

PARLIAMENT OF UGANDA

REPORT OF THE PARLIAMENTARY TASK FORCE ON THE NATIONAL COVID-19 RESPONSE

OFFICE OF THE CLERK TO PARLIAMENTS AUGUST 2021

#### LIST OF ACRONYMS

COVID-19 Corona Virus Disease

CTU **Critical Treatment Unit** 

GoU Government of Uganda

**HBC** Home Based Care

HDU High Dependency Unit

**HSC** Health Service Commission

ICU **Intensive Care Unit** 

МоН Ministry of Health

NMS **National Medical Stores** 

PCR Polymerase Chain Reaction-test

PPE Personal Protection Equipment

Rapid Detection Test RDT

RRH Regional Referral Hospital

Standard Operating Procedures **SOPs** 

WHO World Health Organization

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#### 1.0 BACKGROUND

In accordance with Rule 8 (1.2 &3), of the Rules of Procedure of Parhament, the Rt. Hon. Deputy Speaker constituted a Parliamentary Task Force on the National COVID-19 Response to:

- inquire into and report on Government's preparedness and response to COVID-19:
- provide assessment of the health impacts of COVID-19 in the community and country at large;
- assess operation, administration and management of funds and other iii. resources appropriated for them to manage the pandemic;
- assess the role of private sector health care providers in COVID-19 management;
- v. carry out field visits to assess the state of healthcare system in the Regional Referral Hospitals, both selected General Hospitals and the lower health facilities:
- vi. conduct sensitization and awareness programs on mass media to educate the population; and
- prepare and submit a report to Parliament.

The Task Force is comprised of Representatives of Parliament to the National Task Force including the following;

1. Hon. Abdu Katuntu

/ Chairperson

2. Hon. Dan Atwijukire Kind

Deputy Chairperson

3. Hon. Agnes Kunihira

Member

4. THon. Bernard Odoi

Member

5. Hon. Anna Adeke

Member

6. Hon. Dicksons Kateshumbwa

Member

7. Hon. Abed Bwanika

Member

8. Hon. Victoria Nekesa (Dr.) (Col)

Member

The Parliamentary Task Force on the National COVID-19 Respons further comprised of/Regional Teams as follows;

Northern Regical

1. Hon. Dr. Charles Ayume

Team Leader

2. Hon. Dr. Samuel Opio Acuti

Member/

Hon. George Didi Bhok

Member

4. Hon. Dr. Lilian/Aber

Member

5. Hon. Charles Dner

Member

6. Hon. Jonathab Odur

Member .

7. Hon. Ojara Mapenduzi

Member

Faith Nakut Loru

Member

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9.	Hon. Emmanuel Ongiertho	Member
	Hon. Jimbricky N. Ochero	Member
Easte	ern Region	
1.	Hon. Dr. Emmanuel Otaala Otiam	Team Leader
2.	Hon. Dr. Mutono Lodo: Patrick	Member
3.	Hon. Muwuma Milton	Member
4.	Hon. Dr. Batuwa Timothy Lusala	Member
	Hon. Pamela Kamugo	Memb <del>e</del> r
	Hon. Margret Makhoha	Member
	Hon. Karim Masaba	Member
8.	Hon. Jonathan Ebwalu	Member
Cent	ral Region	
1.	Hon. Dr. Michael Iga Bujenya	Team Leader
2.	Hon. Dr. Lulume Bayiga	Member
3.	Hon. Nakazibwe Hope	Member
4.	Hon. Pauline Kemirembe	Member
5.	Hon. Fortunate H. Nantongo	Member
6.	Hon. Michael Kakembo	Member
7.	Hon. David Kabanda	Member
8.	Hon. Charles Tebandeke	Member
9	Hon. Joseph G. Ssewungu	Member
		J
	ern Region	
	Hon. Ruyonga Joseph	Team Leader
	Hon. Mwijukye Francis	Member
	Hon. Dr. Asiimwe Florence Akııki	Member
	Hon. Bebona B Josephine	Member
	Hon. Kamara Nicholas	Member
_	Hon. Nyakato Asinansi	Member
<b>~</b>	Hon. Rutahigwa Elisa	Member
	Hon. Atwijukire Dan Kimosho	Member
. ج	Hon. Dickson Kateshumbwa	Member
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#### 1.1 THE CORONAVIRUS OUTBREAK

On 31 December 2019, the World Health Organization (WHO) office in China received a report of 29 pneumonia cases of unknown etiology or cause in Wuhan city in Huber province, central China. Within 1 week it became clear that the initial cases were associated with a seafood market where live poultry and wild animals were also sold. The virus was quickly identified as a novel beta-coronavirus and the genetic sequence was shared on 12 January 2020. The infection is now officially termed COVID19 and the virus SARS-CoV-2. News of this outbreak gave many public health officials an involuntary shudder as they recalled the parallels with the severe acute respiratory syndrome (SARS) outbreak that arose in China in November 2002. That outbreak was also caused by a novel coronavirus spilling over from an animal reservous and transmitted by respiratory droplets. SARS spread to many parts of the world through international air travel, caused more than 8000 cases and 774 deaths and cost in the region US\$20 billion to control.

Within less than a month COVID-19 had spread throughout China and to neighbouring countries, even to the USA and Europe. It became clear that the new virus was highly transmissible from person to person but was considerably less virulent, with less than 20% of cases being classified as severe. It has the clinical features of an atypical pneumonia with fever, dry cough, fatigue, dyspnoea and myalgia and is more often severe in those with domorbidities and the elderly. Since there are no specific therapies or vaccines available, standard public health measures appropriate for a virus spread by droplets, close contact and on environmental surfaces were instituted.

To contain the crisis, the Chinese Government conducted active case finding and testing, contact tracing and quarantining of cases and contacts. The public was advised to stay at home if sick, in an effort to control the spread of the virus. On 30 January 2020 the WHO declared the onthreak a public health emergency of international concern, their highest level of severity, at a time when there were almost 10 000 confirmed cases, more than 200 deaths and it had spread to 20 countries. The Chinese authorities had by then instituted highly stringent control measures, including stopping flights public transport in Wuhan and other major cities, melosing animal wet markets, excepting the New Year heliday period in an effort to prevent mass travel, reducing movements within cities minimizing mass gatherings, keeping schools closed, staggering office and factory working hours and estricting movement on the streets. The wearing of lace masks became compulsory and, in effect, the population of Hubei province,

more than 50 million people, were in quarantine. The authorities also built two new hospitals with more than 2500 beds within 2 weeks to cope with the surge in demand for medical care.

As at 20th July 2021, sixteen months into the pandemic, there had been more than 191,000,000 cases confirmed worldwide with more than 4,100,000 deaths, vastly surpassing the SARS epidemic It should be noted that while the number of cases reported first peaked in China, cases have now been reported in 203 countries and territories on six continents. In addition, Countries such as the United States of America and Italy have recorded more confirmed cases than China while Spain has so far recorded less confirmed cases than China but has more deaths. Over 70 countries have instituted travel restrictions. The main initial battle to control this epidemic has been in China, where heroic public health measures have bought the rest of the world time and may have reduced the effective reproduction number to close to 1, thereby bringing the epidemic under control However, the rest of the world needs to maintain high vigilance, as this virus is highly transmissible and can cause severe disease and death, as has been seen in countries such as South Korea, Iran and Italy. Indeed, the number of new cases is now highest in Europe. Containment through case finding and isolation and contact tracing and social distancing remain the key public health approaches to controlling the epidemic in all parts of the world. This is particularly important for countries in sub-Saharan Africa and also those parts of South and Central America and Asia that are not well-prepared for outbreaks. Global solidarity and support are essential, as infectious diseases can easily cross borders, and as John Nkengasong, from the Africa Centres for Disease Control and Prevention (Africa CDC) has said, The global health chain is only as strong as its weakest link, so a disease threat anywhere can quickly become a threat everywhere'.

Preparedness to respond to outbreaks is weak in many countries. Of the 45 low-income countries that have undertaken a national preparedness assessment, none have been deemed ready to respond, making them particularly vulnerable to outbreaks. There are many reasons for this, including poor health and nutrition, exacerbated by high rates of concomitant human immunodeficiency virus and tuberculosis, and low influenza vaccination rates; poor quality of healthcare and resource constraints, as low- and middle-income countries (LMICs) spend on average only \$267 annually per person on health; and vulnerable supply chains and weak medicine procurement, and up to 30% of medicines are substandard or falsified.

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In response to the outbreak, the African Union Commission is strengthening partnerships and coordination across the continent, including a common approach for monitoring and movement restriction of people at risk for COVID-19 and for information sharing. The WHO has found the regional readiness level to be only 66%, with critical gaps and a need to strengthen the capacities for countries to investigate alerts, treat patients in isolation facilities and improve infection, prevention and control (IPC) in health facilities and communities. More than 40 experts have deployed to 10 countries to support preparedness activities and the diagnostic capacity for COVID-19 has been strengthened, with 17 countries now having at least some capacity for laboratory testing.

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In addition, the World Health Organisation has, in the last fortnight, mobilised USD 108million from 203,000 individuals and organisations for the COVID-19 Solidarity Fund set up to augment individual countries' response to the pandemic.

The threat posed by COVID-19 has cast a spotlight on the shortcomings of health systems in all Countries. Countries must invest in emergency preparedness. This is worthwhile considering the cost of responding to outbreaks, which for the 2014-16 West Africa Ebola outbreak was estimated at close to US\$3 billion. One longer-term solution might be to establish a Global Health Security Fund that provides incentives for countries to make capital investments to close their preparedness gap. There are already some preparedness efforts in place that are paying off with COVID-19. For instance, investments in Ebola preparedness for the nine countries neighbouring the Democratic Republic of the Congo, such as Uganda, have ensured partner coordination structures are in place, pointsof-entry screening has been strengthened (particularly at major airports) and isolation units have been upgraded to manage suspect cases. Over the years, the WHO has developed a national influenza network of laboratories and health facilities, which have been able to scale up their diagnostic capacity quickly in order to monitor for severe acute respiratory infections and influenza-like illnesses. This has provided a useful interim surveillance mechanism while awaiting the scaling up of specific diagnostic tests.

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Ministries of health, national public health institutes, universities and other public health agencies are working in many ways to fight this new public health threat across the globe. But this pandemic is not only a medical emergency and human tragedy, it has affected economic activities, and without urgent action, the socio-economic effects could have wide implications for trade, travel, provision of aid, economic markets, supply chains and the daily lives of people living around the world.

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#### 1.2 COVID-19 IN UGANDA

#### 1.2.1 Current Situation

The review by the Task Force revealed that, as at Thursday 29 July, 2021, the country had registered 92,795 cumulative confirmed cases of COVID-19 with 78,415 recoveries and 2,590 confirmed deaths. There are 677 patients admitted in various health facilities, 631 in public facilities and 46 in private facilities. Of all the confirmed cases, 51,868 representing 56%, have happened in a duration of 4 months of the resurgence.

The Task Force was informed by the Minister of Health that, there appears an apparent reversal of the epidemiological trends from what the country experienced in May and June 2021. At the start of the current wave, numbers grew steadily until it reached a peak of 1,735 on 10<sup>th</sup> June 2021. Following the lockdown, instituted by H.E The President on 18<sup>th</sup> June 2021, until present, the daily average is down to an average of 295 confirmed cases.

Despite the steady drop in the number of daily confirmed cases, mortality continues to occur among severe and critically ill patients who report to the hospital late. This partly explains the non-declining number of deaths.

On average, 34,247 cases were registered between 10<sup>th</sup> June and 26<sup>th</sup> July 2021. The highest number of daily hospital admissions for severe and critically ill patients registered was 204 on 20<sup>th</sup> June 2021 with a daily average of 142 patients between 10<sup>th</sup> to 30<sup>th</sup> June 2021 when the number of confirmed cases started declining. Since then, the daily admissions stand at 50 patients.

As a result of the drop in the daily cases and hospital admissions, the pressure on bed space has since eased and bed space has been freed up in almost all the COVID treatment units countrywide. The positivity rate has also dropped from 21% at the peak of the resurgence and stabilized at an average of 10% in the past 10 days. The desirable positivity rate which indicated control of the pandemic is 5%.

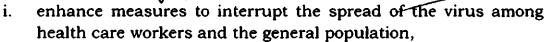
1.2.2 Uganda's Response To The Resurgence

The primary measure taken to combat the spread of COVID-19 and address the resurgence is the lockdown which was instituted by H.E the President on 18th June 2021 to achieve the following outcomes:

on 18th June 2021 to achieve the following outcomes;

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- ii. enhance risk communication and community engagement,
- iii. streamline and strengthen Home Based Care for COVID-19,
- iv. increase the capacity of our health facilities to optimally manage COVID-19 cases,
- v. continue with vaccination depending on availability of vaccines,
- vi. sustain continuity of essential health services,
- vii. smoothen access to medical emergency services.

In addition to the nationwide lockdown, a costed resurgence plan was prepared and presented to this August House by the Rt. Hon. Prime Minister as follows;

SN	Pillars/Items	Estimated Total in UGX			
1.	Vaccination	2,628,000,000			
2.	Community Engagement	6,544,069,136			
3.	Coordination	12,050,615,000			
4.	Surveillance	59,351,555,000			
5.	Risk Communication	68,192,074,850			
6.	SIRI	70,338,280,000			
7.	Laboratory	84,980,169,800			
8.	Case Management	93,803,704,350			
9. Continuity of Essential Services		114,194,158,000			
10.	Logistics	808,393,297,732			
GRANI	DTOTAL	1,320,475,923,868			

The Task Force noted that whereas mass vaccination is the proven way to attain the herd immunity required to return to a relatively normal existence and to permanently end restrictions to curb the spread of the virus, it has been allocated the least resources in the costed resurgence plan.

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#### 2.0 SCOPE AND TERMS OF REFERENCE

The geographical scope of the Parliamentary Task Force covered the whole country. This was the basis of operations by the Regional Teams that travelled to all corners of the country to conduct a physical assessment of the situation on the ground in the context of the management of the COVID-19 pandemic.

The conceptual scope of the Task Force was defined by the terms of reference The Terms of Reference of the Representatives of the National Task Force were to;

- a. represent Parliament and coordinate the Parliamentary COVID-19 Response with that of Government,
- b. coordinate the overall interventions of the Regional Parliamentary Task Force Teams, and,
- c. have recourse to the Terms of Reference of the Regional Parliamentary Task Force Teams.

The terms of reference of the Regional Teams were to;

- a. inquire into and report on Government's preparedness and response to COVID-19,
- b. assess the health impacts in the community and country,
- c. Assess operation, administration and management of funds and other resources appropriated for them to manage the pandemic,
- d. Assess the role of private sector healthcare providers in COVID-19 management,
- e. carry out field visits to assess the state of health care systems in the Regional Referral Hospitals, District Hospitals and the lower health facilities,
- f. conduct sensitisation and awareness programmes on mass media to educate the population,
- g. prepare and submit a report to Parliament, and,

h. consider any such matters related to Government Response to COVID-19.

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#### 3.0 METHODOLOGY

### 3.1 Meetings

In performing its mandate, the Task Force held entry meetings with the following;

- i. Ministry of Health
- ii. Ministry of Finance, Planning and Economic Development
- iii. Ministry of Gender Labour and Social Development
- iv. National Medical Stores
- v. Private Health Care Service Providers brought together by the Uganda Healthcare Foundation (UHF). These included International Medical Group/International Hospital Kampala, Medipal International Hospital, Nakasero Hospital, Case Hospital, Norvik Hospital, TMR International Hospital, UMC Victoria Hospital and The Medical Concierge Group/Rocket Health Africa
- vi. the Task Force held exit meetings with the Ministry of Health and National Medical Stores. The Minister of Finance, Planning and Economic Development and the Minister of Gender, Labour and Social Development made written submissions in lieu of a face-to-face interaction.

#### 3.2 Review Of Documents

The Parliamentary Task Force on the National COVID-19 Response, during its preparatory meetings, studied and made reference to various documents including;

- i. the Presidential Addresses to the Nation on the COVID-19 Pandemic since March 2020,
- ii. Ministerial addresses by the Hon. Minister of Health to the public on the pandemic and the pandemic response,
- iii. Statutory instruments, reports and resolutions adopted by the 10<sup>th</sup> Parliament on the subject matter,
- iv. the Report of the Auditor General on the management of COVID-19 funds,

v. Written submissions presented to the Task Force during the meetings in 3.1 above.

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# 3.3 Regional Field Visits

The Task Force has conducted field activities in the regions in accordance with the terms of reference as follows;

SN	REGION	FIELD ACTIVITIES SCHEDULE
1.	EASTERN	(i) Regional Referral Hospitals  The Eastern Region team visited a total of three (3) Regional Referral Hospitals (RRH) including Jinja, Mbale and Soroti.
		(ti) General Hospitals (District Hospitals) A total of seven (7) General Hospitals were visited including Iganga, Bugiri, Tororo, Masafu, Butaleja, Palisa and Katakwi General Hospitals.
		(iii) Health Centre IVs The HC IVs visited include Buyinja, Iyolwa, Budaka, Namatala, Budadiri, Serere and Bukedea HC IVs.
\$10`		(iv) Health Centre IIIs Only Dholwe Island HC III was visited. This facility serves over 160,000 people from the nine (9) islands that make up Bukooli islands.
		(v) Private Not for Profit (PNFP)  The team further visited Kanginima HCIV- a Private Not for Profit (PNFP) in Butebo district.
1		(a) Meetings with District COVID-19 Task Forces  The team held meetings with the district Task Forces of Jinja, Iganga, Bugiri, Tororo, Namayingo, Busia, Butaleja, Budaka, Palisa,
KE.	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Butebo, Mbale, Sironko, Soroti, Katakwi and Bukedea.  Accordingly, Status reports on COVID-19 of
		the respective districts were submitted to the Task Force. The Task Force further received a report from Kibuku District COVID-19 Task Force although no meeting took place with the

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			•
Γ			district.
			(h) Padio Talk shows
			(b) Radio Talk shows
	ŀ		Radio Talk Shows were conducted on in Busia,
	ľ		Tororo, Mbale and Soroti on Jogoo FM,
ŀ			Eastern FM, BIG FM and Varitas FM
			respectively.
	-		
F	2.	WESTERN	(a) Visited selected Health facilities including;
			Designal Defermed Heavatele (Heime
			1. Regional Referral Hospitals (Hoima,
Ì			Fort Portal, Kabale and Mbarara),
			ii. General district hospitals (Masindi,
	[		Kagadı, Kyenjojo and Bundıbugyo),
	1		
ļ	<u> </u>		iii. Health Center IV (Kikuube,
			Bunyangabu, Ntoroko, Nsiika,
1			Kabwohe, Bushenyi, Rukungiri,
			Kamukira and Kazo),
			ıv. Private Not For Profit (Nyakıbaale).
			iv. Trivate Not For Front (Nyakibadic).
	}		
			(b) Conducted radio talk shows at;
			i Kitara FM in Masindi District
ŀ	1		ii. Spice FM and Liberty FM in Hoima
			District
			District
	1		iii. Hits radio and Voice of Toro in Fort
1			Portal
			iv. Radio Rukungıri
> -	XX	<del></del>	v. Radio West ın Mbarara
			vi. and Voice of Kigezi in Kabale.
4	- I		
1 OAAAA	<del></del>		
204	3.	CENTRAL	Butambala and Gomba
$\nearrow$ $\bot$	.		,
M			1. Mubende Regional Referral Hospital
	- 1		(RRH)
	1	11	2. Mityana General Hospital (GH)
1	ľ		3. Held Sub-Regional District Task Force
<b>₹</b> `\			(DTF) meeting for Mityana, Mubende
) 1		<b>-</b>	and Kassanda
<i>_</i> ∤ L		(Signitiza	
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# Masaka and Lyantonde

- 4. Masaka RRH
- 5. Lyantonde Hospital

### **Kyotera**

- 6. Mutukula Border point
- 7. Hold Radio talk Show in Mutukula

# Kayunga

- 8. Bbale General Hospital
- 9. Kayunga RRH

#### **Buikwe and Mukono**

- Nkokonieru HC IV 10.
- 11. Kawolo General Hospital

### **Wakiso** and Kampala

- 12. Mandela National Stadium
- 13. Kiruddu General Hospital
- 14. Mulago National Referral Hospital
- 15. Naguru Regional Referral Hospital
- 16. **Entebbe General Hospital**

#### NORTHERN

#### KARAMOJA SUB-REGION

- Regional Referral Hospitals The team visited Moroto Regional referral Hospital
- General Hospitals (District Hospitals) (u)
  - Abim district hospital
  - 2. Kaboong district Hospital
- Health Centre IVs (uu)
  - 1.Labilatuk HC IV, Labilatuk
  - 2 Amudat HC IV, Amudat district
  - Tokora HC IV, Nakapiripirit
  - 3. Karenga HC IV, Karenga District
  - 4 Kotido HC IV, Kotido District

#### w) Private Not for Profit (PNFP

1. Matany Hospital, Napak District, Missionary Hospital

#### ACHOLI SUB-REGION

i). Regional Referral Hospitals

The team visited Gulu Regional referral Hospita

Ph

- u) General Hospitals (District Hospitals)
  - Kitgum district hospital
- (i) Health Centre IVs
  Padibe HC IV, Lamwo District

Pajule HC IV, Pader District

- w) Private Not for Profit (PNFP
  - 1 St Mary's Hospital, Lacor Hospital
- v) Elegu Border Point

NB/ While in the Gulu meeting, the Members invited and received submissions from the District Task Forces of Omoro & Nwoya District Local Governments and Gulu University Management

(c) Radio Talk shows
Radio talk show was conducted in Mighty fire Fm,
Kitgum and Mega Fm in Gulu

#### **WEST NILE SUB-REGION**

- (1) Regional Referral Hospitals
  The team visited
- 1. Arua Regional referral Hospital
- 2. Yumbe Regional referral hospital
- (ti) General Hospitals (District Hospitals)
  - 1 Adjumani District Hospital
  - 2. Moyo District Hospital
  - 3. Koboko District Hospital
  - 4. Nebbi District Hospital
- (iii) Health Centre IVs
  - 1. Maracha HC IV, Maracha
  - 2. Oli HC IV, Arua City
  - 3. Obongi HC IV, Obongi District
  - 4. Pakwach HC IV, Pakwach District
- w) Private Not for Profit (PNFP)
  - 2. Nyapea Hospital, Zombo District, Missionary Hospital

NB/ While in Arua, there was a joint Task Force meeting with the District Task Force of Arua, Madi Okollo and Terego, they made submission, however the team did not get to the facilities that is Health Center IVs

Radio Talk shows

Radio talk show was conducted in Spirit FM

Border Post

The team also visited a Oraba border post in Koboko district

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#### LANGO SUB-REGION

- 1) Regional Referral Hospitals
  The team visited Lira Regional referral Hospital
- ii) General Hospitals (District Hospitals)
  Apac District Hospital
- uii) Health Centre IVs
- 1. Dokolo HC IV, Dokolo District
- 2. Aboke HCIV, Kole District
- 3. Alebtong HC IV, Alebtong
- 4 Aduku HC IV, Kwania District
- w) Private Not for Profit (PNFP

Aber Hospital, Atapara in Oyam District

NB The team met with the District Task Force from Lira, Amolatar, Otuke districts and submissions were received

Radio Talk shows
Radio talk show was conducted on Unity FM

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#### 4.0 COVID-19 EXPENDITURES AND ACCOUNTABILITY

Government of Uganda has provided a total UGX 4,034.11bn to finance COVID-19 related expenditure since the onset of COVID-19 in March 2020. Out of this, UGX 314bn (7.8%) was provided in FY 2019/20, UGX 2,787.23bn (69.1%) was for FY 2020-21 and 932.58 (23.1%) has been provided in the FY 2021-22.

A total of UGX 1,139.98bn (28.3%) has been provided to finance interventions related to provision of direct health services, UGX 116.38bn (2.9%) has been directed towards social protection specific interventions (SAGE and funds to the Vulnerable populations within Cities and Municipalities) and another UGX 2,665.87bn (68.9%) has been provided to support interventions that have been implemented under the economic stimulus package.

#### 4.1 Lack of Transparency in Accessing Economic Stimulus Packages

By implementing the various economic stimulus packages, Government intended to minimize the negative impact of COVID-19 on the social and economic welfare of the economy with focus on household economic welfare, Firms to survive the crisis and maintenance of financial stability to avoid the potential collapse of the economy (Table 1).

Interventions such as UDB re-capitalization, support to SACCOs through Microfinance Support Centre, Emyooga and the Youth Funds, Uganda Women Entrepreneurship Programme (UWEP) and provision of inputs and support for the e-Voucher systems were well intentioned to boost the private sector, protect economic resilience, and provide some certainty for business. However, they were affected by lack of a transparent mechanism to ensure that the resources trickle down to the intended beneficiaries. Consequently, many small and medium enterprises (SMEs), Women and Youths have continued to suffer from the economic impacts of COVID-19 unabated.

Government, through the Ministry of Finance, Planning and Economic Development should submit to Parliament full accountability backed by an authentic list of Beneficiaries of the funds appropriated in

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respect to the re-capitalization of Uganda Development Bank totaling to UGX 558.18bn and the additional allocation to Support SACCOs under the Uganda Microfinance Support Centre totaling to UGX 77.72bn meant to enable Small and Medium Enterprises (SMEs) access quick and affordable credit to turn-around their businesses that were on the verge of collapsing.

Government should provide to Parliament full accountability indicating the beneficiaries of the funds appropriated under the Youth Fund totaling to UGX 130bn, UWEP under Ministry of Gender, Labour and Social Development totaling to UGX 29.51bn and Emyooga through Micro Finance Support Centre under Ministry of Finance, Planning and Economic Development totaling to UGX 260bn.

Future interventions such as the Youth Fund should be appropriated under the rightful Ministries that ordinarily are mandated to perform such functions to avoid duplication and uncoordinated programmes.

In addition, The Task Force recommends that Government should halt further provision of any form of economic stimulus until the Auditor General conducts a forensic Audit on all funds that have been appropriated for the COVID-19 response.

#### 4.2 HIGH COST OF ENFORCEMENT OF COVID-19 CONTAINMENT MEASURES

The Task Force further notes that whereas there is still having a deficit in the required budgetary allocation towards procurement of the much-needed vaccines to the tune of UGX 365.9bn, Government is still spending huge sums of money on COVID-19 containment measures at the expense of mass vaccination. Since the onset of COVID-19 in FY 2019-20, a total of UGX 142.23bn has so far been spent on enforcement of COVID-19 lockdown directives.

In addition, during the FY 2019-20, Parliament appropriated a total of UGX 22.18bn to support the establishment of twenty (20) Isolation Centers in each district and to undertake surveillance as a means of slowing down on

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disease transmission. However, teams established that in most of these districts, not a single Isolation Centre ever existed.

Government should submit detailed accountability to Parliament for UGX 22.18bn appropriated to facilitate establishment of twenty (20) Isolation Centres per district indicating the location in each district where such facilities were established.

Table 1: COVID-19 Expenditures and Accountabilities (UGX, billions)

8/N	Category	2019-20	2020-21	2021-22	Total	% Share
1	Interventions Direct to Health	119.19	253.59	767.20	1,139.98	28.3%
2	Operational Funds for Enforcement of COVID-19 Lockdown	92.23	-	50 00	142.23	3.5%
3	Food Relief	59.40	-1-	-	59.40	1.5%
4	Establishment of Isolation Centres	22.18	-	-	22.18	0.5%
5	Scaling up Awareness	6 00	•	8.10	14.10	0 3%
6	LG Task Forces & related Activities	-	-	53.74	53 74	1.3%
7	Support to COVID Research	5.30	31 03		36.33	0.9%
8	Supervision to LGs Interventions	10.00		-	10.00	0 2%
9	Social Protection		62.88	53.50	116.38	2.9%
10	UDB Re-capitalization		558 18		558.18	13.8%
11	Support to SACCOs - Microfinance Support Centre		77.72	-	77.72	1.9%
12	Emyooga		260.00		260.00	6.4%
13	Import Substitution & Export Promotion through UDC		128 10		128.10	3.2%
14	Provision of inputs & Support the E-voucher System		125.71		125 71	3.1%
15_	Domestic Arrears		676.90		676.90	16.8%
16	Roads (incl. Labour Intensive Public works)		130.00		130.00	3.2%
17	Uganda Industrial Research Institute (Namanve Machine Making Plant)		10.00		10.00	0.2%
18	Funding for Uganda Women Entrepreneurship Programme		29.51		29.51	0 7%
19	Funding for Youth Fund		130.00		130.00	3.2%
20	Support to Artists		1.20		1.20	0 0%
21	Ministry of Energy (Support to Substations in Industrial Parks)		156.85		156.85	3.9%
22	Development of Industrial Parks		155.55		155 55	3 9%
	Total	314.30	2,787 23	932 54	4,034.07	100.0%

Source: Ministry of Finance, Planning and Economic Development.

