



PUBLIC HEALTH & ENVIRONMENT BULLETIN

DIRECTORATE OF PUBLIC HEALTH AND ENVIRONMENT

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Dear Reader,

We welcome you to issue 2, volume 1 of the KCCA-Public Health and Environment Bulletin. The aim of this Bulletin is to document and communicate the works, achievements, and key challenges with regards to Kampala's Public Health, Environment and other related events. The end goal is to disseminate this information to the policy makers, health professionals, the public, implementing partners and all stakeholders.

In this issue, we are excited to share with you a wide variety of articles focusing on Kampala's health and environment including: articles on medical services, private health sector, COVID-19 highlights and noise pollution. In a special way, we also present success stories from some of our many implementing partners.

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

Enjoy your reading!!

Thank you.

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COVID-19 outbreak highlights in Kampala city, September 2020

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COVID-19 (Corona Virus Disease 2019) was declared a global pandemic on March 11, 2020. Uganda confirmed her first COVID-19 case on March 21, 2020. To contain the spread of the virus, the Ministry of Health (MoH) put in place multiple strategies and restrictions including closure of schools, active search for all at risk people such as international travellers and contacts for screening and testing, banning of mass gatherings, curfew, among others which eventually led to the lockdown.

On May 6, 2020, 91 cases had been detected in the country, with little community transmission detected (8%) and as a result, it was inevitable to gradually relax some of the earlier restrictions. Easing of these restrictions was crucial for Kampala City being the economic hub of Uganda, and most importantly they were not sustainable in the long run.

Therefore, a phased approach to relax the restrictions in the city was implemented to allow continuity of economic growth without losing gains made in COVID-19 control.

In Kampala City, COVID-19 response activities are coordinated by Kampala Capital City Authority (KCCA) taskforce supported by MoH and several implementing partners. By August 2020, numerous interventions have been put in place including; 1) organizing the city response into key pillars that included co-ordination and leadership, surveillance, case management, laboratory, risk communication and social mobilisation, logistics and strategic information 2) setting up of an emergency Operations Centre (EOC) that was eventually expanded to cover the Greater Kampala Metropolitan Area (GKMA); 3) deployment of highly experienced human resource from MoH headquarters, World Health Organization (WHO), United Nations Children's Fund (UNICEF) and Infectious Diseases Institute (IDI) as full-time KCCA COVID-19 response staff to provide technical support and assistance; 4) inter-sector technical committee was instituted to provide guidance on COVID-19 response activities given the heterogeneity of Kampala; 5) recruitment and training of staff for different response pillars; 6) harnessing technology to conduct testing, isolation, contact listing and tracing; 7) community based surveillance and risk communication through full involvement of the community in management of the response; 8) a coordinated evacuation system for confirmed cases to the COVID-19 treatment centres (CTUs) for entire GKMA; 9) use of a City Health Information System (CHIS) to monitor compliance in workplaces including markets, arcades and bus terminals.

As of September 13, eighty one percent of confirmed cases

country wide (81%: 3,804/4,703) were locally transmitted while 19% (899/4,703) imported cases (1). Despite several interventions there has been a continuous surge in cases starting August 2020 as it took Kampala city 100 days (March-July) to record its first 100 cases and only 10 days to register the next 100 cases. By September 09, 2020 Kampala, the city had recorded 1,515 confirmed cases cumulatively accounting for 35% of the national tally and 31 (65%) out of all COVID-19 related deaths in the Country. In addition, a cumulative number of 13,408 samples had been collected, 6,583 contacts listed in the city and workplace-based clusters in the city had been identified and investigated.

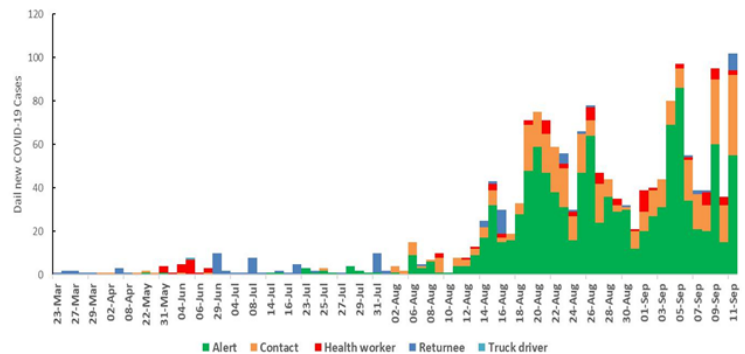


Figure 1: Daily new Confirmed cases in the Kampala Metropolitan (source: Ug_COVID-19_SitRep#206)

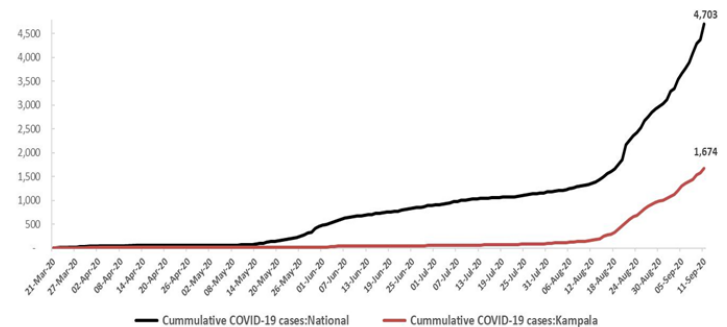


Figure 2: Comparison of Cumulative COVID-19 Cases registered (Kampala VS National) (Source: Ug_COVID-19_SitRep#206)

Conclusion and way forward

Kampala City continues to have the highest rates of new COVID-19 infections in the country affected by geographic variation in testing and day versus night population disparities. High population density in Kampala city makes the COVID-19 response challenging due to the frequent inter personal contacts. However, population density and urbanisation will no longer be an enemy if compliance to the preventive measures is ensured. The situation remains challenging requiring a Joint effort and mobilisation by the public and all the stakeholders to achieve an effective control of the COVID-19 epidemic and future similar public health emergencies.

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COVID-19 Health Facility Operational Readiness Assessment in the Urban Setting of Kampala and Wakiso Districts, Uganda, April 2020

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Summary

COVID-19 was first detected in China in December 2019. Uganda registered its first case on 21 March 2020. Measures including a national wide lock down, closing the airport and ground crossing points with neighboring countries to limiting importation and further spread of the virus were instituted. The Ministry of Health activated its coordination structures to respond to the Pandemic.

We employed a cross-sectional design with a quantitative approach. A total of 59 health facilities were assessed; 44 in Kampala and 15 in Wakiso District. The assessment was administered uniformly across all the facilities in both districts. We adapted a World Health Organization COVID-19 readiness assessment tool with 4 modules.

59 health facilities were assessed for COVID-19 readiness, 44 (75%) from Kampala and 15 (25%) in Wakiso district. In Kampala District, 14% of the health facilities were in the most ready quintile compared to Wakiso District which had 33% in the same category.

Most of the health facilities in Kampala and Wakiso districts had minimal operational readiness capacity to respond and manage COVID-19. We recommend provision of COVID-19 guidelines in the health facilities, intensification of health worker capacity on surveillance and laboratory, and case management and IPC.

Introduction

The first cases of COVID-19 were first detected in Wuhan City and reported to World health organization (WHO) on December 31st, 2019. COVID-19 is a highly infectious disease that spreads through droplets of saliva or discharge from the nose when an infected individual coughs or sneezes (3). Symptoms of COVID-19 may include; fever, cough, shortness of breath/ difficulty breathing, fatigue, muscle/ body aches, headache, loss of taste/ smell, sore throat, congestion/ runny nose, nausea/ vomiting and diarrhea (4, 5). The Incubation period is between two to fourteen days from exposure (4).

On 11 March 2020, World Health Organization (WHO) declared the disease a Pandemic after several countries reported cases of COVID-19 (6). Uganda registered its first case of COVID-19 on 21 March 2020. The Ministry of Health activated its coordination mechanisms at national and district levels.

National and district rapid response teams were oriented on surveillance for COVID-19. Points of entry screening was intensified for all truck drivers, National and Regional Referral Hospitals were designated to treat COVID-19 patients and health workers oriented on case management, infection prevention and control and psychosocial support. Risk management and social mobilization were initiated in all districts and logistics deployed for the response. To understand where additional efforts are needed to enhance health care for COVID-19 at health facility level, we set out to assess health facility readiness for COVID-19 in Kampala and Wakiso districts, identify operational gaps in surveillance and laboratory, case management and IPC and logistics for COVID-19 and inform programming.

Methods

Setting: Kampala City has an approximated population of 1,680,600. Wakiso has an estimated population of 2,915,200 (8). Kampala has 3 general hospitals 15 PNFPs and over 1,000 PFPs. Wakiso district has 1 general hospital, 10 PNFPs and over 200 PFPs.

In Kampala, the assessment was conducted in 44 health facilities while 15 in Wakiso. The assessment was administered uniformly across all the facilities in both districts. Convenience sampling was used as the assessment targeted health facilities that were considered easily accessible and more likely to respond.

Design: This assessment employed a cross-sectional design with a quantitative approach. To evaluate the operational readiness and preparedness of the facilities, we adapted the WHO COVID-19 assessment tool with four modules assessing coordination mechanisms at district level and surveillance and laboratory capacity, case management and Infection Prevention and Control (IPC), and logistics at health facility level.

Study variables, data abstraction, management, and analysis:

Responses for each of the health facility level three modules was measured on a 5-point likert scale that was interviewer administered. Additional data collected included individual health facility characteristics such as ownership, and location.

