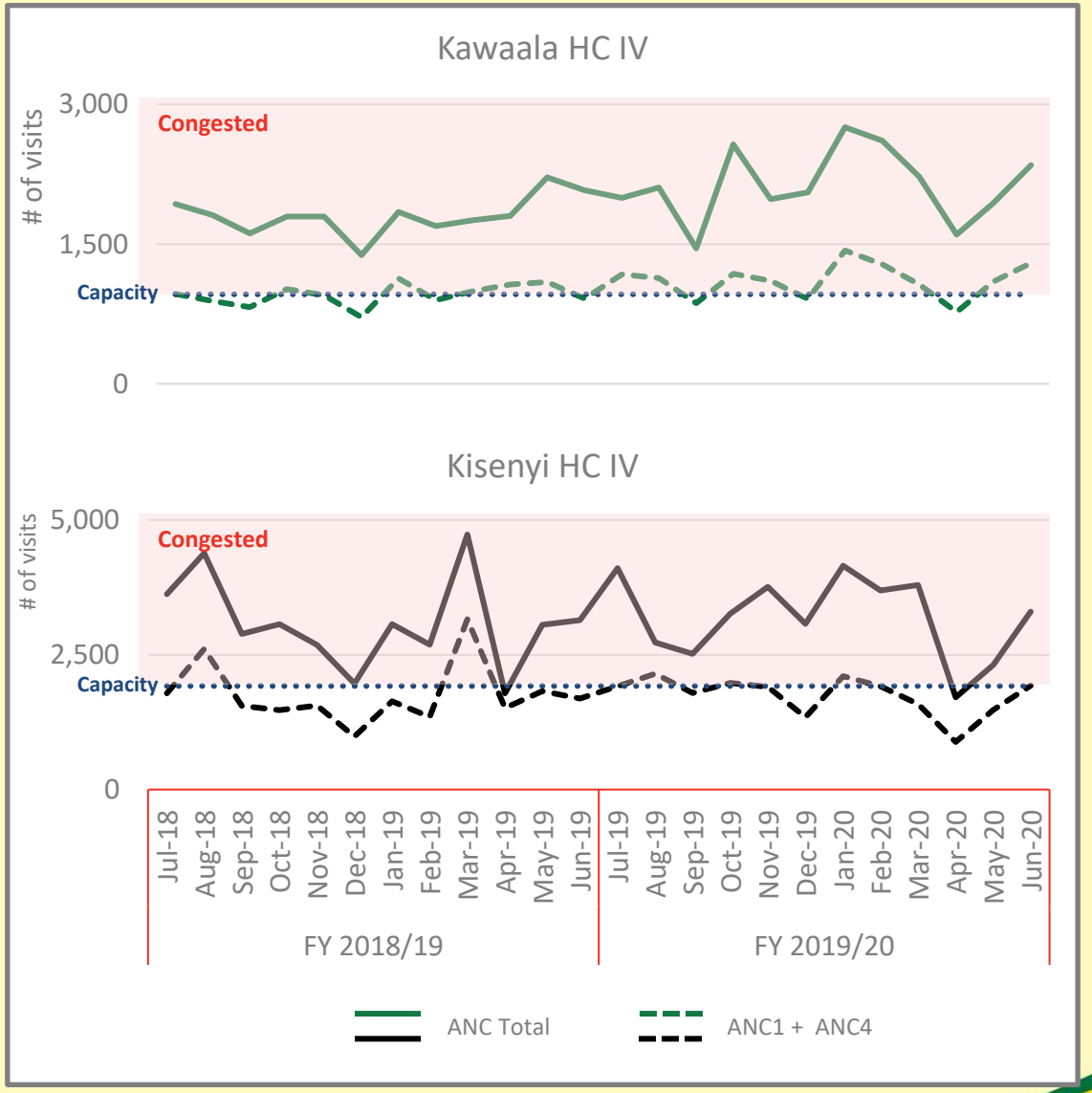
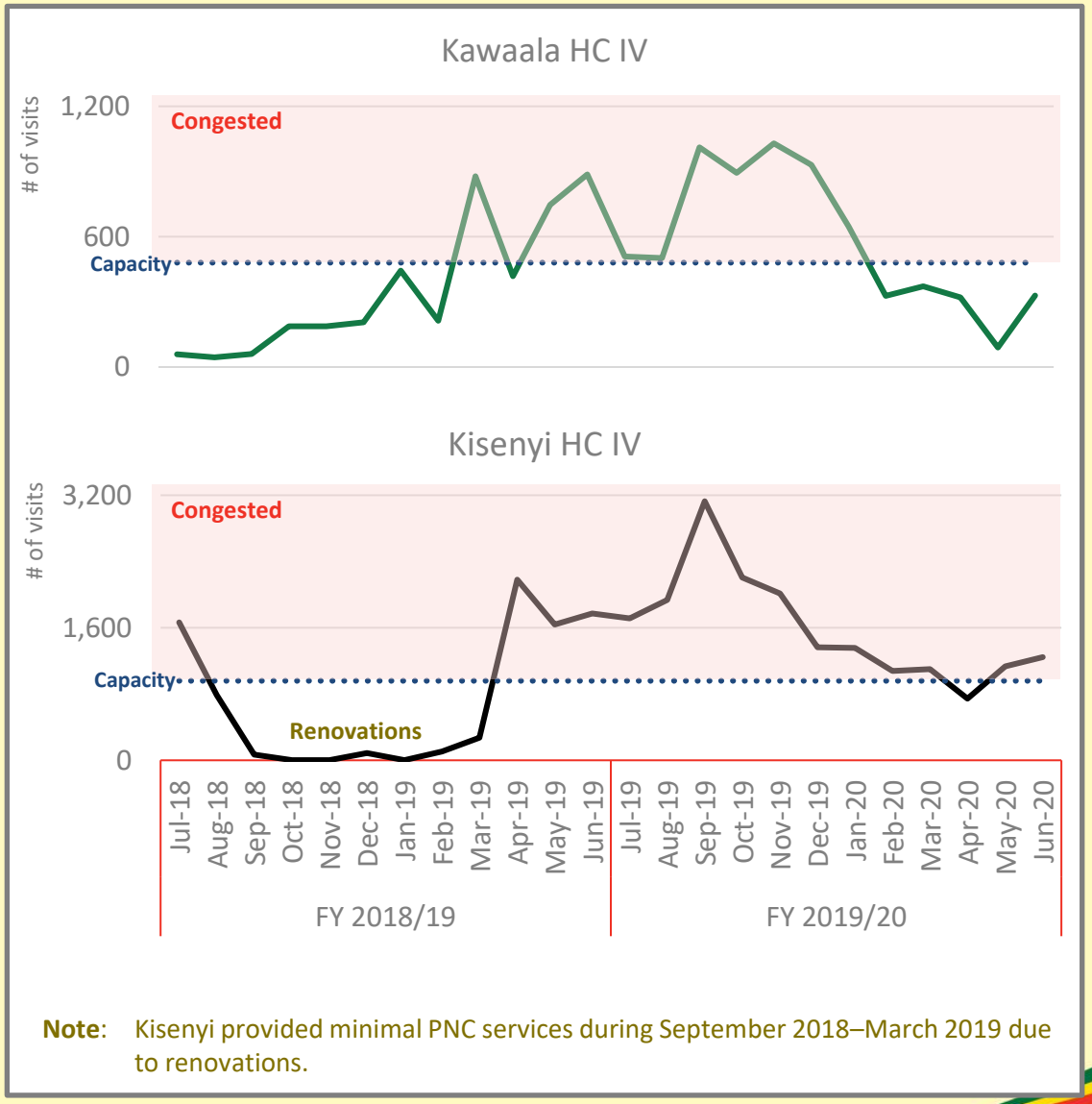
ANC services were very congested at both facilities, especially Kawaala