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## DISCREPANCY IN COVID-19 EXPENDITURE FOR FY 2019-20

Parliament appropriated UGX UGX 94.188bn under supplementary Budget Schedule 1nto Ministry of Health. The Ministry of Health in its submission to the Task Force indicated that by the end of FY 2019-20, a total of UGX 92.431bn had been spent, leaving a balance UGX 1.757bn unspent. The balance is reported to have been returned to the Consolidated Funds (CF).

A review of the actual expenditures submitted to the Task Force revealed a total of UGX 99.069bn as having been spent instead of the reported UGX 92.431bn. The Task Force noted that this amount is over and above the amount appropriated by UGX 4.881bn. The source of the additional funds totaling to UGX 4.881bn remains unknown (Table 2). It is not possible to spend more than what was appropriated.

The Ministry of Health should explain the source of the additional expenditure amounting to UGX 4.881bn.

# DISCREPANCY IN THE PURCHASE AND NATIONAL WIDE DISTRIBUTION OF

As a condition for lifting of the lock down in May 2020, cabinet directed the Ministry of Health to provide non-medical and reusable face masks totaling to 34,109,085 to all persons above six (6) years of age. In addition, as a prerequisite to the reopening of schools, Cabinet further directed that all learners should be provided with fabric masks. Therefore, this necessitated a procurement of an additional 2,592,963 masks for finalists in candidate classes. Consequently, a total of 36,702,048 masks at a cost of UGX 2,400 per mask were procured and distributed to 135 districts and to all finalist learners in candidate classes across the country. At a cost of UGX 2,400 per Tabric mask, the total cost for the 36,702,048 masks comes to UGX 88,084,915,200.

However, a review of the accountability of Government of Uganda (GoU) COVID-19 funding to Ministry of Health for the period March 2020 to June 4 2021 revealed that a total of UGX 90,999,000,000 was spent in respect to procurement of fabric masks for the Communities totaling to 35,323,287

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and finalist learners totaling to 2,592,963. This brings the overall number of community masks to 37,916,250.

Consequently, the analysis of the Task Force revealed a discrepancy in both the reported number of fabric masks procured and distributed by 1,214,202 and the amount of money spent on the procurement of the fabric masks by UGX 2,914,084,800.

The Hon. Minister for Health should explain the observed discrepancy arising from her report titled "Update to Parliament Task Force Task Force on COVID-19 in Uganda" dated 7th July 2021 and the one titled "Accountability for GoU COVID-19 Funding to MoH March 2020 to June 2021".

#### 4.5 External Financing to Ministry of Health COVID-19 Response

The Ministry of Health reported that a total of UGX 389.13bn was received as external financing for the period March 2019 to June 2021. Out of this, UGX 215.19bn was from the Global Fund (GFs), UGX 56.24bn from the World Bank – the Uganda COVID-19 Response and Emergency Preparedness Project (UCREPP), UGX 55.5bn was from World Bank's Contingency Emergency Response Component (CERC), UGX 51.02bn from Islamic Development Bank (IsDB), while UGX 10.4bn and UGX 0.78bn was from GAVI and the Uganda Sanitation Fund (USF) respectively (figure 1).

The Contingency Emergency Response funds were spent on coordination, risk communication, ICT innovations, Case management, Mental Health and Psychosocial support, Surveillance and Laboratory operations as well as logistics (related to testing, PPEs, Ambulances, Motorcycles), among others.

On the other hand, UCREPP funds were spent on Staff salaries, training of mealth personnel and other office operations. Global Funds were mainly spent on purchase of test kits, surveillance, support supervision, purchase

A reviewed of the external financing accountabilities submitted by the Ministry of Health revealed most of the items that were funded were similar

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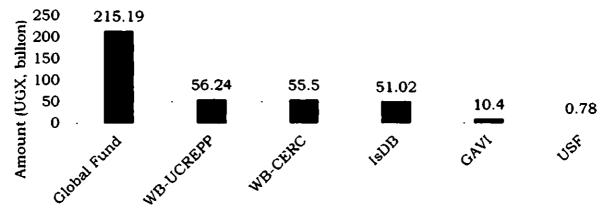
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of oxygen cylinders among others.

in nature and purpose as those funded using the Government of Uganda (GoU) budget. It was not possible to establish whether there was no duplication and therefore multiple accountabilities.

The Auditor General should institute a forensic audit into all COVID-19 Expenditures to ascertain value for money spent.

Figure 1: External Financing to Ministry of Health



Axis Title

Source: Ministry of Health

Table 2: Breakdown of UGX 94.188bn in Schedule 1 FY 2019-20 (UGX, bns)

No.	Items	Amount	Remarks
1	Contract staff	UGX3.98bn. Paid	Recruited 546 staff on contract
	salaries and NSSF	UGX 2.225bn, UGX	including 237 recruited through HSC (56
		1.757bn was	Epidemiologists, 18 Medical Officers Special
ما		unspent by end of	
		June 2020 and was	Nursing Officer Critical Care, 30 Assistant
<b>a</b> .		returned to CF.	NO, 10 Enrolled Nurse/Midwife, 10 Ambulance Assistants, 5Psychiatric Clinical
X			Officers, 4 Aneasthetic Officers, 10 Lab
ĺ			Technicians, 10 Drivers); 50 Call Centre
1 -	1		Agents; 48 Airport Screening team; 28 Alert
1			Management team; 83 Self-isolation follow-
			up team and, 100 Quarantine Centres
			Cleaners.
2	Allowances	12.705	About 2,287 personnel were paid hardship
			allowance as approved by MoPS. Airport
}			staff; Surveillance teams, Points of Entry staff (54 PoEs with 565 personnel), Contact
			Tracing; Follow up of Suspects.
<del> </del>	<b>l</b> .	- 1	Psychological support; Ambulance
1ነ	1 1 -		staff, Case management teams at Mulago,
<u> </u>			Entebbe &Adjumani Hospital; UVRI(115);
,		( ) ALLES	Contract Con
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No.	Items .	Amount	Remarks
			Drivers; Volunteers (309);104 UPDF and; other MDAs (216).
3	Medical Supplies	7.269	Procured assorted Personal Protective
			Equipment (masks, coveralls, gloves, boots, aprons, etc) and these were distributed by NMS.
4	Medical Supplies (Lab Test Kits)	13.155	Procured test kits and laboratory reagents and these have been utilized at UVRI, CPHL and mobile labs at Adjumani, Mutukula, Tororo and Makerere College of Health Sciences.
5	Medical Supplies	0.73	Blood Bank consumables were procured for UBTS for blood collection.
6	Procurement and installation of Intensive Care Unit Equipment	35 912	143 ICU beds and accessories have been procured installed at 3 NRHs and 13 RRHs (with the exception of Mubende RRH due to lack of space) St Mary's Lacor Hospital and Lira University Hospital •Installations have been done in spaces that have been prepared for temporary use and the staff have been trained.
7	Procurement of Oxygen plants	6 466	Procured 7 Oxygen plants comprising compressors, Air tanks, Air driers, oxygen generators, oxygen tanks, filling stations. These have been installed and functional as follows; 4 Mulago, 1 Entebbe, 1 Mbarara. 1 for Kawempe Hospital under installation. Procured 450 distribution cylinders and high flow systems (Included electrical and re-modelling works).
8	Procurement of Ambulances	11	38 fully equipped ambulances were procured (33 are Type B (Basic Life Support) road ambulances; 2 Type C (Intensive Care) road ambulances and; 3 Type C Water ambulances); The ambulances are in use and being managed under the National ambulance system that is regionally coordinated under 14 Regions.
9	Accommodation	1.207	Paid UGX 1.207bn for full board accommodation to hotels that accommodated the returnees and contacts who were quarantined (UGX 1,093). Balance UGX 2.089bn used for procurement of test kits.
	Travel inland	0 594	Distribution of community face masks.

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11-	Tènma	Amount	Remarks
No.	Items	Amount	Veingles
10	Special Meals	1.729	Paid for meals for: Central quarantine sites Staff at the 58 Points of Entry; Patients and staff at Entebbe RRH and Adjumani. Incident Management Team & EOC staff: UVRI staff Call Center agents. Security personnel attached to MoH.
11	Printing and procurement of computer and IT supplies for Border Posts	0 893	UGX 0 743bn Printing of COVID-19 IEC materials, guidelines, Standard Operating Procedures and Laboratory test results UGX 0.15bn procured computers & IT supplies for Border posts.
12	ICT Equipment	0.8	Retooling the local Area Network for the MoH to improve on internet connectivity and development of the Call Center Solution to improve its capacity. At all the three main Call Centers, (MoH/UTL office/Telephone House), a total of 112,525 emergency calls were received from the public and all followed up.
13	Fuel	2.007	Deposited to the fuel supplier and issued fuel cards. All field activities were facilitated from this including distribution of non-medical commodities received at MoH.
14	Vehicle Maintenance	0.48	Servicing and maintenance of all vehicles deployed for the response
15	Stationery	0.188	Procured office stationery and supplies
16	Telecommunication	0.2	Paid for telecommunication and data for teleconferencing facilities.
17	Electricity	0.509	Advance payment to UMEME for MoH and institutional quarantine sites (Allied Paramedical Institute, Kabanyoro, Lands and Survey, Fisheries Institute and Diary Development Authority.
18	Water	0.3	Advance payment to NWSC for MoH and institutional quarantine sites.
19	Cleaning and sanitation	0.7	For cleaning and fumigation services at MoH, Mulago and quarantine centers. Waste management at Mulago NRH
	Total	99.069	

Source: Ministry of Health Accountability for COVID-19 Expenditures

**DONATIONS TOWARDS COVID-19 RESPONSE** 

Janes The Task Force was informed that Government through the National Task Force and District Task Forces received both cash and donations in-kind. The donations in-Kind included Vehicles, Mattresses, Beds and Beddings,

Sanitizers, test Kits, PPEs and food items, among others. The Task Force

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commends all persons and organizations that made a contribution for their support at such a critical time.

However, when the Task Force noted that there were inadequacies when it came to accountability of donations received. Indeed, this is also confirmed in the Auditor General's Report on thematic Audit Report on COVID-19 Pandemic Government Interventions dated February 2021. This report provides findings of the Auditor General in respect to the Management of COVID-19 Interventions for the FY 2019/2020. At an appropriate time, the Accountability Task Forces of Parliament shall review it and make recommendations for the appropriate resolutions.

When the Task Force reviewed the submission of the Ministry of Health on Accountability of COVID-19 GoU funding, it established that a total of UGX 29.6bn is reported as having been collected as cash donations towards COVID-19 response. Out of this, UGX 23.9bn was earmarked toward procurement of 282 Pickup Vehicles, UGX 3.3bn was earmarked and spent towards the construction of a Blood Bank at Soroti while UGX 2.4bn was earmarked and spent on construction of Border Post Health Units at Vurra and Cyanika.

By the time of writing this report, a total of 121 Vehicles had been imported into the Country and were still awaiting clearance of the import taxes totaling to UGX 9bn by Uganda Revenues Authority (URA). The Task Force was informed that the Ministry of Health did not have a budget of UGX 9bn to clear the import taxes and as a result the Vehicles were still parked in SURA Customs bonded warehouses awaiting clearance. It has been established that these vehicles started arriving in June 2021 and as a result the demurrage costs keep accumulating plus other clearance fees.

Whereas the Ministry of Health had written to the Ministry of Finance, Planning and Economic Development requesting for a tax waiver, the Finance Ministry had insisted that the tax obligation had to be met to the Ministry of Health. This process was causing undue delays as the vehicles could not be availed to be deployed as required.

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The Task Force noted that there was poor planning and disjointed coordination amongst the two Ministries on the procurement of these vehicles. It is ill conceivable for Government to imagine that funds donated by the well-wishers would be used to clear Government Tax obligations. It is a disappointment on the part of government towards the public generosity. Why wouldn't government provide counterpart funding to clear the taxes or provide an undertaking to clear the taxes with URA so as to deploy these vehicles urgently to facilitate the much-constrained logistical activities.

Government should urgently resolve this impasse by either availing the funds required to clear the due taxes or settle for a tax waiver altogether with a view of having the vehicles cleared and deployed to serve the deserving population without any further delay. The decision taken should as well apply to the remaining batch of 161 Vehicles yet to be received in the Country.

The Task Force recommends that in such cases of emergency, such imported vehicles should be pre-cleared before arrival so as to deploy them quickly and avoid unnecessary costs. Further still, such vehicles can still be warehoused in-situ within government gazetted facilities as they await clearance from URA to avoid unnecessary demurrage of psts.

Rt. Honourable Speaker, Honourable Members, what seems to have happened is that all procurements undertaken during the COVID-19 response were of emergency nature and therefore cases could not have followed the procurement process.

In the circumstances, a forensic Audit should be conducted within two (2) months to ascertain whether there was value-for-money.

4.7 Budget for COVID-19 Resurgence Plan July 2021 to June 2022

The total budget estimated to deliver the COVID-19 resurgence Plan from July 2021 to June 2022 amounts to UGX 1,763.8bn. Of this, UGX 445.9bn

(25%) is earmarked for the procurement of the much-needed COVID-19

vaccines while UGX 808.4bn (45%) will go to logistics (Table3).

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The Task Force was informed that within the first Quarter of FY 2021-22, a total of UGX 206.3bn has been earmarked. Specifically, these funds will be used to cater for oxygen requirements, surveillance, allowances, case management, and management of ambulances among others. In addition, UGX 255.4bn has been reported as committed. That is, NMS (UGX 80bn), UCREPP (UGX 46.2bn) and GFTAM (UGX 129.2bn). This brings the total amount available towards the budget for COVID-19 resurgence plan is UGX 461.7bn (UGX 206.3bn plus UGX 255.4bn) leaving a funding gap of UGX 1,302.1bn (UGX 1,763.8bn less 461.7bn).

When the Task Force met with the Hon. Minister of Finance, Planning and Economic Development, the Honourable Minister indicated that there were resources from World Bank totaling to UGX 480.8bn and this Money was already in the Ministry of Health budget for FY 2021-22. In addition, an allocation of UGX 80bn was approved under NMS for FY 2021-22. These resources, together with a supplementary budget of UGX 206.3bn approved by cabinet, total to the budget available to the Ministry of health of UGX 767.14bn.

Therefore, going by the Honourable Minister for Finance, Planning and Economic Development, the deficit in financing the budget for the COVID-19 resurgence plan is UGX 996.66bn (UGX 1,763.8bn less UGX 767.14bn) contrary to what is indicted by the Honourable Minister of Health of UGX 1,302.1bn. It is not clear which of the two figures is the true deficit in financing the budget for the COVID-19 resurgence Plan. With this apparent discrepancy between the funding gaps indicated by the two Ministries, it is difficult to ascertain exact deficit in the budget for COVID-19 resurgence plan for July 2021 to June 2022.

Government should undertake realistic and harmonized planning with a view of ascertaining the optimal level of financing required for COVID-19 resurgence plan taking into account interventions that should be, implemented to contain the transmission

of civid-19 virus.





Table 3: COVID-19 Resurgence Plan Budget July 2021 to June 2022 (UGX, billion)

		Commi	tments				
ltem	Estimated Total	GoU (Q1)	GoU (NMS)	UCREPP	GFTAM	Total	Gap
Coordination	12.1	0.7	0	3 1	5	8.8	3.3
Surveillance	59.4	0.8	0	5.7		65	52.9
Laboratory	85	1.9	0	13.3	0.4	15.6	69.4
Case Management	93.8	28.6	0	24.1		52.7	41.1
Risk Communication	68 2	0	0		06	0.6	67 6
Community Engagement	6.5	0	0	]		0	6.5
Strategic Information	70.3	0	0		05	0.5	69.8
Logistics	808.4	174.3	0		122.7	297	511.4
Continuity of essential Services	114.2	0	0			0	114.2
COVID-19 Vaccinations Costs	445.9	0	80			80	365.9
Total	1763.8	206.3	80	46.2	129.2	461.7	1,302.1

Source: Ministry of Health COVID-19 Resurgence Plan July 2021 to June 2022.

Table 4: Breakdown of COVID-19 Budget for Q1 FY 2021-22 (UGX)

Item	Amount (UGX)
Coordination, Supervision and Monitoring	662,790,000
Human Resource (Arrears for hardship allowances for surveillance, UVRI, RRHs & Namboole).	2,290,720,000
Surveillance	85,500,000
Laboratory	1,022,680,000
Case Management at Mulago Women's Hospital and Namboole CTUs.	4,612,000,000
Case Management at National and Regional Referral Hospitals CTUs.	9,208,000,000
Road Ambulance Services for COVID-19.	6,840,800,000
Salary and NSSF for existing (437) and Additional contract Staff.	6,761,840,397
Surveillance (recruitment costs of additional contract staff).	200,000,000
Infrastructure (remodeling 3 ICUs - Jinja, Mubende & Bombo, contraction of 10 ICUS, ICU beds a accessories (20), procurement of 40 Patient Monitors per HDU)	11,900,005,000
Oxygen Requirements (6 oxygen & Medical air plants (200 NM3/hr capacity and oxygen cylinders).	94,962,586,800
Logistics.	67,560,425,000
Total	206,107,347,197

Source. Ministry of Health resurgence Plan Budget June 2021 - July 2022.

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#### 5.0 REPORTS BY THE REGIONAL TEAMS

Rt. Hon. Speaker, Hon. Members,

The Task Force was directed "to carry out field visits to assess the state of health care systems in the Regional Referral Hospitals, District Hospitals and the lower health facilities".

In line with the above term of reference, the Regional Teams coonducted field visits and hereby beg to report.

#### 5.1 EASTERN REGION

#### 5.1.1 Introduction

Rt. Hon. Speaker and Honourable Members,

In accordance with Rule 8 (1,2&3) of the Rules of Procedure of Parliament, the Rt. Hon. Speaker constituted a Parliamentary Task Force on the National COVID-19 Response and charged it with the following Terms of Reference;

(i) To inquire into and report on Government's preparedness and response to COVID-19;

To assess the health impacts of COVID-19 in the community and the country at large;

To assess, operation, administration and management of funds and other resources appropriated for management of the pandemic;

To assess the role of private sector healthcare providers in COVID-19 management;

(v) To carry out field visits to assess the state of healthcare systems in the Regional Referral Hospitals, District Hospitals and the lower health facilities;

 (vi) To conduct sensitization and awareness programs on mass media to educate the population on COVID-19;

(vii) To bring to the attention of Parliament any such matters related to COVID-

(vin) To prepare and submit a report to Parliament.

Subsequently, the Eastern Region team comprising of Hons. Dr. Emmanuel Otaala Otiam, John Baptist Nambeshe, Dr. Mutono Lodoi Patrick, Muwuma Mjlton, Dr.

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Batuwa Timothy Lusala, Pamela Kamugo, Margret Makhoha, Karım Masaba, Jonathan Ebwalu carried out the assignment and now reports.

### 5.1.2 Methodology

The Task Force:

- (i) held field preparatory and planning meetings with teams from;
  - (a) Munistry of Health
  - (b) Ministry of Finance Planning and Economic Development,
  - (c) National medical Stores (NMS),
  - (d) Ministry of Gender, Labour and Social Development and;
  - (e) The Private Healthcare Providers.
- (ii) reviewed the relevant literature including:
  - (a) Addresses from His Excellency the President on the pandemic:
  - (b) Ministry of Health Preparedness and Response Plan March 2020-June, 2021;
  - (c) Brief on Financing the COVID-19 Emergency Response for FY 2021/22 by the Ministry of Finance
  - (d) Thematic Audit Report on COVID-19 Pandemic Government Interventions
  - (e) Ministry of Health Summary Distribution List of Donated Items towards COVID-19
  - (f) Ministry of Health National Corona Virus Disease Resurgence Plan, June 2021- July 2022
  - (g) Resurgence Plan Budget June 2021-July 2021
  - (h) Accountability for GOU COVID-19 Funding to Ministry of Health, March 2020- June 2021
  - (i)Ministry of Health COVID-19 In-Kind Donations received by Ministry of Health
  - (j) Status Report on Delivery of Community Masks to Districts
  - (k)COVID-19 External Funding Accountability Status, March 2020- June 2021
  - (I) Minister of Health Update to Parliamentary Task Force on COVID-19 in
  - (m) A compendium of Ministry of Health COVID-19 frequently asked auestions
  - (n) National Medical Stores Submission on Medical Supplies to the Parliamentary Task Force on the National COVID-19 Response;
  - (o) District Task Force Situational Reports on COVID-19

(p)Tororo Business Community submission on the need for enhanced

functionality and Responsiveness of the District Task Force

collected raw data on the health facilities using the facility monitoring tool; held meetings with the respective District COVID-19 Task Forces of; Jinja, Iganga, Bugiri, Namayingo, Tororo, Busia, Butaleja, Budaka, Pallisa, Butebo,

Mbale, Sironko, Soroti, Serere, Katakwi, Bukedea, Kibuku, Bududa, Sironko, Bugweri and Kaliro.

- held a meeting with the representatives of the business community in (v)
- visited health facilities including Regional Referral Hospitals, General (vi) Hospitals, Health Centre IVs and Health Centre IIIs
- visited the islands of Sigulu and Dholwe in Namavingo District (vii)
- Held Radio Talk shows. (viii)

### 5.1.3 Scope Of The Assignment

The Task Force mapped the Eastern Region into sub-regions and sampled districts, and health facilities to be visited with a deliberate prioritization of the Regional Referral Hospitals and the highest referral facility for every district visited.

### (d) Sub-Regions Covered

The Task Force covered all the sub-regions namely: Busoga, Bukedi, Bugisu, Seber and Teso sub-regions.

#### (e) Districts visited

The districts were further prioritized based on their status as border districts (Tororo, Busia and Namayingo), island districts and/ or those with fishing communities (Namayıngo, Busia, Buyende, Kaliro, Mayuge and Jinja), hıghland districts with difficult terrain (Sironko, Bududa, Kapchorwa and Kween).

Accordingly, the Task Force covered the districts of Jinja, Iganga, Bugiri, Namayingo, Tororo, Busia, Butaleja, Budaka, Pallisa, Butebo, Mbale, Sironko, Soroti, Serere, Katakwi, Bukedea, Kibuku, Bududa, Bugweri and Kaliro.

The Task Force identified three (3) border entry points of Malaba in Tororo, Busia Customs and Lwakhakha in Namisindwa. However, due to time constraints, only Malaba Border entry point was prioritized based on its strategic location and the volume of traffic which includes an average of 600 trucks and over 2000 persons transiting through it every day.

(f) Health facilities visited

The Task Force visited all Regional Referral Hospitals; all General Hospitals (District Hospitals); selected Health Centre IVs, and two (2) Health Centre IIIs. Further, two (2) Private Not for Profit health facilities were also visited as indicated

below;





#### (vii) General Hospitals (District Hospitals)

General Hospitals visited include; Iganga, Bugiri, Tororo, Masafu, Busolwe, Pallisa, Katakwi, Kapchorwa and Bududa.

#### (viii) Health Centre IVs

Jinja, Mbale, Soroti.

Health Centre IVs visited include; Buyinja, Budaka, Butebo, Namatala, Budadiri, Serere, Kıbuku, Bukedea, Busesa and Bumanya HC IV.

#### (bd) Health Centre IIIs

Two public Health Centres IIIs visited include; Dholwe Island HC III and Iyolwa HC III. While Dholwe Island HC III facility serves over 160,000 people from the nine (9) islands that make up Bukooli Islands County, lyolwa HC III serves a population of about 180,000. The uniqueness of these health centres is that they are in constituencies without Health Centre IV as per Government policy.

#### Private Not for Profit (PNFP) (x)

The Private Not for Profit facilities visited include; Kanginima HCIV and Budiini HCIII - Private Not for Profit (PNFP) in Butebo and Kalıro districts respectively.

#### (g) Meetings with District COVID-19 Task Forces (DTFs)

The Task Force held meetings with the DTFs of Jinja, Iganga, Bugiri, Tororo, Namayingo, Busia, Butaleja, Budaka, Palisa, Butebo, Mbale, Sironko, Soroti, Katakwi, Bukedea, Kibuku, Bududa, Kapchorwa and Kaliro and received Status Reports on COVID-19.

#### (h) Radio Talk shows

The Task Force conducted five radio talk shows to sensitize and educate the masses on prevention and management of COVID-19 through the following radio stations; Jogoo FM (Busia), East FM (Tororo), BIG FM (Mbale), Veritas FM (Soroti)

and NBS Radio (Jinja)

5.1.4 Findings And Recommendations

PREPAREDNESS AND RESPONSE TO COVID-19 1.4.1 GOVERNMENT

Presence and Functionality of the District COVID-19 Task Forces



The Committee observed that all districts and cities visited had well-constituted and functional District COVID-19 Task Forces chaired by the Resident District Commissioners (RDC) or Resident City Commissioners (RCC) as applicable.

The teams are comprised of the RDCs /RCCs, District/City Chairpersons/Lord Mayors, Chief Administrative Officers (CAOs), District Health Officers (DHOs), District Community Development Officers (DCDOs), District Probation and Welfare Officers (DPWOs) (District COVID-19 Surveillance Focal Person, District Police Commanders (DPCs), District Internal Security Officers (DISOs), civil society organizations and the media.

The DTFs worked jointly following guidelines issued by the Ministry of Local Government to ensure functionality of all their structures such as Sub County Task Forces (SCTFs) and Village COVID-19 Task Forces (VCTFs) in response to the pandemic. They continued to conduct planning meetings, share information, provide reports on contact tracing and surveillance across all structures.

However, it was observed that due to limited funding, critical functions of the DTFs such as surveillance, contact tracing and home-based care activities operated below optimal. For example, whereas a total budget allocation of UGX 284.4m had been provided to Bukedea district response to COVID-19 Wave Two, the DTF had earmarked only UGX 29.6m towards fuel for both supervision and surveillance but allocated a combined UGX 101 5m in allowances. In effect, the money which is meant to go towards implementation of the critical activities such as surveillance and contact tracing within the communities, is actually going towards administrative costs such as payment of allowances to the DTFs.

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## Recommendations

The Task Force recommends that:

(i) The Ministry of Local Government should revisit the guidelines on utilization of funds expended to Local Governments to ensure that sufficient resources are committed to critical functions of surveillance and contact tracing across districts in the subsequent allocations and releases towards the COVID-19 response;

(ii) All District Task Forces should ensure that the lower level Task Forces

are fully operational and facilitated.

**Human Resource for COVID-19 Management** 

The Task Force observed that;

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The Regional Referral Hospitals visited were finding difficulties in effectively managing the rising number of severe and critical COVID-19 cases partly due to inadequate specialized cadres such as Intensivists, Doctors and Anesthesiologists among others. Despite receiving some reinforcement with emergency staffing from the centre, the RRHs were still not having the required number of health personnel to fully functionalize the COVID-19 Treatment Units (CTUs). For example, Jinja RRH, the only RRH in the East with a functional ICU had only three (3) Nurse Intensivists out of the required 10. The nurses are therefore over-stretched beyond their capacity.

Across all levels of health facilities, staffing stagnated at 52% for all cadres with the exception of Pallisa General Hospital which stands at 75%.

Due to shortage of the required staff at the COVID-19 testing centres, health workers were often drawn from lower health facilities to reinforce services and other COVID-19 related interventions thereby further shrinking the staffing levels per health facility against the established norms hence affecting service delivery. For example, at Malaba Border Testing Point, laboratory staff had been withdrawn from the nearby Malaba HC III to support testing services at Malaba border entry point. This had rendered the HC III nearly non- functional in lab services.

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#### Recommendations

The Task Force recommends that within the next three months, the Ministry of Health in liaison with the Ministry of Public Service and Ministry of Local Government should;

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Expedite the hiring of adequately trained personnel to man the COVID-19 Treatment Units and Testing Centres as a matter of urgency. In particular, the Ministry could explore the possibility of hiring specialist health cadres from countries such as Cuba in order to cover the specialty staffing gaps at the Intensive Care Units (ICU) and COVID-19 Treatment Units (CTUs) in the Regional Referral Hospitals;

Explore the possibility of hiring Third Year Anesthesiology students as a stop-gap measure to addressing the inadequacy of staffing in the ICUs and CTUs and to further undertake the necessary legal framework to pay to them allowances for their services;

Revisit the staffing structures for all health facilities across the country to address the glaring staffing gaps in our facilities.

Payment of Risk Allowance for Frontline Staff

It was widely reported that health workers had often received their risk allowances late. Some health workers indicated that they had received their last pay my

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December, 2020 during the first wave. The allowances were further subjected to a 30% tax. Twelve (12) contact tracers under the Tororo surveillance team had not been paid at all for work done in the first wave. Subsequently, a combination of delayed /non-payment and taxing did not only have the effect of demotivating the already overstretched gallant health workers but further dampened their spirits as they risked their lives daily to save others.

The Task Force further noted with concern the discontent amongst health workers brought about by differences in risk allowances. They noted that whereas the practice ranked risks in various areas, it also served as a disincentive to some and proposed that if possible, the single-spine be adopted to address the issue.

