KAMPALA CAPITAL CITY AUTHORITY

DIRECTORATE OF PUBLIC HEALTH AND ENVIRONMENT

A Profile of Women Seeking Maternal, Newborn, and Child Health Services in Public Facilities in Kampala

P. O. Box 7010 Kampala- Uganda
Plot 1-3 Apollo Kaggwa Road
Tel: 0414 231 446 / 0204 660 000
Web: www.kcca.go.ug, Email: info@kcca.go.ug
f: facebook.com/kccaug, t: @KCCAUG

Table of Contents

List of Tables

List of Figures

Abbreviations

ANC	antenatal care
BOR	bed occupancy rate
FGD	focus group discussion
FP	family planning
HC	health centre
KCCA	Kampala Capital City Authority
LTM-FP	long-term method of family planning
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
PFP	private for-profit
PNC	postnatal care
PNFP	private not-for-profit
SBA	skilled birth attendant
SP4PHC	Strategic Purchasing for Primary Health Care project
STM-FP	short-term method of family planning
UDHS	Uganda Demographic and Health Survey
VHT	Village Health Team

Acknowledgements

This study was completed by a joint research team from the Kampala Capital City Authority (KCCA) and ThinkWell under the strategic direction of Dr. Daniel Ayen Okello, Director of Public Health and Environment, KCCA. The team gratefully acknowledges the support of KCCA Division Medical Officers, Dr. Richard Walyomo (Central Division) and Dr. Mariam Mulungi Nantambi (Rubaga Division); Sr. Elizabeth Egesa, the in-charge of Kisenyi Health Centre IV, and Sr. Ajilong Dorothy, the in-charge of Kawaala Health Centre IV; and the respondents who volunteered their time and information to this study. Special thanks also go to Dr. Sarah Zalwango, Dr. Alex Ndyabakira, Dr. Dennis Buluma, Tapley Jordanwood, and Michael Chaitkin for reviewing this study report, and to Margaret Dadian and Meaghan Koudelka for their editorial assistance.

Financial support for this study came from the Strategic Purchasing for Primary Health Care (SP4PHC) grant from the Bill & Melinda Gates Foundation. ThinkWell is implementing the SP4PHC project in partnership with government agencies and research institutions in five countries, including Uganda. For more information, please visit **https://thinkwell.global/projects/sp4phc/**. For questions, please write to **sp4phc@thinkwell.global**.

**

Recommended citation:

Ssemujju, Richard, Cathbert Tumusiime, Angellah Nakyanzi, Paul Kiggundu, and Daniel Ayen Okello. 2022. *A Profile of Women Seeking Maternal, Newborn, and Child Health Services in Public Facilities in Kampala, Uganda.* Kampala: ThinkWell and Kampala Capital City Authority.

Executive Summary

Introduction: Uganda continues to suffer from high maternal and under-5 mortality rates, with levels surpassing the averages of neighbouring countries. Although the country has made strides, achieving improving maternal health outcomes requires specific and targeted policies, strategies, and approaches. Trends indicate that the demand for maternal, newborn, and child health (MNCH) and family planning (FP) services in Kampala is already greater than what the few available public health facilities can supply and continues increasing. This has resulted in highly congested public health facilities in Kampala that have insufficient resources to meet the demand; clients experience long waiting times and very brief consultation periods with providers. In response, and through a partnership with ThinkWell's Strategic Purchase for Primary Health Care (SP4PHC) project, the Kampala Capital City Authority's (KCCA) Directorate of Public Health and Environment (DPHE) previously evaluated the supply-side challenges of providing MNCH and FP services in KCCA public health facilities. They found that there are more supply-side challenges to providing antenatal care (ANC), postnatal care (PNC), and FP services than for others. To complement that analysis, this client profiling study was conducted to investigate client dynamics and sociodemographic factors that influence their decisions in seeking MNCH and FP services. Findings from this study are instrumental to understanding the client profiles in the design of solutions that bridge the demand and supply gap by providing recommendations and key learnings to inform KCCA's strategic purchasing.

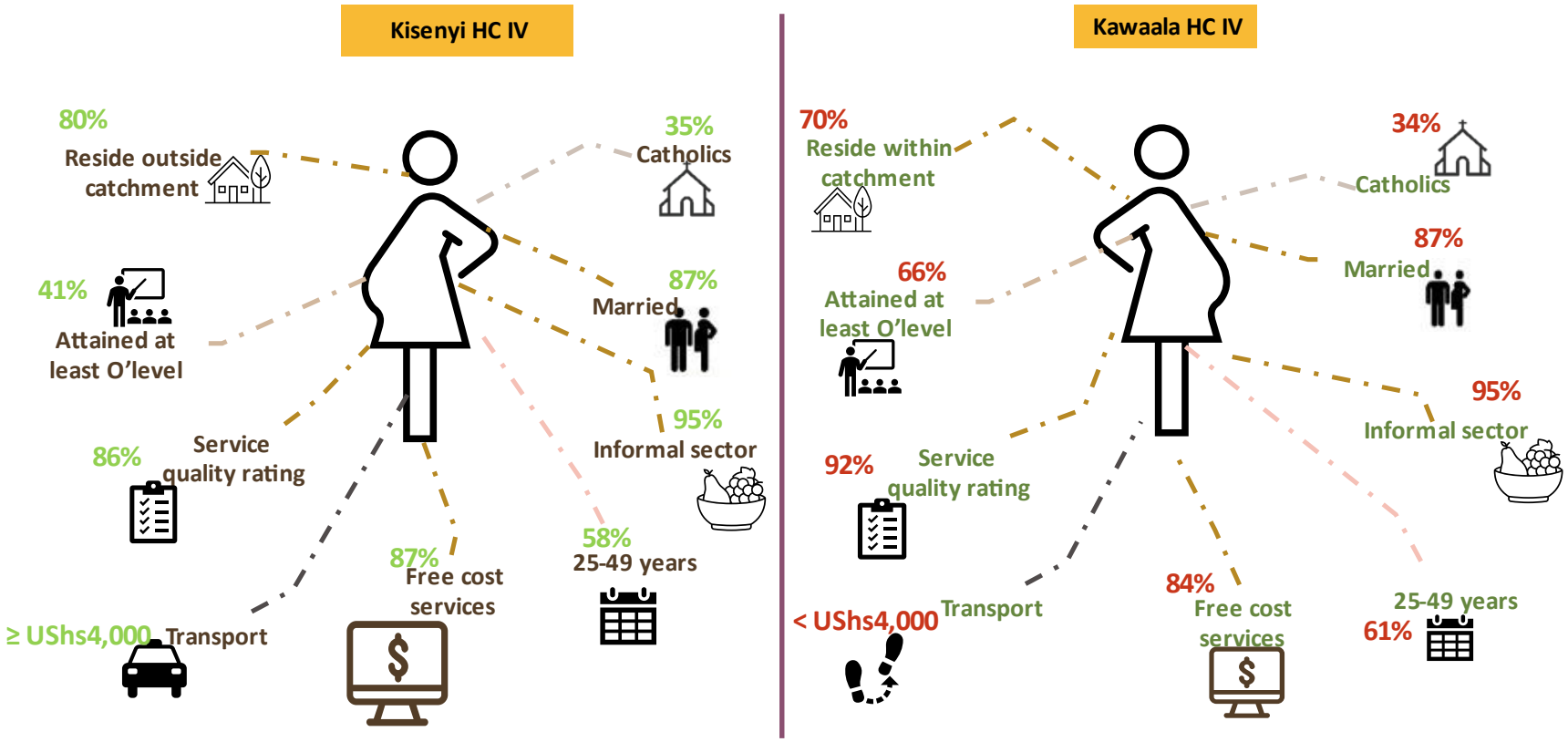
Methods: This was a cross-sectional study that employed a mixed-methods approach. The study focused on women and girls of reproductive age (15 to 49 years) in Kampala who sought MNCH and FP services from the Kisenyi and Kawaala HC IVs during the period of July 2021 to September 2021. It also analyses information from the Village Health Teams (VHTs) attached to these two health facilities who work closely with the MNCH and FP units. Data collection included document reviews, client questionnaires, and focus group discussions (FGDs) with MNCH and FP clients and with VHTs. The goal was to understand client characteristics and factors that influenced their choice to seek services at these KCCA facilities. Using STATA v14, the analysis included quantitative summaries of MNCH and FP client characteristics and dynamics in seeking services, while qualitative analysis was completed by developing thematic codes to examine the factors that drive MNCH and FP client service-seeking behaviour at the two facilities.

Findings: Figure 1 summarises key attributes of women seeking MNCH and FP services at the two focus facilities. The majority of clients seeking services in Kisenyi HC IV (79%) originate from outside its catchment, while the majority of clients at Kawaala HC IV (66%) originate from within the facility catchment. Based on an analysis of clients' sociodemographic characteristics, the majority were of low social status, and over 95% worked within the informal sector. Most interviewed clients

preferred to access free health services from public facilities or highly donor-subsidised services from private health facilities (if they were available). More than 40% of the sampled clients in both facilities completed at least an ordinary secondary level of education (senior 4), a social determinant that positively influences health-seeking behaviour. In addition, the majority of the clients were also married, which influences household decisions in seeking and receiving health services and presents the ability for partners or husbands to contribute to medical costs. Findings show that the key drivers for service-seeking behaviours were client satisfaction and the perceived quality of health services. Key attributes that indicated quality to clients included the presence of health workers, the range of services available, the availability of drugs, and client care. A total of 85% of respondents identified the perceived quality of care as the primary driver in their health-seeking choices. Additionally, most clients, who were responding through peer references (>54%) and through official service ratings (>73%), indicated that they were attracted to the health facility because it provided high-quality services.