Health facilities were assigned readiness scores based on capacity to respond to COVID-19 under three response pillars; (i) surveillance and laboratory, (ii) case management and infection prevention and control and (iii) logistics as well as overall capacity. Capacity to respond under each pillar was assessed based on a standard set of questions from the WHO COVID-19 readiness assessment tool. These readiness scores are derived using principal component analysis (PCA). Readiness quintiles were compiled by assigning each health facility its score, and then dividing the distribution into five equal categories, each comprising 20% of the health facilities. In this study, we present readiness scores categorized into quintiles by district and health facility ownership.

Results

Of the 59 health facilities that were assessed for COVID-19 readiness, 44 (75%) were in Kampala and 15 (25%) in Wakiso. In Kampala, 1 health facility was Government (Govt)

owned; 14 were private not for profit (PNFP) and 29 private for profit (PFP). While in Wakiso 12 health facilities were Government owned, 3 were PNFP and none PFP.

Kampala and Wakiso Districts both have Emergency Response Coordination structures in place called District Task Forces (DTF). The DTF comprises of security officers, district health officer and technical leads from the response pillars of surveillance and laboratory, risk communication, social mobilization and community engagement, logistics, case management, infection prevention and control and psychosocial support. Contingency preparedness and response plans for COVID-19 pandemic were developed prior to the outbreak in Uganda in both districts.

District readiness

All districts in Uganda were elevated to heightened preparedness and response following confirmation of COVID-19 cases in Africa. Capacity was built for case management and IPC, psychosocial support surveillance and laboratory and surveillance. Supplies were deployed to the various health facilities to manage the Pandemic. Enhanced surveillance strategies including active case search and health facility based surveillance were initiated.

We compile and present below summaries of composite indices for surveillance and laboratory, case management and IPC and logistics computed using pillar specific variables and categorize it as quintiles. Figure 1 presents the readiness quintiles by district where the health facility is located. This is important in assessing the overall district readiness for COVID-19.

In Kampala District, 14% of the health facilities were in the most ready quintile. This is in contrast to Wakiso District which had 33% of health facilities in the most ready quintile. Kampala District had 29% of health facilities in the least ready quintile compared to Wakiso District which had no health facilities in the least ready quintile. It is important to note that 83% of health facilities in Wakiso district were either in the fourth or fifth quintile while Kampala District had only 24% of their facilities above the third quintile. (Figure 1).

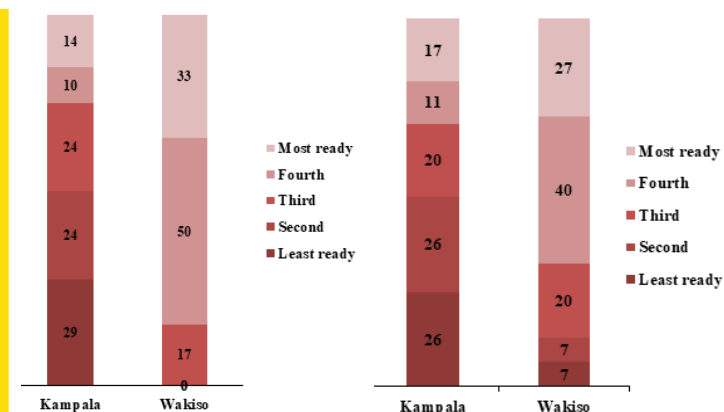


Figure 1: Overall percent distribution of health facilities by readiness quintiles for COVID-19 in Kampala & Wakiso districts, May 2020

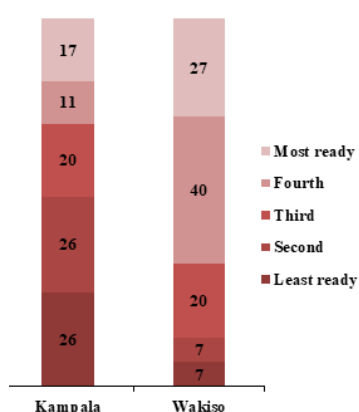


Figure 2: Percent distribution of health facilities by surveillance and laboratory readiness quintiles for COVID-19 in Kampala and Wakiso districts, May 2020

Surveillance and Laboratory

Twenty seven percent (27%) of health facilities in Wakiso District were in the most ready quintile for surveillance and laboratory compared to Kampala District that had 17% of the health facilities in this category. One quarter (26%) of Health Facilities in Kampala District were in the least ready quintile while Wakiso District had only 7% of its health facilities in the least ready quintile for surveillance and laboratory. (Figure 2).

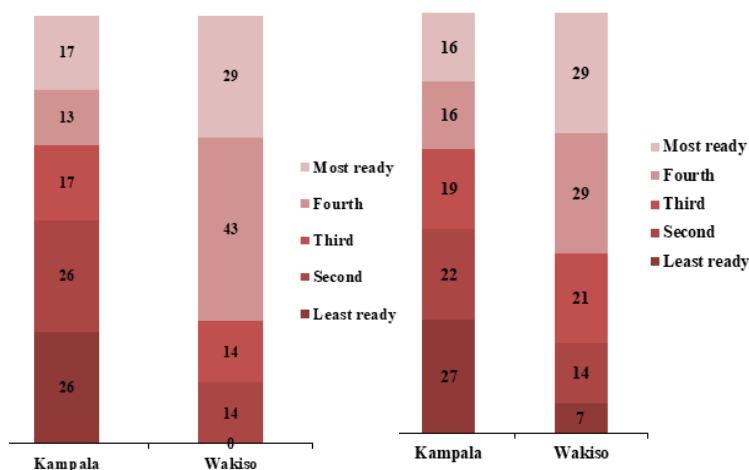


Figure 3: Percent distribution of health facilities by case management and infection prevention and control readiness quintiles for COVID-19 in Kampala & Wakiso districts, May 2020

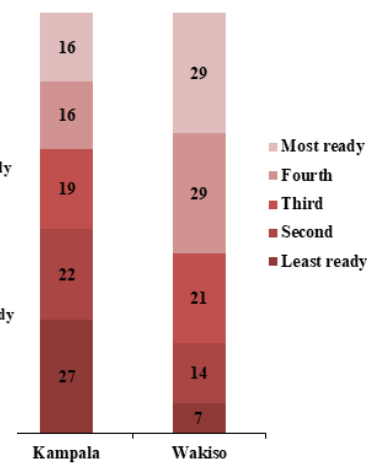


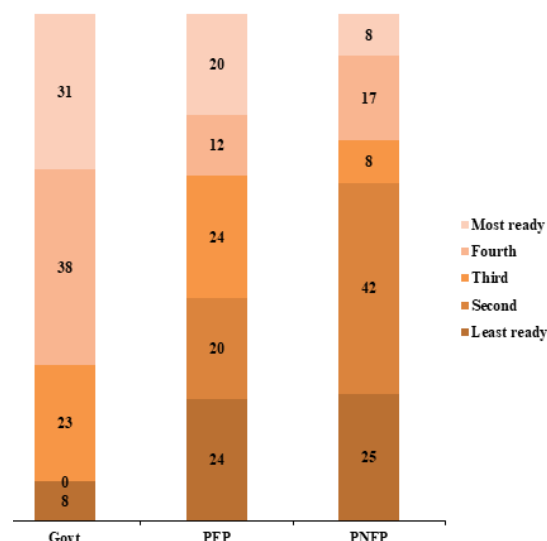
Figure 4: Percent distribution of health facilities by logistics readiness quintiles for COVID-19 in Kampala & Wakiso districts, May 2020

Case management and Infection Prevention and Control

Nearly 3 in 10 (29%) health facilities in Wakiso District were in the most ready quintile for case management and IPC compared to only 17% of health facilities in Kampala District. In Kampala District, 26% of health facilities were in the least quintile while Wakiso District had no health facilities in this category. (Figure 3)

Logistics

About 3 in 10 (29%) health facilities in Wakiso District were in the most ready quintile for logistics. In Kampala 16% of health facilities were in the most ready quintile. In the least quintile, Kampala had 27% of its health facilities while Wakiso District had 7% (Figure 4).



(continued on next page)

Figure 5: Percent distribution of health facilities by ownership readiness quintiles for COVID-19 in Kampala and Wakiso districts, May 2020

Surveillance and Laboratory

More than one-third (31%) of Government; 20% of private for profit compared to 8% of private not for profit owned health facilities were in the most ready quintile for surveillance and laboratory. Private for profit and private not for profit health facilities had 24% and 25% of health facilities respectively in the least ready quintile compared to 8% Government Health Facilities (Figure 5).