- ANC utilization increased in both facilities between FY 2018/19 and 2019/20.
- Visits quickly recovered following the COVID-19 lockdown in early 2020.
- ANC visits at Kawaala exceeded capacity in all 24 months and at Kisenyi in 22 of 24 months.
- In FY 2019/20, average monthly ANC utilization was 223% of capacity at Kawaala and 167% of capacity at Kisenyi.
- On average in FY 2019/20, there were more than 39 excess daily ANC visits per midwife at Kawaala and 21 at Kisenyi.



PNC services were also congested, though not as severely as ANC

- **Monthly PNC utilization increased on average at both facilities, though there were steep declines in FY 2019/20 due to COVID-19.**
- **PNC visits exceeded midwife capacity in 10 of 24 months at Kawaala and 15 of 24 months at Kisenyi (and all but one non-renovation month).**
- **In FY 2019/20, average monthly PNC utilization was 121% of midwife capacity at Kawaala and 165% at Kisenyi.**
- **On average in FY 2019/20, there were more than three excess daily PNC visits per midwife at Kawaala and more than 10 at Kisenyi.**



Note: Kisenyi provided minimal PNC services during September 2018–March 2019 due to renovations.

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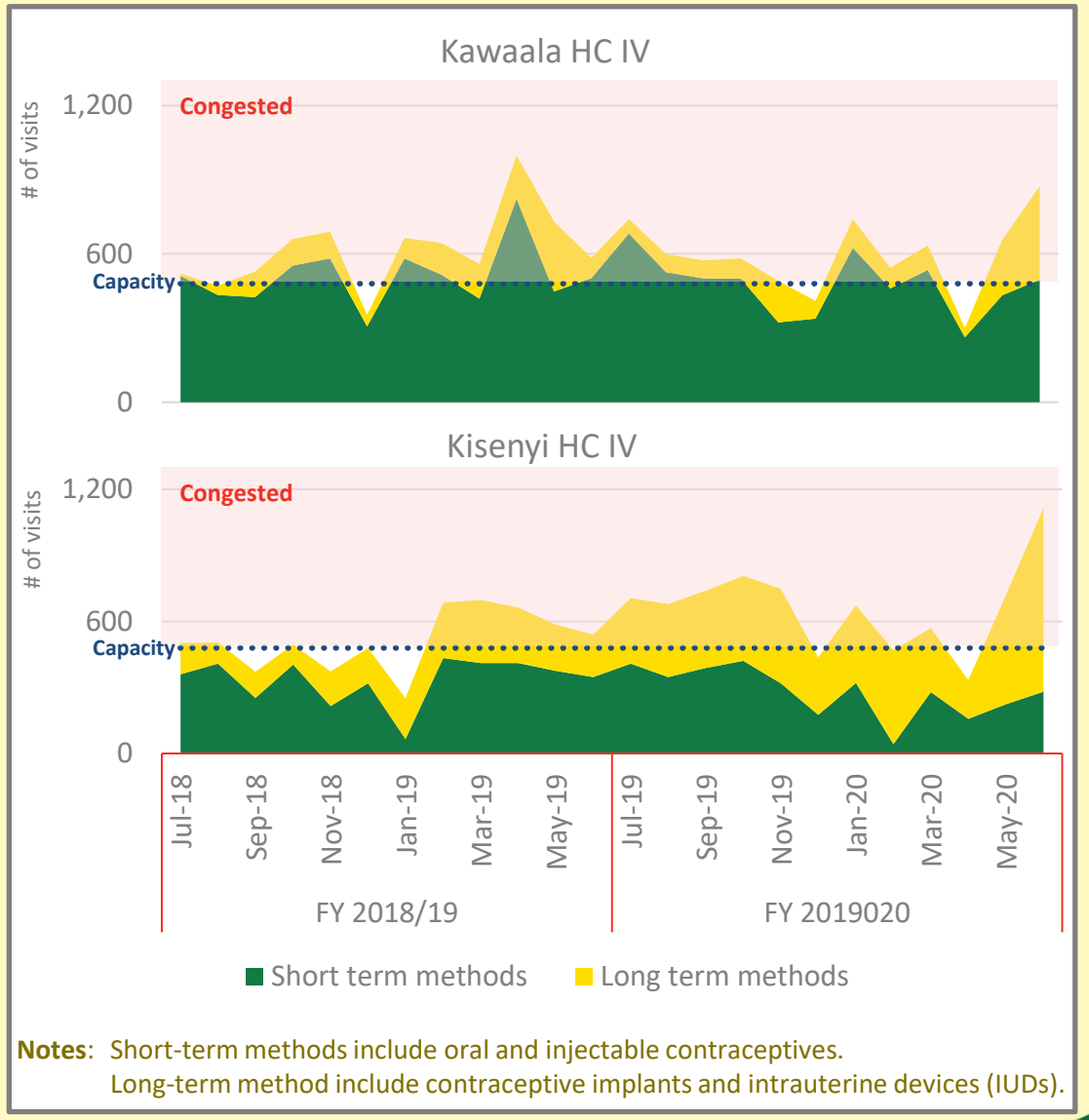
FP congestion reduced at Kawaala and worsened at Kisenyi

- Average monthly FP visits decreased slightly at Kawaala while increasing at Kisenyi.
- Clients at Kawaala mostly use short-term methods; at Kisenyi they increasingly use long-term methods.
- At both facilities, use of short-term methods decreased slightly while long-term uptake increased, especially at Kisenyi (117% growth from FY 2018/19 to FY 2019/20).
- FP visits at Kawaala exceeded capacity in 20 of 24 months and at Kisenyi in 17 of 24 months.
- In FY 2019/20, average monthly FP utilization was 124% of capacity at Kawaala and 139% at Kisenyi.
- On average in FY 2019/20, there were nearly four excess daily FP visits per midwife at Kawaala and more than six at Kisenyi relative to capacity.



Notes: Short-term methods include oral and injectable contraceptives.
Long-term method include contraceptive implants and intrauterine devices (IUDs).