Conclusion: The findings identify the major client incentives for seeking out services from KCCA public facilities despite the congestion. Women who sought services from the two public health facilities were attracted to these facilities due to the free services and the perceived quality of services in public settings compared to private. However, coming to public facilities creates unprecedented congestion. One way to address this is to develop modalities that attract clients to private health facilities and reduce demand on the public facilities. A key recommendation from this study is that DPHE explores purchasing of selected services from private providers within the catchment of their public facilities. In addition to this, addressing challenges around access and proximity to these services, whether through private or public institutions, will also impact the decisions of clients. For example, if MNCH and FP services are made available closer to where recipients are located, it reduces their distance and travel time and saves them money, which can go towards supporting the additional costs of receiving health services that they would not have had if they had to pay for transportation.

Figure 1. Profile of clients who seek services from the two health facilities



1 Introduction

Since 2000, Uganda has reduced the maternal mortality ratio (MMR) from 524 per 100,000 live births to 336 in 2016. Under-5 mortality rates have also decreased from 158 per 1,000 live births in 2000 to 55 in 2016. Both maternal and under-5 mortality in Uganda is worse than the averages in sub-Saharan Africa (UDHS, 2016). A range of factors contribute to the high rate of maternal and child deaths, including the high fertility rate (5.4 births per woman) and considerable unmet needs for maternal, newborn, and child health (MNCH) and family planning (FP) services (MOH, 2020; UDHS, 2016). In addition to this, the COVID-19 pandemic has exacerbated these challenges with a significant correlated increase in early pregnancies among women and girls aged 15 to 19. In an effort to reduce maternal and child mortality rates, the Government of Uganda (GOU) and international development partners have made considerable investments to improve access to and quality of MNCH and FP services (MOH, 2016; Wamajji, 2021; World Bank, 2016).

Although these investment efforts have helped increase service utilisation and improve service coverage, they have also burdened a health system that is slow to adapt. As a result of urbanisation, the strain is especially acute in urban areas such as Kampala, where the demand for MNCH and FP services in public health facilities is greater than the supply. Overcrowding in Kampala's busiest facilities has overwhelmed health workers, impacting morale and their ability to provide a sufficient quality of services (Okello *et al.*, 2021). As a result, the Kampala Capital City Authority (KCCA), through the Directorate of Public Health and Environment (DPHE), is exploring options to alleviate pressure on public facilities and meet consumer demand by improving residents' access to high-quality services delivered in the private sector.

Purchasing services from private providers on behalf of the population is one-way KCCA envisages reducing congestion in public facilities and improving the quality of care,[1] as it remains an unexplored opportunity by government entities. This approach is not completely without precedent. KCCA has in the past partnered with private providers by supplying them with key inputs—such as vaccines, commodities, and equipment—in exchange for reductions in the service prices charged to clients. These arrangements have generally been ad hoc and on a small scale, and while they have helped to increase access to priority services, such as immunisation, they are not scaled enough to alleviate the congestion in the public facilities in Kampala. As a result, KCCA is also experimenting with non-purchasing approaches, such as allowing vetted private providers to market a government endorsement of quality and affordability to prospective clients (PSI, 2020).[2]

[1] In many ways the grant-receiving PNFPs are managed as part of the government's health system, differentiating this financing approach from the more market-oriented contracting arrangements that often characterise public-private engagement in other countries' health systems.

[2] For example, USAID's Kampala Slum Maternal and Newborn Project (MaNe) has supported the KCCA to brand 20 private facilities and provide ongoing support supervision and monitoring.

Despite these activities, and to scale efforts to meet the demand of consumers, it was determined that the DPHE needed to understand and profile the clients seeking MNCH and FP services in their facilities. Although there is considerable data from Uganda and beyond about the drivers of MNCH and FP service use, little is known about the attributes, preferences, and constraints of women and girls who access services at public health facilities in Kampala. Addressing this information gap, this study has been designed to inform solutions to the current challenges of meeting the demand of their clients. As a result, the KCCA, in partnership with ThinkWell, undertook this study to profile MNCH and FP clients at two KCCA-managed facilities, Kawaala and Kisenyi health centre (HC) IVs.

This study sought to understand the factors that influence women's decisions to seek MNCH and FP services in KCCA public facilities while noting their sociodemographic background and preferences, such as whether they seek care within or outside the Kisenyi or the Kawaala facility catchments. The study also attempted to gain an in-depth understanding of the factors that influence the decision of these women to seek these services at the KCCA facilities rather than elsewhere.

The study answered the following questions.

- What are the sociodemographic characteristics of women seeking MNCH and FP services in KCCA facilities? Where are they from? What are their main sources of livelihood and income?
- What factors influence women seeking FP and MNCH services in the two facilities?
- Which other health facilities outside the KCCA public facilities would clients consider to access MNCH and FP services, and why?
- Which MNCH services would mothers prefer to access, either public or private, and why?

2 Literature review on clients who receive MNCH and FP services

MNCH services include a broad range of maternal services and processes targeting women of reproductive age before, during, and after delivery. Utilisation by women of antenatal care (ANC), delivery, and postnatal care (PNC), in addition to family planning services, can greatly impact infant death outcomes and significantly affect the mortality of women and children. More specifically, ANC also plays an indirect role in reducing maternal mortality by encouraging women to deliver with the assistance of a skilled birth attendant (SBA) or in a health facility, versus on their own and without this support.

Despite the importance of MNCH services, MNCH programs face numerous challenges, including competition between maternal and child health programs and actors, demands across the full continuum of care in contexts with scarce resources, and a lack of harmonisation between MNCH and health systems development agendas (Wallace & Kapiriri, 2019)

In most regions of Uganda, there are also challenges to increasing access to MNCH services to clients who are directly impacted by factors such as geographic proximity to health facilities, education levels that influence decisions on seeking out services, income levels, levels of community awareness of the importance of these services, and access to information and quality of treatment of women by health workers (UDHS, 2016). Research shows mothers' level of education directly affects utilisation of ANC services, with highly educated women most likely to utilise them (Gwatkin, Bhuiya, & Victora, 2004).

For example, the educational level of a mother may influence how much knowledge she has or access to the information she uses for her health decision-making, such as deciding to utilise ANC and PNC services. The parity of the mothers may also determine how much experience they have in maternal-related issues, perceptions, and understanding of the need to access care from health facilities. Economic status and income level may also influence the utilisation of maternal health care services. For instance, the existence of users' fees may directly or indirectly hinder the utilisation of maternal services by mothers.

Health facility factors, including the availability and quality of care, the facility environment, distance to the facility, availability, and motivation of health personnel, as well as their attitudes and education, can greatly undermine the utilisation of maternal health care services. Inadequate care along the continuum of MNCH services during pregnancy, birth, and post-delivery is associated with poor maternal and newborn health outcomes. This is significant because research shows that the availability of SBAs and PNC use are key to impacting neonatal mortality (Titaley *et al.*, 2008). As such, the quality of these services directly impacts the health outcomes of mothers and children.

Attitudes of the health workforce may also positively or negatively affect the utilisation of maternal health care services. Health workers, particularly midwives, play a vital role in the delivery of good-quality services. Therefore, continuity of maternal and newborn care over time for every woman and

baby, as well as integrated service delivery in facilities, are necessary (Azfar & Murrell, 2009; Kerber *et al.*, 2007).

Community factors and issues such as gender dynamics in terms of control of resources and decision-making, friends, sociocultural practices, and general society perceptions may also influence a mother's choice about whether to receive services and where to find services. For example, where gender roles allow fewer decision-making powers to women, fewer women may not go to health facilities to seek health care simply because they do not have their husbands' consent. Perceptions of mothers about the good-quality health care services offered by health facilities also affect the utilisation of such services. For instance, women in Malawi preferred to deliver at home because although medical settings were accessible to some and free of charge, they perceived them as being of low quality and unsafe (Machira & Palamuleni, 2018). A study in Mulago Hospital showed that many of the late referrals for the 'near miss cases' also had a low socioeconomic status, and this was explained to limit economic power and freedom that made women who depended on husbands or male counterparts to make decisions.

Finally, individual factors such as a mother's age and gravidity influence her decision to seek health care services, especially during pregnancy and delivery. The UDHS indicates that birth by mothers below 20 years of age and prime gravidas stands at 67% and 74%, respectively, and these were more likely to be assisted by a skilled person. This fundamentally decreased with an increase in age and number of previous pregnancies; for instance, mothers in the age categories of less than 20, 20 to 34, and 35 to 49 showed 65.8%, 56.5%, and 51.1%, respectively (UDHS, 2016). Table 1 highlights selected maternal and child health indicators for Uganda.