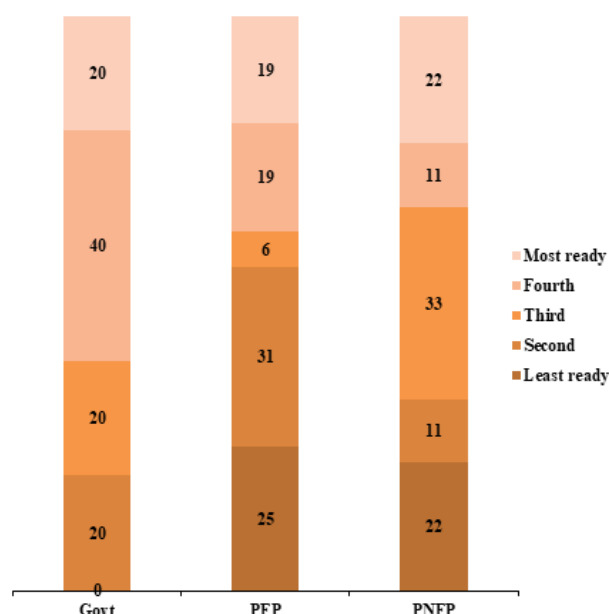
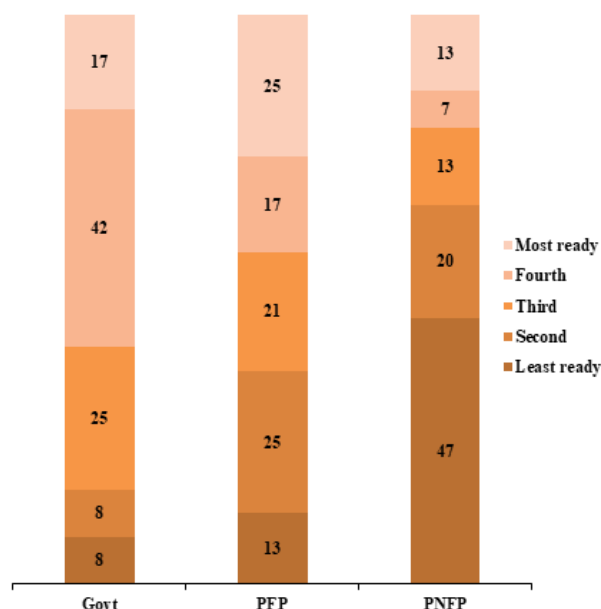


Figure 6: Percent distribution of health facilities ownership and case management and infection prevention and control readiness quintiles for COVID-19 in Kampala and Wakiso districts, May 2020

Case management and Infection Prevention and Control

More than 2 in 10 health facilities of Private for profit (25%) and private not for profit (22%) ownership were in the least ready quintile. However, none of the health facilities owned by Government were observed in the least quintile for case management and IPC. Nearly 2 in 10 health facilities were in the most ready quintile (Figure 6).



Limitations and strengths

Due to the stringent measures instigated by the Government of Uganda on restriction of movement in order to prevent the spread of COVID-19, the number of health facilities reached in Wakiso District were less than planned. However, the study provides gaps in capacity to adequately respond to the COVID-19 pandemic.

Conclusion

Most of the health facilities in Kampala and Wakiso districts had especially Private facilities had minimal operational readiness capacity to respond and manage COVID-19. We recommend provision of COVID-19 guidelines in the health facilities, intensification of health worker capacity on surveillance and laboratory, and case management and IPC. Additionally, we recommend provision of adequate logistics including personal protective equipment, availability of ambulances to transport suspect and confirmed cases to isolation units.

Acknowledgements

We would like to appreciate Wakiso District Local Government and Kampala City Authority for allowing us to access these health facilities.

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World Suicide Prevention Day September 10, 2020

World Suicide Prevention Day (WSPD) is organised by the International Association for Suicide Prevention (IASP) and co-sponsored by the World Health Organisation. The purpose of the WSPD is to raise awareness globally that suicide can be prevented.

According to WHO, close to 800,000 people worldwide die by suicide every year and for each suicide, there are more than 20 suicide attempts. Suicide and suicide attempts can have long lasting impacts on families, communities, friends, colleagues and society at large.

Many suicides and suicide attempts go unreported as they occur at home, however, much can be done to prevent them at individual, community and national levels. In commemoration of the WSPD of 2020, we should work together to watch out for warning signs of suicidal attempts in our communities.

World Patient Safety Day September 17, 2020



Established in May 2019, World Patient Safety day is about recognising patient safety as a global health priority. The main objective is to increase public awareness and engagement, enhance global understating, and spur solidarity and action to promote patient safety. 134 million adverse events reportedly occur each year due to unsafe care in hospitals in low- and middle-income countries, contributing 2.6 million deaths annually. Fifteen percent of hospital expenses can be attributed to treating patient safety failures as 4 out of 10 patients are harmed in the primary and ambulatory settings; up to 80% of harm in these settings can be avoided. During this difficult COVID-19 pandemic, working in stressful environment can make health workers more prone to errors. The theme of the World Patient Safety Day 2020 is "Health Worker Safety: A priority for Patient Safety". Slogan: "Safe health workers, safe patients", Call for action: Speak up for health worker safety!

World Antimicrobial Awareness Week 18-24 November 2020



World Antibiotic Awareness Week

World Antimicrobial Awareness Week 2020

18 – 24 November 2020

World Antimicrobial Awareness Week (WAAW) was endorsed at the Sixty-eighth World Health Assembly in May 2015 with a plan to tackle the growing problem of resistance to antibiotics and other antimicrobial medicines.

WAAW aims to increase awareness of global antimicrobial resistance and to encourage best practices among the public, health workers and policy makers to avoid the further emergence and spread of drug-resistant infections. Antimicrobial resistance (AMR) occurs when bacteria, viruses, fungi, and parasites resist the effects of medications, making common infections harder to treat and increasing the risk of disease spread, severe illness and death. Antimicrobials are used to fight diseases in humans, animals and plants and include antibiotic, antiviral, antifungal and antiparasitic medicines.

WAAW takes place every November to promote global education on antibiotics, how they should be used, and the growing risks of antibiotic resistance. Global awareness of all these issues has improved since its endorsement. The campaign highlights best practices among the public, health workers and policy makers to help stop the further emergence and spread of antibiotic resistance.

Utilization of Family Planning Services in Kampala, August 2020

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Background

Uganda's total fertility rate (5.4%), maternal mortality (336/100,000 live births), and teenage pregnancy rates (25%) remain among the highest globally (UNFPA, 2020). The government of Uganda is committed to scaling-up the use of modern family planning methods both short term (Orals and Injectable) and long term (IUDs and Implants) to ensure that every Ugandan woman can choose when and how many children to have.

According to (UDHS, 2016), Uganda has the highest rate of teenage pregnancy in Sub-Saharan Africa with over 25% pregnancies among teenagers registered every year. By improving the number of health structures in hard-to-reach places, the Government of Uganda strives to expand its reach and provision of services and method mix, including long acting, reversible, and permanent methods. These commitments are envisaged to contribute to the nation's ambitious goal to reduce unmet need for family planning among the marrieds from the current 28% to 10% in 2021, from 30.4% in 2016 to 25% in 2021 and increase the modern contraceptive prevalence rate to 50% by 2020. This is intended to address challenges of teenage pregnancies, unintended pregnancies that sometimes result into maternal mortality rate and infant mortality rate (44 per 1,000 live births)(UDHS, 2016).

Following the global response to the COVID-19 pandemic with strategies such as curfew and countrywide lockdowns, Uganda inclusive, the Continuation of essential health services has been greatly affected overtime and key among these, is family planning (FP). The Directorate of Public Health and Environment at Kampala Capital City Authority (KCCA) has spearheaded, numerous activities aimed at improving

Family Planning uptake of selected methods in Kampala through the 8 KCCA directly managed Health Facilities.

Methods

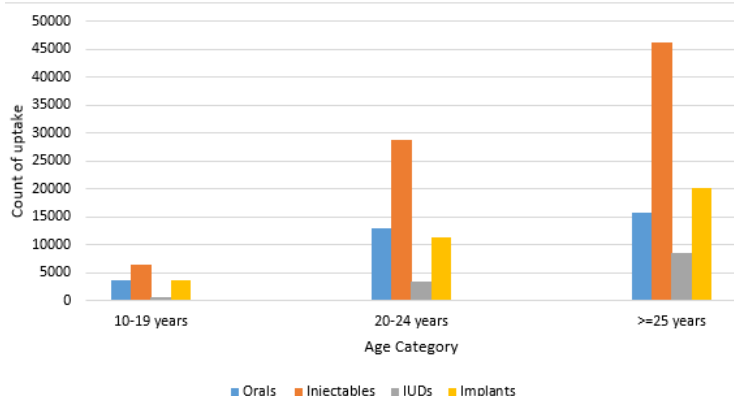
The Ministry of Health (MoH) and KCCA through the Directorate of Public Health and Environment and with support from partners (Jhpiego and PSI) in Maternal and Child Health (MCH) has made numerous interventions to ensure continuation of Family Planning services Kampala. Key among these are:

- Capacity building of health workers in lower level units through in-reach services where government, health workers and experts provide hands-on skills in family planning provision,
- Conducting integrated family planning community out-reaches as a catch-up plan for clients who missed out on their appointments during the COVID-19 national lockdown. This was done under strict observation and adherence to the MoH COVID-19 guidelines.
- Utilization of Community Health Workers (CHWs) to provide; counselling services, short-term family planning services (Orals & injectables), refer clients to the nearest health centres to access extra information and long-term FP methods.
- Integration of family planning with other services among the different service points such as; HIV clinic, TB clinic, young child clinic, post-natal clinic, maternity.

Results

Family Planning uptake by age group and method for FY 2019/20

During the FY 2019/20, a total of 162,093 clients accessed family planning services in Kampala. Of these, majority (50.3%) used injectables as the preferred method followed by implants (22%). The least preferred method being IUDs at about 8%. Generally, 70% are using short term FP methods whereas 30% are using long term methods. This can be attributed to limited capacity by health workers to provide adequate information on long term methods as shown in figure 1.