#### Recommendation

The Task Force recommends that;

- (i) All arrears in allowances for health workers who have been saving lives in the frontline should be paid off within the next two (2) months.
- (ii) Government should adopt single-spine structure for payment of risk allowance to address discontent amongst health workers;
- (iii) Ministry of Finance should exempt taxing health workers' risk allowances;
- (iv) The Ministry of Gender Labour and Social Development should immediately compensate immediate families of health workers who have died in line of duty;
- (v) The Ministry of Gender, Labour and Social Development should process compensation for health workers who have been infected in line of duty within the next three (3) months

# Personal Protective Equipment (PPE) and Infection Control among Health Workers

Whereas PPEs was the primary guard against infection, often times health workers attended to COVID-19 patients without adequate protection and thus were increasingly exposed to contracting the virus especially when handling the known positive cases as well as when dealing with the general patients some of whom are asymptomatic. By reviewing the National Medical Stores Delivery Notes, the Task Force found out that only one delivery was made since the beginning of the second wave moreover the quantities were far too inadequate to meet the needs of handlings COVID-19 patients. It should be noted that NMS follows a routine schedule of supplies once every two months. For example, at Bukedea HCIV, NMS had supplied only one (1) packet of masks of pieces on 31st May, 2021 via delivery note with journey number: 210520-057. According to the estimates of the health workers, such a delivery would last them only three (3) days. Further, at Soroti RRH, NMS had supplied 70 units of a specialized medicine called Enoxaparin that is used in

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critically ill patients in ICU was last supplied on 11th May, 2021 yet each patient would require about 10 units of this drug to be able to pull out of the ICU. The above observation was made on the NMS delivery note with journey number 210506-042. In effect, since May 2021, NMS had only supplied enough quantities for seven (7) patients yet this facility had admitted up to 69 patients since the outbreak of the second wave to date.

Furthermore, the adoption of the Home-Based Care strategy and inclusion of the Village Health Teams (VHTs) among the front-line workers in response to the pandemic had ultimately increased the uptake of PPE. However, there was no evidence of a proportional increase in supply to match the demand. For example, at Dholwe HC III, the inadequacy of the personal protective equipment had forced health workers to recycle masks and disposable aprons.

The Task Force was notified that whenever health facilities order for drugs and essential health supplies, their orders are not honoured by the NMS. The Task Force was further informed that the NMS has not yet adopted the Electronic Logistics Information Management System (eLIMS) for procurement of Emergency Public Health Supplies and has continued to prefer the push system.

With the eLIMS, the facility is able to see the balance on hand, quantity ordered versus amount issued and other details and it further allows the facility ordering to either accept or reject the quantity being supplied by NMS instantly. Moreover, this system has the ability of having information shared amongst the ordering facility, the DHO, the Ministry of Health- Director General of Health Services and the Pharmacy Department of the Ministry

The region reported a worrying rise in the number of COVID-19 infections, hospitalizations and deaths among health workers attributed to the dire madequacy of masks, coverolls, face shields, aprons, goggles, surgical gloves, gum boots and consumables like sanitizers that leave health workers exposed in line of duty. The statistics below illustrate the infection rate among health workers in various districts that could be as a result of inadequate protection while on duty

Table1: Health Worker infection by sample district

District	No. of Infections	No. of Deaths	Total	
Bugıri	06	1	07	
Serere	04	0	04	
Bukedea	49	0	49	<del></del>



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Kapchorwa	28	1	29	
Jinja	05	0	05	
Butaleja	01	1	01	
Pallisa	28	0	28	

Sources: District COVID-19 Task Force Status Reports, 2021

Unfortunately, the infections among health workers had significantly lowered the confidence of the general public in the affected facilities thereby resulting into shunning of health facilities from seeking care for other ailments. For example, the Bugiri General Hospital that had been shunned by non-COVID-19 patients. At the time of the visit, the Task Force found the hospital wards completely empty. Similarly, at Budiini HC III, a PNFP facility that had offered to treat a COVID-19 patient who had been rejected right from her own home, had been equally shunned by the public.

#### Recommendation

The Task Force recommends that;

- (i) The Ministry of Health strengthens the pull system of procurement of essential medicines and health supplies by health facilities;
- (ii) The Ministry of Finance should provide adequate resources to the NMS to facilitate procurement of adequate quantities of PPEs, essential medicines and other health supplies in accordance with the needs of the facilities;
- (Ai) The National Medical Stores urgently adopts the Electronic Logistics Information Management System (eLIMS) within the next two (2) months.

# Cost, Availability and Reliability of COVID-19 Test Kits

The test kits for COVID-19 were inadequate throughout the districts visited hence affecting their diagnostic capacities. Health workers indicated that in the first wave, all suspected cases and contacts of confirmed cases would be traced and tested unlike in the second wave where testing is targeted to only patients presenting to testing points with signs and symptoms of COVID-19. For example, Malaba which is the second largest entry point to the country after Entebbe International Airport, clears an average of 600 trucks and over 2000 persons transiting through it every day but tests an average of 50 people daily. The low testing was partly attributed to the over-reliance on the test results from Kenya, inadequate test kits and the high cost of testing. A total of UGX 150,000 was being charged per test by the Ugandan authorities. Thus, truckers and travelers entering Uganda were cleared using the Kenyan test results which the Task Force considers a weakness and departure

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from the previous mandatory testing for every entrant since the Kenyan PCR test results presented are not subjected to further checks for authenticity and accuracy.

On one occasion, the tests carried out in Kapchorwa using RDT test kits for eightyeight (88) samples turned negative; but when the very samples were subjected to a confirmatory test using PCR, thirty three (33) samples were found to be positive. This indicates an unacceptable error of 37.5% in the batch of the test kits used in that event.

The Task Force observed that this casts doubt on the sensitivity and specificity of the RDT kits procured for COVID-19 response. It was further noted that the turnaround time for PCR test results was between 1-2 weeks in both Kapchorwa and Bududa districts which compromised the safety of the community as the people tested are left at large pending the results. Whereas a holding place is provided at the health facilities for the purpose of isolation for suspects, the same is not done in communities as PCR results are awaited.

It was further noted that some General hospitals like Bududa, Pallisa and Bumanya HC IV had Gene Expert machines that needed enhancement of modules to be able to carry out the PCR tests to reduce on reliance upon the Central Public Health Laboratory (CPHL) or Centre for Disease Control (CDC) laboratories in

The Task Force therefore observed that a combination of inaccuracies or unverified errors by the test results occasioned by poor sensitivity of the test kits or human error and the current practice of lack of mass testing could have far reaching consequences on the spread of the disease.

# Recommendation

The Task Force recommends that;

Kampala and Tororo facilities respectively.

The Ministry of Health should scale up testing through cascading COVID-19 tests at lower health facilities in order to cover at least all contacts of patients:

The Ministry should carry out random sampling and testing of the community in order to ascertain with a reasonable degree of accuracy, the national COVID-19 positivity rate;

The Ministry of Health should revert back to the original testing protocol at all border entries without relying on foreign results whose authenticity cannot be ascertained;

The Ministry of Health should undertake mass testing in selected high-volume areas as well as areas where the positivity/rate is

and strengthen contact tracing, isolation of the sick and repeated target testing; prior to opening the lockdown.

# **General Hospitals Treating COVID-19 Patients**

The Task Force was notified that whereas General Hospitals were ordinarily required to refer moderate to severe cases of COVID-19 to the Regional Referral Hospitals which had been earmarked to have High Dependency Units (HDUs) and Intensive Care Units (ICUs) to treat COVID, many times the patients they referred were either bounced back or admitted very late and ended up dying due to lack of bed capacity at Regional Referral Hospitals. As a result, the General Hospitals of Tororo, Pallisa, and Kapchorwa had taken it upon themselves to earmark one ward where they were treating COVID-19 cases.

It was further observed that Bukedi sub-region had one of the highest number of COVID-19 infections in the country, and Tororo leading with 4,571 as of 26th July, 2021 Tororo General Hospital alone had successfully treated over 252 cases to full recovery as of July 10th 2021. Tororo hospital was the facility with a PCR lab for the whole eastern region and beyond. Further, the Task Force observed that such facilities and many others that the hospital has provided a leverage of services over and above other General Hospitals. This is notwithstanding its strategic location along the Great North Road, border with Kenya and indeed within the sub-region ıtself.

The respective District Task Forces of most of the districts of Bukedı sub-region informed the Task Force that the elevation of Tororo General Hospital to a regional referral status has been overdue since 2006 when it was first earmarked for the same purpose before Moroto and Mubende hospitals. H. E the President has made campaign undertakings to have this hospital elevated to regional referral status since 2001 but this has not been actualized.

Indeed, the Task Force was further informed that due to the unique geographical and population size of Bukedi, H.E the President had on a number of campaigns meetings promised that Bukedi should have two (2) Regional Referral Hospitals -Tororo for South Bukedi and Pallisa for North Bukedi. The above information is consistent with the requirement to establish a RRH based on the population size and geographical catchment area.

Bukedi Sub-Region has a population of over 2.2 million people with only four (4) General Hospitals at Masafu, Tororo, Busolwe and Pallisa some of which are in a sorry state.

Had Tororo and Pallisa been elevated according to the Presidential pledge and policy consideration as well, the management of COVID-19 within the sub-region of



Bukedi would have been different and so many people would not have died as a result of lack of bed capacity at Mbale, Soroti and Jinja RRHs.

Furthermore, the Task Force was informed and noted that Sebei sub-region has a very mountainous and difficult terrain and referral of COVID-19 patients had posed great difficulties to the healthcare system within the sub-region. Sometimes, COVID-19 patients are referred and decline to go to Mbale or Soroti Regional Referral Hospitals on allegations of discrimination and opt to go back home. Indeed, some of them have ended up dying in their communities.

On the day of the visit, the Task Force found one (1) moderate case of COVID-19 admitted in the hospital and further, the hospital management indicated that Kapchorwa General Hospital was managing COVID-19 patients every time they failed to get a bed either in Mbale or Soroti. The situation is worsened by the lack of an ambulance for the General Hospital that makes it heavily reliant on the ambulances from Kween and Bulambuli districts for referral.

The Task Force observed that the COVID-19 ward at Kapchorwa Hospital was illequipped and not fully functionalized to manage cases of moderate COVID-19 yet it is the first call of the sub-region with a population of over a million people.

#### Recommendation

The Task Force recommends that;

- (i) Government should urgently establish COVID-19 treatment centres at Kapchorwa, Pallisa and Tororo General Hospitals as a matter of emergency and urgency to decongest Mbale and Soroti RRHs and to save the sub-region from many deaths;
- (ii) In addition, Ministry of Health should fast-track the Presidential pledge to elevate Tororo and Pallisa General Hospitals to regional referral status;
- (tit) Kapchorwa General Hospital be elevated to regional referral status because of its unique geographical status and difficult terrain to save our people from unnecessary death.

State of COVID-19 Screening and Sample Collection

The general state of COVID-19 sample collection facilities across health facilities were appalling- old, torn, dirty, worn out and not manned by any staff and without furniture or equipment. Some of them were under trees like in Dholwe HC III, Namatala HC IV and Kibuku. A number of tents were donations from UNICEF and UNHCR and outlived their usefulness. There was no evidence of direct Governmen

een patients hence lack of

involvement in setting up the required structures for screen patients hence lack of preparedness on the side of Government

#### Recommendation

The Task Force recommends that:

- (i) Government should set up reasonable structures that are fully furnished for COVID-19 screening and testing within three (3) months of the adoption of this report;
- (ii) The Ministry of Health should ensure that all COVID-19 screening and sample collection centres are readily manned all the time as a matter of urgency.

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# Intensive Care Units (ICUs) and High Dependency Units (HDUs) for severe COVID-19 case management

The Task Force observed that all Regional Referral Hospitals were in dire need of both ICU space and functional assorted equipment crucial in critical care. The ICU beds, medical oxygen and oxygen cylinders, concentrators, humidifiers, oxymeters, nasal masks, rebreather masks among others were inadequate to meet the growing need of managing patients with severe COVID disease. Most facilities reported less than 40% of the daily oxygen requirements and less than 50% of the needed oxygen cylinders. The daily Availability of oxygen was reported to be between 30-35%.

For example Jinja RRH daily oxygen needs stood at 96 cylinders but the plant's capacity is 34 cylinders in 24 hours while Soroti RRH's demand is 150 cylinders of oxygen per day but their oxygen generator can only fill 40 cylinders per day.

The Task Force was further informed that the quality of oxygen produced by the plants at RRHs was low due to the strain on the oxygen generating plants and that the personnel manning these plants did not have the requisite competence.

Apart from Jinja RRH, no other facility at the same level had a functional ICU. The available space earmarked for ICU in Mbale needed remodeling and the process was ongoing. Consequently, Mbale and Soroti had resorted to use of High Dependency Units (HDUs) for management of critical COVID-19 cases. The lack of functionality of ICUs at the RRHs had forced General Hospitals and some HCIVs to

The Task Force further noted that whereas RRHS were easied to distribute oxyge to lower health facilities, they are currently unable to meet their own demand.

take on management and treatment of COVID-19.

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Due to increased demand for oxygen even in private facilities, connivance and theft of oxygen cylinders by health workers was reported. Mbale RRH reportedly recovered 50 oxygen cylinders from a private health facility attached to one of its medical staff and instituted police investigation into the matter.

#### Recommendation

The Task Force recommends that:

- H) In the short term, Ministry of Health should procure liquid oxygen for use in the COVID Treatment Units:
- ΑÜ The Ministry of Health should fully functionalize all Intensive Care Units at RRHs:
- (titl) The Ministry of Health should procure adequate oxygen cylinders for all General Hospitals and Health Centre IVs:
- (tv) The Ministry of Health should revisit the policy of limiting ICUs to RRHs and have them functionalized at General Hospitals and HC IVs that have already initiated CTUs in their facilities:
- (v) The Ministry of Health should recruit, train and deploy qualified personnel to man oxygen generating plants at the RRHs;
- In the medium and long term, delivery of oxygen to patients in health (vi) facilities should be by piping.

# The Ambulance System

Whereas Minister of Health indicated that there was a functional Ambulance System at regional level centrally controlled and coordinated, the Task Force finding was that this was only functional in Kampala Metropolitan Area. This information was verified by the Commissioner for Emergency Medical Services.

The RRHs visited did not receive the ambulances that were supposed to be received under the Regional Ambulance System as indicated in Annex 2 of the Minister's address to the Parliamentary Task Force. However, they were aware that the ambulances had been distributed within the regions under their jurisdiction and so did not have direct control over them. For example, Jinja RHH received two (3) ambulances out 10 ambulances earmarked to be under its control. However, the one for Red Cross was recalled back to Kampala. In Mbale region, the ambulances were distributed to Red Cross, Mbale City and Mbale District.

Another ambulance was allocated to Bududa hospital without the knowledge of Mbale RRH and so they could not coordinate its activities.

The discrepancy in the distribution list of ambulances indicated in Annex 2 of the Minister's communication to the Task Force and the actual placement and operational areas for the ambulances raises questions on the transparency and

functionality of the regional ambulance system. The poor ambulance system

challenges the ministry's COVID-19 management approach where treatment is at RRHs and the lower health facilities are expected to evacuate and refer patients to the RRHs.

The Task Force observed along the different routes of the region, a number of ambulances operated privately by individuals such as Members of Parliament. The Task Force is not aware of any regulatory provisions on privately owned ambulances.

Further, it was observed that most of the health facilities continued to grapple with maintaining old ambulance some of which had been in use for over 15 years and broke down quite frequently thereby raising the cost of maintenance and running them. As a result, health facilities' meagre Primary Health Care (PHC) funds frequently and quickly got depleted. The Task Force is aware of Government policy on use of vehicles for not more than five (5) years. However, our finding in the eastern region is at variance with this policy.

#### Recommendation

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The Task Force recommends that:

The Ministry of Health should urgently put in place a proper (t) coordination and management mechanism, and prioritize resources to fully functionalize the Regional Ambulance System to ensure effective referral of patients that require urgent medical attention within six months of the adoption of this report;

The Ministry of Health should provide all classes and categories of (ii) ambulances for all levels of care right from HC III to the National Referral facilities including specialized boat ambulances for island areas;

The Ministry should provide a framework to regulate individual ownership, category and management of ambulances in the country; In the long run, Ministry of Health should explore the easiest way of acquiring air ambulance system for the country and at least one (1) category A ambulances for each of the RRH.

# Home-Based Care (HBC) Strategy for case management

The Task Force noted the introduction of a Home-Based Care strategy to treat mild and moderate COVID-19 patients from the community due to the high level of transmissions. However, despite a robust health structure from the top to the grassroots, to date, mechanisms of facilitating follows up on the patients by the health workers had been hampered by lack of transport, allowances, inadequate

personal protective equipment and lack of drugs recommended for the treatment of COVID-19 such as Vitamin C, Zinc, Azithromycin, Vitamin D which are not included on the list of essential drugs.

The Task Force observed that HBC was not being implemented beyond the point of testing, advice and prescription. Whereas under the Malaria Control Strategy, a standard HomePack kit was used by the VHTs to support the intervention, there was no such arrangements under the HBC strategy to ensure its effectiveness. The situation is further compounded by acute shortage of PPE, difficulty in movements, lack of motivation for VHTs.

#### Recommendations

The Task Force recommends that:

- (4) The Ministry of Health should provide adequate supplies of PPEs to the VHTs and patient attendants while not negating on the responsibility of individuals and families to uphold their health;
- Government should provide the necessary supplies to monitor and (H) manage patients under HBC including medicines, and at least one (1) oximeter per VHT to monitor the oxygen saturation of patients under HBC:
- The Ministry of Health should, within one (1) year come up with an (HH) integrated Home-Based Care policy for all applicable diseases
- (tv) The District Task Forces should strengthen the surveillance, monitoring, reporting and follow up of COVID-19 cases under HBC.

### Availability of drugs for treatment of COVID-19

The Task Force noted the whereas Government was to ensure the availability of drugs in the treatment and containment of COVID-19, the amounts sent to districts medicines sent to the health facilities were not able to meet the need. Almost all the drugs including Vitamin C, Zinc, Azithromycin were out of stock and patients were being required to buy from private pharmacies. To date, the essential drug list had not been updated by the National Drug Authority to include drugs for treating COVID-19 hence, maintained under emergency drugs.

Further, supplies from NMS were based on the discretion (Push factor) of the centre and not the actual need (Pull factor) at the health facilities gazetted for treatment of COVID-19. This had resulted into constant stock-outs and delays in delivery of supplies.

It was therefore observed that delayed delivery of the required drugs, the constant stock-outs and eventual relegation of the responsibility of purchase of those drugs

by individual patients from private health providers did not only make it expensive for an ordinary citizens and practically impossible to contain cases at mild and moderate levels but also difficult to supervise treatment and assess levels of adherence to medication amongst the patients.

#### Recommendations

The Task Force reiterates its recommendation that the Ministry of Health provides COVID-19 drugs including COVIDEX to all patients under Home Based Care

#### Policy on Testing

The Task Force was notified that as a result of the sudden surge of COVID-19 cases during the second wave, most testing centres could only afford to pick sample from persons presenting with signs and symptoms. This was a departure from the previous policy of mandatory testing of suspected cases and their contacts. Moreover, it is a known fact that the WHO estimates that more than 70% of patients are asymptomatic. The Task Force was informed that some districts such as Katakwi and Kapchorwa had tried random testing and discovered several asymptomatic cases in the community.

#### Recommendation

The Task Force recommends that;

Government should consider reviewing the current policy on testing to one which estimates the positivity rate with accuracy including the asymptomatic cases for avoidance of doubt.

# State of COVID-19 Management at General Hospitals

The Task Force noted that the overwhelming numbers of COVID-19 cases that require ICU services were often turned away due lack of capacity at the RRHs and left to fate. Despite this reality, Ministry of Health had not reviewed the COVID-19 treatment policy to bring on board General Hospitals and HCIVs as lower treatment centres.

The delay in reviewing the policy had prompted management at some General Hospitals to take administrative decisions to gazette part of the available space at their facilities for management of mild and moderate COVID-19 cases. This had enabled many to recover from the virus without needing to go to the ICUs hence preventing to a larger extent, the progression of patients to critical/severe stages of COVID-19. It was indicated that a total of 252 had recovered from COVID-19 in Tororo as a result of this initiative. However, these facilities are ill equipped,

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understaffed and some have very limited space to take on the task despite the goodwill from staff and management.

The Committee observed that further hesitation by the Government to revise its policy on treatment of COVID-19 patients and elevate General Hospitals and HCIVs as treatment centres for the same detrimental to the country and threatens to erode the gains made by Uganda in the fight against the pandemic.

#### Recommendation

The Task Force reiterates the recommends that treatment and management of COVID-19 be cascaded to General Hospitals, HC IVs and HC IIIs which had already started on the treatment of COVID-19 out of necessity.

#### Performance of the Vaccination Drive

Government adopted mass vaccination as the best alternative to mitigate the adverse effects caused by the pandemic. However, there was shortfall of vaccine dosages required to fully cover the second jab across all districts visited. This was against the increasing demand for vaccination by the general public

It was further observed that the shortage in vaccine doses had affected the pace of the immunization drive. For example, key populations such as health workers and teachers were not fully covered under the first and second vaccination drives. Whereas Bukedea covered 100% and 75.2 % of the health workers for the first and dose respectively, Kapchorwa had vaccinated 38.2% of its health workforce while Kaliro 3, 241 of the expected 3,520 and 798 for first and second jabs.

The low performance of the vaccination program this has far reaching consequences in terms of exposure to the virus and the likelihood to delay opening of schools and other critical service centres when such essential workers are not fully vaccinated.

#### Recommendation

The Task Force recommends that Government should provide sufficient dosages of vaccines to address the growing public demand and to achieve herd immunity of the population.

1. ASSESSMENT OF THE HEALTH (AND OTHER) IMPACTS

THE COMMUNITY AND COUNTRY AT LARGE

# 5.1 Impact of COVID-19 on other Essential Health-Services

Essential services such as immunization, ART services and malaria control had been significantly affected as the focus shifted to COVID. The restrictions in movements had disrupted routine health activities. Additionally, some services such as mental health services had been relegated to the periphery of essential health services. In Mbale and Soroti RRHs for example, psychiatric units were converted into CTUs thereby completely phasing out mental health services at this level of care and resulting into referral of mental health patients who would ordinarily be managed at this level of care to Butabika National Referral Hospital.

The Task Force observed that the halt in the provision of mental health services and the conversion of psychiatric units into CTUs exhibited madequate preparedness on the part of Government and exerted pressure on Butabika National Referral Hospital which was already operating at 150% capacity before the onset of the pandemic.

#### Recommendation

The Task Force recommends that;

- The Ministry of Health should urgently reinstate mental health (4) services at Regional Referral Hospitals to ensure provision of mental health services at that level;
- The Ministry of Health should provide resources for construction and (tt) equipping of the COVID-19 Treatment Units at Regional Hospitals, General Hospitals and Health Centre IVs that are already treating COVID-19.

#### 5.2 Use of concoctions in the treatment of COVID-19

The Task Force was informed of the increasing use of locally made herbal concoctions such as marijuana, "mululuza" and other herbal medicines in an attempt to treat COVID-19. This was partly attributed to the inadequacy of drugs for COVID-19 treatment at the health facilities. For example, the Busia DTF indicated that locals from Masınya Sub-County had particularly resorted to marijuana as a remedy for COVID-19. Further, in Kaliro District, Mr. Kihuluka Eric, a local researcher presented to the Task Force his concoction which he claimed was able to cure COVID-19 and other respiratory ailments in a matter of minutes. He further expressed his frustrations with the National Drug Authority and the National Chemotherapeutic Research Department for failure to support him in the development and patenting of his medicing.

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In Tororo, another herbal research by the names of Jothurin Okumu Raymond Leonard claimed to have administered his concoction to a number of patients presenting with signs and symptoms of COVID-19 and cured them within one week.

The increasing use of herbal concoctions has also been instigated by the approval of COVIDEX and COVILYTE by the National Drug Authority as a supportive remedy in the treatment of COVID-19.

The Task Force observed that this practice could have far reaching health consequences to the population. Whereas medical use of marijuana has been recommended in certain countries for pain relieving, it is worrying that uncontrolled dosages may have harmful effects to the consumers.

#### Recommendation

The Task Force recommends that:

- Government should come with a clear policy to support indigenous H) research in herbal medicines and facilitate the patenting of local medicines:
- (ii) Government ensures that indigenous researchers follow the WHO recommended protocols for introducing drugs into the population

# 5.3 Socio-economic Impact of COVIDi-19

The Task Force noted that COVID-19 had contributed to increase in cases of child labour, child neglect, physical abuse, gender-based violence (GBV), teenage pregnancy and redundancy in communities. For example, in Bukedea district, the number of teenage pregnancies had risen from 72 in 2019 to 1000 by the end of 2020. The District Community Development Officer also reported unprecedented levels of commercial sex among girls organized in informal groups such as "Team No Sleep", "Team No Size" and "Team No Condom" among others. However, in Kaliro district the teenage pregnancy rate of 24 in the second wave is a decline from 27 in the first wave although this is still one (1) point above the regional of 23.

The movement restrictions imposed to curb the spread of the virus had affected small businesses and increased cost of doing business due to the high cost of transport. For example, Bududa and Kapchorwa have been hit hard with almost no sources of livelihood due to travel restrictions that have cut them off markets. This is because most people depend on agricultural produce particularly matooke for both home consumption and income.

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The financial institutions have put debtors under immense pressure to meet their loan obligations amidst inability to meet the financing targets occasioned by low purchasing power of the people. For example, in Tororo, representatives of the Business Community informed the Task Force that their merchandise were rotting away as a result of the significantly reduced purchasing power of the residents. Furthermore, , in Bukedea district, the Task Force was notified that the pandemic had significantly affected Government programs such as Youth Livelihood Program (YLP), UWEP and Emyooga due to the inability of the beneficiaries to transact business as planned amidst a raging pandemic.

Further, closing of rural markets for food, cattle and other merchandise had rendered many locals unemployed as most rural districts depend on those markets for their business transactions.

The District Community Development Officers of Katakwi and Bukedea had similar reports regarding the rise in psycho-socio conditions such as depression, stress and suicidal tendencies in their areas. As a result, they felt overwhelmed with incidences that require urgent intervention for psycho-socio support, counselling and arbitration.

The Task Force noted that despite the above socio-economic challenges, no direct allocation for psycho-socio support had been made towards the District Community Development Offices and Probation/ Welfare offices to increase on their outreach activities in response the psycho-socio challenges posed by COVID-19 pandemic.

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#### Recommendation

The Task Force recommends that;

(i) Government should again reign in on the financial institutions to further reschedule the loan re-payment in view of the on-going COVID-19 situation;

The Ministry of Gender, Labour and Social Development should scale up their interventions to of empowering youths with skills and viable sources of livelihood to prevent them from falling into risky behavior including transactional sex in identified hot spots;

Ministry of Local Government should provide and ring-fence additional resources commensurate with the current needs of the District Community Development and the Probation/Welfare offices in order to reinforce community mobilization and supportive services to those with psycho-socio conditions

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(iv) Ministry of Health should explore implementation of targeted lockdowns in hot spots basing on surveillance information in order to minimize the socio-economic effects of a generalized lockdown of a whole country.

2. ASSESSING OPERATION, ADMINISTRATION AND MANAGEMENT OF FUNDS AND OTHER RESOURCES APPROPRIATED FOR THEM TO MANAGE THE PANDEMIC

# 6.1 Utilization of the Resources appropriated for COVID-19 response in the first wave

The Task Force noted that during the first wave, Parliament approved resources to support Government response towards the pandemic. Each district received a total of UGX 165m towards the cause and spent the money in accordance with guidelines issued by Ministry of Finance Planning and Economic Development and Ministry of Local Government. Further, cash and in-kind donations were made by the respective Members of Parliament, civil society and the community.

Task Force also observed that whereas all the districts visited acknowledged receipt and utilization of these funds, the criterion used to allocate UGX 165m across board was not clear. The peculiarities of districts such as vastness, population, terrain, accessibility (for mountainous and districts with islands), porosity for border districts among others were not considered to ensure equitable distribution of resources.

Districts also received the District Discretionary Equalization Grants (DDEG) in FY 2020/21 to address low per capita allocation under DDEG in non PRDP districts and the desire to mitigate COVID-19 impact and carry out specific socio-economic activities geared towards improving identified socio-economic status. The funds where also to be used in procurement of motor cycles for health workers for sub counties and town councils where they are not, renovation or construction of health staff quarters, surveillance of COVID-19 cases, procurement of temperature guns and sanitizers for schools, procurement of additional furniture for schools, renovation of class-room, provision of water, sanitizers and temperature guns at public officers. Guided that the local government should utilize these funds with a strong inclination towards compliance and adherence to COVID-19 SOPs as issued

by Government. However, these funds were not reported on by districts except

Bududa and Tororo upon probing

It was further noted the UGX 165m was too small to efficiently finance surveillance and contact tracing, meals for suspects under quarantine, transportation of suspected cases and payment of risk allowances to the frontline workers.

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#### Recommendation

The Task Force recommends that:

Subsequent allocations of resources for management of COVID-19 to districts should be based on their peculiarity for equity.