Table 1: Key selected maternal and child health indicators for Uganda

Performance of Selected MNCH & FP Indicators	Status
Maternal mortality ratio (per 100,000 live births)	336
Prenatal care coverage (%) at least one visit in the last five years	97
Prenatal care coverage (%) at least four visits	60
Births delivered at a health facility (%)	57
Births attended by skilled health personnel (%)	73
Births by caesarean section in urban areas (%)	11
Post-natal care visit within two days of childbirth (%)	54
Total fertility rate (number of children per woman)	5.4
Unmet need for family planning (%)	28
Contraceptive prevalence (%)	35

Source: ***(UDHS, 2016)***

As a result of the literature review above, the current study sought to understand factors that influence women's decisions in accessing MNCH and FP services at KCCA public facilities (both Kisenyi

and Kawaala HC IVs). Finally, the study also aimed to identify trends among existing clients and their decisions by documenting the sociodemographic characteristics of mothers who access MNCH and FP services from within or outside the facility catchment of Kisenyi and Kawaala HC IVs.

3 Approach and methodology

This section details the study approach and methodology, including a description of the design, setting, sample size, and methods used.

Study design

This was a cross-sectional study that used both qualitative and quantitative methods to understand the characteristics and perspectives of clients seeking MNCH and FP services in two health facilities.

Study setting

The study was conducted in two KCCA public facilities, Kisenyi and Kawaala HC IVs, which were purposively selected as high-volume facilities with a catchment population (Kisenyi at 104,347 and Kawaala at 54,367) compared to other KCCA public health facilities. The DPHE determined the study sites and rationale based on MNH service outputs (Table 2). In the reporting period (July 2019 to June 2020), Kisenyi HC registered 8,063 deliveries and 38,385 ANC visits, while Kawaala HC registered 5,334 deliveries and 25,652 ANC visits, which were high compared to other KCCA health facilities (DHIS2, 2020).

Table 2: KCCA health facility catchment population estimates

Health Facility Name	Catchment Population Estimates	Services ANC 1	Deliveries	PNC (6 weeks)	FP (STM)	FP (LTM)
Kisenyi HC IV	104,347	15,998	7,462	2,643	2,765	5,036
Kawaala HC IV	54,367	11,029	5,679	2,209	3,612	1,944
Komamboga HC III	54,878	6,659	2,970	138	2,829	1,661
Kisugu HC III	45,891	4,952	2,424	1,145	4,483	2,959
Kiswa HC III	79,641	5,312	0	419	2,356	2,322
Kitebi HC III	46,786	7,876	4,518	414	3,612	1,944
Bukoto HC II	7,771	724	98	174	521	326
City Hall Clinic II	10,869	-	-	-	-	-

Source: *KCCA DPHE Report 2020/21 & DHIS2*

Sample size determination

The sample size for the exit interviews was estimated using the formula for a single proportion (Kish, 1965). The reason for this sampling is that the population from which the sample was being drawn was large (>10,000).

$$n = \frac{Z^2_{\alpha/2} pq}{d^2}$$

Whereby; n was the required sample size,

Z-score is the standard normal value corresponding to a 95% confidence interval which is 1.96

p - the proportion of identifying a suitable respondent and was estimated at the maximum value of 0.5, q is 1-p, and d is the estimated error margin expected = 0.05.

$$n = \frac{1.96^2_{\alpha/2} 0.5 * 0.5}{0.05^2}$$

n = 384 participants.

The sample size was subjected to a design effect (deff) using the following standard formula: deff = 1+δ(n-1) Where n is the sample size, δ is the interclass correlation for the statistic, thus, n = 384; δ≈0.004 which generates a design effect (deff) of 2.5. The Effective Sample Size (ESS) is equal to the sample size (SS)/design effect (deff).

$$ESS = \frac{Sample\ Size}{Deff} \quad \frac{384}{2.5} = 154\ respondents$$

The sample size was further subjected to a catchment population for the two facilities (Kisenyi: 104,347; Kawaala: 54,637; total: 158,984) to inform the proportional allocation of the sample size across the two facilities.

$$n_i = \frac{N_i}{N} * n$$

Where:

N was the overall target population in the selected facilities (i.e., Kisenyi and Kawaala)

N_i was the target population for the i^{th} facility (i.e., Kisenyi)

n was the sample size in the computed sample size for both facilities (i.e., Kisenyi and Kawaala);
n_i was the required sample in the i^{th} facility.

For Kisenyi HC IV

$$n_{Kisenyi\ \text{HC}} = \frac{104347}{158984} * 154 = 101\ respondents$$

For Kawaala HC IV

$$n_{\ Kawaala\ \text{HC}} = \frac{54637}{158984} * 154 = 53\ respondents$$

Data collection

Both quantitative and qualitative data were gathered through an exit survey with clients and focus group discussions (FGDs) with clients and members of Village Health Teams (VHTs) attached to the facilities (see Appendices). Both FGDs and the exit survey were conducted concurrently at both facilities. These respondents were randomly identified and subjected to the selection criteria prior to enrolment. For FGDs, the respondents were identified by the VHTs attached to the respective health centres. The VHTs were oriented on the selection criteria, which they used to identify and approach clients as they exited the service points. The criteria included women or mothers aged 15 to 49 years seeking MNCH services from the two KCCA facilities (Kisenyi and Kawaala HCs). Among the VHTs, the study only targeted those attached to the two health facilities and closely working in the MCH and family planning department/units. The study, on the other hand, excluded clients who did not provide informed consent, clients who sought no MNCH and FP services from the two facilities, and clients who were below 15 or above 50 years.

The data collection process involved:

- Use of a semi-structured questionnaire programmed into an ODK version (Kobo Collect).
- Pretesting of the tool conducted in relatively similar KCCA facilities.
- Conduct of the exercise by trained research assistants (RAs) with the close supervision of the Principal Investigator (PI) and Co-PI in the field.
- Uploading daily ODK data automatically and backing up at an access-restricted central server. FGDs were undertaken to provide other perspectives to supplement the quantitative findings and the process involved.
- Mobilisation of respondents with the help of the VHTs attached to the two facilities.
- Facilitation of the FGDs by two RAs (a moderator and a note-taker).
- Assignment of codes to participants (i.e., R01–R08) to easily de-identify the respondents, then interviews, with notes taken accordingly.
- Management of all field notes by the principal and co-principal investigators, which were secured on password-protected computers and lockable cabins for the hard copies.

Data analysis

For qualitative analysis, focus group discussion notes were processed thematically through content analysis and documented insights. These were further backed up with respondent-specific quotations, where applicable, for emphasis. For quantitative data, analysis was undertaken using both STATA (v14) and Microsoft Excel. Analysis was conducted on three major parameters:

1. **Socioeconomic and demographics characteristics**
    - Age
    - Marital status
    - Education

- Livelihood source

2. **Proximity**
    - Residence and workplace relative to facility catchment
    - Distance travelled and means used
    - Amount spent on transport
3. **Drivers of service demand at the KCCA facilities**
    - The influence of factors, including perceived quality, peer influence, cost, and others; consideration of other providers

Inclusion and exclusion criteria for study participants

Inclusion criteria: The study included all women and mothers of reproductive age who sought MNCH and FP services from Kisenyi and Kawaala HC IVs. VHTs, specifically those attached to the two health facilities and closely working in the MCH and FP departments/units, were also targeted for FGDs.

Exclusion criteria: The study excluded clients who did not provide informed consent, other clients who were not seeking MNCH and FP services from the two facilities, and clients who sought MNCH and FP services but were either below 15 or above 50 years.

Ethical considerations

The study protocol was approved by Mildmay Uganda Research Ethics Committee (MUREC). Information gathered from respondents was anonymised and safely kept in ThinkWell's electronic and password-protected database. The data were accessible only to the investigators, and the team ensured strict confidentiality.

A formal permission letter signed off by the DPHE was sent to the two facility in-charges. Informed consent was sought from all study participants (see Appendices). Clients were informed that participation in the study was voluntary, and they were at liberty to withdraw from the study at any time, without any consequences. In addition, VHTs who participated in the FGDs were compensated for transport to come to the study sites.

4 Findings

The findings in this chapter are presented according to three main domains, including sociodemographic characteristics, factors influencing service-seeking behaviour, and drivers to continue client access to health services in public facilities despite the congestion. The response rate for exit interviews during the study was 84% (Table 3), which was impacted by the ability to conduct the study during COVID-19 movement restrictions.

Table 3: Summary of response rates

Category	Kisenyi HC	Kawaala HC	Total	Target	Response rate
Exit interviews	92	38	130	154	84%
FGDs	3	2	5	5	100%

Sociodemographic characteristics of the clients in Kisenyi HC and Kawaala HC

This section presents findings on the sociodemographic characteristics of clients who sought services from Kisenyi and Kawaala HC IVs during the study (Table 4). The majority of clients (57.6% from Kisenyi and 60.5% from Kawaala) were 25 to 49 years old, while the minority of clients were under 15 to 19 years of age (6.5% from Kisenyi HC and 5.3% from Kawaala HC).