Source: DHIS2, August 2020

Figure 1: Family planning uptake by age group and method for FY 2019/20

FP uptake by age group for the last four years (FY 2016/17 – FY 2019/20)

In comparison with FY 2018/19, the uptake of family planning among the adolescents aged 10-19 years stagnated at 9% for FY 2019/20. Young adults aged 20-24 years, there was a decline of 1% from 36% in FY 2018/19 to 35% in FY 2019/20. However, for adults aged >=25 years, there was a 2% increment in utilization of family planning services between FY 2018/19 and FY

2019/20. Table 1 shows the trend in FP uptake by age-group over the last four financial years (FY 2016/17 – FY 2019/20).

Period	10-19 yrs		20-24 Yrs		>=25 Yrs		Total
	Users	Contribution (%)	Users	Contribution (%)	Users	Contribution (%)	
FY2016/17	16255	11%	54231	38%	73447	51%	143933
FY2017/18	16017	11%	54155	37%	77447	52%	147619
FY2018/19	16110	9%	63495	36%	95147	54%	174752
FY 2019/20	14475	9%	56563	35%	91055	56%	162093

Source: DHIS2, August 2020

Table 1: Trend of FP uptake by age group for the last four years (FY 2016/17 – FY 2019/20)

Couple Years of Protection (CYP) provided

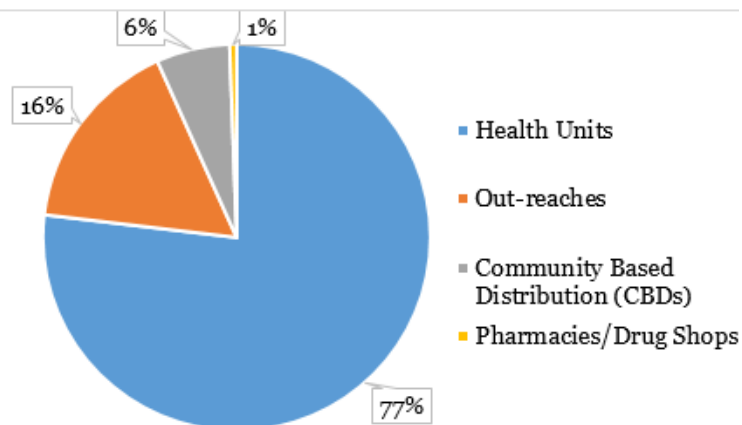
During FY 2019/20, a total of 195,000 couple-years protection were provided and as a result an approximate of 182,520 Disability Adjusted Life Years (DALYS) and 86,248 unintended pregnancies were averted. Table 2 shows the contraceptives dispensed, couple year's protection services provided, DALYS averted and unintended pregnancies averted by FP method.

Family Planning Methods	Users/Contraceptives dispensed by method	CYP - provided	DALYS - averted	Un intended Pregnancies averted
Oral Contraceptive	57,415	3445	2705	1272
Injectables	81,539	20385	15174	7135
IUD	13,021	59897	57003	27048
Implanon	25,693	64233	65038	30672
Jadelle	9,528	32586	32430	15336
Tubal Ligation	437	4370	3755	1794
Vasectomy	154	1540	1323	632
Emergency contraceptives	15,493	775	439	207
Female Condoms	98,096	736	441	207
Male Condoms	937,712	7033	4212	1981
Total		195,000	182,520	86,284

Source: DHIS2, August 2020

Table 2: Couple Years of Protection (CYP) provided.

In the recently revised HMIS tools, other points that provide family planning methods were brought on board such as Pharmacies and Drug Shops. In the last 6 months (January – June 2020), a substantial (77%) proportion of the contraceptives were dispensed at health units, 16% dispensed at out-reaches. At community level, using community structures of Community Health Workers, 6% of the total contraceptives were dispensed and on only 1% dispensed at either pharmacy or drug shops. Figure 2 shows the proportion of contraceptives dispensed by the respective distribution points.



Source: DHIS2, August 2020

Table 1: Contraceptives dispensed by distribution points, Jan-June 2020

Conclusion

While there have been interventions to improve access and to and utilization of family planning services among all age groups, it is worth noting that service utilization among adolescents and young adults is still low compared to adults. This ultimately increases the country's dependence ratio where about 25% of this category are already sexually active and have limited access to sexual and reproductive health services.

Recommendations

There is still effort needed to: invest in youth friendly services at community and health facility levels to curb stigma among teenagers and young adults on access to family planning information and services, to train health workers to provide method-mix (both short-term and long term) and enhance provision of family planning services at different service points to increase access and utilization.

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Out Patient visits for the leading Non-Communicable diseases at Selected Health Facilities in Kampala Metropolitan, January-April 2020

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Background

Globally, Non-Communicable Diseases (NCDs) reportedly kill 41 million people annually, an equivalence of 71% of all deaths. In addition, about 15 million people die from an NCD between ages 30 and 69 years with 85% of these occurring in LMICs (1). There has been an upsurge in the burden of NCDs in Sub Saharan Africa, Uganda inclusive in the past 2 decades with anticipation that they will most likely overtake communicable diseases by 2030 (2). Evidence shows that majority of the African countries are undergoing a

rapid demographic transition that has subsequently led to an increase in prevalence of NCDs (3).

Some recent assessments have highlighted a rise in hospitalisations and outpatient department (OPD) visits due to the 4 leading NCDs: i) Hypertension and other Cardiovascular diseases, ii) Diabetes Mellitus (DM) and other metabolic disorders, iii) Cancers and iv) Chronic respiratory illnesses. We therefore sought to evaluate the trends and recent burden of the 4 leading NCDs at randomly selected facilities in the Kampala Metropolitan area. We analysed data from the HMIS 105 OPD Monthly Report in the DHIS-2 system from January through April 2020.

Objective: To examine the epidemiology and 3 months trend in outpatient visits for the 4 leading NCDs at seven selected facilities in the Kampala Metropolitan

Methods

We randomly selected Kisenyi HC IV, Kasangati HC IV, Mukono Gen Hospital, Mukono COU Hospital, St Francis Nsambya Hospital, Mengo Hospital and Nakasero Hospital. Data on the total number of OPD visits and visits due to each of the 4 leading NCDs was abstracted from the DHIS2 for the 3-month period. Using MS Excel 2019, descriptive analyses were done.

Results

Of the overall 86,882 OPD visits at the seven facilities, the 4 leading NCDs accounted for 6,482 (7.5%) of the OPD visits for 3-month period. The OPD visit rate for these NCDs was higher in females 4256 (65.7%) than males 2226 (34.3%), higher in individuals above 20 years of age 6256 (96.5%) than in other age groups 226 (3.5%). Hypertension (HTN) accounted for the largest proportion of these visits 4522 (69.8%), followed by Diabetes Mellitus (DM) 865 (13.3%), other cardio vascular diseases 418 (6.4%), chronic respiratory illnesses 386 (6.0%) and cancers 291 (4.5%). The OPD visit proportions for Hypertension were higher for females for all the 3-months at Mengo hospital as shown in figure 1.

OPD visits for Hypertension at Mengo hospital, Jan-March 2020

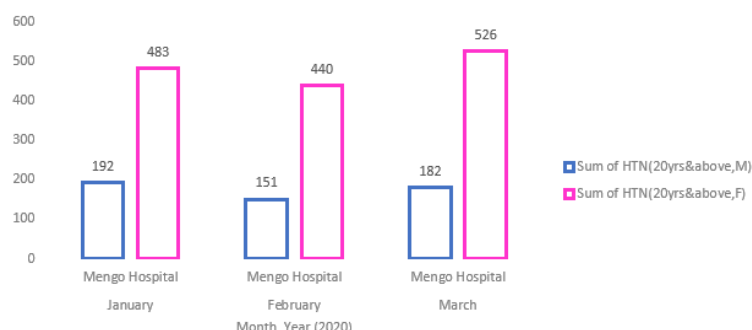


Figure 1: OPD visits for Hypertension at Mengo Hospital, Jan-March 2020

The OPD visit proportions for Diabetes Mellitus (DM) were higher for females in January and March, higher for males in February at Nakasero hospital as shown in figure 2.

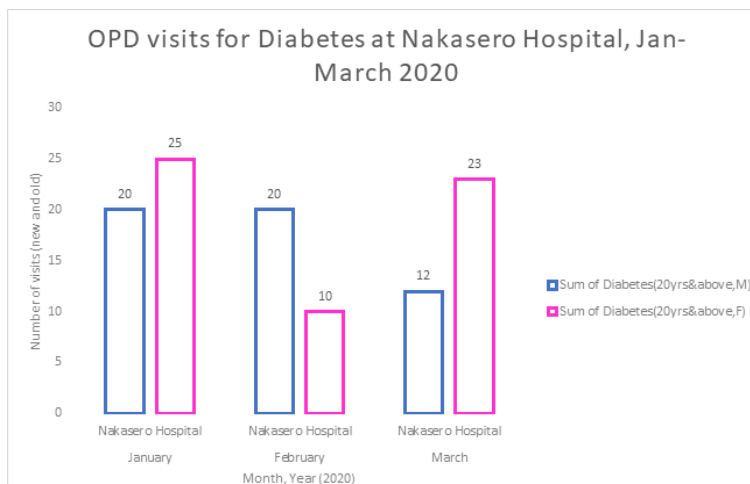


Figure 2: OPD visits for Diabetes Mellitus (DM) at Nakasero hospital

The OPD visit proportions for cancers were higher for females in January, higher for males in February and March at St Francis Nsambya hospital as shown in figure 3.