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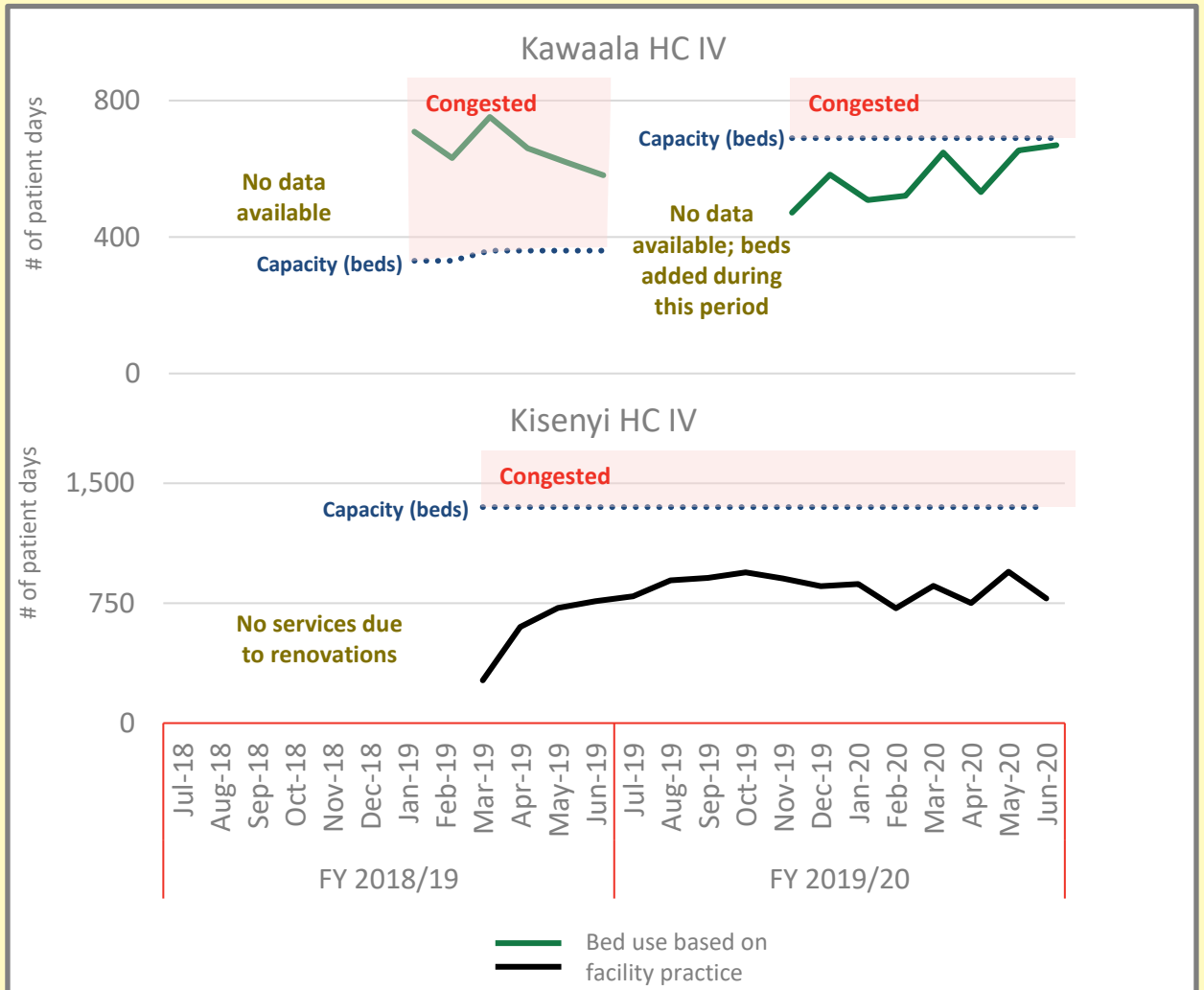
Following expansion, bed space was sufficient for labor and delivery services in both facilities…

- Bed use did not exceed capacity at Kisenyi in any month, and the addition of beds allowed Kawaala to accommodate its client load.
- In FY 2019/20, the estimated need for beds was 83% of capacity at Kawaala and 63% at Kisenyi.
- By the end of FY 2019/20, Kawaala was using nearly all its bed space, while Kisenyi still had spare bed capacity.



Notes: Kawaala did not report on inpatient services prior to upgrading to an HC IV in January 2019. Kawaala's reports for July-October 2019 were misplaced during facility relocation. Kinsenyi was not conducting deliveries during July 2018-February 2019 due to renovations.