The study also revealed that a higher percentage of clients who accessed MNCH and FP services in Kisenyi HC were married (86.9%), which was also consistent with the Kawaala HC facility (86.8% of clients who accessed the same services were also married). According to findings, a substantial proportion of clients had also attended school up to the O Level of education (Kisenyi at 40.2% and Kawaala at 65.8%). It was noted, however, that Kawaala HC clients (73.7%) were slightly more educated than those from Kisenyi HC (68.5%).

The findings also indicate that a significant proportion of the clients were Catholics (34.8% from Kisenyi HC and 34.2% from Kawaala), followed by Anglicans. In other words, the proportion of clients who identify as Catholics is relatively the same between the two facilities.

The study showed that most of the clients who accessed MNCH and FP services at the two facilities were not prime gravidas (pregnant for the first time), with 82.6% of respondents from Kisenyi HC and 71.1% from Kawaala HC.

Finally, most clients at both facilities (50% from Kawaala and 54.3% from Kisenyi) had between one and two children.

Table 4: Client sociodemographic characteristics

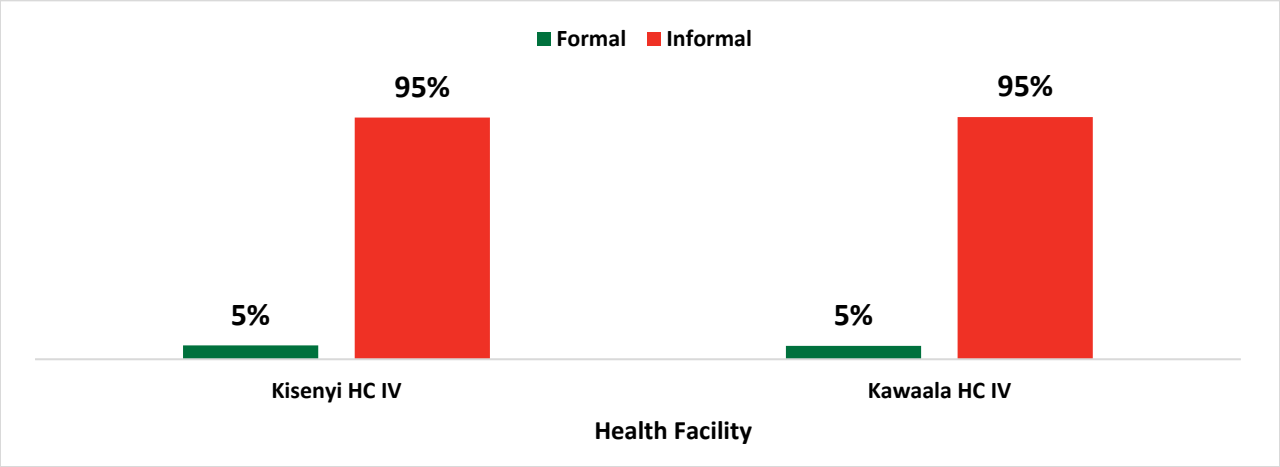
Variable	Item	Kisenyi HC IV [n=92]	Kawaala HC IV [n=38]
		n (%)	n (%)
1. Age category	<15 years	00(0.0)	00(0.0)
	15-19 years	06(6.5)	02(5.3)
	20-24 years	33(35.9)	13(34.2)
	25-49 years	**53(57.6)**	**23(60.5)**
	50+ years	00(0.0)	00(0.0)
2. Marital status	Married	**79(85.9)**	**33(86.8)**
	Single	07(7.6)	04(10.5)
	Separated	05(5.4)	01(2.6)
	Divorced	00(0.0)	00(0.0)
	Other (specify)	01(1.1)	00(0.0)
3. Prime gravida (first-time pregnancy ever)	Yes	16(17.4)	11(28.9)
	No	**76(82.6)**	**27(71.1)**
4. Education level	No education	01(1.1)	00(0.0)
	Some primary	07(7.6)	03(7.9)
	Primary	21(22.8)	07(18.4)
	Middle/O Level	37(40.2)	**25(65.8)**
	Secondary/A Level	15(16.3)	02(5.3)
	Post-secondary/tertiary	07(7.6)	00(0.0)
	University	04(4.4	01(2.6)
5. Religion	None	00(0.0)	00(0.0)
	Catholic	32(34.8)	13(34.2)
	Anglican	20(21.7)	11(29.0)
	Muslim	19(20.7)	09(23.9)
	Pentecostal	20(21.7)	03(7.9)
	Others (specify)	01(1.1)	00(0.0)
6. Number of biological children	None	08(8.7)	05(13.2)
	1-2	**50(54.3)**	**19(50.0)**
	3-4	29(31.6)	13(34.2)
	5+	05(5.4)	01(2.7)

Factors influencing clients seeking MNCH and FP services

Client livelihood source: The study revealed that most clients (95%) who seek services in Kisenyi and Kawaala are informal sector workers such as charcoal sellers, food vendors, hairdressers, fish vendors, boutique operators, cleaners, and hawkers, among others. In contrast, few respondents (5%) earned their income from formal jobs such as teachers, agent bankers, journalists, and health workers, among others. Some clients noted that their livelihood opportunities had been significantly impacted by the COVID-19 pandemic and/or the response measures such as lockdowns and travel restrictions. Some clients who were previously working in the formal sector were pushed into the informal sector or out of work altogether, leading to unemployment. Figure 2 shows the distribution of livelihood and income sources of clients who sought MNCH and FP services in Kisenyi and Kawaala.

"…Some of us who were employed in the formal sector [are now out of jobs] ... I was laid off due to [the] COVID-19 situation and am now … at home dependent on my husband." A client at Kisenyi HC IV

Figure 2: Distribution of client income sources at Kisenyi and Kawaala HC IVs



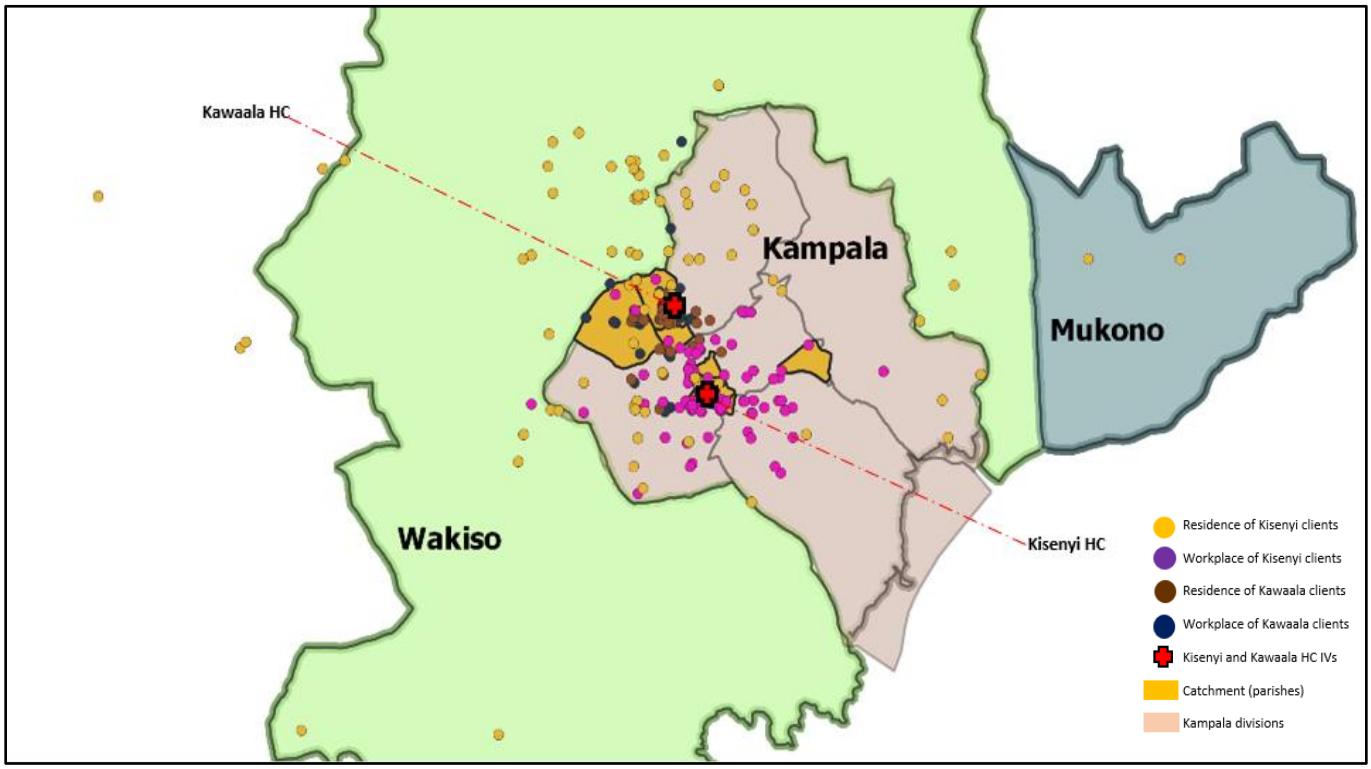
The locations for residences vs. workplace; It was imperative to understand the relationship between residence versus workplace as a factor influencing health-seeking behaviour. Kampala, as a business hub, has an influx of people flocking in for work on a daily commute and thus seek care where they work versus where they reside in the surroundings of Kampala. Findings from this client-profiling study indicate that most of the clients who seek services from Kisenyi reside outside of the catchment but work from areas around the facility. Additionally, clients were also found to be working in areas surrounding the Kisenyi community, such as the busy markets and concentrations of Owino, Kikuubo, Nakasero, Katwe, Ndeeba, and Mengo, among others.