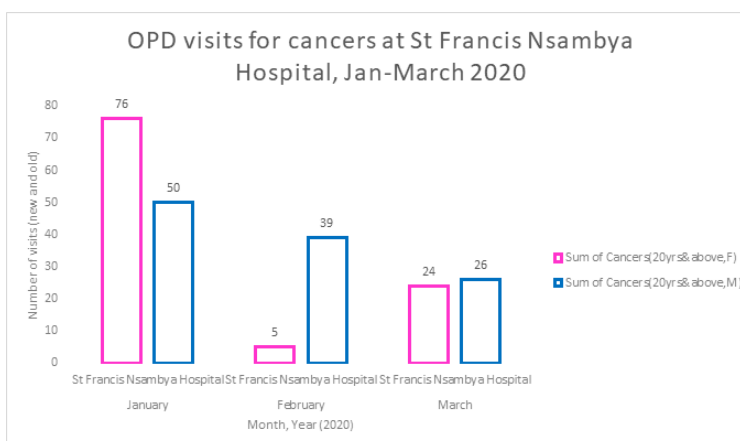


Figure 3: OPD visits for cancers at St Francis Nsambya Hospital, 2020

The OPD visit proportions for Hypertension and/or Diabetes Mellitus (DM) were higher for females for the 3-months at Kasangati HC IV as shown in figure 4.

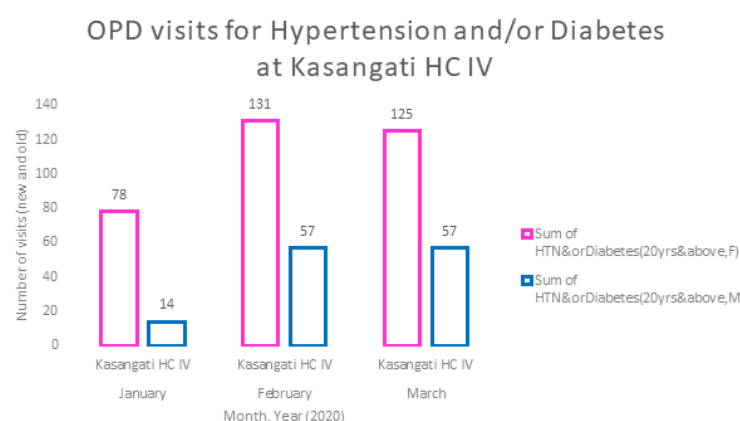


Figure 3: OPD visits for Hypertension and/or Diabetes Mellitus (DM) at Kasangati HC IV, Jan-March 2020

Conclusion

NCDs are responsible for a substantial proportion of the outpatient visits at the selected facilities. Hypertension accounts for the largest proportion of these visits, followed by Diabetes Mellitus (DM), other cardiovascular diseases, chronic respiratory

illnesses, and cancers. Many dynamic factors, acting on both individual and group levels continue to promote the growing burden of NCDs, the trends and epidemiology will probably continue to fluctuate.

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Leveraging Technology and Self-Regulation to Improve Quality of Services in the Kampala Private Health Sector.

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The 2018 Health Facility Inventory details that Kampala has over 1600 health facilities, of which 98% are privately owned, offering a broad range of services at various levels from small practitioners offering specialist services to large hospitals with a diverse and broad scope of services. The Kampala Capital City Authority (KCCA) faces a daunting task of stewarding the private health providers that in Kampala alone have grown in number by over 300% over that last 10 years.

The staggering number of private facilities in Kampala, incorrectly implies there is a lack of regulation and this perception coupled with a growing population, underscores the need to visibly regulate and innovate interactive mechanisms to oversee service provision. This has resulted in a collaboration between the Ministry of Health (MOH), KCCA and the private sector, to leverage technology and self-regulation, a notion that has yielded significant debate in health systems across the world.

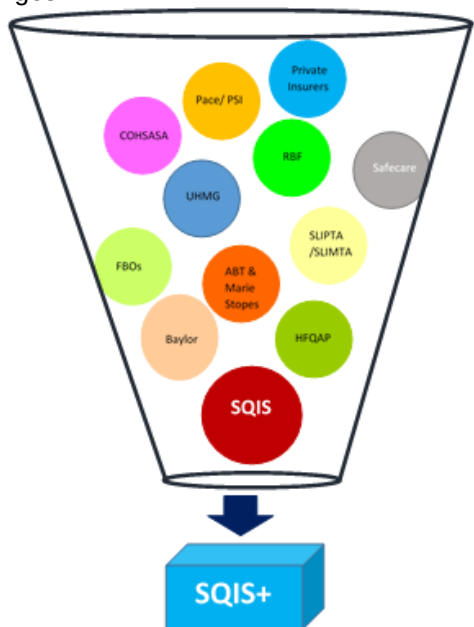
In 2019, the Uganda Medical and Dental Practitioners Council (UMDPC) and the Allied Health Professionals Council (AHPC) launched e-Licensing of the health professionals under their purview and currently the Uganda Nurses and Midwives Council is pursuing the same direction. The brief period leveraging technology to improve efficiency of service delivery of a large constituency has illustrated the potential of going further to introduce technology to improve quality service delivery standards in the private sector.

The MOH, regulatory councils and KCCA, with support from USAID Uganda Private Health Support Program (UPHS) through the Uganda Healthcare Federation (UHF) in partnership with key private sector stakeholders including the Faith Based Bureaus and implementing partners are at the culmination of a 7 year-long journey to develop a Self-regulatory quality improvement system (SQIS). The SQIS

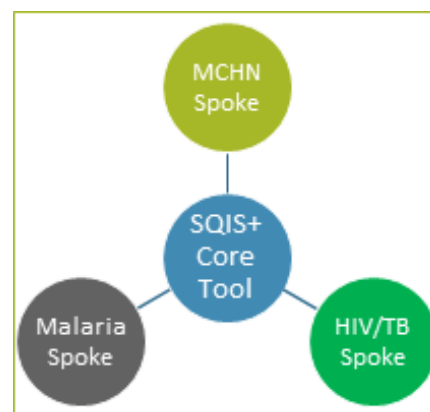
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platform was originally launched in 2016 by the MOH with a view to pilot self-regulation in private health facilities. The SQIS was envisioned to be a digitized online platform, with 16 service elements, with a weighted scoring based on risk factors. The toolkit was embraced by over 700 private facilities in over 72 districts, as well as some KCCA facilities. The SQIS system was also at the heart of two peer-to-peer pilot self-assessment activities in Kampala, supported by the IFC World Bank, executed by the regulatory councils in collaboration with private health providers in Kampala. These assessments saw health professionals from private facilities and members of staff from the regulatory councils and KCCA, form five teams of assessors, that visited facilities from which the health workers were selected, without any health worker visiting their own facility. This innovative support supervision model built on the SQIS's ethos of empowering facilities to demonstrate their interest, passion and ability to embrace quality assurance with minimal resources, while building relationships and confidence in each other that would catalyse improvements in referral relationships. However, most significantly for both the regulators and the participating teams and the facilities, was the fostering of a collaborative dialogue and stepping away from prescriptive support supervision toward dialogue and mutual course correction.

The peer-to-peer support supervision experience highlighted opportunities to improve further on the SQIS system, spurring further discussions between MOH, KCCA and the private sector stakeholders – how can SQIS guide facilities better, to do more independently in order to be compliant? Furthermore, the testing of the tool intensely in Kampala, underscored the limitations of the tool in relation to the focus on only core functions of standard health service delivery against the diversity of the private sector and the need to adapt to be more encompassing, most importantly as is the case with most QA/QI tools, the voice of the consumer was not captured and finally, the implications on ambiguous results of a binary pass/fail two option scoring mechanism amongst other challenges.



IFC World Bank and MSD for Mothers supported engagement of the Council for Health Service Accreditation of South Africa (COHSASA), to build on the content of various public and private sector QA/QI tools including program tools tried and tested in Uganda (some depicted in this graphic), to develop quality assurance and improvement standards appropriate to the Uganda Health system realities which do not fit into the government structure of HCII, HCIII, HCIV etc. This new version of SQIS would be called SQIS Plus (SQIS+). Through discussions, it was highlighted that the persistence of multiple tools applied in private facilities using SQIS, was due to an interest in accreditation to participate in multiple programs/ projects supporting facilities were still over-burdened with having to comply with project specific tools that drilled deeper with their “initiative specific assessment tools”. There was need to ensure special focus on areas of essential services. This called for having a core tool to look at basics across the facility, then an opportunity for a facility to dig deeper into maternal child health and nutrition, HIV/TB and lastly care given for malaria. The result of the COHSASA contract was an SQIS+ with the scope to accommodate facilities of all sizes, general practice and with in-house specialist services, as well as specialty standalone service providers in radiology, ophthalmology, dentistry, pharmacy and drug shops have little utility for numerous existing tools.



The platform SQIS+ would be housed on an MOH server, ensuring data security and to support capacity building, following self-assessment, a facility would receive a one-year quality improvement plan (QIP), unique to the participating facility, with guidance on how to address the quality gaps identified through the assessment. The activities in the QIP would be prioritized for action based on risk and the facility would be able to carry out multiple assessments in the year, and also update the system with any interventions they introduce at the facility to address QIP requirements. The profile of the private sector in Kampala is it is predominantly served by HCII and HCIII sized private facilities, drug shops and pharmacies. These health service outlets are so numerous that they pose the biggest Achilles heel for KCCA to consistently support in knowledge sharing and consistent skills building. Therefore, linked to the SQIS+ will be an E-Learning platform with modules designed to address knowledge gaps identified through the self-assessment process, and provide a virtual support pack in the form of

a resource center of templates and forms that can be downloaded and personalized to the participating facility's brand.

