Summary from the COVID-19 front-line: **Uganda country brief**
Survey of maternal and newborn health professionals

Authors: Aline Semaan, Lenka Benova (lbenova@itg.be) July 15, 2020

Background and methods
As of July 1st 2020, the Coronavirus disease (COVID-19) has resulted in more than 880 confirmed cases in Uganda. As evidence continues to be generated around the impacts of the infection during pregnancy and the postpartum period, it is expected that the outbreak's indirect effects will exceed the direct impacts of infection among women and newborns. This document summarises the findings from a global online survey of maternal and newborn health professionals working in Uganda, and includes responses received between March 29 and June 19, 2020. This brief presents challenges experienced by healthcare providers during the early stages of the pandemic, as well as applied and suggested solutions to overcome them and ensure that care continues to be provided to women and newborns.

The survey collected data on the respondents' background (country and region, qualification and work responsibilities, gender, and basic characteristics of the health facility in which the respondents worked, if any). To avoid concerns over confidentiality, we did not collect names of health facilities. The questionnaire included three core modules focusing on preparedness for COVID-19, response to COVID-19, and health workers' own experience of work during the COVID-19 pandemic. In the fourth, optional module, we asked respondents to elaborate on adaptations to 17 care processes (timing, frequency, modality of contact with patients during various types of outpatient and inpatient care) and to comment on whether they perceived that the uptake of care by the population they serve has changed and, if it had, how. The summary of global responses was published here (Round 1 survey questionnaire is provided as supplementary material).

Respondents' characteristics
We use 26 responses collected from healthcare professionals working in Uganda, 17 of whom agreed to answer the optional module. Around half the respondents worked in Kampala (n=12), and 6 respondents worked in the Central region of Uganda. Half of the 26 respondents were obstetricians/gynaecologists (n=13), followed by nurse-midwives (n=5) and midwives (n=3), and the majority were males (n=17). Respondents mainly provided antenatal care, childbirth and postnatal care. Most of the respondents provided care in referral hospitals and in public sector facilities (n=18 and n=20, respectively). Most of the facilities where respondents worked provided caesarean sections (n=24), accepted maternity patients referred from other facilities (n=25), and had a newborn intensive care unit (n=22). Five respondents reported that their facility had seen maternity patients with suspected or confirmed SARS-CoV-2 infection.

Part 1. Preparedness for COVID-19

Access to information	The vast majority (23 of 26) of respondents reported receiving information on COVID-19 from their facilities. Covered themes included disease signs and symptoms, transmission mode, protective measures (e.g. hand hygiene, personal protective equipment (PPE) use, social distancing and isolation), patient screening and case reporting and referral. Almost all respondents searched for guidance themselves and took part in informal sharing with colleagues.
Trainings and drills	13 respondents received training on providing care during COVID-19. 12 respondents reported being mostly or completely clear on what to do in case they need to provide care to suspected or confirmed COVID-19 maternity patients.
Updated guidelines	13 respondents received updated guidelines on care provision to pregnant, laboring or postpartum women and their newborns in the context of COVID-19.

	Respondents mentioned the WHO and the Uganda Ministry of Health as main sources of these guidelines, followed by the Royal College of Obstetricians and Gynaecologists (RCOG, United Kingdom). Some respondents expressed concerns over their lack of access to practical guidelines and protocols: "*We have no protocols for handling suspected/confirmed COVID-19 pregnant women during delivery*." "*There is no clear information on how to handle pregnant women who contract the virus, what mode of delivery is better to both the mother, and baby, [or on] whether this virus can be congenitally transmitted to the baby."*

Part 2. Response to COVID-19 at the facility level

Screening and isolation	Almost all facilities where participants worked had established a sign-posted entrance and COVID-19 screening area. 14 respondents reported that their facilities screened maternity patients for COVID-19 symptoms. "*[we are making sure that] history is picked and symptoms not missed out as screening is performed at the entrance of the hospital or at emergency triage points*." 15 respondents reported that their facilities had dedicated isolation rooms for suspected patients.
Testing capacity	Five respondents reported being able to order a RT-PCR test for the SARS-CoV-2 virus for maternity patients. Range of time periods to receive results was one to three days.
Infection prevention	Among the 26 respondents, 20 reported that they did not have a sufficient quantity of gloves, face masks (n=9), and aprons (n=4). Two out of 26 respondents felt well protected from COVID-19 in the workplace. "*There is no adequate protective gear to deliver a mother infected with COVID-19*." "*For those at highly risky areas, like the screening points, triage at the emergency wards and laboratory staff are encouraged to wear eye shields, N95 masks at all times. These supplies have been mainly provided by Government of Uganda and some well-wishers to the hospital staff.*" *"Appeal to WHO to [provide] PPE to developing countries"* 11 participants reported an increase in routine cleaning in their facility's maternity ward.