"……this health facility is in Kampala city centre, and there are many mothers who come to work from there, it becomes easier for them to access those services here since it is even a government health facility that offers free services..." VHT FGD participant at Kisenyi HC IV

"Some of the clients who access services at Kisenyi HC come from outside the catchment, from Areas like Hoima Road in Wakiso, Entebbe Road from Kajjansi areas, Ggaba road." VHT FGD participant at Kisenyi HC IV

In contrast, the majority of clients interviewed from Kawaala HC were residents within the catchment and worked in nearby communities. The map in Figure 3 illustrates the workplaces and residences of clients who sought services from both Kisenyi and Kawaala HC among the sampled clients.

Figure 3: Map showing residence and workplace locations of Kisenyi and Kawaala HC clients



Proximity vs. means of transport to the health facility; Study findings indicate that a good proportion of clients (53%) who came to seek services at both facilities used the motorcycle (boda-boda) means of transport (53.2% from Kisenyi and 52.6% from Kawaala), followed by taxi (33.7% from Kisenyi and 17% from Kawaala HC) (Table 5). According to the clients, the boda-bodas were flexible and convenient, and Kawaala HC clients in particular preferred boda-bodas because of their proximity to the facility since most of them were coming from within the catchment.

"…for me I don't waste my time in taxis, my home is close and using boda-boda is cheaper in terms of the time and use shortcut instead of using the main road." FGD participant at Kawaala HC IV

The amount of money clients used on transport to and from the respective health facilities varied, with 52.2% of Kisenyi clients spending around 4,000 to 8,000 Ugandan schillings (~1–3 USD), whereas

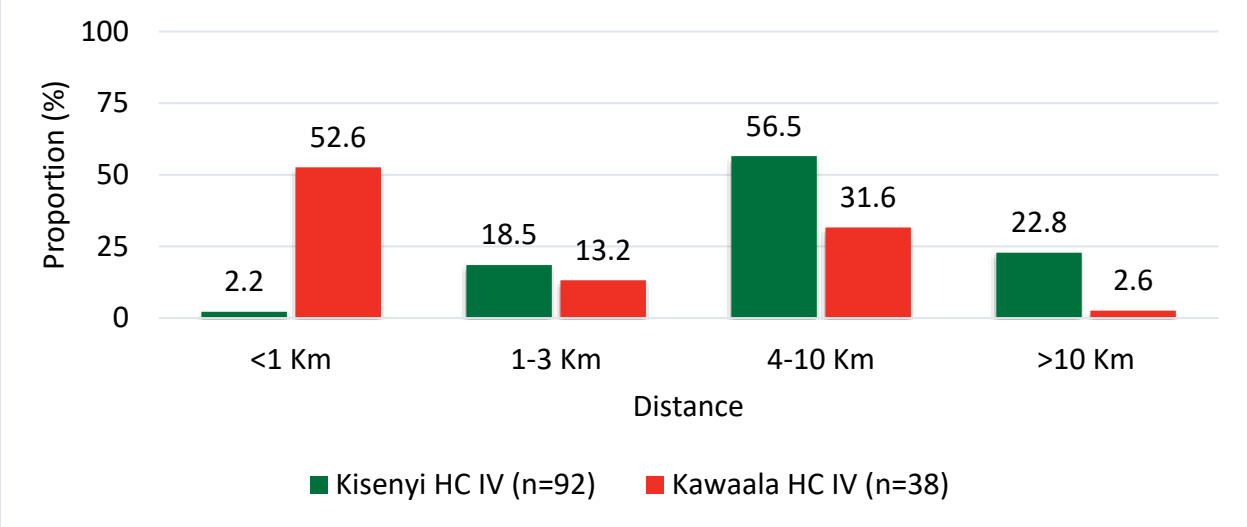
the majority (71.1%) of Kawaala clients used less than 4,000 Ugandan schillings (< ~1.1 USD) (Table 5).

Table 5: Approximate distance travelled, transport means used, and costs of clients

Variable	Item	Kisenyi HC IV	Kawaala HC IV
		n (%)	n (%)
Approximate distance to the facility	<1 Km	02(2.2)	**20(52.6)**
	1-3 Km	17(18.5)	05(13.2)
	4-10 Km	**52(56.5)**	12(31.6)
	>10 Km	21(22.8)	01(2.6)
Main transport means used	Walked	08(8.7)	12(31.6)
	Boda-boda	49(53.3)	**20(52.6)**
	Taxi/bus	31(33.7)	05(13.2)
	Private means	04(4.4)	01(2.6)
	Other(s)	00(0.0)	00(0.0)
Average expenditure on transport (UGX)	0-<4,000	21(22.8)	**27(71.1)**
	4,000-<8,000	**48(52.2)**	08(21.1)
	8,000-<12,000	18(19.6)	02(5.2)
	12,000+	05(5.4)	01(2.6)

Distance travelled to seek health services at two health facilities: The majority (56.5%) of Kisenyi HC clients who sought MNCH and FP services travelled between 4 to 10 km to the facility, while 52.6% of Kawaala HC clients travelled less than 1 km (Figure 4).

Figure 4: Distance travelled by clients to both Kisenyi and Kawaala



Drivers for health care service-seeking behaviour by clients

Table 6 summarises client responses regarding whether the services they received were free, the quality of services, whether they were referred to the facility, and whether they would recommend the facility to others.

Table 6: MNCH and FP service ratings, referrals, and levels of satisfaction

Variable	Item	Kisenyi HC IV	Kawaala HC IV
		n (%)	n (%)
All services received today – free	Yes	**79(85.9)**	**32(84.2)**
	No	13(14.1)	06(15.8)
Satisfaction with care received	Very unsatisfied	09(9.8)	00(0.0)
	Unsatisfied	01(1.1)	00(0.0)
	Not Sure	03(3.3)	03(7.9)
	Satisfied	**49(53.2)**	**23(60.5)**
	Very satisfied	30(32.6)	12(31.6)
Service rating	Good	**71(77.2)**	**28(73.7)**
	Fair	20(21.7)	10(26.3)
	Poor	01(1.1)	00(0.0)
Referred to this facility	Yes	42(45.7)	08(21.1)
	No	**50(54.3)**	**30(78.9)**
Recommend this facility to a friend or relative	Yes	**92(100.0)**	**37(97.4)**
	No	00(0.0)	01(2.6)

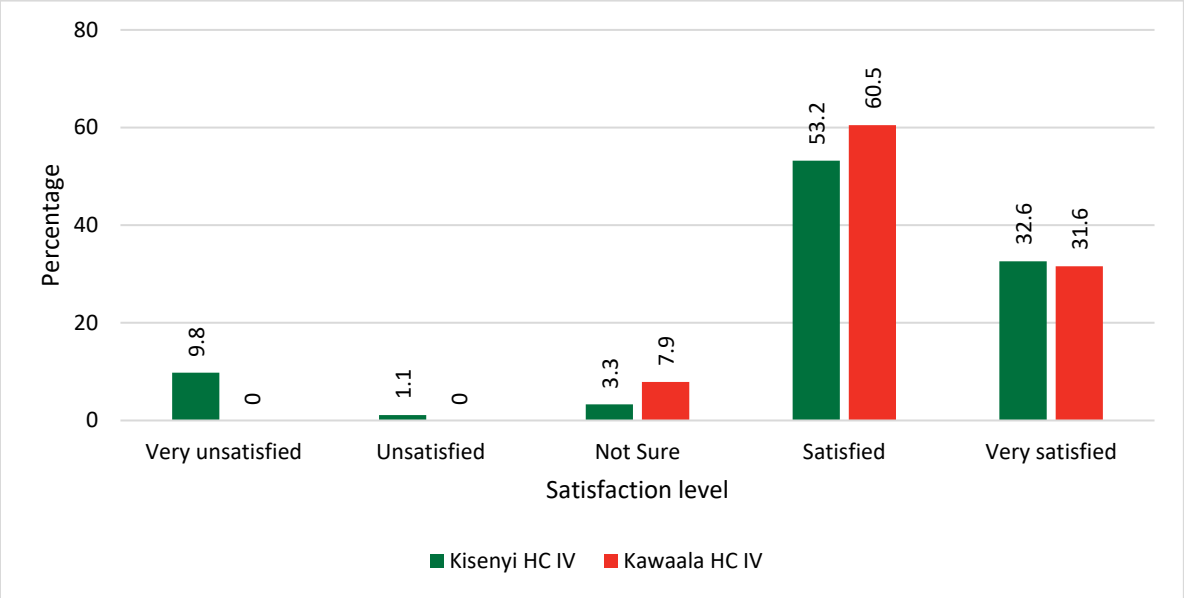
Most of the clients (77.2% from Kisenyi and 73.7% from Kawaala HCs) said that the health services were good at the two facilities. According to this study, most MNCH/FP clients (86% from Kisenyi and 92% from Kawaala) were either very satisfied or satisfied with the services they received (Figure 5). In the study again, 77.2% of clients from Kisenyi HC and 73.7% from Kawaala HC rated the MNCH and FP services as being good.