While the health consumer is at the center of the health system, often neglected in QA systems is the consumer feedback component. The SQIS+ will have a portal for health consumers to share a feedback rating on their experience at facility level. With the scoring visible to the facility and the oversight bodies, giving a 360-degree perspective of service provision.



In May 2020, the Private Sector Foundation Uganda (PSFU) partnered with MasterCard Foundation to develop the COVID-19 PSFU Economic Recovery and Resilience Response Program (CERRRP) to extend immediate relief, recovery and resilience interventions. Through the CERRRP, PSFU, committed to support the digitized upgrade of the SQIS+ platform through the Uganda Healthcare Federation. The new platform would be accessible by facilities on a smartphone, tablet or computer for assessments and tracking progress against quality improvement plans. Facilities that complete an assessment will be given a star-rating and certificate, and the results channeled to the regulatory bodies. An Advisory Committee with representatives from MOH, KCCA, UHF, the regulatory councils and the faith-based bureaus will be charged with ensuring timely delivery of a rigorous system. Once developed, umbrella bodies, district level supervisors, the regulatory councils and the MOH as well as oversight Authorities such as KCCA will have catchment-based user rights to review results of the self-assessments, track progress of implementing changes against the quality improvement plans and review dashboards comparing performance with other regions and facilities. Access to these dashboards will allow a more targeted approach to support supervision by the District Health Teams, as well as regional and national quality assurance oversight functions. It will also facilitate improved planning for capacity building, coaching and mentoring as well as tailoring CME and training to address gaps and needs more accurately as they will be mapped clearly through the system. Lastly, health development partners and IPs will thus have a rational source of information to conceptualize programs to support the private sector.

The blended tools into SQIS+ offers a robust single self-assessment tool that addresses a key challenge of regulating the private sector related to the inconsistency of multiple tools and a prescriptive approach. Kampala offers an ideal environment to put any QA/QI system through its rigors, the sheer volume of facilities, their diversity in scale, scope and size, can be applied to any facility irrespective of size and complexity of services offered. It is anticipated that driving quality assurance through technology will turn the tide on the

capacity of KCCA, the regulatory councils and the MOH to regulate the private health sector, for now in Kampala, but in the future across the country. Digitizing this system will realize a vision of the MOH to keep improving regulation of the private sector, quality measurement for all facility types. In light of the current challenges in mobility, the digitized tool accessibility through smartphones or similar devices will ensure quality in these times where physical assessments are a challenge.

- Consumer feedback component
- Certificate and star rating

	SQIS	SQIS+
Scoring structure	Yes/ No	Compliant, Partially Compliant, Non Compliant
Scope of services assessed	Health facilities only	Health facilities, standalone: Lab, Pharmacy, Radiology, Dentistry
TA to assessing facility	No support post assessment	12 month risk prioritized quality improvement plan based on assessment
Capacity building component	No capacity building support	eLearning component
Analysis of results	No dashboards or analytics, just data	Analytics dashboard with scaled access rights
Business and Finance Support	Amin assessment component	Business and finance assessment in-built additional stringent process assessment with templates and QIP

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Harnessing Public-Private Partnerships to Cater for Unmet Need for Antenatal Care among Urban Poor Amidst the COVID-19 Outbreak.

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Background

One of Uganda's initial interventions in the COVID response was a total lockdown of public and private transportation to reduce mobility of persons and allow for successful surveillance and contact tracing in communities. This led to a major decline in ANC attendance in public and private facilities in Kampala during the March to May 2020 period, with total ANC attendance in 4 public facilities and 29 private facilities in Lubaga and Makindye divisions reducing by 54% and 49% respectively¹. The major causes for this sharp decline was because pregnant women especially the urban slum poor,

were delaying their facility ANC visits due to travel challenges, lack of clarity on whether ANC clinics were open, anticipated delays in receiving ANC in time to travel back home before curfew time and for fear of getting the COVID-19 infection at facilities.

The Innovation:

Supported by United States Agency for International Development (USAID), The Kampala Slum Maternal and Newborn Health Project (MaNe), a partnership between Population Services International (PSI) and Kampala Capital City Authority (KCCA), provided 5-days free antenatal check-ups in selected private clinics closer to the urban poor in slum areas (within walkable distances from their homes). This brought the MNH services nearer to the urban slum poor who were less likely to afford existing allowable means of transportation.

The partners worked with 29 private-for-profit, slum-based health facilities in the two divisions, and waived consultation and ultrasound fees for pregnant women, making them free of charge. They partnered with Makerere University Department of Obstetrics and Gynecology which seconded resident doctors² from to work alongside private midwives to provide free ANC services in the private health clinics while mentoring providers in providing Respectful Maternity care.

The private sector engagements by the project also ensured the project secured resources to support this cause. The first was a fund from MTN foundation towards provision of PPE for health care workers and ultrasound scanning services to pregnant women during these ANC visits. The second was the engagement of the Association of Radiologists of Uganda to provide sonographers and Mulago specialized women's Hospital to provide portable ultrasound scanning machines that were used during the free ANC visits. To alert urban slum pregnant women about these free ANC services, the project engaged community Health Workers (CHWs) attached to selected private clinics and the village leadership to inform pregnant women in their respective slums about availability of free ANC at various clinics.



Photo 1: An expectant mother at a triage point at one of the clinic offering free ANC services

The benefits of this innovation

The innovation benefitted up to 1,050 slum dwellers who received ANC care in the 5 days of free antenatal check-up. A total of 258 mothers with pregnancy related complications that couldn't be handled at private clinics were also successfully referred to public health facilities. During the camps, a relationship between pregnant women and private clinics was established, and a database of consenting urban poor pregnant women was set up, giving them an opportunity to be monitored by facilities and to enable them plan for their delivery. Mothers now have an opportunity to be linked to the UNICEF supported ANC messaging program to get routine critical pregnancy and birth planning information and reminders to attend ANC.

Lessons learnt:

Responding to COVID-19 has increased the possibility and opportunities for harnessing private sector institutions, professional associations and academic institutions to address a common goal in MNH. Private health providers are willing to subsidize MNH care for urban poor and can therefore be harnessed to contribute to free MNH services for these poor populations. They were inspired to invest more in MNH on seeing the present demand for MNH care. A relationship was also established with MTN Uganda through which opportunities for further support of MNH work among the urban poor can be explored. The role of slum community resource persons in organizing their peers and networks to receive care in such a pandemic situation was recognized and appreciated.

Looking to the future:

Following this successful partnership, KCCA intends to formalize this arrangement with Makerere University Departments of Obstetrics and Gynecology, and Medical radiology to periodically deploy resident doctors to selected private clinics serving slum dwellers. Resident doctors will be able to use this as part of their field training experience/ attachments, while supporting clinics and serving urban slum dwellers. KCCA also plans to initiate a private-public MNH referral network by affiliating Private-for-profit clinics to KCCA public facilities to facilitate private-public MNH referrals. This linkage will make it easy to trickle down MNH support in terms of training, and support supervision from KCCA public facilities to lower level private clinics once they are accredited.

References

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2. Resident doctors are Medical doctors doing post graduate training in Obstetrics and gynecology

Improving quality and affordability of maternal and newborn care services in the private health facilities through accreditation

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Background

Kampala Capital City Authority (KCCA) through its Kampala Slum Maternal and Newborn health project (MaNe) conducted a series of qualitative and quantitative studies, scoping reviews, rapid field learning visits to slums and health facilities to generate an explicit understanding of the MNH market and market failures on both the supply side and demand side which potentially lead to the high morbidity and maternal/newborn mortality in the slums. Findings revealed several private sector barriers in providing Maternal and Newborn (MNH) services which included; i) poor readiness and commitment to invest in MNH by private health facilities; ii) lack of essential MNH infrastructure, supplies, drugs and commodities; iii) unaffordable cost of MNH services for the urban poor hence low utilization of MNH services in the private facilities by the urban poor among others.

Proposed solution and process

To address the above gaps, KCCA MaNe with funding from USAID is testing the feasibility, acceptability and appropriateness of using accreditation as an approach to improve quality and affordability of MNH services in the private clinics to benefit the urban slum dwellers. In collaboration with Uganda Medical and Dental Practitioners Council (UMDPC) and Uganda Nurses and Midwifery Council (UNMC) using the Self-Regulatory Quality Improvement System (SQIS) Plus tool, 20 private clinics in the slums of Makindye and Lubaga divisions were assessed for accreditation. Assessed facilities have been grouped into four stages based on their performance on accreditation assessment for MNH services. To-date, five facilities are accredited (stage 3) while other five are on probation (stage 2) and subject to make further improvements before they are accredited.

Early benefits and lessons learnt from accreditation

Proprietor motivation to invest in MNH: Learnings from the exercise show that accreditation is a big incentive for private clinic owners to invest and maintain quality for MNH services in the private clinics. Most clinic owners have prioritized investing in refurbishment of the facility premises and buying additional MNH equipment to improve on quality of care and hence score higher in subsequent accreditation assessments and get accredited. For example, at one of the accredited clinics, the proprietor procured an oxygen cylinder, set up a functional drainage system in the labor suite, did other general renovations to improve on the quality of MNH services prior to the accreditation assessment.



Photo 2: Proprietor-led refurbishments at Family Clinic, Lusaze prior to the accreditation assessment.