# 3. ASSESSING THE ROLE OF PRIVATE SECTOR HEALTH CARE PROVIDERS **IN COVID-19 MANAGEMENT**

#### 7.1 Complimentary Role of the Private Sector

It was observed that private sector healthcare providers especially the Private not for Profit had contributed to treatment of COVID-19 patients at a subsidized cost in response to the difficult financial times. For example, Kanginima HC IV in Butebo district had partly bridged the gap in blood transfusion services that are not available in the public health facilities in the surrounding districts due to lack of requisite equipment such as fridges. Similarly, St. Francis Budiini HC III had admitted and treated COVID-19 patients for 15 days at a cost of UGX 500,000. The facility also readily provides its ambulance for evacuation and transportation of COVID patients to treatment centre.

The private health facilities also ensured strict adherence to the SOPs and were more open to treatment of other diseases other than COVID-19 in comparison to the government facilities.

However, they solely depend on user fees and Primary Health Care support which is insufficient to meet the operational costs such as payment of salaries for health workers, procurement of adequate PPE and maintenance of ambulances

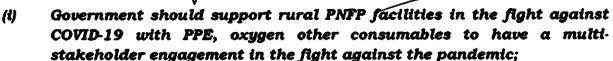
The Task Force observed that other non-health private players including companies, individuals and civil society organizations had played a significant role in supplementing Government efforts in the response to the pandemic. As such, Tembo Still Works and Nile Breweries gave donations of 15 and 10 oxygen cylinders to Iganga and Kapchorwa hospitals respectively last month, PPE, fuel donations and transport. Individual Members of Parliament, civil society (World Vision, Rhites-EC, Children's HopeChest among others) and the community. Their contribution towards support interventions such as contact tracing and supplementation on the

inadequate personal protective equipment for the work force

Recommendation

The Task Force recommends that;

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(ii) In the short to medium term, Government should second health workers to the PNFP facilities.

4. CARRYING OUT FIELD VISITS TO ASSESS THE STATE OF HEALTHCARE SYSTEM IN THE REGIONAL REFERRAL HOSPITALS, BOTH SELECTED GENERAL HOSPITALS AND THE LOWER HEALTH FACILITIES

### (a) Sub-Regions Covered

The Eastern region Task Force team mapped out the different sub-regions within the eastern region as follows; Busoga, Bukedi, Bugisu, Sebei and Teso sub-regions.

#### (b) Districts visited

The district were further categorized as border districts (Tororo, Busia and Namayingo, Namisindwa), districts with islands and those with fishing communities (Namayingo, Busia, Buyende, Kaliro, Mayuge and Jinja), highland districts particularly those in mountainous areas that include Sironko, Bududa, Kapchorwa, Kween,.

Accordingly, the Task Force covered the districts of Jinja, Iganga, Bugiri, Namayingo, Tororo, Busia, Butaleja, Budaka, Palisa, Butebo, Mbale, Sironko, Soroti, Serere, Katakwi, Bukedea, Kibuku, Bududa, Sironko, BUgweri and Kaliro districts.

Of the three (3) border entry points of Malaba in Tororo, Busia Customs and Lwakhakha in Namisindwa, only Malaba Border entry point was visited.

c) Health facilities visited

Jour levels of health facilities were visited. These include Regional Referral Hospitals, General Hospitals (District Hospitals), Health Centre IVs, and Health Centre III. Further, Private Not for Profit health facilities were visited.

(1) Regional Referral Hospitals

The Eastern Region team visited a total of three (3) Regional Referral Hospitals

RRH) ıncluding Jinja, Mbale and Soroti.

(2) General Hospitals (District Hospitals)

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A total of seven (7) General Hospitals were visited including Iganga, Bugiri, Tororo, Masafu, Butaleja, Palisa and Katakwi, Kapchorwa and Bududa General Hospitals.

### (3) Health Centre IVs

The HC IVs visited include Buyinja, Budaka, Butebo, Namatala, Budadiri, Serere, Kibuku, Bukedea and Busesa HC IVs.

#### (4) Health Centre IIIs

A total of 2 health centres were visited. These are; Dholwe Island and Iyolwa HC III. Dholwe HC III facility serves over 160,000 people from the nine (9) islands that make up Bukooli islands.

#### (5) Private Not For Profit (PNFP)

The team further visited Kanginima HCIV and Budumi HCIV- Private Not for Profit (PNFP) in Butebo and Kaliro districts respectively.

#### (d) Meetings with District COVID-19 Task Forces

The team held meetings with the district Task Forces of Jinja, Iganga, Bugin, Tororo, Namayingo, Busia, Butaleja, Budaka, Palisa, Butebo, Mbale, Sironko, Soroti, Katakwi, Bukedea, Kibuku, Bududa, Kapchorwa and Kaliro.

Accordingly, Status reports on COVID-19 of the respective districts were submitted to the Task Force.

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# 5. CONDUCTING SENSITIZATION AND AWARENESS PROGRAMS ON MASS MEDIA TO EDUCATE THE POPULATION

9.1 Conducting Radio Talk Shows and Live Feedback on Television

From the four radio talk shows conducted, the Task Force noted consistent themes of police brutality, discontent regarding the criteria used in identification of the beneficiaries of COVID-19 Relief of UGX 100,00 to vulnerable homesteads, questions on the efficacy and dangers of vaccines, distance from vaccination centres in view of movement restrictions, questionable standard of the Government masks distributed, lack of facilitation for VHTs to sensitize communities, locally made vaccine, use of herbal medicine and fruits in treating COVID-19, high COVID testing fee f UGX 100,000.



Recommendations

The Task Force recommends that;

Parliament should provide adequate resources to cater for enough air time.

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#### 6. OTHER GENERAL OBSERVATIONS

#### 10.1 Little attention accorded to the Islands

The island-based facilities in the districts of Namayingo, Mayuge and Jinja are affected by both the lack of facilities and equipment capable of managing COVID-19 and inadequate PPE which is supplied after a long time.

The requisite emergency equipment such as water ambulances for quick referral of patients is also lacking. For example, Dholwe Island has a HC III which serves the surrounding 9 islands with a population of over 160,000 people. However, due to lack of space, the COVID Isolation Centre was a tree shade in front of the health centre. Further, although it was completed in 2018, the facility has no beds in the male, female wards and maternity wards which, in the worst possible scenario would be converted in CTUs.

It was thus observed that the delay to gazette CTUs at lower level health facilities especially the hard to reach areas like islands reflected a lack of inclusive planning for and prioritization of hard to reach areas in management and control of COVID-19.

#### Recommendation

The Task Force recommends that:-

- (i) Ministry of Health should support every Isolation Centres for COVID-019 at the Islands;
- (ii) For Islands, the highest level facility at islands should be fully equipped to provide COVID-19 case management and only refer severe cases;

(iii) Dholwe HC III on the Island should elevated to HCIV since it serves Bukooli Island county.

10.2 COIVID-19 Relief Support to the Vulnerable /

The well- intended policy by Government to cushion the vulnerable households in cities and municipalities had taken off with a total of UGX 41bn of the UGX 53bn earmarked for COVID-19 Relief support already transferred to the very poor affected by the lockdown. However, the support fell short of covering a significant portion of eligible beneficiaries due to mismatch in the NIN and phone contact data provided during registration. This anomaly had resulted into the rejection of names of thousands of vulnerable persons that met the criterion for relief support. Thus, the City Task Forces of Jinja, Mbale and Soroti and District Task Forces of Tororo, Kapchorwa, Busia respectively reported many cases of the targeted beneficiaries missing out on the package. For example, in Tororo 7,822 households were registered but only 3,785 eligible leaving out a total of 4,037), Mbale and Soroti

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cities while in Kapchorwa a total of 2,894 out of the 3,412 registered households received the UGX 100,000 cash transfer leaving out a combined 518 households.

Further, the eligibility criteria for relief support across cities and municipalities visited was not based on the current UBOS data but the old one The approach used left out vulnerable residents within former municipal jurisdictions of municipalities (for new cities) and town councils (for new municipalities) but now fall within the new boundaries of those jurisdictions.

For example Jinja City which was formerly a municipality with 19,700 households was elevated to city status, the surrounding town councils of Bugembe, Budondo and Mafubira were added to the two divisions of Jinja East and West which now has a total of 65,000 households. However, the number of households earmarked for support were 7,400 representing the 38% of the 19,700 vulnerable households under the old municipal arrangement and not the 25,000 that represent a 38% of 67,000 households.

The Task Force noted that whereas the Presidential Directive on relief for was to first determine the number of vulnerable households through registration, the Ministry of Gender set a ceiling of 38% across cities and municipalities moreover based on the old UBOS data. In some municipalities, the number of boda bodas registered were almost equivalent to the total number of those eligible to receive relief (Tororo has 3,222 boda bodas out of 3, 785 eligible beneficiaries).

The Task Force observed that the deviation from the Presidential directive and setting of threshold/ ceiling had resulted into inaccurate calculation thereby denying tens of thousands of households covered by the policy from accessing what was due them.

Recommendations

Sectors should desist from the habit of bending Presidential directives



#### Recommendation

The Task Force recommends that:

Government should revisit its policy to ensure that the most vulnerable are the majority beneficiaries in such interventions.

#### 10.3 Health Infrastructure and Health Systems

The Task Force observed that most of the infrastructure at the health facilities visited were in dire need of renovation. From leaking roofs to sagging cailings

cracked hospital floors and walls, broken windows, broken sewage and drainage systems, broken beds, filled toilets and old tiny operating theatres. This was particularly evident among the General Hospitals and Health Centre IVs that serve as general hospitals.

The Task Force noted that the diagnostic capacities of most facilities visited were compromised due to non-functionality of critical equipment such as X-Rays and Ultra Sound Scans. This cut across all RRHs, GHs and HC IVs. Notably, all X-Ray machines given to Masafu, Busolwe and Palisa Hospitals under the JAICA project were all non-functional due to lack of spare parts that can only be obtained from Japan. As such, patients were often referred to private providers who charge a high price.

For example, Busolwe GH was constructed in 1963 and has never been renovated. Its entire roof leaks and the hospital had not had running water for over 10 years. Its sewer system was blocked and toilets closed to patients. Further, just like Masafu GH, the X-Ray machine donated by the Japanese Government in 2009 under the JAICA project to Busolwe hospital was completely broken down and needed replacement. These facilities also lack enough oxygen, cylinders, oximeters, humidifiers and Intensivists that could provide critical care to COVID-19 patients. The challenge was with a three- phase power supply, which UMEME was mandated to address. Further, the Atomic Energy Agency shut up the machines for not meeting the minimum requirements

The Task Force therefore observed that the double tragedy of poor health infrastructure and non-functionality of diagnostic equipment in addition to other challenges such as frequent drug stock-outs, low staffing and poor referral system due to lack of ambulances had left health facilities as white elephants,

#### Recommendation

The Task Force recommends that:

Government in accordance with NDP III should prioritize maintenance of health facilities;

Expand operating theatres to cater for surgical and obstetrics and gynecological operations at the same time;

Government should urgently dispose off the non-functional JAICA X\_Rays from the General Hospitals and procure new effective and efficient ones:

Government should urgently identify resources to rehabilitate Busolwe

General Hospital within one year;

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- (v) Elevate Bumanya, Budaka, Kibuku, and Bukedea HC IVs to General Hospital;
- (vi) Elevate Dholwe and Iyolwa HC IIIs to HC IV in accordance with Government policy of a Health Centre IV per every Constituency/County;
- (vii) Ministry of Health should ensure that all HC IVs are equipped with functional Ultra Sound scan machines.

#### 10.4 Adherence to Standard Operating Procedures

The Task Force observed that Standard Operating Procedures were generally adhered to. Majority of the people in communities and health facilities across all districts visited wore face masks appropriately and washed their hands often as measures of COVID-19 prevention. Hand sanitizers and handwashing equipment were placed at strategic points such as hospital gates, outside admission wards, at Out-Patient areas, landing sites and at district headquarters to encourage handwashing.

However, social distancing was still a challenge as evidenced by the continued preference of group activities especially on the islands and upcountry trading centres. Further, the standard of hygiene for masks was not being considered especially by the Boda Boda riders.

Notably, people acknowledged receiving Government-procured masks but were less worn in comparison to the privately acquired.

It was further observed that health facilities maintained routine screening for COVID-19 symptoms in designated triage areas equipped with infrared thermometers/temperature guns. Management of facilities endeavored to constantly disinfect workspaces and surfaces through regular cleaning and sanitization.

The Task Force further noted inadequacy of the Information, Education and Communication (IEC) materials from the Ministry of Health on infection prevention, management and control thereby causing majority of the health facilities to resort to printing locally made home-based IEC materials.

#### Recommendation

The Task Force recommends that;

(i) Government procures more masks for distribution to the population;

(ii) Government should scale up regular sensitization programs on prevention and management of COVID-19.

10.5 Outstanding Utility Bills

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General hospitals across the board were grappling with unpaid utility bills for water and electricity. These bills have accumulated since the advent of COVID-19 that occasioned over consumption of water and electricity.

#### Recommendation

The Task Force recommends that:

Government pays off all outstanding utility bills in order to make facilities start paying their own bills hence forth.

# 10.6 Servicing of oxygen Plants at Regional Referral Hospitals

Oxygen plants were not being serviced in time. This explains the depreciating capacity in production of oxygen required for management of patients under critical care.

#### Recommendation

The Task Force recommends that:

- (1) Ministry of Health should ensure that the oxygen plants are routinely services to minimize depreciation and ensure quality oxygen production
- (ti) All Oxygen plants should be manned and maintained by qualified personnel

### 10.7 Challenges of Enforcement of the Standard Operating Procedures

The Task Force received feedback about enforcement of the SOPs by security agencies across all districts visited and noted circumstances of resistance from the population against attempts by the security agencies to enforce the SOPs. For example, in Butaleja, a 15-year-old girl was fatally shot by a stray bullet while the police attempted to enforce curfew measures against a resistant population. Further, in Bududa and Mbale, the police expressed their vulnerability to attacks by angry boda boda riders. It was reported that on a number of occasions, the boda boda riders would gather in groups armed with stones and attack the police on duty.

On the other hand, the communities across the region expressed concern about excessive use of force and brutality while enforcing the SOPs. Several callers in claimed that in Mwello parish in Tororo district, Police attacked them in their homes to enforce curfew measures including violating their family privacy. In addition, in Busia, a nurse was fatally wounded by a police officer enforcing curfew

while coming from duty. The officer was apprehended and remanded to Masafu Prison in Busia.

There were concerns of inadequate PPEs for the police officers on duty who come into contact with suspects whose COVID-19 status is unknown and while enforcing SOPs. This had left them exposed to infections especially from the asymptomatic cases.

#### 10.8 Enforcement of Curfew and Movement Restrictions

(a) Indiscriminate enforcement of restrictions

The Task Force noted that health workers across the region were often stopped and prevented from attending to night duty in spite of holding travel permits issued by the City Medical Office and the staff identifications. This was reported in Mbale particularly by the Namatala HCIV staff.

The Task Force therefore observed that, the indiscriminate enforcement of lock down restrictions affected pregnant women, nursing mothers and other in-patients who are often left un-attended through-out the night due to absence of workers on night duty.

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(b)Limited capacity to enforce restrictions by security teams

It was further noted that security was over-stretched particularly in border districts such as Bududa, Namisindwa, Tororo and Busia. The situation was worse in Bududa which has twenty- eight (28) sub counties, 1441 villages and a highly porous border but with only 57 police officers expected to enforce restrictions in addition to handling other routine responsibilities. In some districts, such as Bukedea, police reported that UGX 1.2m was the total budget allocation for the monthly fuel making difficult to carry out operations across the vast districts.

The Task Force thus observed that there was no allocative efficiency to deliver the desired outcomes of police operations aimed at restricting movements to slow the spread of the virus.

Recommendations

For health workers that were not cleared to travel during curfew time, local arrangements should be reached in consultation between

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security and the medical offices as travel permits are processed to enable front liners move to their places of deployment

(ii) In the long run, Government should provide accommodation to all critical medical staff at their places of work.

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#### **5.2 WESTERN REGION**



#### 5.2.1 Introduction

# Rt. Hon. Speaker and Hon. Members,

In accordance with Rule 8 (1,2 &3), of the Rules of Procedure of Parliament, the Rt. Hon. Deputy Speaker of Parliament constituted a Parliamentary Task Force on the National COVID-19 response with the following terms of reference;

- 1. Inquire into and report on Government preparedness and response to COVID-19:
- ii. Assess the health impacts in the Community and Country;
- iii. Assess operation, administration and management of funds and other resources appropriate for them to manage the pandemic;
- iv. Assess the role of the private sector health care providers in COVID-19 management;
- v. Carry out field visits to assess the state of health care systems in the Regional Referral Hospitals, District Hospitals and the Lower Health Facilities:
- vi. Conduct sensitization and awareness programmes on mass media to educate the population; and
- vii. Prepare and submit a report to Parliament.

The Western region team comprised of the following members;

i. Hon. Dr. Ruyonga Joseph

ii. Hon. Mwijukye Francis

iii. Hon. Dr. Asiimwe Florence Akiiki

iv. Hon. Bebona B Josephine

v. Hon. Dr. Kamara Nicholas

vi. Hon Nyakato Asinansi

vii. Hon. Dr Rutahigwa Elisa

viii. Hon. Atwijukire Dan Kımosho

ix. Hon. Kateshumbwa Dickson

The team visited selected districts within; Bunyoro, Toro, Rwenzori, Kigezi and

Ankole regions and hereby reports.

Hoima West

Buhweju County

**DWR** Masındi

**DWR Bundibugyo** 

Kabale Municipality

**DWR Hoima City** 

Rukungiri Municipality

**Kazo County** 

Sheema Municipality

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# 5.2.2 Methodology

In conducting the business at hand, the Western Region Task Force;

- a) Held field preparatory and planning meetings with teams from;
  - 1. Ministry of Health
  - ii. Ministry of Finance Planning and Economic Development,
  - iii. National medical Stores (NMS),
  - iv. Ministry of Gender, Labour and Social Development and;
  - v. The Private Healthcare Providers.

#### b) Reviewed the following documents:

- 1. Addresses from His Excellency the President on the pandemic;
- ii. Ministry of Health Preparedness and Response Plan March 2020-June, 2021;
- iii. Brief on Financing the COVID-19 Emergency Response for FY 2021/22 by the Ministry of Finance
- iv. The Summary of COVID-19 Budget Support Supplementary expenditure approvals by Parliament and the Supplementary funding for COVID emergency requirements for FY 2021/22;
- v. The Update on the National COVID-19 Response interventions by the Ministry of Gender, Labour and Social Development;
- vi. Ministry of Health COVID-19 In-Kind Donations received by Ministry of Health
- vii. Status Report on Delivery of Community Masks to Districts
- viii. COVID-19 External Funding Accountability Status, March 2020-June 2021
- ix. Ministry of Health Summary Distribution List of Donated Items towards COVID-19
- x. Ministry of Health National Corona Virus Disease Resurgence Plan, June 2021- July 2022
- xi. Minister of Health Update to Parliamentary Task Force on COVID-19 in Uganda
- xii. District Task Force Situational Reports on COVID-19

xiii. Hospital Management reports submitted to the team.

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- d) Held meetings with the respective District COVID-19 Task Forces visited.
- e) visited health facilities including Regional Referral Hospitals, General Hospitals, Health Centre IVs and Private Not for Profit (PNFP);
- i) Held Radio Talk shows.

#### **5.2.3 SCOPE OF THE ASSIGNMENT**

The Task Force sampled districts in the sub-regions of Western Uganda sampling districts, and health facilities.

# 5.2.3.1 Sub-Regions Covered

The Task Force covered the sub regions of; Bunyoro, Toro, Rwenzori, Kigezi, and Ankole.

#### 5.2.3.2 Districts visited

The Task Force covered the districts of Masindi, Hoima City, Kikuube, Kagadi, Kyenjojo, Fort Portal City, Bunyangabu, Ntoroko, Bundibugyo, Kasese (Bwera), Buhweju, Sheema, Bushenyi, Rukungiri, Kazo, Mbarara, and Kabale.

#### 5.2.3.3. Health facilities visited

Visited all Regional Referral Hospitals; all General Hospitals (District Hospitals); selected Health Centre IVs, and three (3) Private Not for Profit health facilities as indicated below;

a) Regional Referral Hospitals;

Hoima, Fort Portal, Kabale and Mbarara.

b) General Hospitals (District Hospitals);

Masındi, Kagadi, Kyenjojo, Bundibugyo and Bwera

c) Health Centre IVs;

Kikuube, Bunyangabu, Ntoroko, Nsiika, Kabwohe, Bushenyi, Kitagata Rukungiri, Kamukira and Kazo.

d) Private Not for Profit (PNFP);

5.2.3.4 Held stakeholder meetings at different levels including;

Regional Strategic consulatative meetings in Hoima City and Kabale district;

Nyakibaale, Rugarama, and Rushoroze

5.2.3.5 District Task Force meetings in Masindi, Kikuube, Kyenjojo, Hoima, Fort Portal, Ntoroko, Bundibugyo, Bunyangabu, Buhweju, Sheema, Bushenyi, Rukungiri, Kazo, Mbarara, and Kabale Districts;

5.2.3.6 Hospital and Health centre meetings in all health units visited.

#### 5.2.3.7 Radio Talk shows

Conducted eight radio talk shows to sensitize and educate the masses on prevention and management of COVID-19 through the following radio stations; Kitara FM in Masindi, Spice FM and Liberty FM in Hoima, Hits radio and Voice of Toro in Fort Portal, Rukungin FM in Rukukarri, Radio West in Mbarara, and Voice of Kigezi in Kabale.

# 5.2.4.0 Observations And Recommendations

# 5.2.4.1 Tor 1: Government's Preparedness and Response to COVID-19 5.1.4.1.1 Coordination, Planning, Financing and Monitoring District/City **COVID-19 Task Forces**

All the districts/cities had task forces to ensure coordination, planning, financing and monitoring of districts preparedness and response.

The teams were formed following the guidelines for management Epidemics/Pandemics and also in consultation with the ministry of Health. The members included; RDCs /RCCs, District/City Chairpersons/Lord Mayors, Chief Administrative Officers (CAOs), District Health Officers (DHOs), District Community Development Officers (DCDOs), District Probation and Welfare Officers (DPWOs) District Surveillance Focal Persons, District Police Commanders (DPCs), Regional Internal Security Organization (RISO), District Internal Security Officers (DISOs), civil society organizations and implementing partners.

In some districts like Hoima; Sub county Task Forces had been formed and the members on the committee include; Sub county chiefs, GIISOs, Police and the in charge of a health facility. These Task Forces had been formed at the village levels as well, enhancing DTF interventions at the lower levels. There are continued planning meetings, sharing of information, providing reports and feedback on risk communication and contact tracing and surveillance across all structures.

However, there was no clear source of funding to the lower level structures. The Task Force further noted that logistical and financial support provided to these

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task forces has been inadequate with the last Government release having been made in March, 2021 while the surveillance teams were last paid in November, 2020. It should also be noted that these DTFs didn't vehicles for conducting surveillance, contact tracing and monitoring of home based care services. This has resulted into the interventions by development partners, an instance is Masindi district where Baylor Uganda has recruited staff to handle COVID-19 surveillance in the district.

Cohesion is also a major challenge between the DTFs and the politically elected heads as the political leadership was vehemently opposed to the RDCs leadership of these task forces. Cases of these were reported in Buhweju and Sheema districts.

#### Recommendation

#### The Task Force recommends that;

- i. All task forces should be boosted with enhanced financial and logistical facilitation in order to make them fully operational.
- ii. Cohesion should be attained by including political leadership on the DTFs.

# COVID-19 Relief Support to the Vulnerable

Government intervention to address the financial constraints among the most vulnerable households in cities and municipalities had UGX. 53bn earmarked for COVID-19 Relief support. The beneficiaries in the different categories were successfully identified by the DTFs, with the lists of these beneficiaries submitted for consideration to the Office of the Prime Minister.

However the relief fell short of covering a significant portion of the eligible beneficiaries due to mismatches in NINs, and phone contacts data provided. This affected the receipt of relief by the intended beneficiaries.

should also be noted that there was no clear information provided on the criteria of registration of people to benefit from the relief fund, leading to complaints and disgruntlement from the communities on the groups which were left out especially those that were outside the municipalities and the transparency of the process queried. The process was thus marred by irregularities, which affected the fulfilment of government commitment in a timely manner.

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The exercise of registration was equally characterized by delays in the inputting of information in the system for onward transmission to the office of the Prime Minister which had caused agitation and frustration among the intended beneficiaries. This was reported in different areas, Masindi Municipality which instead of the eight thousand one hundred forty four slots allocated, only four thousand had been processed into the electronic system. This process exposed Government weak data base system and should be addressed for future interventions.

It was further noted that the wage/pay of the workers involved in this exercise had not been remitted and this had affected the morale of the staff employed.

#### Recommendation

#### The Task Force recommends that:

- i. Government should revisit its policy to ensure that the most vulnerable are the beneficiaries in COVID-19 relief interventions and not only the most affected by the pandemic.
- Ħ. Government should ensure that the workers employed under the exercise are remunerated, as the delayed payment portrays the Government in bad light.
- iii. Government must integrate data of Ugandans from the different government agencies for better budgeting and implementation of government programs.
- Government engages the lower LCs for identification of vulnerable iv. individuals within their communities.

# 5.1.4.1.2 Risk Communication and Community Engagement.

In all the districts visited, the DTFs have designated risk communicators working jointly with the RDCs/RCCs to ensure that communities are sensitized on prevention, control and management of COVID-19. The stakeholders include. religious leaders, Health educators, and development partners like UNICEF/WHO, CARE and Baylor Uganda

Radio talk shows were being conducted and there was a clear schedule. Radio talk shows were funded by development partners, RDCs airtime, and radio stations had

offered free airtime for the same. The talk shows were being held in different languages. Community dialogue meetings were also being conducted.

The Challenge with this however, had been that the radio sensitization and community engagement programmes were not regular due to inadequate funds.

Some few VHTs had been trained in community surveillance much as they needed facilitation.

In Ntoroko, the team received reports of belief that the disease is by which craft and prevented the patients from seeking health care services thus affecting the COVID-19 interventions as some of these resulted into severe infections and deaths.

Bundibugyo and Bweera had a problem of influx of refugees from DRC due to the porous border which encouraged illegal entry of infected people who had relative's on the Ugandan side making it difficult to track, access and control this border movement. This had escalated cases in these border districts.

No IEC materials had been received in the districts in the local languages thus making community sensitization difficult.

There was fear towards the COVID-19 interventions by the local people during the different radio talk shows as the communities queried the vaccines and masks in place due to the negative propaganda spread which affected the community responses to COVID-19 especially in the districts of Ntoroko, Kasese (Bweera).

#### Recommendation

The Task Force recommends that;

i. Government should urgently produce IEC materials on COVID-19 in the local languages of the different areas in the region.

i. The Ministry of ICT & NG be fully facilitated to develop regular on spot messages, activities and programmes to counter misinformation and demystify the fear associated with COVID-19 interventions.

All DTFs should be adequately supported to conduct radio programmes more regularly in the different languages to strengthen the risk communication and behavior change in communities.

14.3 Surveillance, Epidemiological Investigation, Contact Tracing and

Adjustment of public health and social measures

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#### Facilitation for surveillance activities

Surveillance, contact tracing and home based care activities are some of the very critical roles of the DTF with fully constituted teams from the village to District levels reporting to the District Surveillance focal person. The Task Force noted that the activities of these teams had been greatly affected by inadequate financial allocations to a point that some of them had not received payment from November 2020, case in point is Masindi District.

It was observed that the budgeting by the DTFs is more tailored towards administrative costs like payment of member's allowances at the expense of critical services like surveillance and contact tracing.

It was also noted that the surveillance function which entails follow-ups with especially the communities did not have transport means allocated to it and thus officers relied on means of transportation from other district offices including the RDC/RCC offices, and hospital vehicles which slowed down the process of contact tracing, and management of home based care, thus operated below the optimal.

Surveillance also had no adequate fuel allocation and as such districts relied on development partners for fuelling, and vehicle repairs which in itself is not sustainable as was reported in; Bunyoro region supported by Baylor and Care; Rwenzori Region supported by UNICEF/WHO and Medicins Sans Frontiers while; Kigezi region was supported by RHITES and CARE which is quite is not sustamable.

Recommendations

We Task Force recommends that;

The Ministry of Local Government should revisit the guidelines on utilization of funds extended to Local Governments to prioritize and ensure that sufficient resources are committed to critical functions of surveillance and contact tracing across districts in the subsequent allocations and releases towards the COVID-19 response:

All DTFs should forthwith, provide adequate financial and logistical support to the surveillance function for allowances of staff and

operations.

State of COVID-19 Screening and Sample Collection Areas

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There were no special arrangements made in the COVID-19 treatment centres, instead structures already in existence were converted into COVID-19 sample collection facilities across health facilities. Most of the structures visited including the RRHs like Hoima, Fort Portal and Kabale had reported inadequate structures and equipment including screening and sampling reagents having converted the mental health units into COVID-19 treatment areas which were dilapidated and worn out. Masindi Hospital for instance had a tiny room which fit only three rooms for all COVID-19 interventions.