"…good care given to my friend who gave birth from here prompted me to come and give birth and get health services from here…unlike other hospitals where you go to access the services and everywhere it's smelling, here at Kisenyi HC, the hygiene is relatively good; I delivered here and referred many of my friends to come because the place is clean, including toilets." FGD participant at Kisenyi HC IV

"We are very okay with the service, and we find it good because here, it is first-come, first-served. That is, the first person to arrive at the HC is the one to be served first and so forth." FGD participant at Kisenyi HC IV

"The services are good, and I rate it at 80%, and the reason for it is that I can access all services I need in one place without struggling." FGD participant at Kawaala HC IV

Figure 5: Levels of client satisfaction at Kisenyi and Kawaala HC IVs



Free services versus prices clients were willing and could afford to pay for selected MNCH and FP services charged in private facilities; Most clients from Kisenyi HC (85.9%) and Kawaala HC (84.2%), as well as respondents from the FGD, indicated that they prioritised their facility because the services were free. From the client responses, it was very evident that, except for STM-FP services, most clients (59.8% from Kisenyi HC and 52.6% from Kawaala HC) were not willing to pay for ANC services above 5,000 schillings, and more than 50,000 schillings for a normal delivery (54.7% from Kisenyi HC and 60.5% from Kawaala HC), or more than 100,000 schillings for a caesarean delivery (35.9% from Kisenyi HC and 63.2% from Kawaala HC) as shown in Table 7.

"…to some extent, clients can afford [services] but [the] majority cannot because not all of us earn well and if there are charges imposed, most clients will not get treatment and end up dying." FGD participant at Kawaala HC IV

"...70% of women would not manage to access services on their own if charges were affected and hence other people would not afford." FGD participant at Kisenyi HC IV

"….to a greater extent, most women can afford to access family planning in a private hospital, but the antenatal, delivery, and treatment is sometimes very expensive in the private hospitals." A VHT participant in FGD

"…no, Kawaala has good services; therefore, I can be patient until I am worked on because even if I go to private clinics, they will refer me back. And also, private[s] charge a lot of money…" FGD participant at Kawaala HC

Table 7: Prices clients were willing and could afford to pay for selected MNCH and FP services charged in private facilities

Variable	Item	Kisenyi HC IV	Kawaala HC IV
		n(%)	n(%)
a. ANC visit	<5,000	**55(59.8)**	**20(52.6)**
	5,000 -< 10,000	25(27.2)	15(39.5)
	10,000 -<20,000	07(7.6)	01(2.6)
	20,000 - 30,000+	05(5.4)	02(5.3)
b. Normal delivery services	<50,000	**42(54.7)**	**23(60.5)**
	50,000 –< 80,000	31(33.7)	12(31.6)
	80,000 -<100,000	15(16.3)	02(5.3)
	100,000+	04(4.3)	01(2.6)
c. Caesarean section services	<100,000	33(35.9)	**24(63.2**
	100,000 -<150,000	29(31.5)	10(26.3)
	150,000 -<200,000	23(25.0)	03(7.9)
	200,000+	07(7.6)	01(2.6)
d. FP–short-term method	<2,000	39(42.4)	17(44.7)
	2,000 -< 5,000	42(45.7)	**19(50.0)**
	5,000 -< 10,000	07(7.6)	02(5.3)
	10,000+	04(4.3)	00(0.0)
e. FP–long-term method	<10,000	41(44.6)	**20(52.6)**
	10,000 -<30,000	31(33.7)	15(39.5)
	30,000 -<50,000	17(18.4)	02(5.3)
	50,000+	03(3.23	01(2.6)

MNCH and FP client preferences related to seeking health services from private providers

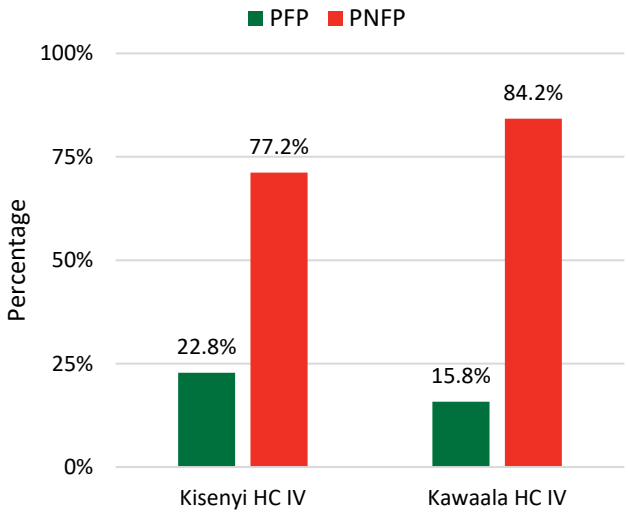
In terms of service-seeking preference outside the public facilities, most clients from both Kisenyi HC (77.2%) and Kawaala HC (84.2%) preferred to access services from private not-for-profit (PNFP) facilities compared to private for profit (PFP) facilities (Table 8). According to the clients interviewed, the main reason for this preference was that these were relatively lower-cost and higher-quality facilities that served as referral sites. Figure 6 shows client preferences for access of services in PNFP versus PFP facilities.

Clients reported that as much as accessing services in private clinics wouldn't be a problem, there are cost implications in private facilities. With the exception of costs that are charged for services in the private clinics, clients said that the availability of services both in the private and public facilities also provides them a choice.

Table 8: Client preferences to accessing MNCH and FP services from either public or private facilities

Variable	Item	Kisenyi HC IV	Kawaala HC IV
		n(%)	n(%)
Preference for PFP and PNFP	PFP	21(22.8)	06(15.8)
	PNFP	71(77.2)	32(84.2)
Bypassed other medical facilities	Yes	92(100.0)	32(84.2)
	No	00(0.0)	6(15.8)

Figure 6: Client preference for accessing services at either a PFP or PNFP



Clients bypassed other facilities in preference to Kisenyi or Kawaala HCs; The study revealed most clients who sought MNCH and FP services in the two study sites (100% from Kisenyi HC IV and 84.2% from Kawaala HC IV) passed up more than 10 private health facilities in preference to the public health facilities (Table 8).

"I would have wished to access services from private, but I fear the costs, but if the government can subsidise, that can save me the cost and time of coming to this facility." FGD participant from Kisenyi HC IV

"Yes, a facility that has integrated services in one place because Kawaala used not to have most of the services such as scanning [and] dental which are now available." FGD participant from Kawaala HC IV

According to some of the responses from clients interviewed, the main deciding factor of a health facility of choice was the availability of integrated services beneficial to both the child and mother. VHTs also highlighted that the mothers prefer a range of specific services based on their individual financial ability that is provided by both private and public facilities. These services included maternity, ANC, and immunisation. When respondents were probed further to understand their preferences for which category of facility, clients would opt to go for specific MNCH and FP services

and were able to express their choices based on their experiences in seeking services. These views were confirmed by VHT focus group discussions. Table 9 presents selected MNCH and FP services recommended to be accessed from either public or private health facilities.

Table 9: MNCH and FP services recommended from either, or both, public and private facilities

Preferred MNCH & FP services at public facilities	Preferred MNCH & FP services at private facilities	Preferred MNCH & FP Services at Both public and private
▪ All labour and delivery services and caesarean section ▪ Complicated deliveries (CeMOC Services) ▪ Referral services for MNCH & FP related services ▪ Obstetrics and gynaecology consultations and check-ups ▪ Birth registration ▪ Permanent family planning ▪ Nutrition assessment	▪ ANC services ▪ Short-term and long-term family planning services ▪ Immunisation services for children under 5 ▪ Malaria treatment in pregnancy	▪ STD Services ▪ Maternal-related laboratory services ▪ Malaria treatment in pregnancy ▪ Mama Kit distribution ▪ Maternal counselling for birth preparedness ▪ Managing hypertension and diabetes screening and treatment cases in mothers

The study identified a set of services clients thought were better sought/delivered in public facilities vs. private facilities, and a set of services that could be sought from both.