Formation of facility quality improvement teams: In all the 20 facilities assessed for accreditation quality improvement teams have been formed to continuously track improvements towards the accreditation standards set by KCCA.

Facility-led exchange visits: Peer to peer visits have been rolled out by respective facilities that were assessed for accreditation. Paid for by the respective facility owners, providers visit other facilities to learn on how to improve on certain aspects of the SQIS where they scored low during the accreditation assessment.

Maternal and newborn care price negotiations for the urban poor: Negotiations for price reductions have been held with all accredited clinics. To-date, eight of the 10 (stage 3 & stage 2) accredited have agreed to reduce pricing for maternal and newborn services by about 40% to facilitate affordability for the slum dwellers. This has been achieved by selling the vision of turn-over for increased profitability as opposed to charging higher unit prices for MNH services.

Clinic-driven initiatives to improve demand for MNH services: Leveraging support from MTN Uganda, Makerere University department of Obstetricians and Gynecology and department of medical radiology, KCCA MaNe project engaged Community Health Workers (CHWs) to mobilize pregnant mothers in slums for free antenatal care (ANC) at the accredited private clinics. This was intended to facilitate increase to antenatal services for the urban poor but also trigger increased demand for the MNH services in the private clinics. As a result, accredited clinics have prioritized having monthly schedules for free antenatal, postnatal and immunization days. This is viewed as a mechanism to further increase clientele for MNH for these clinics.

Next steps: KCCA will continue collaborations with UMDPC and UNMC to continuously assess private clinics to be accredited, provide support supervision, trainings and mentorships in essential maternal and newborn care to improve and/or maintain quality of MNH. Memorandum of Understanding (MOUs) will be signed with all accredited clinics, branding of these clinics and demand creation done through interpersonal communication using CHWs and the mass media.

Noise Pollution: a Public Health Threat

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Noise pollution is defined as the release of uncontrolled noise that is likely to cause danger to human health, or damage to the environment by The National Environment (Noise standards and Control Regulations), 2003. It is measured using a Noise meter and the unit of measure is decibels (dBA). Previous epidemiological assessments have indicated that even a lifetime non-stop exposure to environmental and leisure-time noise <70 dBA would not cause hearing impairment in many people (over 95%) (1).

The Maximum Permissible Noise Levels for places or establishments of entertainment in residential areas are 60Db during day and 40dB at night, commercial areas 75 dB during day and 50 dB at night and for industries 85 dB during day and 65 dB during night. For Places of worship the Maximum Permissible Noise Levels in residential areas during day time is 60dB and 40dB during night, commercial areas 75dB and 50 dB while industries should be at 85dB and 65dB for Day and Night respectively. The case of construction sites, the Maximum Permissible Noise Levels in residential areas during day time is 60dB and 40dB during night, commercial areas 75dB and 50 dB while industries should be at 85dB and 65dB for Day and Night respectively.

Worldwide, cities have become epicenters of noise pollution and Kampala is no exception. Noise pollution is a growing problem across Kampala City and one which many people may not be aware of the impacts on their health as it affects both public health and behavior. The sources of most outdoor noise in the city are mainly caused by entertainment facilities, mobile phone shops, construction activities, religious activities/ churches, and microphones installed on various facilities ranging from mobile vehicles, markets and buildings. Our environment in Kampala city is such that it has become difficult to escape noise, even electrical appliances at home have a constant hum or beeping sound and lack of effective urban planning has also increased the exposure to unwanted sounds in some areas.

According to the World Health Organisation, Noise pollution is the second largest environmental cause of health problems just after the impact of air pollution (1). It is estimated that noise pollution contributes to 48,000 new cases of ischaemic heart disease a year and 12,000 premature deaths globally (2).

Noise Pollution has contributed to various potentially fatal negative impacts including hearing problems, psychological Issues including stress, fatigue and Depression, physical problems such as headaches, high blood pressure and respiratory agitation, cognitive Issues, behavioral changes, sleeping disorders and cardiovascular disease. Stress-related heart problems are on the rise and communication troubles as

Maximum Permissible noise Levels have been violated affecting free communication between people (2).

Surveillance of Noise pollution in Kampala City, Statistics for July 2019 to June 2020

The highest proportion of hotline calls for noise pollution were from Makindye division (34.9%), while the lowest proportion were from Lubaga Division (4.8%) as shown in table 1.

Location	No. of Hotline calls	Percentage (%)
Central Division	197	25.1
Nakawa Division	228	29.0
Makindye Division	274	34.9
Lubaga Division	38	4.8
Kawempe Division	49	6.2
Total	786	100

Table 1: Hotline calls for Noise pollution per division in Kampala, July 2019-June 2020

The Directorate of Public Health and Environment at KCCA provides an oversight role in planning, coordinating, compliance monitoring, technical guidance and enforcement to ensure sustainable infrastructure, spatial planning and social economic development which enhances environmental quality in Kampala City. The directorate aims to effectively establish the noise pollution monitoring strategy and increase public awareness of this health threat, these statistics will most likely fluctuate.

The Noise Pollution Team comprises of Environmental Inspectors, Police and Enforcement Officers. The team guides, manages and streamlines noise pollution control in the City by; i) Prescribing the maximum permissible noise levels from a facility or activity to which a person may be exposed and ii) Providing for the control of noise and for mitigating measures for the reduction of noise.

To address the noise pollution problem, the team has adopted several strategies such as sensitization or engagement of the public, routine monitoring for compliance, enforcement i.e. serving of notices to noise offender to stop, minimize or discontinue which eventually results into seizure of musical or noise equipment and prosecution in courts of law. As a key environmental agency, KCCA has supported and maintained a strong monitoring team with a framework for conducting compliance monitoring in a way that will help alleviate the current noise pollution problem while providing a basis for solving tomorrow's health problems.

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For any complaints and further information, please engage the **Noise Pollution Hotline: 0794663333**.

Ensuring continuity of HIV related community engagements in the face of a pandemic

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Given the nature of work we do at Reach Out Mbuya Parish HIV /AIDS Initiative (ROM), in serving clients with comprehensive HIV/AIDS management and associated support interventions in Kampala, Wakiso, Luwero, Nakaseke, Mubende and Kassanda districts, our interventions have greatly been affected by the COVID-19 pandemic. With COVID-19 infections continuing to sky rocket in Uganda we are witnessing lesser engagements with the communities a challenge causing massive set backs in the fight against HIV. Though our engagements before the pandemic we held community outreaches of about more than 100 beneficiaries something that currently is not possible given the COVID -19 guidelines banning mass gatherings. Similarly, before the pandemic, staff and field structures would conduct home visits regardless of the distance, however, during the lockdown, only a few beneficiary households would be reached and others would not be reached due to transport related challenges. Currently these are being reached through phone calls a measure that is quite expensive, often psychosocial support through phone is not effective.

Our Orphans and Vulnerable Children (OVC) supported to access education are currently not supported. This implies that once the year ends, the donor may claim refund of their grant to this cause thus our OVC missing out their chance to attain education. Currently we are only encouraging these OVC to carry out home based schooling, listen to radios and watch TV when education sessions organized by the government are ongoing, however, we also notice that quite a number of our beneficiaries don't own a radio nor a TV set to benefit from this government arrangement.

Caretakers were mobilized and supported to start Village Saving and Loans Association to improve on their economic station through borrowing money to start up small scale business and saving their earning. However, during the pandemic outbreak some of our VLSAs have ceased their activities since their businesses are at a standstill and also, they are not allowed to seat in groups of many members. This has significantly reduced their household incomes. The challenge many implementing partners are grappling with is how to reach out to the community in the face of COVID -19 as they did before the pandemic. With no vaccine breakthrough yet, one on one engagements with community are still very minimal. Engagements through online tools to continue communicating, including through radio, WhatsApp groups and other messaging platforms, as well as social media to reach audiences have taken center stage and are most safe at the moment.

ROM has continued engaging the young people it serves through virtual meetings though zoom where those who can access smart phones link up with those who do not have to gather their views so they are represented during the meeting. Also, we impart short term skills in group of fives as they attended clinics. ROM has increased the resilience of people living with HIV through the provision of food during the pandemic.

Until we have a vaccine for COVID-19, organizations may have to carry out multimonth dispensing of antiretroviral medicines as they revisit the appointment system for clients with the most critical having to visit the clinic or scheduling for fewer clients visits per day to avoid congestion at the clinics. Also, well-wishers should continue providing food to those in need and yet still have to get a balanced diet which moves hand in hand with their medication.

Lastly, continued utilization of the free telephone hotline for those living with HIV to ask questions regarding their health and get real time feedback should be done. The available hotline number to contact ROM is 0800200044.

We do not need to get a setback in the fight against HIV. Now more than ever community service providers need to be supported as they are at the forefront in the fight against both diseases.



Image 1: An engagement with some of our clients during clinic visits (Photocredit:ROM)

Finding the Missing People with Tuberculosis in the Communities of Kampala and Wakiso

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Institution: ¹ Infectious Diseases institute (IDI), Kampala, Uganda

Katono, is a 50-year-old a domestic worker in Kawempe division. He suffered from a persistent cough for over 3 months, had lost weight and was always sickly. His visits to nearby clinics provided limited relief he needed in his suffering. Furthermore, because of this persistent illness, his employer condemned him to live in an old tank shelter in the home compound. Fortunately, Katono's employer, upon hearing about a community liaison officer and her TB screening work at the local pharmacy, invited her to his household. There she took a sputum sample for a TB test that turned out positive.