Kazo HC IV had converted the maternity ward into a COVID-19 screening, sampling and admission areas. Ntoroko district reported a lack of COVID-19 facility and no equipment in place with a worn out tent with only three beds donated to the hospital by UNICEF during the Cholera outbreak as a COVID-19 centre. Other districts that had tents included Kazo HC IV, Kabale and Fort Portal RRHs, unfortunately these were not in use due to a lack of concrete floors, toilets and bathrooms.

The task force observes that direct Government involvement in setting up the required structures for screening patients is very limited showing the country's inadequate preparedness in the implementation of COVID-19 interventions.

### Recommendation

The Task Force recommends that:

- Government should set up reasonable structures that are fully (HU) furnished for COVID-19 screening and testing.
- The Ministry of Health should ensure that all COVID-19 screening and (iv) sample collection centres are fully manned at all times.

Policy on Testing

Initial testing at the RRHs entailed only RDTs with the PCR samples being transported to the centre for disease control (CDC) for analysis of results between 48 to 72 hours. This had however been affected by the sudden surge of COVID-19 cases during the second wave, with an overwhelming number of tests carried out against the few accredited institutions. The tests take between 7 to 14 days before

returning which in most cases is late with patients at this point presenting critical and severe symptoms.

It was further reported that most testing centres could only afford to pick samples from persons presenting with signs and symptoms which was a departure from the previous policy of mandatory testing of suspected cases and their contacts.

On a positive note, the Task Force reports that RRHs had recently been accredited and availed equipment for conducting PCRs which is envisioned to improve the turn-around period for results, and ensure timely interventions on the infected.

#### Recommendation

#### The Task Force recommends that:

- i. Government should consider reviewing the current policy on testing by emphasizing and encouraging PCR and Gene expert testing as these estimate the positivity rate with accuracy including the asymptomatic cases for avoidance of doubt.
- ii. Government should ensure that the laboratories are fully equipped with staff, necessary equipment and reagents to carry out these tests.

#### Enforcement of curiew and movement restrictions

a) Increased incidences of Police brutality

The Task Force received reports of brutality and use of excessive force by law important officers in enforcing SOPs especially the curfew on community members. This affected the essential health workers as well owing to the fact that job entails working and movement during curfew hours.

The Task Force observed that whereas the RDCs are the heads of security in the Districts, police brutality, extortion and detention of suspects in an effort to enforce SOPs and adherence to curfew time was largely reported to be inhumanely done against the directives of the RDCs.

The Task Force recommends that the security leaderships at the districts composed of the Resident District Commissioners and the District Internal Security Officers should reign on the enforcement officers to ensure that they exercise their roles with restraint.

b) Indiscriminate enforcement of restrictions

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The Task Force noted that health workers across the region were often stopped and prevented from attending to night duty in spite of holding travel permits issued by the City Medical Office and the staff identifications. Cases of this nature were reported in Hoima City and Kabale district where the security agencies had clashed with health workers for movement during curfew hours with the health workers being manhandled and at times arrested.

The indiscriminate enforcement of lock down restrictions affected pregnant women, nursing mothers and other in-patients who are often left un-attended through-out the night due to absence of workers on night duty.

# The Task Force recommends that:

- i. Local arrangements should be reached in consultation between security and the medical offices as travel permits are processed to enable front liners move to their places of deployment
- ii. The security and enforcement officers conduct their duty with a human face and with professionalism.
- In the long run, Government should provide accommodation to all iii. critical medical staff at their places of work.

#### c) Limited capacity to enforce restrictions by security teams

The border districts especially Bundibugyo, Kasese, Kabale and Rukungiri presented challenges of enforcement of SOPs and curfew restrictions to the porous border areas by the thin enforcement personnel officers who were already overstretched.

The same was the case in the communities that are adequately served by the security personnel and the VHTs grossly underfunded to effectively enforce festrictions and carry out operations. There were also concerns of inadequate PPEs for officers on duty who come into contact with suspects whose COVID-19 status is unknown while enforcing SOPs, exposing them to infections.

There was no allocative efficiency to deliver the desired outcomes of police operations aimed at restricting movements to slow the spread of the virus

Recommendations

The Task Force recommends that:

i. The security and enforcement officials be reinforced in numbers and also facilitation to increase efficiency.

ii. The security and enforcement teams be categorized under the most vulnerable and availed the necessary PPEs to avoid exposure to COVID-19.

# 5.1.4.4 Point of Entry, International Travel and Transport and Mass gathering

The test kits for COVID-19 were inadequate throughout the districts visited hence affecting their diagnostic capacities. Unlike the first wave where all suspected cases and contacts of confirmed cases would be traced and tested, testing is targeted to only patients presenting to testing points with signs and symptoms of COVID-19 in the second wave, an instance of this is are the border districts of Bundibugyo and Ntoroko which have porous unmonitored borders due to inadequate human resource for enforcement.

The gazetted border at Ntoroko shared between Uganda and DRC with numerous truckers moving in and out of the country equally has low testing figures attributed to inadequate test kits and the high cost of testing which is at UGX 150,000. This failure to test the people coming into the country especially the truckers is a departure from the previous effective mandatory testing for every entrant.

#### Recommendation

The Task Force recommends that vigilance be taken at the border points by ensuring that mandatory testing is enforced on all entrants.

#### 3.1.4.5 Laboratories and Diagnostics

The COVID test kits were inadequate in all hospitals visited affecting their diagnostic capacities. The health centres reported inadequacies and irregular supply of test kits by the NMS. Hoima and Kabale RRF had reported limited number of the test kits in store to serve their regions. This was further compounded by faulty equipment that increased reliance on laboratories in Kampala.

The Task Force further observed the inadequate human resources in the laboratories with requests for increased laboratory staff. The structures accommodating these laboratories were also in need of renovation.

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It was further noted that the turn-around time for PCR test results was between 1-2 weeks in Masindi, Bundibugyo and Ntoroko districts which rely on the RRHs for admission of these patients compromised the safety of the community as the people tested are left at large pending the results. It should also be noted that holding places were not available at most of the health facilities visited for the purpose of isolation and most of suspects were sent back into the communities. This could have far reaching consequences on the spread of the disease.

#### Recommendation

# The Task Force recommends that;

- (v) The Ministry of Health should scale up testing through cascading COVID-19 tests at lower health facilities in order to cover at least all contacts of patients;
- (vi) The Ministry should carry out random sampling and testing of the community in order to ascertain with a reasonable degree of accuracy, the national COVID-19 positivity rate;
- (vii) The Ministry of Health should revert back to the original testing protocol at all border entries without relying on foreign results whose authenticity cannot be ascertained;

3.1.4.6 Infection Prevention and Control, and protection of the health workforce

Inadequate and inconsistent supply of Personal Protection Equipment

tersonal Protection Equipment such as masks, surgical gloves, gum boots and consumables like sanitizers provided by NMS are grossly inadequate leaving frontline workers exposed to infections while on duty with numerous health workers reported sick while others have since succumbed to the pandemic due to very low budgetary allocations provided resulting into occasional stock outs that are managed by constant requests for more supplies.

Despite NMS indicating the presence of huge consignments of PPEs in its stores and pledging to distribute them across the country in the second week of July, 2021, the deliveries made were insufficient to take care of the increasing demand

for PPEs forcing health workers to recycle masks and gloves

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Furthermore, the adoption of HBC and inclusion of VHTs among the front-line workers in response to the pandemic had ultimately increased the uptake of PPE. However, there was no evidence of a proportional increase in supply to match the demand.

It should also be noted that there is a general inadequacy of PPEs for the rest of the hospital staff (that is not from CTU) that has led to a majority of the infected staff being identified from within these. The exposure of the health officials and staff to infections and at times death, has scared health personnel from attending to COVID-19 patients on the one hand and significant loss in confidence of the general public in the health systems, resulting into shunning of health facilities to seek care for other ailments.

The Task Force also observed that most of the hospitals including RRHs such as Fort Portal, Kabale and Bundibugyo general hospital had no basic medicine for COVID-19 treatment including; Zinc, Azithromycin, and Vitamin C, with the bills for medicines burdening patients, most of them unable to afford thus relying on herbal medicines.

The statistics below illustrate the infection rate among health workers in various districts that could be as a result of inadequate protection while on duty.

Table 1: Health Worker infection by sample district

District	No. of Infections	No. of Deaths	Total	
Masindi	24	1	25	
Houma	52	2	54	
Fort Portal	30	1	31	
Bweera	21	1	22	
Bundibugyo	11	0	11	
Bushenyi	23	0	23	
Rukungiri	60	1	61	
Kazo	18	0	18	

Sources: District COVID-19 Task Force Status Reports, 2021

Recommendation

The Task Force recommends that Government should provide adequate financial resources to facilitate procurement of adequate quantities of PPEs, essential medicines and other health supplies in accordance with the needs of the facilities.  $\mathcal{N}$ 



# Adherence and enforcement of the Standard Operating Procedures

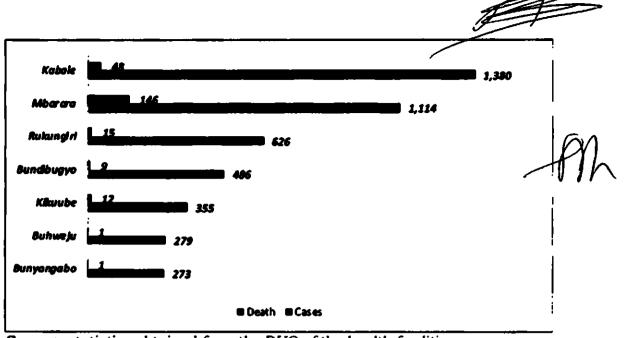
Despite the successes recorded in the management and control of COVID-19 pandemic in Uganda this far, there is a growing level of complacency among the population in as far as adherence to the SOPs is concerned.

The task force gives credit to the DTFs, the health centres and workers, and the enforcement personnel who have emphasized the MoH SOPs, with measures in place, which include wearing of face masks, social distancing, installation of automatic sanitizers at most critical points, temperature screening, continuous and regular disinfection of hospitals, routine screening for COVID-19 symptoms in designated areas equipped with infrared thermometers/temperature guns.

The Task Force however noted inadequacy of the IEC materials from the Ministry of Health on infection prevention, management and control. The team was also concerned about the reluctance of the public to adhere to SOPs and the resistance against attempts by the security agencies to enforce these SOPs especially the boda boda riders, social distancing was still a challenge as evidenced by the continued preference of group activities. Communities especially at the market areas and trading centres in Rukungiri, and Bundibugyo exhibited reluctance in adhering to the SOPs. Wearing face masks and social distancing were not observed by the locals, and enforcement of these wasn't adequately done, yet the emerging COVID-19 variants have been more aggressive.

The Task Force further observed that the locals were wearing very old and dirty masks that defeated the purpose with the locals attributing this failure to wear masks to the high costs, while others stated that the elderly, who are the most vulnerable had been vaccinated. This could have contributed to the increasing district cases

Figure 2: COVID cases reported in selected districts visited



**Source**: statistics obtained from the DHO of the health facilities **The Task Force recommends that:** 

- i. Government should put in place a robust response plan that includes; enhanced surveillance, training the trainers on COVID-19 management to create a critical mass of healthcare workers for national response, adequate PPEs for health workers and the general population and other supplies as well as provision of allowances for frontline workers.
- ii. Government through the Ministry of Health should prioritize the procurement of COVID-19 vaccines for all Ugandans as a means of mitigating infections.
- ili. Sensitization of masses on the adherence and observance of SOPs be enhanced by the MoH through the village health teams.
- iv. Government procures more masks for distribution to the population.
- v. Government should scale up regular sensitization programs on prevention and management of COVID-19.

3.1.4.7 Case Management, Clinical Operations and Therapeutics

Non-operational intensive Care Units (ICUs) for severe COVID-19 case

management

The Task Force noted the dire need of both ICU space and functional assorted equipment crucial in critical care. The Task Force observed that whereas the RRHs received ventilators, they are however currently not fully operational with Mbarara

RRH, the closest to operationalization still lacking an MRI machine.

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Kabale, Hoima and Fort Portal RRH do not have medical air, CI- scans, MRI, and Mobile X-rays, medicines, concentrators, humidifiers, oxymeters, and a lack of critical staff such as anesthesiologists and critical care nurses to operationalize these ICUs beds. These were all inadequate to meet the growing need of managing patients with severe COVID disease.

The delays in the operationalization of the ICUs have further been attributed to lack of space to accommodate the ten (10) bed capacity with some of the identified spaces for the ICUs requiring remodeling due to inadequate space which has not been undertaken to date. This was reported in Kabale, Fort Portal and Hoima RRH.

The Task Force was also informed that due to inadequate anesthesiologists and critical care nurses offering ICU services, Mbarara and Kabale RRH had taken on final year student interns to boost the thin human resource offering this care thus bridging the human resource gap.

# The Task Force recommends that;

- i. Government fast tracks the installation and equipment of all ICUs in the remaining RRHs by providing for the required staffing and remodeling of the earmarked spaces without further delays to ensure that the Population benefits from these Services.
- ii. Government encourages and invests in specialized training of critical staff including anesthesiologists and critical care nurses to manage the ICU equipment.
- iti. The Ministry of Health should procure adequate oxygen cylinders for all General Hospitals and Health Centre IVs;
- iv. The final year and internship medical students studying related courses to the management of COVID-19 should be regularized and a stipend be provided to them to boost the staffing gaps of critical services.

The Ministry of Health should revisit the policy of limiting ICUs to RRHs and have them functionalized at General Hospitals and HC IVs that have already initiated CTUs in their facilities;

iman resources for COVID-19 management in health facilities

The MoH undertook emergency recruitment of additional medical personnel on contractual basis. These included; medical officers' (special grade), epidemiologists,

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nursing officers, assistant nursing officer, ambulance drivers and assistants to boost numerical strengths in the fight against the COVID-19 pandemic which raised the overall staffing levels to at least 50 percent for most departments in the Regional Referral Hospitals, for instance Hoima RRF reported having received eight new staff, while Fort Portal received twenty three health workers

Health facilities have however continued to report shortage of critical staffing across all levels of health service delivery especially with the senior cadre positions which have one third of their staffing levels filled to date translating to an average of 33 percent. Kazo HC IV for instance had only one medical officer offering COVID-19 treatment.

To date, the serious staffing gaps for key staff in COVID-19 interventions such as laboratory officers, and anesthesiologists have been attributed to low wage bills to recruit and an unattractive salary scale. This has been compounded by the low retention of critical health workers, with some of the assigned workers having left their stations. RRHs such as Hoima, Kabale and Fort Portal reported lack of anesthesiologists and critical care nurses which has rendered ICUs in operational. The figure below shows the staffing level of some of the selected health facilities visited in the western region by the Task Force.

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Figure 1: Staffing level in selected health facilities in Western region

**Source**: statistics obtained from the DHO of the health facilities

The shortage of staff has resulted into overloading of the few who are available. creating gaps in emergency services, specialized care and health services management. Overall, it has compromised the quality of services rendered and

constrained attainment of an effective health system that needs a qualified and accessible health workforce.

#### Recommendation

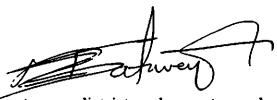
# The Task Force recommends that:

- Government should provide for enhancement of salaries and other benefits including housing, and transport for Consultants, and anesthesiologists, to attract and retain these cadres within the public sustem.
- ti. The Ministries of Public Service and that of Health should expedite the process of reviewing and implementing the revised Staffing norms.
- iii. Contract staff who were deployed to the RRHs to provide COVID-19 interventions should be regularized since government has invested a lot of funds in training them.
- Expedite the hiring of adequately trained personnel to operate the iv. CTUs and Testing Centres. In particular, the Ministry could explore the possibility of hiring expatriates as specialist health cadres to cover the specialty staffing gaps at the ICUs and CTUs in the RRHs;
- Explore the possibility of hiring Third Year Anesthesiology and v. nursing students as a stop-gap measure to addressing the inadequacy of staffing in the ICUs and CTUs and to further undertake the necessary legal framework to pay to them allowances for their services;
- Government should review the policy on provision of Hard-to-reach allowance especially targeting health facilities that have failed to attract and retain the much needed critical staff.

#### Staff Remuneration/ Risk Allowance to frontline staff

Health workers involved in COVID-19 interventions have often received their risk allowances late and irregularly with some indicating that they had last received payment far back as December, 2020. In addition, the risk allowances were subject to a 30% Pay as You Earn (PAYE) tax which was demotivating to the health workers.

should also be noted that risk allowances for the other frontline categories have also not been paid out, yet Parliament appropriated funds channeled towards allowances to these staff, these include; security enforcement teams, village health



teams and surveillance teams, district, sub county, and village Task Forces with some of these officials having never received allowances from the commencement of the COVID-19 lockdown in March, 2020.

This has been a huge demotivating factor with some of these officials including police officers and local defence officers manning road blocks resorting to receiving bribes from people not observing the SOPs and enforcement guidelines including breaking curfew hours, and not wearing masks.

# Recommendation

# The Task Force recommends that the:

- i. An audit of the appropriated allowances to the front line staff be conducted to ascertain whether these funds were received by the intended end-user.
- All arrears in allowances for health workers who have been saving il. lives in the frontline should be paid off within the next two (2) months.
- iii. Ministries of Health and of Finance Planning and Economic Development should amend the Law to exclude taxation of risk allowances to frontline workers.
- iv. In the Government should consider providing accommodation to all critical medical staff at their places of work as a risk incentive.

#### Absence of COVID-19 Treatment Centres at General Hospitals

The overwhelming numbers of COVID-19 cases that require ICU services at RRHs has rendered these units inefficient and at times unable to handle cases beyond their capacity, leaving many of referred patients unattended to and worse off.

Despite the above trend, MoH has not reviewed the COVID-19 treatment policy to include general hospitals and HC IVs as COVID treatment centres. The delay prompted some lower health centres to take administrative decisions to gazette some spaces at their facilities for provision of COVID-19 treatment.

One such hospital is Bwera hospital, which has a fully-fledged ICU centre with twenty-eight (28) oxygen cylinders, twenty-five (25) beds, and twelve (12) treatment tents having previously been involved in the provision of emergency services to

Ebola victims

The hospital administration was castigated, denied risk allowances and asked to apologize for offering COVID treatment services without accreditation from the MoH.

It should however be appreciated that the health centre has successfully treated forty-two (42) patients, registering only one (1) death since the start of the pandemic.

The decision by the MoH discouraged many health workers with twenty-seven (27) medical workers leaving the health centre, presently only five (5) staff are manning the CTU.

The limited support from the Government has further left the hospital in dire need of medical supplies and thus relying on development partners like medicines sans frontier for provision and transportation of oxygen, repairing damaged and nonfunctional equipment, and supplementing of human resources.

The Task Force observed that further hesitation by the Government to revise its policy on treatment of COVID-19 patients and elevate General Hospitals and HCIVs as treatment centres is detrimental to the country and threatens to erode the gains made by Uganda in the fight against the pandemic.

#### Recommendation

# The Task Force recommends that:

Ministry of Health reviews the COVID-19 treatment policy to bring on i. board General Hospitals and HC IVs as lower treatment centres for COVID-19.

Ministry of Health reconsiders its position on payment of arrears and ii. allowances to staff in lower health centres that have engaged in the management of COVID-19 cases, though not accredited.

#### Home based Care (HBC) Delivery System

The second wave of the COVID-19 surge in Uganda has seen Government adopt the home based care management for patients that presented mild and moderate COVID-19 symptoms and only institutionalizing the severe and critical cases as opposed to the first wave where all patients were admitted in health care facilities

which had overwhelmed the health care system which lacked the necessary human resource, equipment, and facilities to contain the pandemic.

The Task Force established that patients under home based care only received testing, advice and prescription services from the health centres. They also freely interacted and mixed with the communities they belonged to especially family members without any form of observance of the SOPs. This was attributed to poverty and the fact that most families have shared spacing including bedrooms, bathrooms and toilets.

Surveillance and monitoring of patients under HBC was also not effectively done by the surveillance, village health care teams and the medical personnel due to constraints in resources and patients are tasked purchase medicines, and supplements for treatment of the pandemic including Vitamin C, Zinc, Azithromycin, and Vitamin D which are not included on the list of essential drugs.

The Task Force observed that home based care had the highest potential of fueling community infections and as such, urges Government to ensure that a more robust option of handling COVID-19 patients is identified and used in the place of home based care. Alternatively, guiding policies on the management and provision of home based care be developed for better management by the health teams as opposed to the current practice of letting communities manage the infected.

The Task Force recommends that:

i. Government should review the home based care delivery system with a view to strengthen it further. This component of intervention should cater for provision of medicines for patients therein. It should also offer and ensure that enforcement to the guidelines especially by the village health and surveillance teams.

The District Task Forces should strengthen the surveillance, monitoring, reporting and follow up of COVID-19 cases under HBC. . ,

3.1.4.8 Operational Support and Logistics, and Supply Chain

Inadequate ambulance Services at the hospitals

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Standard hospital ambulances with ICU and HDU services are very few in the

hospitals visited with most health centres using taxi like vehicles and pickups to offer ambulance services, cases in point were Bushenyi and Rukungiri HC IVs.

Mbarara RRH atleast reported having four (4) ambulances, although one (1) of them was over fourteen (14) years old and should have been bonded off a while back, the other RRHs including Hoima, Fort Portal and Kabale each had one (1) old ambulance serving all the districts under their jurisdiction. This was a clear indication that the RRHs visited did not receive the ambulances that the MoH had undertaken to provide under the Regional Ambulance System as was indicated in the Minister's address to the Parliamentary Task Force.

The health facilities continue to grapple with maintaining old ambulances some of which had been in use for over 15 years and break down quite frequently thereby raising the cost of maintenance and running them.

It was further revealed that these RRHs neither received the daily facilitation alluded to of UGX 960,000 earmarked for each ambulance.

Cascaded downwards to General District Hospitals and HC IVs, the task force observed that there were no ambulances in place in most of these including Masındi, Kikuube, Kagadı, Ntoroko, and Kyenjojo general hospitals which have to rely on the RRHs for ambulance services in times of emergencies at a very high cost of fueling and time wastage sometimes leading to death of some of the patients due to delays in evacuation.

Districts were using ambulances purchased privately by individuals, development partners and organizations such as CARE, UNHCR and Members of Parliament.

It should further be noted that due to insufficient funding, most of these ambulances frequently lacked fuel to satisfy demand for their services and are not regularly and timely serviced due to the lack of direct budget lines and allocations, to cater for this.

# Recommendation

The Task Force recommends that:

The management of the ambulance system should be made transparent and clear to the respective regional referral facilities to ensure proper accountability.

Ministry of Health allocates funds to support the purchase, fuel, and servicing of ambulances across the country in atleast all District and

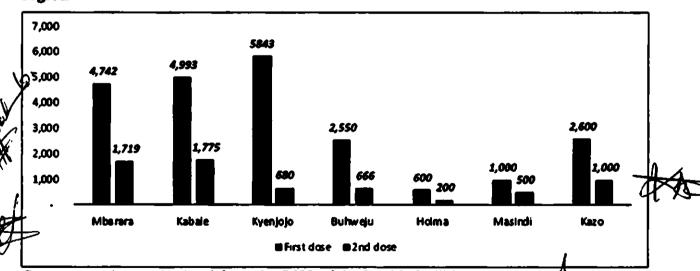
Regional Referral Hospitals to ensure quick evacuation of patients that require urgent medical attention.

#### Performance of the Vaccination Drive

The second batch of vaccines provided was grossly inadequate compared to the first across all districts visited. This was attributed to the few doses availed and also the increasing demand for vaccination by the general public, with most health centres reporting that unlike the first batch that was characterized by stigma towards the intake of the vaccines, the second dose was consumed within two (2) days of release. This was attributed to enhanced community mobilization and sensitization on the benefits of the vaccination.

The frontline workers were equally affected as some didn't receive the second jab including health workers and teachers which has far reaching consequences in terms of exposure to infection and the likelihood of delay in opening of schools and other critical service centres. Kabale district for example reported that 4,993 people have so far received the first dose with 1,775 receiving second dose; Mbarara district, reported that 4,742 received the first dose and only 1,719 have received the 2<sup>nd</sup> dose. See figure 2 below.

Figure 3: Performance of the vaccination drive in selected districts of western region



Source: statistics obtained from the DHO of the health facilities

The Task Force recommends that Government should provide sufficient dosages of vaccination in a phased manner to meet the growing demand for

the same, addressing the most vulnerable and susceptible to infections especially the front line workers and the elderly.

6 ASSESSMENT OF THE HEALTH (AND OTHER) IMPACTS OF COVID-19 IN THE COMMUNITY AND COUNTRY AT LARGE

6.1 Maintaining Essential Services and Systems

# Socio-economic Impact of COVID-19

The task force noted that COVID-19 had immensely affected the economic livelihoods of the communities visited. The movement restrictions imposed to curb the spread of the virus had affected small businesses and increased cost of doing business due to the high cost of transport hence many retail shops were out of business. The travel restrictions had also cut the business community from the markets.

The Task Force also received reports of financial institutions and associations including banks, microfinances, and SACCOs demanding clients to facilitate their loan obligations during the lockdown. The business community stated that the loan restructurings by the financial institutions were not helpful as these only increased the cost of the loans in the long run, asking rather that loan repayments instead be halted during the period of lock down without accruing any penalties.

Additionally, the task force was informed that because of the COVID-19 containment measures such as closure of school, many teenage school going girls have been impregnated. It was indicated that household conditions, such as Poverty have been a major cause of girls' vulnerability to early pregnancy/marriage. Parents no longer have a source of income because of the economic impact of COVID-19, resulting to giving away their daughters in exchange for bride price for survival.

Recommendation

the Task Force recommends that:

i. Ministry of Health should explore implementation of targeted lockdowns in hot spots basing on surveillance information in order to minimize the socio-economic effects of a generalized lockdown of a

whole country.

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- ii. Government should provide capacity building and resourcing to the institutions of the police, local councils, probation officers to enable them perform their role.
- iii. Government should engage financial institutions to provide a grace period to the borrowers and further reschedule the payment of loans in view of the prevailing circumstances.
- iv. Parliament should probe an investigation on the defilement and teenage pregnancy cases that have been regionally reported ensure that the perpetuators are prosecuted by law

# Impact of COVID-19 on other Essential Services

The hospitals visited by the Task Force reported that essential services such as antenatal services, mental health services, immunization, ART services and malaria control had been significantly affected by the efforts, finances and physical resources diverted to COVID-19 management.

The Task Force observed in Kazo HC IV that the maternity ward had been used to accommodate patients indiscriminately, these included; women, men, children. It was also accommodating COVID and Non-COVID patients with security officers placed in the ward to ensure that the different groups of patients do not physically meet, increasing the likelihood of patients being infected by other diseases

The Task Force also received reports of restrictions in movements that had disrupted routine activities of health workers despite their cadre as essential workers. The security forces enforcing lockdown had been reported to be very brutal and interfered with the movement of health workers who were working and moving during the day and night.

Additionally, some services such as mental health services had been technically phased out at the regional referral level as these units were converted into CTUs in Hoima, Kabale and Fort Portal RRH.

The Task Force recommends that:

Government ensures that all essential medical services are adequately taken care-off as per the budgets and allocations, there should be a balance in essential service provision across the board, not all

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Government efforts should be channeled to COVID-19 interventions at the cost of the other services.

- ii. The Ministry of Health should budget for construction and equipping of the COVID-19 Treatment Units at Regional Hospitals, General Hospitals and Health Centre IVs that are already treating COVID-19 and the Ministry of Finance should provide the resources.
- 7 ASSESSING OPERATION, ADMINISTRATION AND MANAGEMENT OF FUNDS AND OTHER RESOURCES APPROPRIATED FOR THEM TO MANAGE THE PANDEMIC

# 7.1 Operational Support and Logistics and Supply Chain Utilization of the Resources appropriated for COVID-19 response

During the first wave, Parliament appropriated resources to support Government response towards the pandemic. Each district received a total of UGX 165m towards COVID interventions and spent the money in accordance with issued guidelines. Further, cash and in-kind donations were made by the respective Members of Parliament, civil society and the community.

The funds were also to be used in procurement of motor cycles for health workers for sub counties and town councils where they are not, renovation or construction of health staff quarters, surveillance of COVID-19 cases, and procurement of PPEs. It should however be noted that these funds didn't adequately meet the needs of the DTFs which faced challenges in executing there mandates as it covered risk allowances for frontline workers, transporting suspects, surveillance, means to suspects under quarantine and fuel for the DTFs.

Task Force also observed that whereas all the districts visited acknowledged receipt and utilization of these funds, the criterion used to allocate UGX 165m across board was not clear. The peculiarities of districts such as vastness, population, terrain, accessibility, porosity for border districts among others were not considered to ensure equitable distribution of resources.