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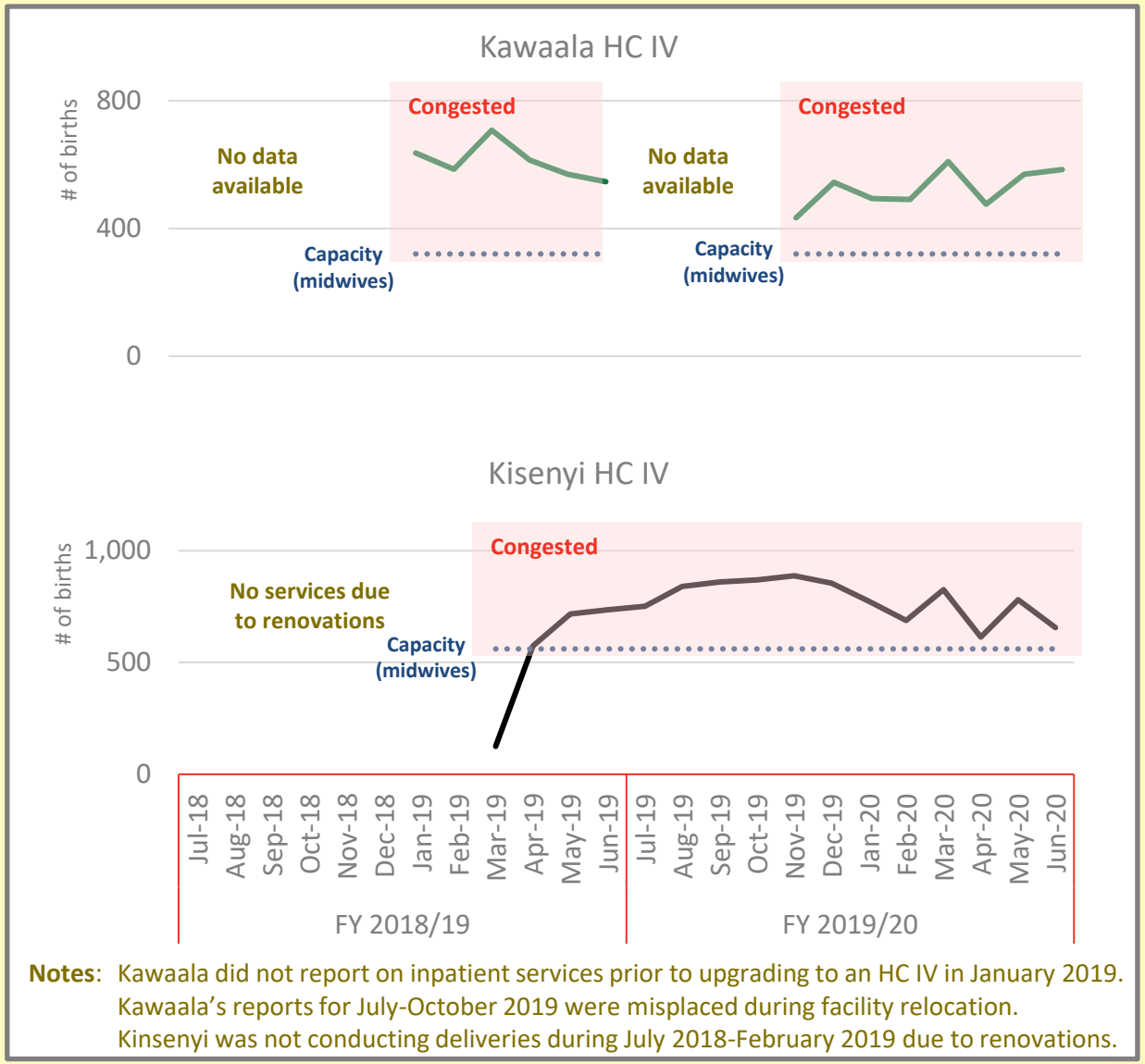
…however, the mother-to-midwife ratio was also very high for L&D

- **Monthly births per midwife exceeded capacity every month at Kawaala and all but one at Kisenyi.**
- **In FY 2019/20, average monthly births were 164% of midwife capacity at Kawaala and 140% of capacity at Kisenyi.**
- **On average in FY 2019/20, there were around seven excess daily births at each facility relative to midwife capacity.**