Katono was immediately linked to a nearby health facility for treatment and is currently adhering to his medication. He no longer has the body-racking cough and has since resumed his work.

The Infectious Diseases institute (IDI) has supported work to end Tuberculosis in various health facilities in the central region under the IDI-KHP HIV/AIDS grant. However, seven in ten health facilities in Kampala are private for profit and are the first point of contact for about 40% of people with signs and symptoms of TB. Public health facilities represent only 3% of TB cases reported in Kampala. The Pharmacy Engagement in Screening for TB (PRES TB), a project run by IDI in partnership with the National TB and Leprosy Program (NTLP) serving communities in Kampala and Wakiso districts is designed to fill this gap by improving TB notification through engaging private health facilities.

Katono, like many others, is a beneficiary of the PRES TB project. "We discovered that most people are likely to visit private pharmacies to get pain relief for a bad cough before they go to a clinic. Others stay at home and suffer silently," Dr Christine Sekaggya, the Principle Investigator of the project, says.

The project engages trained community pharmacy, drug shop and clinic staff, and selected female community liaison officers to conduct TB screening in the communities. Despite the fact that men are more likely to get TB, women are disproportionately affected with a burden of taking care of the sick and fending for families. The project empowers them by giving them opportunities to work as volunteers and impact change in their communities. By June, in spite of the COVID-19 lockdown, over 10,000 people were screened, of whom 153 were diagnosed with TB and are now accessing treatment at different public health facilities in Kampala and Wakiso districts.

In November 2019, Uganda's Ministry of Health declared TB a national public health emergency calling on district leaders and partners to mount a national emergency response targeting three regions, including the Acholi-Lango region. Following the successes of the PRES TB in the central region, the Stop TB partnership with the World Health Organisation's funding a new grant wave where private facilities in Gulu, Lira and Kitgum district will now be engaged in finding missing people with TB.

The TB screening services are available where there is a pink poster with a fist sign in Wakiso and Kampala Districts.

Call the following telephones for more information; Airtel-0754927783 / MTN-0771256495



Image: After testing positive for TB, Katono was linked to a nearby health facility (photo credit: IDI)

Medication saved Wambi, he Wants it to Save others

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Alex Wambi is a 46-year-old living in Nansana-Ganda. He is a father of 7 and works in a carpentry shop in Bwaise. He collaborates with Kawaala Health Centre III under the Infectious Diseases Institute to deliver HIV treatment to several patients in the areas around Kawaala, Nansana urban and remote villages. With supervision and guidance from the health workers at the health centre, Alex delivers the medication using his motorcycle.

Inspiration to assist

When Alex was 21 years old, he was tested for HIV and was informed that he was HIV positive. At the time, he had a family to take care of including a 2-months old baby.

"If it wasn't for this medication, I would not be alive today. I had a family to take care of and the best option was to start treatment immediately and ensure consistency. Many years later, I am healthy and alive", Alex says.

Due to his commitment towards treatment, he was trusted by patients to help deliver their medication.

"I remember what it was like when I was first diagnosed. It was difficult. I think of many people out there; some are suffering from the effects of stigma and others cannot reach these health centers for medication due to high transport costs. I decided to work with the health centre to deliver medication to these people."

Relationship with IDI and KCCA

In 2007, Alex was enrolled in HIV care at Kawaala H C III; an IDI-supported Kampala Capital City Authority (KCCA) health centre. Due to his commitment and consistency in receiving treatment, he developed a good relationship with the health workers and offered to share reading material about HIV testing and treatment to the people in his community. Through this, many patients approached him and he used this as an opportunity to advise many to go for HIV testing and treatment.

The COVID19 effect

Alex's role proved to be a God-send during the lockdown as many patients (including pregnant HIV+ breastfeeding mothers, children, adolescents and the elderly) in the

(continued on next page)

communities he went to were not able to reach the health centers due to the transport costs and restrictions. With assistance from the clinic management, he was able to receive a sticker, infection prevention and control supplies, transport and tools to aid his safe movement to different patients.

Experience supporting people with HIV

Several people living with HIV suffer from stigma from both family and community members. For this reason, many of them stay in their homes without treatment. COVID-19 restrictions worsened this situation. In addition to the deliveries, Alex talks to the patients about the importance of adhering to treatment in order to protect their loved ones. He encourages them to be consistent with treatment and works to boost their confidence in fighting against stigma from family and community members. Over the four-month intense lockdown period, Alex was able to successfully support antiretroviral therapy refills for over 80 PLHIV who were stranded in communities as far as Entebbe road and Namityango.



Image: Wambi Alex delivers the medication using his motorcycle (photo credit: IDI)

Client-Provider dialogues stimulate health workers in public facilities to improve the quality of MNH services in public facilities

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

In July 2020, the project supported KCCA to hold client – provider community dialogues at four KCCA public health facilities; Kisugu HC III, Kitebi HC III, Kawaala HC IV and Kisenyi HC IV. In the dialogues, clients (including mothers, their spouses and care takers) who receive antenatal and postnatal care, and delivery services at these four public health facilities, the health care service providers that serve them at the facilities, along with other senior KCCA health officials exchanged ideas (including feedback) about the MNH services provided at these facilities.

The dialogues also generated commitments from health care providers to address the gaps identified regarding respectful maternal and newborn care (RMNC) and to improve the quality of MNH services. MaNe project supported KCCA to implement these dialogues as part of their efforts to strengthen client-centered and respectful maternal and newborn care in public and private facilities, especially for the urban slum poor in these project divisions.

The most common issues raised during the dialogues included patients being asked for bribes (or informal / 'under-table' payments) before accessing free MNH services, and service providers not treating clients with respect and dignity during ANC and delivery.

To increase their effectiveness, the dialogues were hosted by a local television channel – Bukedde Television who video recorded each of the sessions. During the dialogues, some of the KCCA officials gave out their phone numbers and urged clients to call them whenever they faced challenges at these health facilities. To inform the public about what KCCA is doing to improve quality of care in facilities, hold duty bearers accountable for the commitments made and generate community understanding of their rights and the dialogues will be aired on TV.



Image: Dr. Daniel Okello, KCCA Director of Public Health and Environment, responding to community representatives at the dialogue in Namuwongo Zone B

The events following the dialogues

Testimonies following the end of the client-provider dialogues give early signs of change in provision of client-centered and respectful maternal and newborn care services in the public facilities. Feedback suggests that MNH services in the four public facilities have started improving following the dialogues.

The story of respectful care to a mother at the health facility, post-dialogue

Anecdotal feedback from clients who receive services from public facilities suggests that post-dialogue, client-handling at the facilities has improved. They affirm that before the dialogues, they used to be mishandled, shouted at and abused. However, following the recent dialogues, there has been a practical shift in how providers handle the clients. They don't abuse them, and treat them with care, performing all routine checkups and monitoring, as one client narrates;

"When I was seven months pregnant, I went to the facility because I had a complication. I found a mother being shouted at by a midwife. When we came in, she again shouted at me and my husband saying she is tired of us, she needs to rest.... After two months I went back to deliver and things had totally changed, there were writings on the wall with numbers to call that if someone treats you badly, I now have some trust in my facility."

The changing narrative on informal payments in public facilities

Similarly, field testimonies suggest that given the awareness that has come with the publicized numbers of health workers following the client-provider dialogues, clients' confidence in demanding for their health rights has also gone up, and so has the response of health workers in acting on the demands of the clients and being more accountable regarding aspects of respectful maternal and newborn care. There have been reported cases of clients being asked for money to be offered health services but upon calling the responsible health workers using the numbers they were offered; their money was refunded, and a service was offered to them free of charge. One client who visited the public facility narrates;

"We recently went to the health facility with my husband. They asked us for money. My husband called the numbers that were pinned up recently on the walls and reported this case as we were advised, and then our money given back to us and we were worked on."

These proclamations have also been continuously raised by key female champions in the communities. They claim that several mothers have reported cases where health workers no longer shout at them, they are not rude and no longer request for under-table payments.

"Mothers have been telling me they go to the facility and things have now changed, health workers no longer shout at them, they are no longer rude to them, and they no longer ask them to pay money. And when I went to the facility myself, I also witnessed this."

Conclusion:

As evidenced in the MaNe project formative research in year 1 of the project, findings exposed cases where the urban poor mothers are not treated with respect and dignity especially in the public health facilities such as being denied access to MNH services (supplies, skilled birth attendance, and admission beds) unless bribes are provided to health providers, and physical and verbal abuse of women during ANC and labor. These early success stories from the dialogues affirm that through the USAID-funded MaNe project, KCCA is on course towards substantively strengthening client-centered and respectful maternal and newborn care (RMNC) in these public facilities.

Going forward:

MaNe through the support of USAID will continue holding client-provider dialogues in public facilities and make follow-up visits in facilities that participated in the previous dialogues to continuous track the commitments made in the previous dialogues.

Acknowledgements



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

KCCA COVID - 19 Response Hub

This COVID-19 Response Hub is designed to aid real-time monitoring, to catalogue GIS data that supports mapping and analysis, and to increase overall community preparedness with general public health resources and media stories related to COVID-19 outbreak in Uganda.

Uganda's COVID-19 Statistics			
Confirmed Cases	Active Cases	Deaths	Recovered
457	385	0	72
Source: Ministry of Health Uganda	Source: Ministry of Health Uganda	Source: Ministry of Health Uganda	Source: Ministry of Health Uganda

GIS COVID-19 Coronavirus Response Applications

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