Part 3. Personal experience and work

Transportation	Respondents reported difficulties in reaching their workplace due to reduced availability of public transport. "*I am not able to continue going to work because public transport was stopped for some days and I live about 25 kilometers away.*" "*Transport to work is a big challenge due to lockdown many staff live far away from the hospital. The staff who manage to come to work hurry to leave the hospital early to observe the curfew time of 7.00 p.m."*
Staff workload	Respondents reported a shortage of healthcare workers resulting from the lockdown and observed curfew. *"Difficult to bring the night team first [because they] claimed they felt cheated by reporting earlier at 16:00 hours and leaving their work station by 10:00 hours the next day without any incentives*." This shortage was compensated for by multi-tasking and longer working hours among healthcare providers who managed to reach the health facility. "*We are also multi-tasking as some of our cadres were locked far away by the lockdown."* "*Working overtime due to screening of patients and health educating of patients, few workers [available] since some of the workers stay far away*."
Stress levels and concerns	24 out of 26 respondents reported that their stress levels were somewhat or substantially higher than usual. "*The staff are very anxious and panicky and need talking to all the time, which is exhausting*." Few respondents reported that their concerns about COVID-19 had been addressed well by the facility where they work (n=3). Fear of becoming infected and about own safety and livelihood was a common theme. "*The fear of health workers contracting the disease may limit their ability to offer quality care.*" *"Staff are afraid to handle positive patients due to inadequate protective gears, and inadequate knowledge of handling patients with COVID-19."* Respondents noted being concerned about patients' non-compliance with infection prevention measures. **Recommendations from respondents** on how to better support health providers: - Increase the availability of transportation means - Provision of trainings - Support from technical surveillance teams for screening patients - Provision of psychological support - Extra 'risk' allowances in addition to salary

Part 4. Changes to the care provided to women and newborns

The table below reports responses from 17 health professionals who completed the optional module.

Women's use of care	Fewer women were reportedly seeking services from health facilities either because of fear of contracting the illness or because of lockdown measures and the shutting down of public transport. Respondents reported that: - Fewer routine antenatal and postnatal checks were taking place; - There was a perceived increase in home-based childbirth with traditional birth attendants *"No functional ambulance services. Pregnant women have difficulties in reaching the facility, so numbers are lower than usual."*
Care and service availability	Respondents noted suspending outpatient and community services, and prioritizing high-risk patients for certain services. *"In the hospital, we have had to scale down on the OPD clinic; Gynaecology, oncology, infertility, family planning clinics have been closed for over a month."* "*All project support has ceased and so many of the community activities have been suspended*." "*The ANC clinic has been modified to cater for those with risk factors or more than 28 weeks gestations*."
Inpatient antenatal care	Respondents mentioned stricter admission criteria to reduce the number of women on the maternity ward. Attempts were made to reduce time women spent in the health facility. "*Tightened admission criterion for the patients that should be admitted on the antenatal ward from the usual 60 to 70 mothers to less than 30 mothers."* *"We discharged most of mothers waiting for delivery especially normal [delivery] and then accelerated elective surgeries for mothers awaiting elective surgeries."*
Intrapartum care	Reduction or suspension of elective caesareans was mentioned by two respondents. Healthcare providers reported limiting the number of labour companions to one or two. Shortening of visiting hours, cancelling visits altogether or reducing the number of allowed visitors were also reported. *"Discouraged the unnecessary visit and company of the males for they are encouraged to stay at home to care for the other siblings"*
Postnatal care	Respondents mentioned shortened length of stay in facility postpartum: *"A normal delivered mother to go home in 12 hours postnatal"* *"Early discharge after caesarean delivery between 72 hours to 120 hours."* Postnatal follow-up was delayed or cancelled, including home visits: *"At least to follow-up a mother once in two months postnatal, not like it was of seven days follow-up at [home]"*
Newborn care	Continued provision of routine newborn care, with the addition of infection protection measures: *"Encourage mothers to breastfeed as she wears a mask, remind them of routine hand hygiene with soap and clean running water prior to breast feeding neonates. The rest is routine care of warmth, feeding, vitamin K, National immunization schedule followed, eye care with TEO all done and advised on cord care. Report danger signs to health care providers nearest to the parents' home."*

	Reduced sharing of beds and equipment at the newborn intensive care unit: *"One neonate per each bed, single use nose prongs"* *"Social distance is observed, sharing of equipment is minimized and in case it is shared like pulse oximeter, maximum cleaning with antiseptic is done."*

Key challenges to and solutions for maintaining provision of maternal and newborn care: In respondents' words

Increased workload in some facilities with poor resources due to the closure of others

"At enforcement of the presidential directives on the lockdown, it felt like all other hospitals closed off and our hospital which is a national referral hospital but with limited supplies had a huge influx of patients in a poor shape for the first 72 hours and hence worked around the clock to salvage lives"

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Inability of implementing social distancing

"The huge number of pregnant women seeking care at this facility with the huge following of their attendants doesn't easily allow for social distancing."

Difficulty in screening paediatric patients

"The actual problem of screening paediatric patients the majority of whom present with fever, cough, and their next of kin can't discern contact for these paediatric patients… And all these [patients] can't easily be subjected to testing since the tests are still very expensive (PCR tests) as compared to use of COVID-19 antibody tests."

Scarcity of available resources

"Lack of ventilators for severe cases if needed"

Solutions

Attempts to enforce social distancing measures

"The waiting area has been made less crowded - mothers wait from outside the clinic and only those for examination are allowed in."

"Birth companions are sent off level 4 and level 3 where C-sections are conducted to the level one and the open compound to reduce huge crowds that used to crowd at level 4 balcony and ward plus theatre area. This is what was recommended but burnout of the security team at times seems like the recommendations are bleached and companions gather up again."

Increased compliance with infection prevention and control measures

"*Covid-19 has helped our facility - health care workers and administrators to understand the importance of infection prevention and control. Use of alcohol and hand washing have dramatically improved.*"

"*Hand hygiene at all entrances at the facility, entrances to wards, administration building, lift entrances where accompanying hand sanitizers were placed."*

Evolution of the response with the easing of precautionary measures

"*First closed antenatal clinics, then phased opening with long spaced antenatal visit and social distancing.*"