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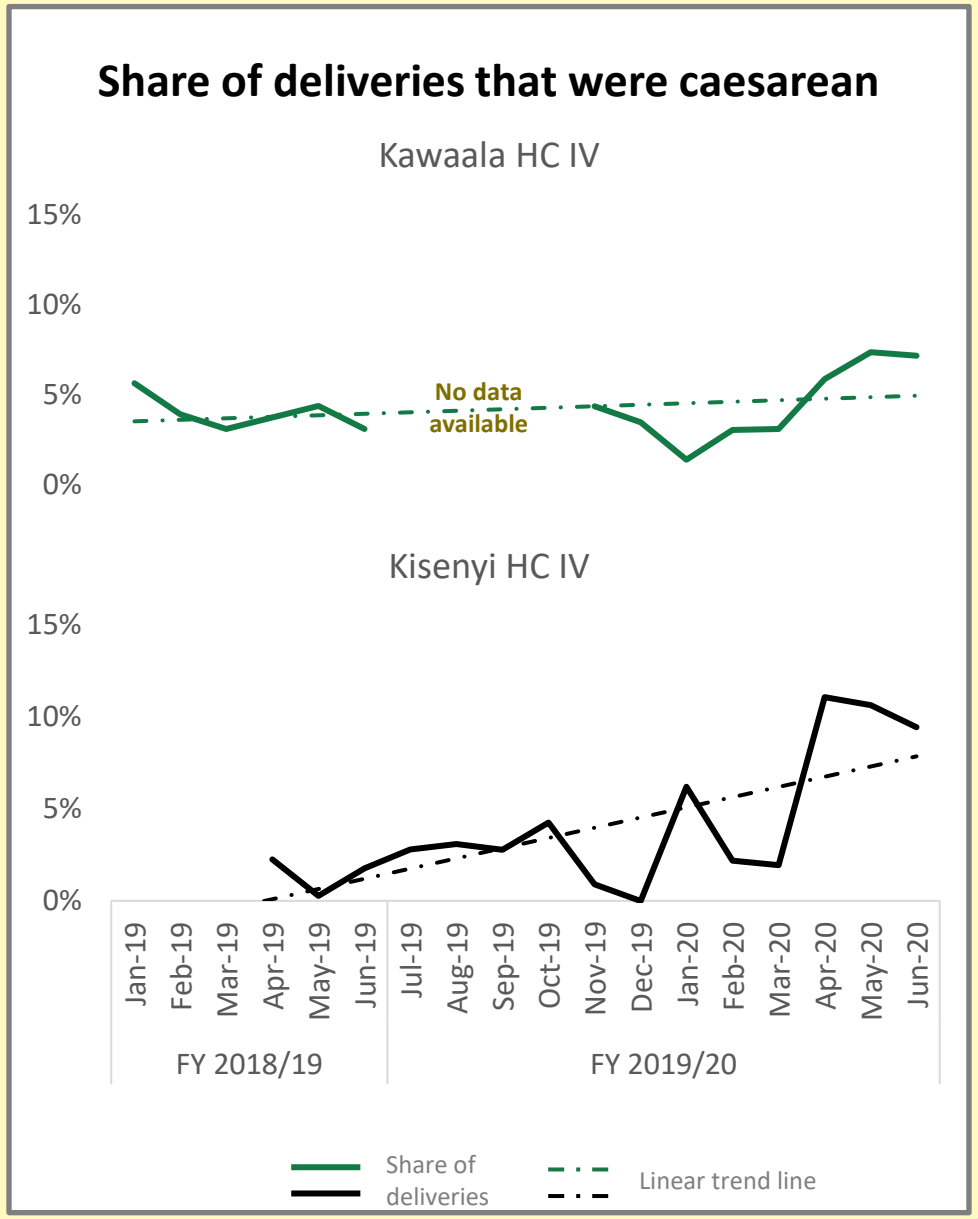
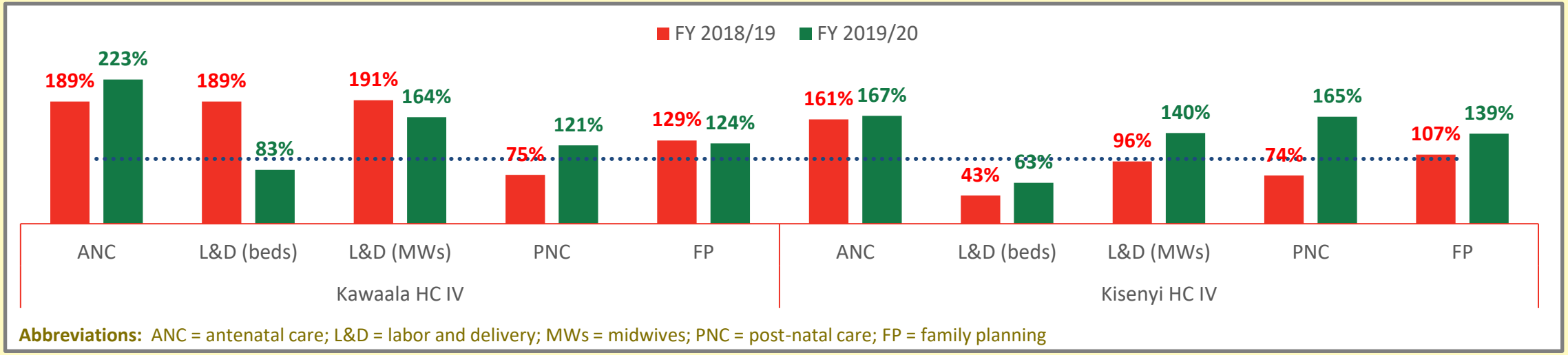
Growing rates of C-sections could strain capacity in the future

- The share of total deliveries by C-section increased in both facilities, especially Kisenyi.
- The rate remained well below the 15% of deliveries estimated to require C-sections per WHO guidelines.
- If the C-section rate continues to grow, it could put pressure on bed capacity because the length of stay for mothers delivering by C-section is three times longer than for those with normal deliveries.
- Some of the growth was due to renovations at Mulago National Referral Hospital, so both facilities received extra clients needing C-sections during the study period.
- Another driver of growth was the expansion of bed capacity at both facilities.
- Increasing numbers of C-sections raise the need for full-time anesthetists at both facilities.



Quantification of service congestion – summary



Abbreviations: ANC = antenatal care; L&D = labor and delivery; MWs = midwives; PNC = post-natal care; FP = family planning

- **ANC, PNC, and FP were all congested in both facilities, with demand for most increasing relative to capacity between FY 2018/19 and FY 2019/20.**
- **The COVID-19 lockdown in early 2020 temporarily alleviated congestion, though these facilities may have absorbed demand from inactive sites during that period.**
- **As of FY 2019/20, both facilities had enough beds to handle growing demand for labour and delivery services, with spare bed capacity greatest at Kisenyi; however, the mother-to-midwife ratios are much higher than ideal.**

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Health workers' perspectives on the drivers of service demand

Clients prefer these facilities' services

- Services are free and perceived by clients to be of high quality.
- Other providers, both public and private, refer clients to these facilities.
- The facilities are strategically located: Kawaala services the urban poor plus growing suburbs, while Kisenyi is central and draws both residents and commuters.
- Other facilities were inactive during the COVID-19 lockdown in FY 2019/20.

Incentives work!

- Results-Based Financing (RBF) payments have motivated the facilities to attract more clients to these services, with some spillover effects (e.g., health workers try to attract women for PNC visits so they can also be offered FP counseling).
- Mothers attend PNC services at public facilities to secure birth registration certificates.

Clinical practices attract clients

- Mothers are counseled and booked for PNC visits when discharged after delivery.
- Kisenyi offers FP counseling to all women who come seeking MNCH services, while Kawaala mainly provides FP counseling to PNC clients.