"The services here in public are good, and I rate them at 80%, and the reason why it's not 100% is that the doctors are few compared to the number of clients that seek services. If the government could be willing to reduce the cost of services in private, I would prefer going to the private to save time." VHT FGD participant

"… sometimes we refer mothers to private health facilities if they need simple services like tetanus injection, short-term family planning methods or immunisation; they always react positively when we refer them for such reasons." VHT FGD participant

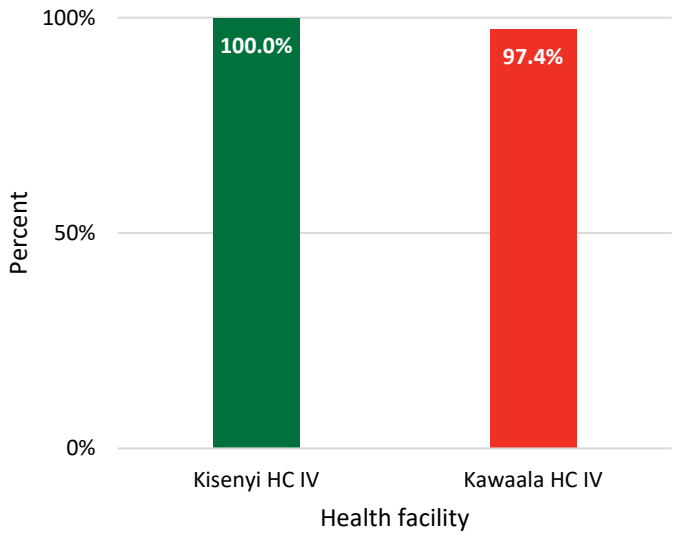
Client peer referral factor; The study revealed that most clients (54.3% from Kisenyi HC and 78.9% from Kawaala HC) who receive MNCH and FP services in the two study facilities were simply referred by their peers and/or by VHTs.

"We mainly refer mothers to our centres to receive specific services such as tetanus injection, long-term family planning methods, and immunisation." VHT *FGD participant*

During this study, when recipients of services were asked whether they would refer a friend or relative, clients overwhelmingly affirmed that they would refer their peers (100%) to Kisenyi HC and 97.4% from Kawaala HC), as shown in Figure 7. The main reasons they gave for recommending their peers to these facilities were because of free cost, health work care, good-quality services, and one-stop service, among others.

"Yes, I can easily recommend many mothers because all maternal services here are affordable, and even if some doctors ask for you to outsource a certain service from out, it's usually little compared to private hospitals." FGD participant at Kisenyi HC IV

Figure 7: Percentage of clients willing to refer a relative or friend to Kisenyi or Kawaala HCs



5 Discussion

This section examines the sociodemographic characteristics and drivers for the service-seeking behaviour among clients who seek services from the selected KCCA public health facilities.

Sociodemographic description of MNCH and FP clients

Age: The study revealed that the majority of MNCH and FP clients from both Kisenyi and Kawaala range between 25 to 49 years. According to the Uganda Bureau of Statistics, this age group is also considered to be a highly productive part of the workforce and is held accountable for increasing the productivity of the economy (UDHS, 2016). As such, it was determined that these clients come to work in the town and, at the same time, use the opportunity to seek services from the facilities.

Marital status: Findings from this profiling study indicated that women who seek MNCH/FP services are also more likely to have a partner than the average woman i.e Kisenyi HC IV - 85.9% and Kawaala HC IV – 86.8%. This result however, is relatively higher compared to UDHS (2016) where 61% of women age 15 to 49 are married or living together with a partner.

In addition, Kisenyi HC clients had an average of three children per woman, while Kawaala HC clients had an average of two per woman. These findings relatively compare with UDHS (2016), where the total fertility rate (TFR) is fewer than four children per woman of childbearing age among women in the urban setting. This therefore confirms that the clients who came to Kisenyi and Kawaala largely hail from urban settings.

Client education status: The study revealed that a substantial proportion of the clients (40% from Kisenyi HC and 55% from Kawaala HC) were relatively educated with at least an 'O' level education and above. These findings are consistent with UDHS (2016) report findings that show institutional deliveries increase steadily with increasing education in mothers. More specifically, 61% of births to women with no education take place in a health facility, while 96% of births to women with more than a secondary education level take place in a health facility. This implies that the educational status of clients is also higher in urban areas and increases the likelihood of this target population seeking out MNCH and FP services.

Religion: The religious patterns of clients who sought MNCH and FP services in the study were relatively distributed among the different denominations. More specifically, Catholics and Anglicans accounted for 35% and 22% in Kisenyi and 34% and 29% in Kawaala, respectively. The UDHS (2016) also indicates that 37.1% of the population practices Catholicism, while Anglicans account for 31.1% of the population. This implies, to a lesser extent, that some Catholics may hesitate to seek out FP services due to their religious affiliation. This, though, may or may not have a substantial influence on service-seeking behaviour by the client.

Livelihood source: The clients from both facilities were earning their livelihood from the informal sector. According to some of the FGD respondents, they were mostly involved in market food

vending, restaurants and hotel business, retail and kiosk shops, charcoal selling, mobile money business, roadside businesses, and laundry works in the community, among others. In contrast, other women were housewives and largely dependent on their partners for their livelihood. Those involved in the formal sector worked in schools as teachers, in hotels and factories, and in registered businesses as managers, among others. In Kawaala HC, the study revealed that a substantial number of respondents (42%) were housewives and depended on their partners for their livelihood. This is significant as it also impacts decision-making in the household.

As the DPHE explores a purchasing mechanism to decongest Kisenyi and Kawaala, the profile of the women seeking care in these facilities includes an age between 25 to 49 years, currently married or living with a partner, and mature multi-gravidas with one or two biological children. Most are Catholic, have attained at least an ordinary level (O' Level)[3] of education, and work in the informal sector.

Drivers for health care service-seeking behaviour by clients

Several factors influenced seeking out MNCH/FP services in both Kisenyi and Kawaala HC IVs. Trends from the study identified the following as the main factors influencing the decision-making process.

Proximity to service points: The study revealed that over 80% of clients who sought MNCH and FP services in Kisenyi HC came from outside the catchment area, while 70% of clients from Kawaala HC came from within the catchment. Even though some clients came from outside the catchment areas, as is the case in Kisenyi HC, proximity played a significant role for clients from Kawaala HC, who needed the ability to physically walk to the facility to access services. For instance, Kisenyi HC is strategically located in the central business district and close to the main markets and commuter taxi parks, making it easy for clients to access as they board and disembark the taxis.

Distance to health facility: Many clients from both clinics used the boda-boda means of transportation to get to the facilities. When asked about their decision to use the boda-boda transportation to the Kisenyi HC facility, respondents indicated it was a quick and flexible means of transportation in which they only spent 45 minutes, on average, travelling from their homes to the health facility. Kawaala HC clients usually preferred to receive services from a facility that was a shorter distance away. A client from the Kawaala HC stated:

"It is nearer to where I stay, and therefore, I don't spend transport while moving."

This factor of proximity suggests that it would be ideal for KCCA to consider contracting private health providers from within the catchment of KCCA facilities to decongest the public facilities and

[3] In Uganda, students receive the Uganda Certificate of Education (UCE) when they finish the four-year lower secondary school. It is comparable to GCE O-Level in the United Kingdom. UCE is also called "O-Level" by Ugandans. The UCE examinations are administered by the Uganda National Examinations Board.

incentivise clients to seek services through them. This is because the data show that there is an increased likelihood of success when focusing on serving the population living and or working within the catchment of the two KCCA health facilities. Thus, if MNCH and FP clients save money by not spending on transportation costs, and if the facilities are close to their home or place of work, the more likely they can afford and be willing to seek out services from the private facilities.

No-cost services for MNCH and FP services: Study results show the majority of MNCH and FP clients prefer free or highly subsidised services. They acknowledged that they were aware of the services provided by the private sector but were concerned about affordability and their current economic situation***.*** As such, the study shows that the free services from the KCCA facilities were a significant decision factor for clients, despite the high volume of clients and the long wait time.

Quality of services: Clients stated that they found the services good at the two public health facilities because the health workers were caring and trustworthy, responsive, and patient with them, despite the high daily volumes. Some clients also indicated that they are attracted to the facility because the environment was kept clean and tidy, and the facility's sanitation was well maintained. Numerous clients have had a positive experience and developed a history of accessing services from these facilities, and this keeps them coming and referring their peers.

In addition to free-cost services, clients reported that better patient care and quality services were offered at the two KCCA public health facilities***.***

> *"Despite the high number of clients here at Kawaala HC, the staff work at a very high speed, and they ensure that everyone is worked on."* FGD client from Kawaala HC IV

> *"There is professionalism of doctors at this health facility; however, much as they know they won't receive all the drugs, clients come to at least see the doctor and be diagnosed, the doctor would rather prescribe for them drugs to buy in the pharmacy, and they are sure the drugs would be effective."* VHT FGD participant

The implication for this positive service attribute is that KCCA will have to ensure that all accredited private sector providers meet the same quality ratings during pre-qualification to keep clients satisfied and willing to go to the private sector providers. A part of this will also be ensuring that services complement the mother's and child's health at one site.

Client level of satisfaction: The study revealed that there was a considerable level of satisfaction with the services received at the two study sites. This satisfaction level motivates clients to continue coming for the services at the two facilities. This finding is confirmed and is consistent with findings from the MOH annual client satisfaction survey for the health sector 2021/2021.[4] More specifically, Kawaala HC received a score of 80% on client satisfaction and was awarded among the best-

[4] MOH Annual Client Satisfaction Survey for the Health Sector 2021/2021.

performing facilities during the 27th MOH Health Sector Joint Review Mission (Nov. 2021). Despite the delays, the clients were patient enough to wait, knowing they would receive good-quality services.