# Recommendation

The Task Force recommends that Subsequent allocations of resources for management of COVID-19 to districts should be based on their peculiarity for

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- 8 ASSESSING THE ROLE OF PRIVATE SECTOR HEALTH CARE PRO **IN COVID-19 MANAGEMENT**
- 8.1 Case Management, Clinical Operations and Therapeutics

# Supplementary Role by Private not for profit health Providers

The Task Force observed that private health providers especially the PNFP hospitals had contributed to treatment of people at a subsidized cost in response to the difficult financial times and the work load in the public health centres. The Task Force visited; Karoli Lwanga Hospital in Rukungiri, Rugarama and Rushoroze Hospitals in Kabale.

Karoli Lwanga Hospital, Nyakabale which is acting as Rukungiri District General Hospital, has partly bridged the gap in COVID-19 related treatments boosting the public health facilities within Rukungiri and the surrounding districts of Mitooma, Kanungu, Ntungamo and Bushenyi districts, that lack the requisite treatment equipment, offering both specialized services in Surgery and OBS/GYN, and general services.

Cumulatively, the hospital has run COVID-19 tests on seven hundred nine (709) patients with one hundred fifty (150) positive cases, of which ten (10) have since succumbed to the virus. Twenty (24) of the hospital staff have also successfully been treated from COVID-19 since the outbreak.

The challenges experienced by the PNFPs are no different from those in public hospitals as they reported issues such as; inadequate health staff, inadequate PPEs, need for oxygen, HDUs and ICUs, and inadequate ambulance systems with the ones in place facing challenges of the physical terrain. The PNPFs requested that Government supplement their services by providing essentials like human resource, PPEs and the necessary equipment for handling COVID-19 patients.

# Recommendation

The Task Force recommends that:

ŧ. Government provides accreditation to the Private not for hospitals as COVID 19 treatment centres in order for them to provide services to the community and play their part in the fight against the

pandemic.

- Government enhances support to the PNFPs in terms of PPEs, bedside ii. monitors, ventilators, oxygen (setup a plant or provide free oxygen refills and cylinders), standard ambulances and human resource so as to increase the capacity of these hospitals to better manage the pandemic. This will also reduce the hospital bills, making it possible for the community to afford treatment of high quality within their districts.
- Government through the MoH extends mentorship and Support iii. Supervision from the District Health team and officials will go a long way in improving the way PNFPs relate and provision of healthcare to the communities they serve.
- Government increases its quota of vaccines provided to the PNFPs iv. especially to the staff will help protect these staff from contracting COVID-19 severe disease and reducing the spread amongst staff.
- Government should take over the management and coordination of v. health workers and systems in the PNFPs including retraining all these health workers in managing patients. This will help improve the quality of care and infection prevention.

5. CONDUCTING SENSITIZATION AND AWARENESS PROGRAMS ON MASS MEDIA TO EDUCATE THE POPULATION

Communication, Community Engagement Infodemic and Management

Onducting Radio Talk Shows

The radio stations in the districts visited provided the RDCs weekly hour for sensitization of masses about COVID-19. Radio stations such as Liberty FM in Hoima district had also provided weekly airtime for education of communities on COVID-19 by specialists. This was also done by Development partners like CARE and Baylor Uganda.

The Committee noted that community engagements and sensitizations had been enhanced by VHTs and the surveillance teams on measures to fight the pandemic as well as distribution of IEC materials in communities.



The Task-Force held eight radio talk shows in Kıtara FM in Masındı, Spice FM and Liberty FM in Hoima, Hits radio and Voice of Toro in Fort Portal, Rukungiri FM in Rukukgiri, Radio West in Mbarara, and Voice of Kigezi in Kabale.

From the talk shows conducted, the Task Force noted frequent issues revolving the demand for vaccination on the efficacy and dangers of these vaccines as well as COVIDEX drug, police brutality, discontent regarding the criteria used in identification of the beneficiaries of COVID-19 financial relief of UGX 100,00 to vulnerable homesteads, use of herbal medicine and fruits in treating COVID-19, high COVID testing fee of UGX 100,000, movement restrictions, questions on the observance of the SOPs, and lack of facilitation for VHTs to sensitize communities.

The Task Force recommend that all the relevant stakeholders especially the MoH enhance efforts of conducting sensitization and awareness programmes through increased budgetary allocations to mass media and to community development officers.

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#### 6. REGION SPECIFIC OBSERVATIONS

# 11.1 Case Management, Clinical Operations and Therapeutics

# 11.1.1 Health Infrastructure and Health Systems

The Hospitals had inadequate physical structures while others were in dire need of renovation. There was thus a need for more physical structures to cater for critical facilities like operating theatres, isolation centres and maternity wards. Hospitals that had been upgraded to general hospital status continue to operate within the structures of HC IVs with much of their infrastructure lacking the much needed equipment and structures including X-Rays, ultra sound scans surgical, obstetrics and gynecological operation theatres. This cut across all RRHs, general district hospitals and HC IVs to effectively deliver services.

Masindi General Hospital which was constructed in 1924, had structures that were dilapidated with leaking roofs, cracked hospital floors and walls, broken windows, broken sewage and drainage systems, broken beds, and old tiny operating theatres. The hospital had been earmarked by the MoH for structural rehabilitation in the FY 2004, this has however not been realized to date due to an inadequate resource

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Kazo hospital also had appalling structures that were dilapidated with inadequate services to effectively serve the huge population with critical cases referred to Mbarara and neighboring Kiruhura and Ibanda districts. The hospital further has no ambulance which has affected the evacuation of patients' especially critical and severe cases in need of oxygen. While at the hospital, the Task Force was taken aback when they visited a ward that accommodated men, children and women and also had COVID patients.

Hoima, Kabale and Fort Portal RRH, Kazo and Ntoroko HC IVs constructed in the 1960s also had inadequate and dilapidated buildings that the hospitals had opted to use the tents as wards. Unfortunately, the MoH had provided tents without funds for concrete floors, toilets and bathrooms rendering non-functional.

It should be noted that the non-functionality of Lower level health facilities continues exerting pressure on higher level health facilities yet, they are equally ill-equipped with the overall burden falling on the RRHs.

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## The Task Force recommends that;

- i. Government should ensure that there is phased rehabilitation and reconstruction of the dilapidated health infrastructure across all RRHs, General Hospitals and HC IVs in the country.
- ii. Government should ensure that the tents provided to the hospitals are fully equipped to render them relevant services and operational as hospital wards.
- iii. Ministry of Health should ensure that all HC IVs are equipped with the much needed equipment to deliver on their mandate.
- (viii) Government should elevate Rukungiri, Bushenyi, Kazo, Kabwohe, and Kikuube HC IVs to General Hospital and all the attendant benefits provided including increased financial release and infrastructural development.

Outstanding Utility Bills and arrears

The Task Force was notified that health facilities across the board were grappling with unpaid utility bills for water and electricity. These bills have accurately

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since the advent of COVID-19 that occasioned over consumption of water and electricity. Hospitals visited all reported being heavily indebted with regard to utility bills. Masindi Hospital reported owing sixty-four (64) million in water bills and another thirty six (36) million in electricity bills. This has affected operations in the hospital.

Other hospitals reported staff salary arrears. Hoima RRH reported having arrears of two hundred seventy-seven (277) million which had demotivated the affected staff. There was a general plea for Government intervention.

#### Recommendation

The Task Force recommends that Government should pay off all outstanding utility bills and salary arrears in order to make facilities start paying their own bills hence forth.

# Maintenance of Oxygen Plants and Other Equipment

Availability of reliable and steady supply of oxygen is critical for the functionality of ICUs and HDUs across all RRHs. However, this is not the reality in the hospitals. The oxygen plants in all four RRHs visited unfortunately do not have the capacity to adequately meet the needs of the patients admitted, let alone provide oxygen to district hospitals and HC IVs that fall under their jurisdiction.

These health centres have resorted to sourcing for oxygen through development partners and also engaging private suppliers like BM steels in Mbarara, Oxygas in Kampala and Roofings Limited Uganda which is not only expensive but also time consuming.

It should also be observed that due to irregular maintenance and servicing, these oxygen plants produce oxygen which is far below their installed capacity, as the quantity and quality for management of patients under critical care is low. Case in point was Hoima and Fort Portal RRHs whose service had been long overdue, affecting the supply of oxygen, thus resorting to sourcing oxygen from Mbarara and Kampala.

The Task Force recommends that;

i. Government should prioritize the maintenance and the functionality of Oxygen plants by providing adequate budgetary allocations.

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- Government should boost the production of the oxygen plants by ii. enhancing the necessary equipment of the RRHs to match that of Mbarara RRH if these hospitals are to realistically serve the regions with oxygen.
- Government installs oxygen piping at the COVID-19 treatment units to iii. ease administration of oxygen and improve outcomes.
- The Ministry of Health should recruit, train and deploy qualified iv. personnel to operate the oxygen generating plants at the RRHs;

#### Conversion of mental Units into COVID-19 Treatment Centres

The mental health Units in Hoima, Fort Portal, and Kabale RRHs, had been converted into COVID-19 treatment centres (CTUs) thereby relocating mental health patients into unsatisfactory facilities within the hospital not tailored to serve the purpose.

The Task Force observes that this was a reflection of Government inadequate preparedness to handle emergencies and the low level of priority of the mental health services on the ranking of critical health services in the country.

# The Task Force recommends that:

- Government should consider setting up dedicated isolation wings for all district hospitals fully equipped with relevant sections such as the maternity ward/unit in addition to the general ward to address future health emergencies, avoid similar disruption in the provision of essential medical services when epidemics re-occur.
- ii. Ministry of Health should consider opening up Mental Health Units at all the Regional Referral Hospitals.

# Unstable and irregular Electricity (Power) Supplies

Unstable electricity supply compounded by inadequate generator facilities has affected the quality of health service delivery. Kabale RRH reported massive power outages compounded by the hospital generator's inadequate capacity to power the oxygen plant as well as the HDU. This has put the hospital in a very unique situation of depending purely on UMEME and having to call the electricity supplier

whenever there is a power blackout.

Some of the critical medical equipment had been destroyed by the unstable power supply, which pauses a risk of damage to the recently acquired COVID-19 equipment especially in the ICUs and HDUs as well as the oxygen plants. Hoima RRH had reported losing the functioning capacity of the oxygen plant due to inadequate and unstable electricity supply and had to rely on oxygen from Mbarara and Kampala to meet its supply which was inconvenient and also time wasting.

# Recommendation

# The Task Force recommends that:

- i. Government should ensure that dedicated power lines are provided for the RRHs to ensure stable power supply to mitigate the risk of destroying medical equipment as well as losing lives that would otherwise have been saved.
- The Ministry of Health should henceforth adequately provide for ii. health equipment maintenance budgets guarantee functionality.

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#### CONCLUSION

The onset of the COVID-19 pandemic in March 2020 paused a challenge unlike any other faced before to the health system in Uganda. Government is applauded for the efforts it made in providing the necessary measures for COVID-19 management.

However, it is prudent that the Government ensures that the necessary infrastructure, medication, equipment and personnel to manage the health systems are in place to ensure efficiency and effectiveness of interventions.

The task force further underscores the importance of prioritizing mass vaccination to all the eligible twenty two (22) million Ugandans in the long run as a more sustainable measure as opposed to the short term and unsustainable measures

presently under implementation.

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# 5.3.1 Background

The Central region team of the Parliamentary Task Force on the National COVID-19 Response undertook field visits in, Masaka, Mubende, Mityana, Lyantonde, Kalungu Kyotera, Mutukula, Kayunga, Buikwe, Mukono Wakiso and Kampala.

The team was composed of the following Members;

i. Hon. Dr. Michael Bukenya (Chairman) -Bukuya County

ii. Hon. Dr. Lulume Bayiga - Buikwe South iii. Hon. Nakazibwe Hope - DWR Mubende Hon. Pauline Kemirembe - DWR Lyantonde ıv.

Hon. Fortunate Hope Nantongo - DWR Kyotera V.

- Entebbe Municipality Hon. Michael Kakembo vi.

- Kasambya County vii. Hon. David Kabanda

viii. Hon. Charles Tebandeke - Bbale County Hon. Gonzaga Ssewungu - Kalungu West ix.

Hon. Abed Bwanika X. - Kimaanya

Methodology/Scope Of Work

In conducting the business at hand, the Central region team mapped out Districts and health facilities to be visited in Kampala, Entebbe, Mubende, Mityana, Masaka, Kyotera, Lyantonde, Kalungu, Buikwe, and Kayunga.

The team:

Reviewed hospital management reports submitted to the team;

Held meetings with;

District task force teams:

Port authorities at Mutukula and CAA;

Hospital and Health centre management teams;

Private not for profit health service providers including Nsambya, Mengo and Rubaga Hospitals;

Visited selected Health facilities including;

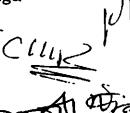
Regional Referral Hospitals in Mulago, Kiruddu, Mubende Masaka, Kayunga. The taskforce also visited Mandela National Stadium to assess the preparedness of the facility in handling COVID19 cases.

General Hospitals (District Hospitals) in Mityana, Kalisizo, Entebbe Grade B, China Uganda Friendship Hospital (Naguru), Lyantonde, Kawolo, Mityana.

Health Centre IVs in Kakuto, Baale, Kalungu

iii.





Conducted radio talk shows in Lyantonde on Radio Kaaro Fm, iv. Bbuyamba Community Radio and in Masaka on Centenary Radio Fm.

Interviews and observations were also employed while in the field. These mainly took a form of key informant oral and written interviews. Ouestionnaires and monitoring tools to be filled by the hospital directors and medical supretendants were sent prior to the visits.

# FINDINGS, OBSERVATIONS AND RECOMMENDATIONS

TOR 1; INQUIRE INTO AND REPORT ON GOVERNMENT'S PREPAREDNESS AND RESPONSE TO COVID-19:

# PREVENTION: HOSPITAL EQUIPMENT AND PPES.

The team established that Mulago, Kirrudu and Entebbe grade B hospital had in place functional X-ray machines and CT-scans. However, these were lacking in Kayunga, Masaka, Mubende and Naguru regional referral hospitals. Refer to appendix 1.

The PPEs, that are primary guards against infections were grossly inadequate in most of the hospitals posing a high risk of exposure to infections of frontline health workers while on duty. There has been an increase in reported cases of health workers contracting COVID while on duty and some have actually succumbed to the deadly virus. In July, 2021, NMS revealed to have stocked up huge consignments of PPEs ready for distribution to the various hospitals across the country. Unfortunately, the increased demand has rendered the supplies insufficient forcing health workers to recycle PPEs such as masks and gloves.

# Recommendation.

The budgetary allocations to the National Medical Stores spould be increased to provide for purchase of more PPEs and his required to treat COVID-19.

#### COMPLIANCE TO SOPS IN HEALTH FACILITIES.

The Team established all health facilities visited were observing SOPs. There were handwashing points at major points in the facilities, patients and caretakers were observed to have their face masks on, health workers were protected in masks and those in CTUs had PPEs donned. Most referral hospitals had in place water and sanitation teams that ensured steady wsupply of water for handwashing and fumigation of contaminated areas. Screening of the public at the entrance of the hospitals was mandatory. The

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Team observed that whereas water was available, there were few facilities with functional rain water harvesting facilities.

# EFFORTS ON VACCINATION OF HEALTH WORKERS AND SECURITY PERSONNEL.

The team was informed by the police commandants on the various District task forces the majority of the security personnel had at least been given the 1<sup>st</sup> jab of the vaccination. However, it was hard to conclusively establish whether they all got the 2<sup>nd</sup> jab for full vaccination. Furthermore, it was reported that health workers response to vaccination was still below expectation. This was largely eminent at Masaka regional hospital where concerns on the nature of the vaccine being administered to the population were raised.

This could partly account for the high numbers of health workers exposed and contracting COVID. As for the required doses for both the 1st and 2nd dose, it's not clear what would be the fate of those who got 1st dose and are due for the 2nd jab. Given the current rate of vaccination, there is need to strengthen public awareness campaign on adherence to SOPs as the surest way to minimise spread and infections as efforts to obtain the required vaccines is hastened.

# Recommendation.

Government should expeditiously institute a programme for mass COVID19 testing so as to map out the hotspots to guide intense surveillance, isolation and vaccination to curb the escalation of community transmission.

The population should be encouraged to get vaccinated as scientific evidence is increasingly showing that the vaccines are safe and effective. Science is indicating that individuals fully vaccinated continue to present mild symptoms than those unvaccinated. The later have been observed to easily succumb to severe illness which often results into hospitalisation and possible death.

Government should focus on procurement of enough vaccines for the population to allow massive vaccination giving priority to the vulnerable groups and urban centres with high populations.

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ROLE OF DISTRICT TASK FORCES.

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The Team established that the various district taskforces have been instrumental in identifying and rounding up COVID suspects who are later subjected to tests. The various district taskforces collaborate with the district surveillance teams that respond to public alerts to identify, test or quarantine suspects. Despite their presence and efforts amidst challenges, they had not yet received any financial support during the 2nd wave as it was the case in the 1st wave at the time of the visit. Although the Team was informed that there was some allocation earmarked for all local

Governments for COVID-19 financial support, these funds were yet to be

received in the various accounts of the beneficiary Entities.

It was noted that the taskforces at the District level ought to have been comprised of the RDC, DHOs, CAO, DPC, DISO, medical superintendents, surveillance officers and area MPs and others. However, this was not the case in Buikwe. Additionally, the team noted that cohesion in the leadership of the taskforce and elected leaders was lacking. Most of the elected area MPs were not involved in the taskforce meetings and yet these are crucial in mobilizing and sensitizing constituents. Furthermore, whereas the RDCs are the heads of security in the various Districts, police brutality, extortion and detention of suspects in an effort to enforce SOPs and adherence to curfew time was largely reported to be eminent. Lugazi, Kigaya and Nkombwe police posts in Buikwe were reported to be some of the most notorious.

# Recommendation.

- All District task force teams that are not currently composed as per the guidelines in place should do so immediately.
- ıi. Security enforcement officers should be trained to enforce SOPs and curfew time in compliance with the law.

# Sensitization of the public about COVID.

The Team noted there was still laxity in the adherence of SOPs and Ministry guidelines on COVID by the public. In most communities, people only wear face masks and maintain social distance on sight of security personnel or when accessing officially designated areas. The RDCs and RCCs were at the forefront in sensitizing the public about the COVID pandemics. This was attributed to the free airtime on various radio stations that had been allocated to the RDCs and RCCs considering that they are the Chairpersons

of the various district task forces.

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However, the involvement of the health workers in sensitizing the public has barely been done. Almost all regional referrals do not have a budget to pay for airtime on radio to sensitize the public in their respective localities yet they are critical considering that they are at the frontline of fighting this pandemic and by default, understand the management of the pandemic much better. Key messages on the status of the epidemic concerning community surveillance, number of cases, prevention measures and community engagement for prevention and social protection may be easily distorted or misguided by politics if only done by RDCs on community radio stations. The Team believes that for sensitization to be effective, there is need for continued sensitization and mindset change towards the perceptions of Ugandans on COVID.

# Recommendation.

i. Government should review the policy on communication to allow space for subject specialists which will enhance effective communication in regards to sensitization on SOPs and COVID19 awareness.

#### CASE MANAGEMENT.

#### COVID TREATMENT CENTRES HOUS AND ICUS.

A high dependency unit (HDU) is a hospital unit (ward) in which patients in critical condition need constant monitoring and are dependent on oxygen to support their respiration. When such patients deteriorate and suffer organ (or multiple organ) failure, they are managed in an intensive care unit (ICU). The Team established that other than Mulago, most of the regional referral hospitals did not have in place fully functional ICU centers. At Masaka referral for instance, construction of a 400 bed maternal and child complex that would house the ICU was still in progress. At Mubende referral, a designated area as an HDU had been converted into an ICU. **Refer to appendix 1.** 

Owing to the directive of the Ministry of Health, COVID treatment centers were established at regional and national referral hospitals strictly. This decision was premised on the fact that most of the lower health units other than the regional and national referrals lacked the prerequisite facilities and attendant human resource capacities to manage and treat COVID patients. General hospitals and HCIVs were not accredited to treat and manage (COVID patients. As a matter of fact, only testing was being done at the lower

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level health facilities and those found to be in critical condition were being referred to the regional and national referral hospitals.

The Team noted that in an effort to treat COVID patients sent by the lower health units, some general wards have been turned into ICUs, HDUs, the implication of which is such that other patients other than those suffering from COVID, cannot be admitted for fear of contracting the disease from hospital facilities due to congestion.

Further still, Lower health facilities are being overstretched considering that the regional and national referral hospitals by implication as CTUs, have scaled down on handling other medical cases in efforts of managing the pandemic. Unfortunately, the lower medical health centers are not specialised and lack capacity to handle complex medical cases which still continue to exist. This has intensified management of additional disease burden on the lower health facilities. In Buikwe for instance, it was reported that only 3 HCIIIs were in existence in the entire district where testing was being done. There was not in place a single HCIV. Additionally, in places like Masaka, the only General hospital was upgraded into a regional referral that serves the entire greater Masaka region. Consequently, the district does not have a general hospital which causes a gap in the referral protocol.

#### Recommendations.

Government, through MOH, fast tracks installation and equipment of ICUs in regional referral hospitals where these are lacking.

Government, through the MOH, invests in specialised training of ii. critical medical health personnel to handle the ICUs.

Government, through the MOH, builds capacities and accredits iii. some of the General Hospitals and HCIVs to treat COVID and handle future pandemics and other complex medical cases that require specialised medical attention. A review of the COVID19 treatment policy should be expeditiously done to bring on board General Hospitals (GH)s and HC (IV)s in the treatment of COVID19.

**B**ÚLANCES AT HOSPITALS.

he team observed that standard hospital ambulances in the hospitals were inadequate. Those available mostly require mechanical improvements and are not sufficient to meet the demand. The ambulances frequently lack fuel

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and are not regularly serviced due to insufficient funding. Often times, patients are left with no choice but to either endure unavoidable costs of facilitating fuel for the ambulances and drivers so as to be transported to and fro the hospital during referrals.

Furthermore, the movement of patients to access medical services has been constrained by restriction in public transport. This has not been helped by the intricate process of attaining travel permits from the LC1s and RDCs which is impractical in cases of emergencies. Most of the regional referral hospitals serve wide catchment areas and therefore, patients have to move long distances to access medical services.

Management in many hospitals have to constantly engage implementing partners and well-wishers to fill this gap. A huge outcry of this deplorable situation was witnessed in Kalisizo and Kakuto both in Kyotera district where the only ambulance at Masaka regional referral has to move over 40km and 50km to pick patients to and fro Kalisizo and Kakuto respectively. In Buikwe district where a number of manufacturing industries are housed, there was no ambulance given by MOH at any health facility. Members may wish to note that the proprietors of these industries donated ambulances and pickups to government in an effort to strengthen the fight against COVID but not a single ambulance of vehicle exists at the health facilities in the district. The public is desirous that government is transparent in accounting for the COVID donations it has so far received inform of ambulances and other form.

It is noteworthy also that the testing for COVID has been greatly affected by constraints in movement. It is feared that the cases may be seen to go down due to limited testing and not genuine reduction in the spread as thought.

# Recommendations.

i. Ministry of health puts in place a transparent mechanism of managing the ambulance system to ensure accountability to the respective regional referral hospitals.

Ministry of health, under the COVID fund, allocates funding for the purchase, fueling and servicing of ambulances in the regional referral hospitals and the lower health facilities across the Districts. Owing to referral protocols, it would be more logical and appropriate to have more ambulances at the lower health

facilities.

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# OXYGEN SITUATION IN THE HEALTH FACILITIES.

Almost all regional referral hospitals and Mulago national referral hospital had in place functional oxygen plants installed to supply oxygen needed by the patients. Availability of a reliable steady supply of oxygen is critical in the functionality of ICUs and HDUs in hospitals. Unfortunately, the capacities of all these oxygen facilities in the various hospitals were inadequate to sustain the demands. Deliberations with the various hospital managements revealed that the consumption of oxygen required to manage COVID patients was unprecedented, a phenomenon that could not have been anticipated especially in the second wave. This situation has not been helped by the insufficient number of functional oxygen cylinders in all the hospitals which has more than doubled cost.

The public has now resorted to stocking up oxygen in cylinders at homes which is highly risky but also creating more scarcity on the already constipated supply. The public risks using nonmedical oxygen on COVID patients under home based care.

This inevitably led to the huge outcry for oxygen which was witnessed throughout the country. The established oxygen plants are not able to produce beyond the capacity they were built for. Consequently, hospitals have had to improvise by looking for distant alternative sources (Roofings limited in Namanve and Oxygas ltd in Kampala) to supply them with oxygen so as to supplement what the hospital is able to produce. The Team was informed that in this second wave, most of the COVID patients in critical condition are oxygen dependent and on average, a patient consumes 3 cylinders of oxygen per day. Given the huge numbers of patients in these COVID treatment centers, the supply of oxygen is deficient. Refer to appendix 2 for specifics as per Hospital.

Recommendations.

ii.

The Ministry of Health should prioritize the maintenance of, oxygen plants and provide for adequate budgetary allocations to the referral hospitals.

Using the COVID fund, Ministry of Health should allocate funding necessary for enhancing the capacities of the existing oxygen plants to boost production of oxygen so as to meet demand and also install oxygen piping at the COVID treatment centers.

OMEBASED CARE DELIVERY SYSTEM

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Whilst at the onset of COVID-19, the Ministry of Health (MOH) had issued a policy to admit all COVID-19 patients in health care facilities, this has since changed when the pandemic expanded, and outpaced the health care system due to the fast-growing number of positive cases that get admitted to health care facilities.

Consequently, Government adopted the homebased care for patients that test positive but with mild disease. The team established that whenever a patient is confirmed to be positive there is no mechanism of transporting them back to their homes. In some cases, a positive patient was forced to us a Boda-bodas without any protection. In addition, many families in rural areas do not have adequate space to guarantee effective isolation. This has potential of fuelling community transmission.

Whereas the success of homebased care had been premised on presence of a homebased care-provider, this has been found to be lacking. As a result, patients have ended up mixing with communities and their family members heightening the risk community infections. This situation is compounded by low levels community surveillance.

Much as parliament had appropriated money for isolation centers in every district, this has not been done.

#### Recommendation.

i. Government should review the homebased care delivery system to strengthen it further. Efforts to functionalize the surveillance chain right from its linkage with the district, sub-county and village level taskforces as a means enforcing compliance to Homebased care guidelines should be supported.

.Government should avail the money for the building of adequate ii. isolation centers to accommodate patients in isolation away from family members.

Ministry of health should engage in a national re-skilling and retooling of the VHTs to enhance the effectiveness of home based care.

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# Tor 2; Provide Assessment Of The Health Impacts Of COVID-19 In The COMMUNITY AND COUNTRY AT LARGE:

# COVID-19 TESTS, POSITIVITY RATE AND MORTALITY RATES

The data from the health facilities visited reveals that out of the total 41,659 tests conducted in these facilities, 9,595 have turned positive. This translates to a positivity rate of 20%. The deaths reported in these facilities amounts to 880 translating into a mortality rate of approximately 11%. Table 1 shows the top ten health facilities with the highest COVID-19 mortality rate.

Table 1: Health workers recorded to have contracted COVID in selected Health facilities

Pacility	Cases		Total Cases	
	1 let Wave	2nd Wave		
Kıbulı Hosp	!	<u>-i</u> 8 - ·	8	
Lyantonde Gen. Hosp.	30	i 20	50	
Uganda Martyrs Rubaga	<b>-  -</b>	 . 66	66	
St Francis Hosp. Nsambya	-   14	35	49	
Mityana Gen Hosp.	-	-1 26	26	
Kyotera District		20	20	
Kayunga District	- i	. }	5	
Masaka RRH	ï5	34	49	
Naguru RRH	-+ <sub>34</sub> ·	<u>6</u> . — . –	40	
Kawolo Gen. Hosp.		13	13	
Nyenga Hosp. Buikwe	<u> </u>	9	9	
St. Charles Lwanga Hosp. Buikwe	-	4 -	4	
Total	- L 93	246	339	

Source: Specific Health Facility Statistics

These ten facilities alone account for 84% of the overall mortality in facilities reported (Refer to table 3). It is important to note that other than Mulago Hospital Complex, Nambole, Masaka RRH and Kibuli Hospitals, the rest of the facilities are not accredited to admit and manage COVID-19 patients in their facilities. It is important to establish the main factors that are driving the observed deaths both in the accredited health facilities and among those that are ordinarily not.



From the selected Hospitals, a total of 339 health workers were reported to have contracted COVID as shown in *table 1*. This could be attributed to inadequacy of PPEs as well as low response to vaccination by health workers. Whereas Mulago did not report the number of health workers infected with COVID, it was reported that 6 health workers succumbed to the deadly virus.

The Team established that many health facilities were forced to admit and manage COVID-19 patients even without the Ministry's accreditation amidst the surging cases of COVID-19. These included all the general hospitals in the selected districts and identified PNFPs. Whereas patients were testing positive and deteriorating in condition, it was increasingly becoming difficult to have them referred to accredited facilities. This was attributed to absence of a reliable and effective Ambulance system to facilitate faster referrals.