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Health worker-reported consequences of congestion

Health workers and facility leaders validated many of the prior impressions about the harms of congestion, including:

- ✓ Hasty consultations
- ✓ Early discharges
- ✓ Long wait times
- ✓ Staff burnout

"We work on all mothers … those who delivered from here … and those who are referred and those who are self-referred … usually when they [are] many I reduce the time I spend on the mother and her baby, ***so consultations time is compromised.****" (Kawaala)*

"Our clients tell us through health education that we offer good services irrespective of where you come from … all private health providers (PHPs) keep pushing to us mothers, thus the ***overwhelming numbers causing staff burn out*** *because of working till late daily." (Kisenyi)*

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Health workers described a range of strategies used by facilities to cope with overcrowding

Some measures raise serious concerns about the quality of MNCH and FP care. These include:

- Devoting most of midwives' time to routine maternity services, while taking them away from important needs like complicated deliveries.
- Re-deploying midwives away from their specialties to more under-staffed, non-MNCH or FP services.
- Deferring the initial PNC to the first week post-partum rather than within the recommended first 24 hours after delivery (MOH 2006, 2018; Warren et al. 2006).
- Using RBF income to buy mattresses to support "floor cases."

Others indicate operational creativity, including:

- Adopting a rotation system to re-deploy midwives from other departments to support crowded services.
- Using RBF income to hire more MNCH staff, particular for managing complicated deliveries.
- Offering weekend hours and introducing appointment systems.

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4. IMPLICATIONS & THE WAY FORWARD

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KCCA and the facilities can overcome congestion in several ways

Strategy to overcome congestion	Specific actions	Prospects and limitations
Expand facility capacity	• Hire more staff • Add beds	Both facilities were renovated recently to add beds, and both have already used RBF income to hire more MNCH personnel. Additional, large investments are unlikely.
Increase operational efficiency	• Re-deploy staff within the facility in proportion to service demand • Add a second operating theatre to better exploit doctor capacity	Facilities are already rotating staff to the extent possible. Ongoing efforts are likely to only yield modest gains. Financing and space for adding an operating theatre are scarce.
Divert or attract clients to other public facilities	• Work with referring facilities to retain more uncomplicated cases • Down-refer ANC, PNC, and FP clients	Although Kawaala and Kisenyi attract the most patients among KCCA's facilities, the others are also overcrowded, so this would merely displace the problem.
Outsource services to PHPs	• Design and test model for the KCCA to purchase MNCH and FP services from private providers • Profile clients • Assess PHP readiness	There is considerable interest and capacity in the private sector. Key issues will include terms and conditions of a purchasing contract and source(s) of financing.

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Outsourcing has the greatest potential to address congestion at scale.

Why should KCCA pursue outsourcing to private providers?

- In the absence of resources or space to significantly expand the city's public health infrastructure, there is an urgent need to shift some clients elsewhere.
- The abundance of private providers in Kampala suggests there may be considerable capacity to absorb clients currently served at congested KCCA public health facilities. This requires further investigation.
- An expanded purchasing relationship between the KCCA and private providers could enable more clients to access timely, high-quality services, as well as alleviate congestion and its harms at KCCA public health facilities.
- Private providers are an important source of referrals to KCCA public health facilities; therefore, partnerships could help to regularize patient inflows and ease planning.
- Reducing congestion of simpler services could free up human resource capacity for the KCCA facilities' more complex services, such as labour and delivery (especially complicated deliveries).

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Next steps for the KCCA to explore purchasing from private providers are:

1. Profile clients to understand their preferences and constraints

The rapid assessment provided initial insights into who seeks services at Kawaala and Kisenyi HC IVs. KCCA and ThinkWell are undertaking a deeper analysis of client backgrounds, behaviors, and preferences, with results expected in late 2021. It will also be critical to consider who may not be seeking services at all due to congestion (Delzer et al. 2021).

2. Assess private provider readiness and willingness

Outsourcing services will require capable private providers who are interested in partnering with the government. KCCA and ThinkWell are conducting a provider readiness assessment to determine what types of purchasing arrangements will be feasible initially and over time. Preliminary results are expected in October 2021.

3. Convene public and private stakeholders to co-create a purchasing model

Private sector engagement requires mutual understanding and trust building between the government and providers. The KCCA will convene a group of government and private sector actors to identify areas of mutual interest and work towards a common vision for the purchasing of MNCH and FP services. The first consultative meeting will take place in September or October 2021.

4. Pilot and evaluate the model for ANC, PNC, and/or FP services

Once a prototype purchasing model is developed, the KCCA and partners will test it to determine what works and what requires refinement for future implementation. KCCA aims to develop a pilot-ready model by mid-2022.

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APPENDIX 1: DATA SOURCES & COLLECTION

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Data collection methods

18 semi-structured key informant interviews were conducted with KCCA officials at headquarters and division level, facility in-charges, department heads, other health workers, and HMIS focal persons.