***Clients' preference for either public or private services*:** During the study, clients were asked about their preference for receiving MNCH and FP services from other facilities aside from KCCA. VHTs reported that clients are aware that MNCH and FP services can be sought from both the public and private sector, but because of the challenge of affordability, not all services can be accessed through private providers. Clients would prefer to receive services such as ANC and FP from private facilities and receive other services such as delivery, permanent FP methods, and emergency care from public facilities, which cost less.

The place of service delivery is often related to the quality of care received by the mother and infant, an important factor for influencing maternal and child health care outcomes. It was highlighted that PNFP provided relatively similar services to public facilities, and their costs were relatively subsidised compared to PFP. Here, the reasons for preference varied from personal to community perceptions.

> *"Clients prefer a facility that has available and quality services in place—a one-stop service point."* VHT FGD participant

The two KCCA study sites were preferred by clients for being referral facilities and were reported to handle and manage pregnancy and delivery-related complications on top of providing laboratory services. As such, ensuring a facility has the full range of services provided and is of good quality is an important decision factor.

Existence of alternative private facilities offering MNCH and FP services: Client attitudes towards seeking MNCH services from either public or private facilities were positive, as clients were open to either option. However, some barriers still hinder effective utilisation, especially the affordability question. In the study, MNCH and FP clients were asked which services they would prefer to access from either a public or private facility and why they reported that services such as maternity should be handled by public facilities, since they require specialised staff and equipment. In contrast, it was suggested that private health providers handle minor services such ANC, FP, and PNC. Clients also acknowledged that the health services at the two study sites are good but that health workers are overwhelmed by the number of patients. There are many private health providers who are mostly within the catchment areas around the facility. These offer some of the MNCH and FP services and could serve as run-to facility services in order to relieve some of the pressure on the public facilities.

Many of the clients passed on more than 10 private facilities to seek services in KCCA facilities, which could otherwise serve as alternative facilities. As such, KCCA should explore the identification and accreditation of private health providers within the catchment of the public health facility to leverage and complement service delivery.

During the study, MNCH and FP clients were also asked how much they would spend on the selected MNCH and FP services at a private health facility (ANC, normal delivery, caesarean section, FP STM, and FP LTM). The FGD respondents highlighted that some clients might not be able to afford the charges in private facilities unless there were mechanisms to reduce the fees. There was, however, a positive move towards clients seeking services from the private providers because when the study sites experienced shortages of medications, mothers were asked to buy these medications or seek services from private clinics, which they did, despite the scepticism about price charges. Some clients indicated that services like family planning would be affordable in private facilities depending on the method one opted for.

Peer influence: Prompt and efficient identification and referral for pregnancy and emergencies from peers are key factors in seeking out services. Similarly, for rural settings, women have also been a source of inspiration to their peers in urban settings, influencing their decisions on accessing health services. This has been a key factor influencing women to receive a series of maternal health services continuously from early pregnancy to postpartum stages. When asked whether they would refer their peers from the community to the KCCA facilities, most of the respondents indicated that they would refer their friends to receive services from these facilities because they serve as referral sites and the services are free since they are government facilities.

Study limitations

The study experienced three limitations, including:

- KCCA has eight directly managed public health facilities, and only two (Kisenyi and Kawaala HC IVs) were studied, as they are high-volume facilities. Despite this limitation, the results can be generalised to reflect all eight KCCA facilities, given the similar nature of the clients served across the facilities.
- The study did not explore the views and perceptions of partners or husbands of MNCH and FP clients regarding seeking services in the two study facilities. This missed opportunity could have enriched insights with a deeper understanding of the client's dynamics towards seeking MNCH and FP services in Kampala.
- The study did not include women who had sought care in private facilities.

6 Conclusions and recommendations

The section presents conclusions and recommendations developed as a result of the study. The study sought to understand the MNCH/FP clients at these two facilities, their sociodemographic backgrounds, their reasons for choosing these public health facilities over private health providers, and key insights regarding where else they would seek services aside from the KCCA public health facilities.

Conclusions

- The study confirmed that most Kisenyi HC clients hail from outside the facility catchment, while Kawaala HC clients come from within the catchment of the facility.
- Based on the sociodemographic characteristics of the MNCH and FP clients, it was evident that the majority of clients were of low social status and preferred to access free health care services from public facilities or highly subsidised services in the case of private health facilities.
- The study revealed that most of the clients were fairly educated, which may have had a direct influence on service-seeking behaviour.
- The majority of the clients were married, which implied their partner's influence in decision-making about seeking health services and their ability to contribute to medical costs.
- Key drivers for service-seeking behaviours were availability of free services, client-perceived quality of services in terms of availability of health workers, availability of a variety of services at one stop point, availability of drugs, and client care, among others.
- Both referred or self-referred clients were attracted to health facilities that provided good-quality services.

Study recommendations

- MNCH and FP services should be provided in both public and private facilities, and since the preference is for no-cost services, KCCA and/or the government should develop modalities to subsidise select services at private health facilities to divert the volume of clients and reduce demand on public facilities.
- In order for KCCA to decongest services in their limited public health facilities, they should contract private providers for selected services such as antenatal, FP, immunisation, and laboratory services to private providers at subsidised costs.
- MNCH and FP services should be made available closer to recipients, either through public or private providers. Proximity to facilities was a significant factor impacting decisions on receiving services from certain facilities and will be a strong incentive for clients.

- KCCA should ensure improved quality services in private facilities through the implementation of effective accreditation and monitoring of service quality and client satisfaction. This will give clients the incentive to go to private health facilities.
- KCCA should purchase selected MNCH and FP services of private providers within the catchment of their public facilities to help address the demand of clientele currently overwhelming the public facilities.
- Planning for health services such as MNCH and family planning services in Kampala should not only be based on clients in the catchment areas but should also consider other factors, including but not limited to accessibility, proximity to workplace, cost of services, and peer-to-peer referrals, among others.
- The team recommends further research on the community. A community-based study should be conducted to complement findings from this study in regard to health service-seeking behaviour for clients in the general population.

As mothers are steered to the private sector, key considerations when thinking through the purchasing model to decongest the KCCA facilities include the proximity of service points, distance from the public facility to the contracted private facilities, and the quality of services provided to offer the same level of satisfaction as at the public facilities but at free or subsidised rates.

References

Azfar, O., & Murrell, P. (2009). Identifying Reticent Respondents: Assessing the Quality of Survey Data on Corruption and Values. *Economic Development and Cultural Change, 57*(2), 387-411. Retrieved from https://EconPapers.repec.org/RePEc:ucp:ecdecc:v:57:y:2009:i:2:p:387-411

DHIS2. (2020). Health Information Management System; Ministry of Health.

Gwatkin, D. R., Bhuiya, A., & Victora, C. G. (2004). Making health systems more equitable. The Lancet, 364(9441). 1273-1280. Retrieved from https://doi.org/10.1016/S0140-6736(04)17145-6

Kerber, K. J., et al. (2007). Continuum of care for maternal, newborn, and child health: from slogan to service delivery. (1474-547X (Electronic)).

Kish, L. (1965). *Survey sampling*. New York: John Wiley & Sons.

Machira, K., & Palamuleni, M. (2018). Women's perspectives on quality of maternal health care services in Malawi. *International journal of women's health, 10*, 25-34. doi:10.2147/IJWH.S144426

MOH. (2016). *Sharpened Plan*. Retrieved from Kampala-Uganda:

MOH. (2020). *Annual Health Sector Performance Report (AHSPR)*. Retrieved from Kampala, Uganda:

Okello D A, et al. (2021). *Magnitude and Consequences of MNCH and FP Service Congestion in KCCA Public Health Facilities: Findings from a Rapid Assessment of Utilization and Capacity at Kawaala and Kisenyi Health Centre IVs. Kampala*. Retrieved from Republic of Uganda https://thinkwell.global/wp-content/uploads/2022/02/KCCA-Landscape-Analysis-Final-2022-2.pdf

PSI. (2020). *USAID's Kampala Slum Maternal and Newborn Project (MaNe); Profiling of the Urban Poor Woman.* . Retrieved from Kampala, Uganda:

Titaley, C. R., et al. (2008). Determinants of neonatal mortality in Indonesia. *BMC public health, 8*(1), 232. doi:10.1186/1471-2458-8-232

UDHS. (2016). *Uganda Demographic and Health Survey 2016*. Retrieved from Kampala, Uganda:

Wallace, L. J., & Kapiriri, L. A.-O. (2019). Priority setting for maternal, newborn and child health in Uganda: a qualitative study evaluating actual practice. (1472-6963 (Electronic)).

Wamajji, R. (2021). *The Impact of COVID-19 on Women and Girls: Policy Brief Presented to the Parliament of Uganda. Kampala:* . Retrieved from Westminster Foundation for Democracy https://www.wfd.org/wp-content/uploads/2021/07/Impact-of-COVID-19-on-women-and-girls..pdf

World Bank. (2016). URMCHIP PAD.

Appendices

Appendix 1 (Consent Forms) and Appendix 2 (Data Collection Tools): view here.