Table 2: Facilities with highest Mortality Rates

/N	Health Facility/District	. Admissions	Mortality	Mortality
	i	1		Rate
l	Nyenga Hospital	20 -	٠٠٠ ۋا	45%
;	Masaka RRH	.1 179	i 74	41%
;	St. Francis Hospital Nsambya	307	86	28%
	St Charles Lwanga	25	5	20%
;	Kawolo General Hospital	100	19	19%
	Mulago NRH	1 <sub>2,551</sub>	472	19% —
•	St. Joseph Kitovu Hospital	- 90 · · ·	14 "	16%
•	Kıbulı Hospital	L —	13	14%
•	Kangulumira HCIV	73	8	11%
.0	<sup>+</sup> Kıruddu RRH - Namboole	±380 · · · ·	.I . <b>40</b>	11%

Source: Specific Health Facility Statistics

For the case of Mulago Hospital Complex, it is important to note that it reported a total of 5,858 laboratory tests done for the period April to June 2021. Out of these 1,057 tests turned positive. This translates to a positivity rate of 18% (Refer to table 3). The team was informed that Mulago was performing both the RDT (mostly for patients with symptoms) and the PCR test (best for asymptomatic patients since it is more specific to the Genetic structure of the virus). By the time of the Team's visit, a total of 86 patients were in the CTU (of which 13 were in ICU). Unlike in the 1st Wave, all patients admitted in the CTU during the 2nd Wave are poxygen dependent

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atient would review shout 20 litres of

(one patient would require about 20 litres of oxygen per minute). This explains the high level of oxygen consumption during this period.

On the other hand, China Uganda Friendship Hospital (Naguru) forisntance was only performing the COVID-test using the RDT and not PCR. By the time of the visit, Naguru RRH had performed a total of 8,032 test had been done. Out of which 1,560 had turned out to be positive. This translates into a positivity rate of 19.4%. Refer to the table below.



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0 1st Wave The positivity rate of 13.8% applies to Jan - June 2021. Tests are for the period April - June 2021. Out of started with 2nd Wave. Of the positive The total of 335 incl 91 cases managed during the Nambole does not carry out tests Out of which, 40 tested, positives and death reported by the DHO & Health Only 380 cases have been admitted in 2nd Phase the no. admitted 2,551 last six months, 472 died 110 400 cases. There is a discrepancy between cases Admissions are which the Dead were 31 cases, 20 are H/Ws The cumulative patients died Comment Unit Staff. **Festing** 10 50% 7.80% 8.00 9.30% Death Rate 19% % % 8 Positivity Deaths Table 3: COVID19-statistics of visited health centers in Central region 472 31 3] 13.80% 19 80% Rete 14% 13% 18% 21% 26% 18% 19% Cases 1,064 2,274 1,057 . 125 350 312 73 ļ\$ Parliamentary Taskforce - Central Region COVID-19 Statistics No. of Tests 2,536 1,765 5,363 1625 5,981 96 346 415 358 Kıruddu RRH - Namboole Kalısızo General Hospital Bbaale HCIV - Kayunga River Conte Mubende RRH - CTU Kangulumra HCIV Kayunga Hospital Mubende District 2 Mubende District Mityana Hospital Kayunga District S/N Health Pacifty Naguru RRH Mulago NRH

J JA G			Admissions in CTÜ were 179 Of which 74 died		100 cases admitted and 19 Deaths Of the Positives, 4 H/Ws.	Out of the Positives, 9 H/Ws. Out of the 20 admitted, 9 died.	Only 1 Admitted	Only 25 admitted		A total of 94 were admitted.	First wave had a total of 399 of which 48 deaths	There was no data recorded/availed on deaths	Data not yet Availed	; ; 			HOV HOV	
Te la	. %1	_ %0	41%	16%	19%	45%	  % 	. 50%	%	14%	28%	<u> </u>	<b> </b>	1%	11%		The state of the s	
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his	64	110 -	- 9 <u>8</u> 8	  -  &  -	590	16	104	. 82	105		307	140	! -	_   781	9,595	1		
		6991	3 <u>7</u> 28	<u>678</u> .	: :	386	_ 295	192	- 808	1737	   !   !	i <u>1181</u>		3669	41,659	lity Statistics	Amusement of the state of the s	
Emu	Kakuuto HCĬV	Mutukula Port Health	Masaka RRH — —	St. Joseph Kitowa	Kawolo General Hospital	Nyenga Hospital	Nkokonjeru Hospital	St. Charles Lwanga, Buikwe	Meghta Hospital	Kibuli Hospital	St Francis Hospital Nambya	Kalungu HCIV	Villa Maria Hospital	Lyantonde	Total	Source: Specific Health Facility Statistics	A STATE OF THE STA	
	\$ P	14	 15	16	, <u>r</u>	81 S-18	- 38 -/-	20	21	.zz	23	8	7 25	8	h	!	CILLE	

Whereas the high positivity rates consisted of both critically ill and asymptomatic individuals tested, the positivity rates over 20% are indicators of poor home base care systems and poor surveillance mechanisms.

### Recommendations.

- The Ministry of Health should urgently examine its accreditation policy with a view of expanding it to include other facilities in order to undertake effective monitoring and supervision.
- ii. The Ministry should urgently review and assess the challenges faced with the current emergency Health Ambulance System that was instituted to facilitate patient referrals but has been overstretched. Parliament should be informed of the steps the Ministry has taken to improve the functionality of the National Emergence Ambulance System within one (1) week from the date of consideration of the Taskforce's report.

# DELIVERY OF OTHER HEALTH SERVICES.

Having noted the policy to restrict COVID patient admission and treatment to regional and national referral hospitals by the Ministry of Health, on the basis that most of the lower health units other than the regional and national referrals lacked the prerequisite facilities and attendant human resource capacities to manage and treat COVID patients, health service delivery was affected. As a matter of fact, some of the general hospitals such as the Entebbe grade B that was turned into a CTU stopped with immediate effect to offer other health services other than treatment of COVID to the Community. In Masaka, the only general hospital had been upgraded into a regional referral, now treating COVID patients. There wasn't in place, a functioning general hospital to render other health care services to the public.

This is an indicator of reduced service utilization during the pandemic. For instance, antenatal care visits by pregnant women reduced drastically hence causing a drop in the number of hospital births during the pandemic. This endangers the lives of pregnant women and children during birth. Patients of different categories of ailments are not getting the adequate care for failure to access the health facilities. But also, the closure of logistics, y related workplaces and transport services which has interrupted supply lines has caused shortages of medical supplies in health facilities. The fear of contracting the disease due to the perception of increased risk of exposure to COVID at health facilities has not helped the situation. A large range of health care services that are considered essential have been greatly

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affected considering that most referrals are now designated CTUs and consequently, the traffic of patients accessing such facilities have been rationed down to minimize on the spread.

The team observed that the provision of other medical services were affected not only at the regional referral hospitals but also at lower health facilities.

#### Recommendations.

- i. Government must strengthen the health care system and emphasis should be skewed to building the capacities of lower health care facilities to be able to render adequate services and handle future pandemics.
- **ii.** MOH must strengthen policy on COVID management at hospitals to enhance the triage of COVID19 victims and also provide for gazette areas for isolation, other basic routine services are still on going.
  - Ministry of health should integrate COVID19 management into routine health care.

Government must intensify the COVID19 and other health awareness campaigns to reduce stigma of COVID19 in society.

#### IMPACT OF COVID-19 ON THE COMMUNITY AND THE ECONOMY.

There was a general outcry from the population on the negative impact of the lockdown on the incomes of Ugandans and businesses. The continued lockdown has crippled their capacity to meet committed financial obligations with financial institutions as a result of the freeze on economic activities. Many Ugandans are being faced with a reduction in their incomes due to job and livelihood loses, reduced flow of remittances, loss of market and demand for domestic products, to mention but a few. Furthermore, a reduction in revenue collections by governments is projected to affect service delivery by government MDAs.

#### Recommendation.

- i. Government should institute relief mechanisms to compel financial institutions to revise loan repayment timeframes and interest rate charges on all loans for the rest of the half year 2021 to resuscitate businesses and the economy.
- ii. Government must institute a clear response strategy needed to ensure adequate attention and protection for the vulnerable sections of the population and measures must be applied in a way that is clear and inclusive in the short, medium and long term mitigation plan.

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Tor 3; Assess Operation, Administration And Management Of Funds And OTHER RESOURCES APPROPRIATED FOR THEM TO MANAGE THE PANDEMIC:

The Team noted that Parliament appropriated funds to manage the COVID pandemic. However, due to the short timeframe within which to report, the team was not in position to investigate the utilisation of the same. We therefore recommend that the auditor general audits the usage of funds appropriated for COVID management and the Public Accounts Committees of Parliament on Central government and Local government consider the reports for accountability.

#### Recommendation.

A forensic audit be undertaken by the auditor general on all funding appropriated for COVID19 management.

#### LATE PAYMENT OF RISK ALLOWANCES FOR HEALTH WORKERS AND OTHER STAFF.

At the time of the visit, the team noted that the risk allowances allotted to health workers is UGX. 80,000. However, recognizing that these heroes are putting their lives at risk while in line of duty, it is unfortunate that the government continues to subject this small pay to tax. The delays in receiving this allowance has only exacerbated grievance among the frontline health workers. The Team was also informed that the last batch of these payments were being paid through mobile money services, where withdrawals are further subject to charges. Further, some health workers complained not having received any risk allowances. Other front liners such as security enforcement teams, village health teams and surveillance teams have not been provided for. These factors have been a recipe for demotivation and discontent among health workers and other front liners.

It is paramount that government appreciates the efforts of the health workers and waive taxes on the pay and also find more appropriate means of, effecting these payments without subjecting them to unnecessary and

expensive withdrawal charges.

Government should give a tax waiver on this allowance considering that it is already meagre.

Recommendations.



ii. Government should expand on the scope of beneficiaries of the risk allowance to include all cadres of staff involved in handling COVID-19 patients at health facilities.

#### FINANCIAL SUPPORT TO COVID-19 MANAGEMENT AND SURVEILLANCE

The team noted that whereas during the first wave of COVID-19 (FY 2020/21), Government provided financial support to regional referral hospitals (RRHs), District taskforces, RDCs, Police and Prisons. By the time of the visit, the Government had not provided any budgetary resources specifically for COVID-19 for FY2021/22.

In addition, in Nambole/Kirudu and Mulago National Referral Hospital, it was reported support in form of risk allowances to Health Workers and all staff in the management of COVID-19, provision of Food to patients, medicines and medical supplies but the resources were being managed centrally by the Ministry of Health.

The team was informed that Government was planning to release resources to all regional referral hospitals and to all local Governments for COVID-19 support as supplementary expenditure for FY 2021-22. However, these resources were yet to be received on the respective accounts of the recipient by the time of the visit.

In addition, efforts to intensify community engagement interventions to curb the outbreak were frustrated by inadequate transportation. The intentions of robust Community based disease surveillance systems have not been achieved. As such, contact tracing which is critical in controlling spread is jeopardized. It is important that all potential contacts are systematically identified and put under strict observation for 14 days.

#### Recommendation.

i. Resources earmarked for COVID19 management must be sent to the respective votes for effective utilization.

Government should earmark adequate resources towards surveillance activities to ensure effective tracking of COVID-19 alerts as well as follow-up on COVID-19 patients on homebased care as opposed to previously in the 1st wave when meagre resources were provided. Efforts to dedicate a pick-up vehicle and attendant resources for fuel should be supported.

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Government should consider procuring more motorbikes for iii. surveillance teams.

# TOR 4; Assess The Role Of Private Sector Health Care Providers In COVID-19 MANAGEMENT:

## COVID19 MANAGEMENT IN PRIVATE NOT FOR PROFIT AND PRIVATE FOR PROFIT HEALTH FACILITIES

The team noted some of the PNFPs were not accredited to treat COVID-19 patients, they are doing a commendable job in complementing Government's effort in the management and containment of COVID-19 pandemic amidst challenges.

Private-not-for-profit health facilities just like many Government facilities, do not have the adequate health personnel to manage COVID-19 patients. There is an apparent lack of adequate PPEs, HDUs, ICU, diagnostic equipment, ambulances, the much needed oxygen and oxygen cylinders for better management. This has been compounded by increase in prices of medicines and medical supplies.

Although many lives have been saved by these facilities, there have been high mortalities reported during this 2nd wave. For example, St. Joseph Hospital Kitovu in Masaka City reported a total of 721 COVID-19 tests done (of which 158 PCR), admitted 79 COVID-19 patients, 65 cured with 14 deaths registered. This translates to rather high a mortality rate of 17.7%. The high death rate was attributed to delay in seeking medical care, lack of Oxygen and absence of quick means of referral for better management. The team was informed that in many cases, patients would reject referrals and Preferring treatment in the facility due to lack of resources.

In the resurgence of COVID19 in the second wave, the PNFPs were observed to be charging exorbitant fees for the treatment of the COVID19 patients considering that government health facilities were not only insufficient but also overstretched. It was just inconceivable that government was seen to be failing to ensure a robust public health system that would subsidize costs in the PNFPs. Government investment in the health sector is paramount to make it more competitive with the private sector in the provision of health services. This will help to subsidize costs of accessing

health services in the private facilities.

#### Recommendation.



- i. Government should consider additional support to PNFP health centers with critical facilities needed in the management and treatment of COVID-19 such as Ambulances, Oxygen and Oxygen Cylinders, medicines and medical supplies (including PPEs), training and secondment of health personnel and subsidizing them on the cost of utilities (water and electricity).
- ii. In addition to Kibuli and Mengo hospital, government should review the accridation policy and consider accrediting more capable PNFP health providers to admit and treat severe and critical COVID patients.
- iii. In addition, the Ministry of Health should institute a robust reporting system that can capture all COVID-19 related data from PNFPs to inform policy and decision making.
- tv. Government should strengthen efforts to improve health care in public health facilities which would help reduce demand for health services in private health facilities. This would subsidize the cost of acquiring health services in private health centers.

# Tor 5; Carry Out Field Visits to Assess the State of Healthcare System in the Regional Referral Hospitals, Both Selected General Hospitals and The Lower Health Facilities;

In the selected health facilities visited by the team, the state of health facilities in the regional referral hospitals, general hospitals, HCIVs and HCIIIs still leaves a lot to be desired.

# OUTSTANDING POWER BILLS AND INSUFFICIENT WATER SUPPLY

The health facilities visited across the region were grappling with unpaid electricity bills and insufficient water supplies. In Kakuto health center IV, the facility lacked sufficient water supply and the water reservoirs available were in dilapidated concrete tankers that had worked beyond their useful life. This endangers the lives of both the patients and health workers at the facility as the water from reservoirs is contaminated and not suitable for consumption. Noting that laboratories in health facilities require sufficient water, it was observed that the unreliable supply of piped water at Kakuto health center IV in the laboratory at the facility makes work cumbersome and also increases the risk of contamination as hygiene is compromised.

Furthermore, the visited regional hospitals reported that the costs of electricity bills suffocated the approved budgets. The oxygen plants at the regional referrals require a stable supply of electricity so as to produce oxygen for patients. Unfortunately, the already pigh, electricity bills are not

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helped by constant black outs at the health facilities. As such, hospitals have to rely on standby generators that consume huge quantities of fuel to supply the hospitals with electricity. The hospital budgets cannot sustain the maintenance and fueling costs of the standby generators. These bills have accumulated since the advent of COVID-19 that occasioned over consumption of water and electricity.

#### Recommendation

- i. Government pays off all outstanding utility bills in in the selected general and referral hospitals within two financial years.
- ii. All regional referral hospitals should be connected to major electricity grid lines and major water grids to ensure a reliable and constant supply of electricity and water in the health facilities.
- iii. The government should compel the MOH to enforce alternative utility mitigating measures such as sustainable water harvesting, employing the use of prepaid meters and solar systems in health facilities.

#### STAFFING AND ACCOMMODATION OF HEALTH WORKERS.

The Team noted that a number of regional referral hospitals were understaffed especially in the ICUs and yet demand for medical services is immensely high. **Refer to table 4.** Even those that have been assigned to the various hospitals are hardly available. This situation was attributed to low wage bills to facilitate recruitment. In addition, the non-competitive Government employment terms have continued to constrain efforts to attract and retain the much-needed critical medical personnel especially the specialists and consultants.

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The shortage of health personnel has overstretched the available staff hence creating gaps in emergency services, specialised and holistic care which has compromised delivery of quality services. The Team was further informed that the Ministry of Health (MOH) conducted trainings of medical workers in the management of COVID19 during the 1<sup>st</sup> wave. Not so many have been trained in the 2<sup>nd</sup> wave. As such, only small fractions of medical workers in the hospitals have undergone COVID management training.

Additionally, there is a huge outcry of lack of accommodation at the hospitals. Only a few of these are able to reside in hospitals. The majority of health workers commute from home and sometimes, using public transport is inevitable in instances where transport is not provided by the hospital. Owing to the fact that these same health workers attend to the COVID patients, this situation undermines efforts to curb the spread as they are

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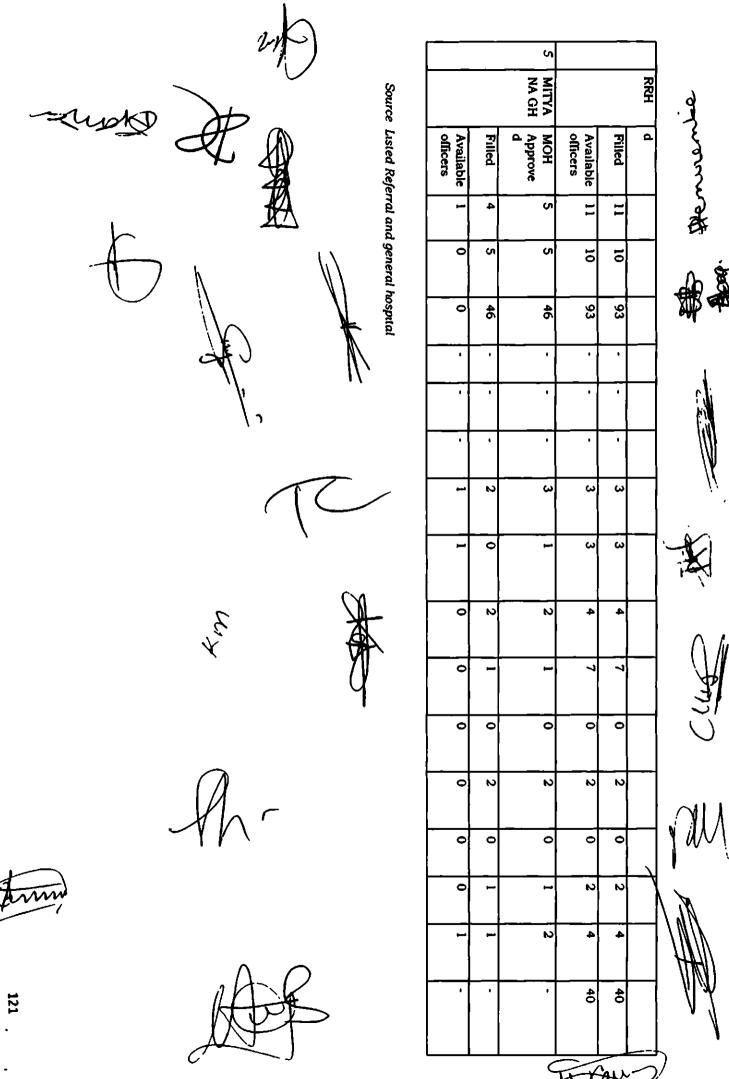
potential conduits for spreading the disease or contracting it from outside the hospital facilities.

#### Recommendations.

- i. Government should enhance salaries and benefits including housing, lunch, transport for consultants and specialists to attract and retain these cadres and all other health workers in the health sector. Where applicable, accommodation facilities for critical health workers at health facilities should be prioritised.
- ii. To curb absenteeism of health workers, the MOH and District health administration should ensure the enforcement and implementation of work performance sheet to monitor availability of health workers.
- iii. The MoFPED should avail the required wage bill to allow for the recruitment of the required health personnel in health facilities.
- **iv.** Contract staff deployed by MOH to the various regional referral hospitals should be recruited on permanent basis to supplement the existing human resource.
- v. Ministry of Health, through the Health Service Commission and District health service commission should conduct emergency response recruitments to fill the gaps.
- vi. Government through the Ministry of Health should undertake and expedite a health manpower planning and review to ascertain critical health personnel gaps with a view of a dedicated training and capacity improvement programme aimed at bridging these gaps.

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# TOR 6: CONDUCT SENSITIZATION AND AWARENESS PROGRAMS ON MASS MEDIA TO EDUCATE THE POPULATION

The team noted from feedback on radio talk shows that there were consistent complaints of police brutality, discontent regarding the criteria used in identification of the beneficiaries of the UGX. 100.00 COVID-19 relief, concerns on the efficacy and dangers of vaccines being administered, distance from vaccination centres in view of movement restrictions, questions on quality of government masks distributed, lack of facilitation for VHTs to sensitize communities, use of herbal medicine and fruits in treating COVID-19, and the high COVID testing fees at Mutukula and at Entebbe airport.

The team notes that this has been over taken by events as the Prime Minister to date has presented to Parliament a breakdown of the beneficiaries of the COVID19 relief fund which is under consideration by the relevant Committees.

#### Recommendations

Government should earmark adequate resources for mass sensitisation to the lowest Community throughout the country. Sensitization should be geared to changing the mindsets of all Ugandans about vaccination and control on the spread of COVID19.

#### OTHER MATTERS INCIDENTAL THERETO.

#### MANAGEMENT AND CONTAINMENT OF COVID-19 AT ENTEBBE AIRPORT.

It should be recalled that the COVID-19 index case entered Uganda through Entebbe International Airport on 21st March 2020. Consequently, border posts (the Airport inclusive) have remained the major sources of COWID-19 including the many new variants to-date.

The team was informed that in order to mitigate the risk of transmission, Uganda Civil Aviation Authority (UCAA) has been implementing a number of measures as directed by H.E the President through SOPs, WHO and in liaison with international aviation bodies. Consequently, COVID-19 Protocols for EIA have been developed. These include:

Standard requirement for a negative PCR test certificate obtained within 72 hour from the time of sample collection to boarding aircraft leaving the country of origin. This applies to departure as well. In order to enforce this,

countries have been categorized in three:



- Category 1 India (only returning Ugandans from India holding) Ugandan passports are currently allowed into the country). Non-Ugandans from India are only allowed in if they have spent 28 days in a quarantine Centre in a category 3 country. On arrival in Uganda, they are subjected to a PCR test at USD 65 at their cost.
- Category 2 countries include USA, UK, UAE, Turkey, South Africa, Ethiopia, Kenya, Tanzania and South Sudan.
- Category 3 all countries not in category 1 & 2. These are not subject to PCR on arrival.

The team was informed that arriving passengers from category 1 & 2 countries are subjects to a COVID-19 PCR test on arrival in Uganda in addition to the negative test undertaken from their country of origin. However, individuals from category 2 countries who have received full COVID-19 vaccination and have no signs of COVID-19 are exempted from PCR tests on arrival.

In compliance with H.E the President's directives and Ministry of health SOPs, UCAA has implemented a number of measures and modifications at the Airport to facilitate implementation of these requirements. These include:

Emphasis on wearing of face masks.

• Erection of a tent at the departure where port health formalities are handled.

• Implementation of an open lounge concept to create more space to comply with COVID-19 requirements.

- Social distancing stickers installed on the ground and on passenger waiting seats within the lounges.
- Installation of automatic sanitizers at all critical points within the terminal building.
- Temperature screening at all points of entry to the airport. An ultra-modern thermos scanner to detect temperature of any one within a radius of 30 meters on arrival, VIP and VVIP.
- Continuous and regular disinfection of Airport premises focusing on transport facilities, offices and passenger facilitation areas.

Although the team appreciated the protocols and COVID-19 containment measures instituted by UCAA at Entebbe International Airport, it was concerned about the laxity in the supervision and quality assurance mechanism in place to enforce COVID-19 PCR test compliance at the

Airport.



The team was informed that Port health which is manned by Staff of a private company known as Kazuri Medical contracted by Ministry of Health is responsible for screening of all passengers arriving and departing to and from the Airport. On the other hand, the PCR testing which is another critical stage in the control and mitigation of COVID-19 transmission through the Airport has been relegated to other private Ministry of Health Accredited Laboratory Companies. These companies are charging a fee of US\$ 65 per PCR performed. This translates to approximately UGX. 230,000 per test. It takes about three (3) to four (4) hours to get the PCR results.

The team was concerned about the cases of forgeries of PCR COVID-19 test results that have been reported despite the presence of these facilities in place.

The team could not ascertain the available means of quality assurance by the Ministry of Health to mitigate any lapses in the system. In addition, it was not clear why a different fee is charged by Test and Fly Medical Laboratory at Mutukula and Entebbe International Airport at UGX. 140,000 and UGX. 230,000 respectively.

The team was informed that in July 2021, a total of approximately 180 passengers are tested per day down from about 400 passengers previously. This translates to US\$ 351,000 per month.

### MANAGEMENT OF COVID-19 AT MUTUKULA BORDER POST.

The team established that a total of 11,768 persons were screened between March 2021 to 14th July 2021. Out of these, a total of 6,997 received their results with 110 positive cases (79 Tanzanians, 20 Ugandans, 1 Congolese, 10 Burundians and 1 Swiss). This translates into a positivity rate of 1.6%. This finding is contradicting the situation in Kyotera district where the positivity rate is reported at 19.2% and at 10.2% for Kalisizo General Hospital and Kakuuto Health Centre IV respectively.

The low positivity level reported for Mutukula is worrying given that the Ministry of Health has relegated its role of screening and testing all travelers and truck drivers, returnees to a private company Test and Fly of Microhaem Laboratory and another newly contracted MAIA medical Group Testing laboratories. The companies are charging high and non-uniform testing fees since they operate purely for profit. The team established that Test and Fly was charging UGX. 140,000 while MAIA Medical Lab, the second company, was charging UGX. 135,000 per PCR test

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Due to high charges, there is a possibility of travelers engaging in bribery as a means of evading these costs and failure of the local communities to undertake COVID-19 tests. In addition, the team noted that there is weak supervision and mechanism for quality control which could compromise on COVID-19 test results. This could partly explain why there is very low positivity rate at Mutukula as opposed to the situation reported in health facilities in Kyotera District.

#### LAKE SHORE ENTRY POINTS.

The Team established that entry points like the ones on Lake Victoria had grossly been left unattended to. In Buikwe for instance, individuals from neighbouring countries of Rwanda, Tanzania and Kenya are entering the Community without screening and testing as the shores do not have designated entry registration points. There is no measure put in place to detect the disease from incoming persons at landing sites such as Kiyindi and Senyi in Buikwe district. With this loophole, the entrance of new variants within the community through these unmanned lakeshore points is glaringly eminent.

#### Recommendations.

- i. The Ministry of Health should provide an explanation as to why the services of COVID-19 PCR test were outsourced to private companies at the border posts and the airport. The criteria used to select the companies should be provided.
- ii. Government through the Ministry of Health should strengthen the mechanism of supervision and quality assurance control of COVID-19 tests to deal with the reliability and authenticity of COVID-19 test results.
- iii. MOH should investigate all companies accredited to perform PCR COVID19 tests at border posts and those involved in forgery of the results must be immediately suspended and penalized in accordance with the law.

Regular reviews of accrediting private companies to carry out PCR COVID19 tests at the entry points should be instituted by the MOH.

All incoming travelers through the airport and other border posts should be subjected to mandatory PCR tests at their own cost.

Government should establish isolation centres at Mutukula and other border posts to contain incoming travelers who have tested positive to stop them from entering and mingling with the community.

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#### ACCREDITATION HEALTH FACILITIES TO TREAT COVID-19

The team noted that whereas the Ministry of Health accredited Mulago national referral hospital and all regional referral hospitals (save for Kawempe RRH & Kiruddu) as the traditional treatment centers and a few non-traditional such as Bombo Military Hospital, Jinja and Gulu Prisons as well as few Private and Private-not-for-profit hospitals such as Lacor, Mengo and Kibuli hospitals; private for profit hospitals such as TMR international, Kampala, and Nakasero hospitals, Case, Norvik and Medipal hospitals, Doctor's hospital (Seguku), UMC Victoria, Platinum, these are located in Kampala. In addition, with the surging numbers of COVID-19 cases in the 2<sup>nd</sup> wave, these facilities were overwhelmed necessitating the Ministry to recommend homebased care for asymptomatic and patients with mild disease.

As a result, many health centers were forced to receive and admit'COVID-19 patients without adequate facilities. Consequently, the team established that many more health facilities are currently admitting COVID-19 patients ranging from Health Centre IVs, General Hospitals, other Private and Private-not-for-profit hospitals.

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Whereas these facilities have greatly contributed to saving of many lives, without clear Ministry of Health policy, monitoring and supervision, there is a risk of registering more COVID-19 related deaths that would otherwise be avoided. For instance, the team was informed that most of the deaths that have occurred in Referral hospitals are partly attributed to delayed referrals from Private health facilities.