Topics covered in the interviews included:

- Facility attributes and capacity
- Bed use practices for deliveries
- Health worker behaviors and attitudes related to service congestion and its consequences
- Client attributes

Following preliminary analysis, a focus group discussion was conducted with health workers at each facility to explore mechanisms for coping with overcrowding.

Utilization data for each service were retrieved from the DHIS-2 and validated through direct review of each facility's registers for outpatient department, ANC, maternity, PNC, and FP.

If there were discrepancies between the DHIS2 and facility registers, data from the registers were used.

The DHIS-2 computes a 'patient days' indicator for deliveries based on a standard norm of one day per normal delivery and three days per caesarean delivery.

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Quantitative data sources for utilization, staffing, and beds

Service	Data source(s)		
	Utilization	Staffing	Beds
Antenatal care	Sources: DHIS-2, facility registers DHIS-2 indicators: AN01a. ANC 1st Visit for women AN02. ANC 4th Visit for women AN05. Total ANC contacts / visits (new clients + Re-attendances)	Key informant interviews	N/A
Deliveries	Number of deliveries Sources: DHIS-2, facility registers DHIS-2 indicators: 105-MA04a. Deliveries in unit - Total Patient days Source: DHIS-2 DHIS-2 indicator: CI04. Patient days	Key informant interviews	Source: DHIS-2 DHIS-2 indicator: CI01. No. of beds Capacity norms for bed days based on guidelines specifying 1 day following normal deliveries and 3 days following caesarean deliveries (MOH 2008)
Post-natal care	Sources: DHIS-2, facility registers DHIS-2 indicators: PN01.Post Natal Attendances	Key informant interviews	N/A
Family planning	Sources: DHIS-2, facility registers DHIS-2 indicators: 105-FP01–09 – short-term methods 105-FP10–14 – long-term methods	Key informant interviews	N/A

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APPENDIX 2: BACKGROUND ON SELECTED SERVICES

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Background – ANC services

- ANC services are vital for all women of reproductive age. They help to monitor and ensure good health during pregnancy, with particular attention to identifying and managing any conditions that may cause a risk to the mother and/or child during pregnancy or at birth.
- Both the assessment facilities offer comprehensive ANC services according to Ministry of Health guidelines.
- The standard of care in Uganda is four ANC visits over the course of pregnancy with a skilled health worker at a health facility. Increasingly, eight visits are being encouraged.
- The ANC service package includes information for a healthy pregnancy and a healthy baby, nutrition advice, HIV and STDs prevention, preparation for a safe delivery, growth monitoring of the baby, and screening and management of tetanus, malaria, HIV, STDs, blood pressure, and anaemia.

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Background – L&D services

- Labour and delivery services are key to the health of mothers and newborns. Ugandan guidelines call for all deliveries to be conducted in a health facility by a skilled health worker, in a clean and safe environment with infection control measures strictly observed.
- KCCA facilities, like Kawaala HC IV and Kisenyi HC IV, are equipped to handle normal and caesarean deliveries and to provide basic and emergency obstetric care.
- Labour care includes monitoring with a partograph; identifying and managing abnormal events; involving the partner and other relatives per the mother's wishes; ensuring the mother's comfort; ensuring a clean and safe delivery of the baby, placenta, and membranes; giving antiretrovirals (if indicated); and ensuring adequate nutrition and rehydration.
- Obstetric care can also include resuscitation; prevention of post-partum hemorrhage; healthy mother and baby check immediately post-partum and prior to discharge; contraception counseling and provision of selected method; and complicated deliveries including ventouse (vacuum), caesarean section, induction, manual removal of retained placenta, and emergency transport to a referral centre.

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Background – PNC services

- In Uganda, providing PNC within the first days after childbirth can help to avert maternal mortality because it allows early detection of problems that could result in adverse outcomes.
- In KCCA facilities, mothers are booked for appointments before discharge and encouraged to return for their first PNC visits within six days of delivery.
- Maternal PNC visits with midwives are meant to include checking for bleeding; supporting breastfeeding; checking the breasts to prevent mastitis; managing anaemia; promoting good nutrition and use of insecticide-treated bed nets; giving vitamin A supplementation; completing tetanus toxoid immunization; providing counselling and a range of options for family planning; counseling on danger signs and home care; and more.
- Newborn PNC visits are meant to include assessing for danger signs; measuring and recording weight; supporting optimal feeding practices, particularly exclusive breastfeeding; promoting hygiene and good skin, eye, and cord care; identifying and treating or referring for skin infections; encouraging and facilitating birth registration; and referring for routine immunizations.

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Background – FP services

- In Uganda, there are concerted efforts to scale up use of modern FP methods, motivated by the knowledge that FP helps women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing. More broadly, FP improves MNCH, facilitates educational advances, and empowers women to make health choices that affect their lives.
- The integration of FP and MNCH programs and services provides multiple opportunities to streamline and improve care at favorable and critical times for maximizing women's reproductive health and the health of their children.
- Women in Kampala can access a broad range of FP services through both facility-based and community outreach efforts.
- Both assessment facilities offer a range of FP methods, including short-term (oral and injectable contraceptives) and long-term (contraceptive implants and intrauterine devices).

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