THE COVID-19 PANDEMIC IN UGANDA:
THE POTENTIAL ADVERSE EFFECTS TO THE CATHOLIC HEALTH NETWORK'S WORKFORCE AND HEALTH FACILITY OPERATIONS.
A CALL TO ACTION

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The world is amidst a global infectious pandemic—the Corona virus disease 2019 (COVID-19) which started in the City of Wuhan, Hubei Province, China in December 2019, and has since then rapidly spread, currently affecting 199 countries and territories of the World.
The evolving adverse effects of COVID-19 on individual & inter-personal lifestyles, on the socio-cultural, economic and health systems of affected countries is proving to be more dire than previously predicted.

As at Saturday 28th March, the total confirmed COVID-19 cases globally were 617,417 with 28,377 reported deaths and 137,336 recovered. The five most affected countries—the U.S.A, Italy, China, Spain and Germany account for 64% of the global caseload (and 70% of the global deaths due to COVID-19)—all of which had their first corona virus case confirmed 3 months ago.
In Uganda, the Ministry of Health has reported 23 confirmed cases scattered across the country—eight (8) days since the first case was reported and fortunately no reported deaths due to COVID-19.
Clearly, the virus is now circulating in the country, and it is possible undetected cases are accelerating transmission—which is likely to escalate given, in part, the fairly prolonged turn-around times for the centralized testing for corona virus. The time interval between the corona virus nasopharyngeal swab at any of the satellite health facilities to the reporting of the test results (and limited self isolation measures)—will have exposed an average 5 - 7 or more persons to the virus—and probably infected half (2 - 3) the number!

In such circumstances, health care workers in contact with the unconfirmed sick with COVID-19 carry the greatest risk of exposure to the infection. The likelihood of a health care worker becoming infected with Corona virus is more than three times as high as the general population. And when they go back to their families, they become primary vectors of transmission.

The risk of COVID-19 exposure and infection to the currently minimally protected and ill-prepared front-line health care workers and the subsequent cascaded transmission to their family members is real and will likely greatly hit Catholic Health Network & other faith-based health facilities particularly those located in the country-side.

It is true that the levels of awareness and knowledge of COVID-19 among the health care workers is considerably better than the general population—despite rural vs. urban inter-health facility knowledge variations, however, the degree of facility and personnel preparedness and capacity to respond suspected cases, and perhaps manage subsequently confirmed cases of COVID-19 is deplorably inadequate and dis-jointed.

The above status quo will likely strain and overwhelm the national health care system especially the PNFP health service providers—which account for 40% of national health outputs, should the COVID-19 caseload escalate across the country.
The first systemic weakness likely to adversely affect faith-based PNFP health facilities are the pre-existing low numbers of clinically qualified personnel. Health care workers are a critical component of the health system.
The Catholic Health Network *for example* has 56% clinically qualified personnel of its over 10, 000 total health work force—this workforce is just about 50% - 60% of the required skilled numbers for the network—these personnel are part of the front-line health workers, whose risk exposure is high.
Considering a 14 - day self or institutional quarantine requirement for exposed staffs, the available numbers are further likely to be depleted, thereby straining (or shutting down) some critical clinical services—especially since multi-tasking is rife in this sector. Quarantining 5 - 7 facility staffs is enough to severely impair service delivery. This is in addition to other individual health worker effects on the available staff such as burn-out, fatigue, and psychological distress.
The effects of the exposed and/or infected health facility staff has adverse ripple effects to the family of the staff some of whom may require quarantining as well.

In the event of an exponential escalation of COVID-19 cases across the country, a multiplicity of intra-health facility issues (*including availability of trained health personnel, operational coordination and management capacity, supplies and related*

health commodities) shall arise, adversely exposing the functionality and resilience of Uganda's health system.

For example, from the global trends, around 20% of the COVID-19 cases require hospitalization, 5% of the cases require Intensive Care Unit (ICU). In the event of cases rising just to 200 - 500+ across the country, a challenge shall arise.

While majority of the faith-based health facilities may improvise on the facilities (i.e. space, beds & personnel) for hospitalization, the appropriate provision of COVID-19 case management and intensive care services are greatly limited and/or impaired across the country - due to in part, un-available commodities & supplies— which would result high fatality rates.

The heavy reliance on Fees-for-Services (patient fees) in these health facilities— accounting for 50 - 70% of the total PNFP health facility revenues—from which 60 - 75% is spent on Medical Commodities/supplies and Employment Costs, is a major challenge in such periods of epidemics!

The nature and response to the global pandemic is such that patient fees are waived off for COVID-19 cases—and therefore supplemental health facility income support is critically vital for the sustenance of the health facilities operations in this crisis period and immediately there after.

Moreover, patient numbers have drastically reduced—in one Catholic Medical Bureau-accredited hospital, the OPD attendances have reduced by 42% in last couple of weeks, due to various restrictions including on public transport (affecting ease of access), reduced household incomes (affecting ability to pay) and hospital deferrals of non-emergency clinical cases (reducing hospital numbers). The revenue shortfalls will impair clinical services and facility operations in the short term.

It is imperative that the National COVID-19 Preparedness & Response Team urgently considers the preparedness and response capacity of the pluralistic (multiple player) health sector (public & private) in Uganda and their respective complementary strengths and roles in flattening the COVID-19 pandemic curve. This consideration should draw its attention to the operational resilience of these facilities in the course of their participation in epidemic response and the immediate after math.

While the standard public health approaches of social distancing, basic hand hygiene and cleaning, targeted isolation and quarantine of the ill and those at high risk

exposure, unified public communication with clear, transparent up-to-date guidelines and data are key in COVID-19 prevention and health promotion and should be strengthened, it is ***vitally important that the PNFP health facility capacity*** *(supplies, shorter turn-around time for testing, personnel and space) is built and/or strengthened especially before COVID-19 case escalation in the country to limit spread and fatalities.*

While the Ministry of Health has effectively implemented case containment measures—making sure most of the cases are identified, controlled, and isolated (encouraging self/institutional quarantining) like has happened in Singapore, Hong Kong or Taiwan, it must include heavy protection to all its health workers (public & private), it should also strengthen mitigation measures—including a heavy and efficient amount of testing, contact tracing, quarantines and isolations to flatten the curve.

It has been noted that countries that ***act fast*** *(including inclusive facility preparedness) can reduce the number of deaths by a factor of ten—and that's just considering the fatality rate—it also means a drastic reduction of the cases.*

In less than 10 days we are counting 23 confirmed cases—we still have an opportunity to influence the epidemic curve.

In the medium to long term, a critical review of the roles and complementary responsibilities of pluralistic health sector for a stronger and resilient health system shall be imperative.

The consideration for an inclusive and integrated implementation of the 2012 Public-Private Partnership for Health (PPPH) policy is a good starting point especially partnership areas of financial resource allocation & management, Human Resource support and management and capacity building.