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In addition, many COVID-19 cases detected and managed in the non-accredited, health facilities are not being captured in the official health statistics. This casts doubt as to whether the COVID-19 data being reported by the Ministry of Health is accurate. It should be noted that without reliable statistics, there is a risk of misinformation in the planning for an effective mitigation and containment of COVID-19 pandemics.

. Recommendations

In view of the surging numbers of COVID-19 patients, Government should support General Hospitals with attendant resources critical in the management and treatment of COVID-19

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to relieve pressure on the few facilities extrently managing and treating COVID-19.

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#### Weaknesses in the distribution of the covid relief fund by OPM.

For the past few weeks after the institution of the 2<sup>nd</sup> lockdown, Ugandans were in limbo and government came forward with a message of hope to extend relief inform of UGX. 100,000/= to vulnerable Ugandans. The team noted that this was over taken by events as the Prime Minister presented a list of beneficiaries to Parliament. The same was sent to the public accounts on Central government and Local Government for consideration.

This notwithstanding, there was a huge outcry from the Communities with regards to the sluggish release of the COVID relief to the vulnerable citizens and the not so transparent process of identifying vulnerable groups. With all the well facilitated government agencies in place such as NIRA, KCCA, UBOS, NPA and public service systems, government's efforts to provide relief are seen to be clandestine in nature. It is appalling for government to be seen to be struggling to easily identify its vulnerable populace with all these institutions (facilitated by taxpayers' money) in place. Ugandans believe that institutions like NIRA should have in place a complete and reliable data base for all Ugandan citizens, KCCA should be able to easily provide data of all the different categories of workers in the city in both the informal and formal sector, and through the public service system, the none vulnerable groups should be easily distinguished to minimise incidences of sending relief to those that are not in the vulnerable category.

In essence, the government systems in place should be reliable enough to sort out this conundrum of identifying vulnerable groups. For those that could not easily be identified, the most appropriate thing to do would be to engage the lower LCs for identification of vulnerable individuals within their communities. The COVID pandemic has exposed the weakness in government's data base systems and the dire need to integrate data to guide future responses to pandemics and other eventualities.

#### Recommendation.

The Committee declines to make any recommendation to the above because the House has already referred this matter to the two Public Accounts Committees of Parliament for consideration.

#### CONCLUSION

Hon. Chair and Members, whereas there has been some government efforts and achievements in Uganda's COVID-19 management, our findings reveal that Government has rather been ad hoc in its /response. The current

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community transmission can be attributed to this ad-hocism. The government health facility preparedness to handle the pandemic is still inadequate.

I would like to appreciate the Members of the team who sacrificed and devoted time to conclude this assignment and I hope the recommendations herein will form part of the main report.

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July Charter	S IMAGING PPE OXYGEN	Infectious The non-functional C. These were largely The installed capacity of the Institute ARM only lacks an inadequate As at the plant is 15 cubic meters possible to Orthopaedic Surgeon. date of the visit, Masaka day. This is insufficient to However, the hospital RRH reported to have meet the current COVID1 strengthy needs a CT scan stock that would last not demand. The hospital and a new robust and yet they had last production capacity to the received supplies from time of at least 100 cubin NMS in less than a meters per day. This mean month.  Am.	hospital that X-RAY IS ongoing and will adequate As at the date installed capacity of the have been been delivered by controlled testing September 2021  The regents are available. It is being bor TB and cancer for TB and cancer cancer cancer cancer career that are delivered by of the visit, Naguru RRH plant is 15 cubic meters per day This is insufficient to reported to have stock day This is insufficient to that would last for not meet the current COVIDI requires UGX 77million.  The repair of the visit, Naguru RRH plant is 15 cubic meters per day This is insufficient to the reported to have stock day This is insufficient to the volid be more at the current covider production capacity to the tune of at least 40 cubic meters per day The hospita supplies froil from the current covider production capacity to the tune of at least 40 cubic meters per day The hospita supplies from the current coviders and the visit in a very poor state current available.	
Ppendix 1	U n HÖSPITAL COVID TREATMENT & MGT DIAGNOSTICS	Masaka An emergency response and management The Infe  Team of 21 members is in place.  The Team is composed of administration, CTU. HBC, Laboratory/Surveillance of Masaka regional referral hospital, security and district staff  Racility conducts OPD and IPD COVID tests. As at the date of the visit, a total of 5342 tests had been done and 1289 tests came out positive. A total of 55 health workers had contracted the disease but only 6 got out of these got admitted as they were in critical condition and 49 were moderate cases. A total of 2 and 102 deaths of health workers and other patients respectively were registered at the hospital  The hospital is in the process of constructing an ICU on the ground floor of the new MCH building (still under construction), with funding provided by MOH We are waiting for 5 more ICU beds to fill the new ICU, which is designed to have 10 beds.	Naguru An emergency response and management Gene-Xpert machine  RH Team of 12 members is in place  Facility conducts OPD and IPD COVID tests As at the date of the visit, a total of 5778 tests had been done and 1181 tests came out positive. Only 3 health workers had contracted the disease but all fully recovered  The hospital registered only 7 death of patients that succumbed to COVID All machine is being critical patients were referred out of the used for TB and hospital to Mulago Hospital and 2 patients to	

	Jak le.		
	Namanve and Roofing: Currently, oxygen produce by the plant is at 97% punt which is below th standards of medical air  The hospital requires standby generator for th plant for continuou production of oxygen whe power is not available  Echo cardiogram machine i needed for patients wit heart diseases.	The oxygen plant at the faculty has the capacity to produce 60 cylinders coxygen per day. This is insufficient to meet the current COVID19 demand.  The hospital requires standby generator to cover the entire hospital and als sustain constar functionality of oxyge plant.	130   Page
12	jund	These were fairly adequate As at the date of the visit, Mubende RRH reported to have stock that would last for not more than a month and had last received PPE consignment from NMS more than 2 months back	R Md:
James James	to diagnose COVID 19 with high resolution of over 60 slices. The maintenance costs of the current machine is too high for the hospital  Digital Mobile x-ray machine with a laser printer is needed to be stationed in CTU for management of false negative CVID 19 that presents with chest complaints. The current mobile X-ray is beyond repair.	The hospital lacked a radiologist	in in
The same of the sa	diagnosis Hospital PCR samples are being referred to CPHL for testing and results sent back to hospital	the hospital reported that the current diagnostics machine is was of poor quality and that it breaks down frequently hence inadequate to handle high volumes of sample at the referral hospital The facility requires a new high quality cobas machine is cobas machine in use because of lack of reagents, which was not being done occurrence at the facility Microbiology was an endemic occurrence at the was not being done occurrence due to lack of culture	راراد کی
	Paramount hospital.	An emergency response and management Team of 25 members is in place Facility conducts OPD and IPD COVID tests. As at the date of the visit, a total of 5675 tests had been done and 244 tests came out positive. A total of 40 health workers had contracted the disease but all fully recovered. The hospital registered a total of 32 deaths of patients that succumbed to COVID  Management reported that the hospital lacked a designated area as HDU. However, in hypothetical terms, each ward had at least 2 beds identified as HDU where oxygen and other close patient monitoring could be done. The hospital requires that real HDUs be set up at the facility.  Management reported to have received 15 ICU beds but only 6 were made functional in the temporary ICU designated area awaiting completion of the hospital building, where ICU, HDU and isolation units are to be	
He number		Mubende RRH	

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7	housed	bottles	-		
	It was further reported that most drugs used in the ICU were never available in the hospital (clexane, heparin, strong antibiotics, albumin etc)				
Mityana	An emergency response and management Team of 16 members is in place.	The hospital needs to increase the range of	The X-ray machine is non-functional and there	These were majorly adequate As at the date	There was no oxygen plar at the hospital and th
	Facility conducts OPD and IPD COVID tests As at the date of the visit, a total of 415 tests had been done and 109 tests came out	ttons, nent	is dire need to expedite the process of repairing the X-ray machine.	of the visit, Naguru RRH reported to have stock that would last for not	essential medicines for treating COVID patient were mostly unavailable
P3	positive A total of 26 health workers had contracted the disease but all fully recovered. The hospital registered only 7 death of patients that succumbed to COVID.	patients instructions requires an increase in the budget support for laboratory reasonics.		more than a month and yet the last delivery was made the same month.	Out of 40 oxygen cylinders
ARC.	The CTU is functional but requires a lot of equipment for it to be able to provide				
	adequate care to patients According to management, these include 10 hospital beds with mattresses, 10 patient monitors, 30				
<u>-/</u>	oxygen cylinders, 2 Oxygen concentrators, 4 Nebulizers, Adequate PPEs for staff, Human resource for health(2 doctors, 2 nursing				- . 49
Tr.	ollicers, 2 Assistant Nursing Officers, 5 Enrolled Nurses, 2 support staffs) paid by the Ministry of Health, Risk allowance of UGX			\ \ '	- Pr
1	80,000 daily for staff working in the CTU, One ambulance and fuel budget provision, 6 Oxygen regulators, Oxygen delivering devices				#
1/	(non-rebreather masks, simple face masks, adult and paediatric nasal cannulas), 4 glucometers, increase in the range of				
	through supply of laborate rease on the amount of dru I salbutamol, azithromycin, zir				7
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#### 5.4 NORTHERN REGION

#### 5.4.1 BACKGROUND



The Rt. Hon. Deputy Speaker constituted a Parliamentary Taskforce on the National COVID-19 Response to;

- viii. inquire into and report on Government's preparedness and response to COVID-19;
- ix. provide assessment of the health impacts of COVID-19 in the community and country at large;
- x. assess operation, administration and management of funds and other resources appropriated for them to manage the pandemic;
- xi. assess the role of private sector health care providers in COVID-19 management;
- xii. carry out field visits to assess the state of healthcare system in the Regional Referral Hospitals, both selected General Hospitals and the lower health facilities;
- xiii. conduct sensitization and awareness programs on mass media to educate the population; and
- xiv. prepare and submit a report to Parliament.

The Parliamentary Task Force on the National COVID-19 Response is further comprised of Regional Teams as follows;

#### Northern Region

	•		
11.	Hon. Dr. Charles Ayume	Team Leader	
12.	Hon. Dr. Samuel Opio Acuti	Member	
13.	Hon. George Didi Bhoka	Member V	
14.	Hon. Dr. Lilian Aber	Member \( \sqrt{1} \)	
15.	Hon. Charles Onen	Member	
<sub>1</sub> 16.	Hon. Jonathan Odur	Member Member	
17.	Hon. Ojara Mapenduzi	Member	
18.	Hon. Faith Nakut Loru	Member	
19.	Hon. Emmanuel Ongiertho	Member	
20. Hon	. Jimbricky N. Ochero	Member /	
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#### 5.4.2 SCOPE

The geographical scope of the Parliamentary Task Force, Northern Uganda team covered the greater North that is **Karamoja**, Acholi, West Nile and Longo sub region.

The conceptual scope of the Regional Teams was to;

- i. inquire into and report on Government's preparedness and response to COVID-19,
- j. assess the health impacts in the community and country,
- k. Assess operation, administration and management of funds and other resources appropriated for them to manage the pandemic,
- 1. Assess the role of private sector healthcare providers in COVID-19 management.
- m. carry out field visits to assess the state of health care systems in the Regional Referral Hospitals, District Hospitals and the lower health facilities ( selected Health Center ( HC) IV and Health Center III),

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- n. conduct sensitisation and awareness programmes on mass media to educate the population,
- o. prepare and submit a report to National Task force on COVID 19, and,
- p. consider any such matters related to Government Response to COVID-19.

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#### 5.4.3 METHODOLOGY

# 5.4.3.1 Meetings

In performing its mandate, the Northern Uganda Task Force team held meetings with the following:

vii. City Task force of Gulu, Lira and Arua

viii. District Task Force of all the districts in Karamoja, Acholi, West Nile and Acholi sub region.

ix. Government Universities that is Gulu and Lira Universities

# 5.4.3.2 Review of Documents

The Parliamentary Task Force (Northern Uganda) on the National COVID-19 Response, studied and made reference to various documents

including;

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vi. the Presidential Addresses to the Nation on the COVID-19 Pandemic since March 2020,

vii. Ministerial addresses by the Hon. Minister of Health to the public on the pandemic and the pandemic response,

viii. Written submissions by the District Task Forces

#### 5.4.3. 3 Radio Talk shows

The team conducted radio talk shows in Kitgum, Gulu, Koboko, Lira

#### 5.4.3.4 Field Visits

The Northern Task Force has conducted field activities in the regions in accordance with the terms of reference as follows;

TABLE 1; FIELD VISIT

N

	SN.	SUB REGION	HEALTH FACILITIES VISITED
ŧ	1	KARAMOJA	(xi) Regional Referral Hospitals
ľ			The team visited Moroto Regional referral Hospital
5			(xii) General Hospitals (District Hospitals)
ŀ			7. Abim district hospital
i			8. Kaboong district Hospital
			(xill) Health Centre IVs
			1.Labilatuk HC IV, Labilatuk
			4. Amudat HC IV, Amudat district
	i	ļ	5. Tokora HC IV, Nakapiripirit
4		A	9. Karenga HC IV, Karenga District
	سيلأ		10 Kotido HC IV, Kotido District
			iv) Private Not for Profit (PNFP
			3. Matany Hospital, Napak District, Missionary Hospital
	2	ACHOLI	i). Regional Referral Hospitals
		•	The team visited Gulu Regional referral Hospital
$\overline{}$			il). General Hospitals (District Hospitals)
			Kıtgum district hospital
Tru			
,,,,			(xiv) Health Centre IVs
/ (A)			Padibe HC IV, Lamwo District
ر لرصم	)	· /~.	(Pan)

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		Pajule HC IV, Pader District
		iv) Private Not for Profit (PNFP
		5. St. Mary's Hospital, Lacor Hospital
		v) Elegu Border Point
		NB/ While in the Gulu meeting, the Members invited and received submissions from the District Taskforces of Omoro & Nwoya District Local Governments and Gulu University Management
	T	(i) Radio Talk shows Radio talk show was conducted in Mighty fire Fm, Kitgum and Mega Fm in Gulu
3	WEST NILE	(xv) Regional Referral Hospitals The team visited
		1.Arua Regional referral Hospital
		2. Yumbe Regional referral hospital
	1	(xvi) General Hospitals (District Hospitals)
		5 Adjumani District Hospital
		6 Moyo District Hospital
		7. Koboko District Hospital  8. Nebbi District Hospital
		(xvii) Health Centre IVs  1. Maracha HC IV, Maracha 6. Oli HCIV, Arua City 7. Obongi HC IV, Obongi District 8. Pakwach HC IV, Pakwach District iv) Private Not for Profit (PNFP)
		4. Nyapea Hospital, Zombo District, Missionary Hospital
		NB/While in Arua, there was a joint taskforce meeting with the District Task Force of Arua, Madi Okollo and Terego, they made submission, however the team did not get to the facilities that is Health Center IVs Radio Talk shows Radio talk show was conducted in Spirit FM Border Post The team also visited a Oraba border post in Koboko district
4	Lango	iv) Regional Referral Hospitals
44		The team visited Lira Regional referral Hospital  v) General Hospitals (District Hospitals)  Apac District Hospital
	CXXX	iii).Health Centre IVs  5. Dokolo HC IV, Dokolo District
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- 6. Aboke HCIV, Kole District
- 7. Alebtong HC IV, Alebtong
- 8. Aduku HC IV, Kwania District

#### iv) Private Not for Profit (PNFP

Aber Hospital, Atapara in Oyam District

NB. The team met with the District Taskforce from Lira, Amolatar. Otuke districts and submission were received.

#### Radio Talk shows

Radio talk show was conducted on Unity FM

## 5.4.4 FINDINGS, OBSERVATION AND RECOMENDATIONS

The following key Findings, Observation and Recommendations have been identified for immediate action if the country is to effectively manage the pandemic in the short to medium term.

5.4.5 INQUIRE INTO AND REPORT ON GOVERNMENT'S PREPAREDNESS AND RESPONSE TO COVID-19:

#### i. PREVENTION

#### **VACCINATION**

The Task Force noted that all districts visited had received the Astrazeneca vaccines from March 2021 and vaccinated according to the set guidelines of frontline health workers, teachers, elderly and those with co-morbidities. Initiatially the uptake was very slow but this improved with the onset of the 2<sup>nd</sup> wave. All districts had exhausted their vaccines with minimal wastages being reported. The average first dose range from between 3000 to 5000 doses across the region.

The team further noted that vaccine uptake by health workers varied across health facilities and district. In Lacor Hospital 94% of the staff were fully

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vaccinated, and while in Gulu 55% of the staff had been vaccinated. The team also noted that of the 4 admitted staff who passed on at Gulu RRH, they was no history of having got a single dose of any vaccine.

#### RECOMMENDION

- 1
- There should be mass vaccination as guided my MOH
- · All health workers should be vaccinated fully
- Continuous mass media sensitization on the merits of vaccination

# AVAILABILITY OF PERSONNEL PROTECTIVE EQUIPMENT (PPE)

Whereas PPE was the primary guard against infection, often times health workers had attended to COVID-19 patients without adequate protection.

Despite National Medical Stores (NMS) indicating the presence of huge consignments of PPE in its stores and pledging to distribute them across the country in the second week of July, 2021, the deliveries made were insufficient to take care of the increasing demand for PPEs forcing health workers to recycle masks and disposable aprons. This comes on the backdrop of adoption of the Home-Based Care strategy and inclusion of the Village Health Teams (VHTs) among the front liners in response to the pandemic by the sector. This ultimately increased the uptake of PPE. However, there was no evidence of a proportional increase in supply to match that demand contrary to the information given by NMS.

The rising number of COVID-19 infections among health workers and the subsequent death of some was attributed to the dire inadequacy of the PPEs such as masks, aprons, goggles, surgical gloves, gum boots and consumables like had sanitizers that leave frontline workers exposed while on duty leading to infections and hospitalization which ultimately affected the confidence of the general public in the public health facilities. For example, some health facilities had been shunned by non-COVID-19 patients. In Lira Regional Referral Hospital the major challenge was PPE and this was the case in Health Facilities

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visited, provision of face masks were inadequate and other staff were repeating the use of face mask for more than 3 days. It was further noted that district hosting refugees like Yumbe, Adjumani, Obongi, Moyo and Lamwo districts were being supported by provision of PPEs and cases of infection of Health workers were lower however in Zombo during 1st wave 3 staff of Nyapea Hospital were infected and 12 during the 2<sup>nd</sup> wave

The Task Force noted that stock where limited due to the peak in June, 2021, and there is need to review the norms during peek in that PPE are provided to HC III and all Health Centers including Private not for Profits (PNFP) facilities such as Lacor, Matany, Nyapea and Kalongo Hospitals

MOH should provide clear guidelines on clear use of N95 since other health workers were using it for a week and double masking require increase in the quantity of face mask.

#### RECOMMENDATION

- The team recommends that MOH should purchased more N95 and body bags for health workers to protect the front line
- Delivery of PPEs should be streamlined with general and must be timely

#### 3. Enforcement of SOPs and Presidential directives

The TF observed that most districts visited were follow enforcing the presidential directives on curfew, lockdown, closure of places of worship, mobile markets, and schools. In Arua city, there was laxity and both human and vehicle traffic was high including nigh discos in some. This might be a possible explanation of the positive rate of 37% in Arua city. There was general compliance of SOPs in banks, hotels and government offices.

#### RECOMMENDATION

Sensitization on SOPs in all for a including mass media; and enforcement should be routine

Availability of Sanitizers and hand washing facilities

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All health facilities visited had functional hand wash facilities in place and there was evidence of their use by both patients and health workers. Automated sanitizers where found mainly in the RRHs while liquid soap and alcohol sanitizers were found at general hospitals and HCIVs. There was evidence of supply of liquid soap and alcohol based sanitizers and NMS and health partners. This practice was also observed in district offices and hotels.

#### **5.4.6 SURVEILLANCE**

The Task Force noted that while there was a comprehensive surveillance strategy to track and trace contacts of those that tested positive for the Corona Virus in the early days, with the second wave, this has not been the case. The Task Force further noted that the absence of this surveillance effort has made the containment of the spread of the virus even more difficult especially now that the spread is happening at the community level.

# 1. Functionality of District Task Forces (DTFS)

District task forces were present and functional in all districts visited and there was evidence of weekly meetings, They are chaired by the RDC and have diverse representation from security, politicians, health-workers, development partners, traditional heads and University personnel where present. Health partners supported the taskforce operations by providing fuel in kind but this is a temporary measure and government needs to shoulder this burden. The structure of the task forces cascades up to the village level. In Acholi subregion, the task force broaden to the region to encompass all the districts and this improved real time sharing of information and addressing regional challenges locally. The main challenge of all task forces was operational funds for surveillance but the respective CAOs acknowledged receipt of IPFs for the taskforce operations.

RECOMMENDATION

Ensure proper implementation of the activities stipulated in the

guidelines and financial accountability,

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2. Diagnostics: Laboratory and Imaging services.

#### a) Laboratory

Test Kits for COVID-19 were available in the districts visited in Northern Uganda and this improved surveillance. All RRHs, general hospitals and HCIVs visited were conducting RDT tests for COVID1-19 suspected cases. MOH delivered PCR machines to all RRHs making PCR testing for COVID available at regional level and a turnaround time of 2 hours. They were further collecting samples for PCR testing which were being sent to the various regional testing centers. The turnaround time was estimated at 48 hours. The team observed that geneXpert machines

Members further noted that Gene X pert machines available in all district Hospitals and currently used for detection of Tuberculosis can be upgraded for PCR test of COVID 19. This needs software installation, cartridges and a 2 day staff training. TB Gene Xpert machines were available in all general hospitals visited and some HCIVs like Dokolo, Obongi, Packwach, Aboke, Aduku, Nabilatuk, Alebtong and Amolatar HCIVs. In Adjumani hospital, TB Gene Xpert machine had been configured and was already conducting COVID PCR.

Koboko, Adjumani, Nebbi and Aber hospitals laboratories had received the Star 4 to 5 accredited laboratory certification from South Africa making them among the few laboratories in northern Uganda with laboratory results which can be used globally. This depends on the equipment, staffing and management protocols.

Phe team observed that there were stock outs of RDTs at the points of entry like Oraba in Koboko and Elegu. This had reduced the diagnostic capacities of respective districts and border entry points. For example, Elegu boarder point clears over 800 vehicles /trucks. At Oraba Border point there was no testing facility while at Elegu Border post there were two private health providers, Test

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and fly and MAIA at a fee of 150,000/=. Although the turnaround time was 2 hours, passengers were left to travel and received their results on phone.

At Elegu border there is no isololation center. When people test positive they are told to go for home based care.

Table 2: show positivity rates as of 15th July 2021

SN	REGION	POSITIVITY RATE
6	Karamoja	Amudat 21%, Napak 12%, Moroto 10%, Nakapiripirit 9%, Nabilatuk 9.1%, Karenga 5%, Kotido 6.6%, Abim 9.5%, and Kaabong 4.8%.  Amudat has an open border with Kenya and this explains the high positivity
7	Acholi	Kitgum 13%, Nwoya 14%. Gulu 8.4
8	West Nile	Arua 37%, Zombo 3% Pakwach 22%, Maracha 4.7%, Nebbi 7.9%, Adjumani 8.2, Madi Okollo 6 %
9	Lango	Otuke 13%, Alebtong 9%, Oyam 8%, Lira 13%, Dokolo 13%, Amolatar 13.5 %, Kwania 9.6%, Apac 10.2%, Kole 8.8%

#### b) X-ray services

X-ray services play an important role in monitoring progress of improvement of a COVID patient but can also help in identifying pathology in asymptomatic patients This vital service is functional in 80% of the hospitals visited but the 4 machines have a long turnaround time when they break down and functionality is hampered power outages and lack of trained personnel. Some have in the recent past been shut down by Atomic Energy Council (AEC) which accredits all imaging and radioactive devices for failure to comply to health and

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safety standards. These include lead doors and wall, lead aprons, protective googles etc. In Abim Hospital, the new X ray machine is not operational because of a wiring problem between the generator house and the X-ray room. This problem has dragged on for 7 months denying patients a critical service. In Lira RRH, the digital component of the X-rya machine is faulty and they have to rely on the manual way of reading X-rays which is longer is time consuming. The only CT scan available and functional in the greater Northern region is located in Aber Hospital Atapara, in Oyam district. This diagnostic device is also a prerequisite for all accident victims who have sustained head injury. This means the nearest access for CT-scan services for the greater north is Kampala.

TABLE 3; FUNCTIONALITY OF X-RAY MACHINES

Hospital	X-ray machine	Comment
Moroto RRH	Functional	Fund for Maintance & Operation to be provided
Gulu RRH	Functional	Fund for Maintance & Operation to be provided
Arua RRH	Functional	Fund for Maintance & Operation to be provided
Lira RRH	Functional	Digital component is non functional so reverted to manual function
	Functional	New mobile X-ray in ICU but not yet operational
Abim	Non functional	Problem with wiring from electric pole and generator
Adjumani hospital	Functional	Fund for Maintance & Operation to be provided
Moyo hospital	Functional	Fund for Maintance & Operation to be provided
Nebbihospial	Functional	Fund for Maintance & Operation to be provided

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Kıtgum hospital	Functional	Fund for Maintance & Operation to
		be provided
Koboko hospital	0	MOH to provide X ray machine
Nyapea hospital	Functional	Fund for Maintance & Operation to
		be provided
Lacor hospital	Functional	Fund for Maintance & Operation to
		be provided
Matanyı	Functional	Fund for Maintance & Operation to
		be provided

#### Recommendations

- Upgrade of TB gene-expert machines found in HCIVs and district hospitals to be able to conduct PCR for COVID.
- MOH should ensure constant supply of testing kits and these should cascade to HCIIIs to improve screening and surveillance
- funds for the procurement of the required diagnostic equipment be provided especially
- The turnaround time of servicing and maintaining medical equipment by the regional maintenance workshops should be shortened to 5 days.
- MOH should procure an X-Ray machine for Koboko Hospital

#### 3. Transport for surveillance

Transport for surveillance was a big challenge in all districts visited with some district heath offices like Kole, Amolatar, Nabilatuk, Packwach, Zombo, Pader, Lamwo and Amudat not having cars for routine health activities. This has affected robust response to community surveillance. The ministry of health has procured double cabin units and they are awaiting distribution. There is need to also procure heavy duty motorcycles for hard to reach areas.

## 4. Points of Entry

Port health services at several border points were found functional though with a number of challenges. At Elegu border in Amuru district, the port health services was handling between 200 to 300 persons daily. Management of the port health had been initially under the Ministry of health but as at February 2021, it had moved to the Amuru district. The district raised concerns on lack

of resources to support the port health and most of the resources were majorly coming in through the development partners.

At Oraba border between Koboko and South Sudan, the static testing services were closed citing limited traffic at the border. The border admits about three inbound drivers per day. An incoming truck driver has to wait for the health worker testing team from Koboko hospital, 17km away.

Concerns were raised on challenges of implementing homebased care for non-Ugandan returnee truck drivers who tested positive on the Uganda side as they returned from South Sudan. Most cannot afford to rent a place for two weeks.

Northern Uganda has a borderline with neighbouring Kenya, South Sudan and Democratic Republic of Congo. These border lines have many ungazzetted entry points making the monitoring and surveillance difficult. The borderline between Lamwo and SSudan in 150km while in Yumbe it's about 70km. Some of the neighbouring countries do not approximate with the Uganda's public health interventions making compliance and disease control difficult.

#### Recommendations

1) Port health services should be decentralized and districts should be provided with a budget to manage them.

2) There should be regional and cross border interventions to handle epidemics and pandemics like dialogues between local authorities across the borders.

#### 5.4.7 CASE MANAGEMENT

#### 1. Human Resources for Health

Inadequate human resources for health is a big challenge across all levels of health facilities visited. Whereas the staffing norm was between 50 to 70%, most of these constituted non-essential clinical workers. Specialists across all the RRHs and GHs were few with some positions being chronically vacant being advertised. Notable among these crucial anesthesiologists and radiologists. Factors responsible for this is low incentives by government to attract and retain specialists include low pay, lack of

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accommodation, lack of equipment, poor infrastructure, shortages of water and power and remoteness of some areas. The whole of northern Uganda has 2 anesthesiologists and these are employed by Lacor Hospital and this a contributing factor to the functionality of its ICU.

The situation within local government facilities is mainly affected by wage bill limitations and expiry of term of office of district service commissions. Some of the ongoing recruitments in Koboko, Moyo, were stopped by the current lock down travel restrictions. In Lamwo and Apac, the tenure of the service commissions had expired and they were not able to explain why they did not use the services of neighbouring districts. Partners like UNHCR, UNICEF and IDI have helped in bridging the staffing gaps especially nurses, medical officers and laboratory personnel. In Padibe (Lamwo) and Obongi HCIVs, 2 doctors are seconded by implementing partners since these are refugee hosting districts. In Padibe and Pajule (Pader) HCIVs, the government medical officers have been in acting position for 3 years and are being paid remuneration of clinical officers. In Aduuku HCIV in Kwania district, the two positions of medical were occupied. However, two clinical officers who took study leave and graduated as medical doctors are back in the district service and are still being paid as clinical officers because there are no vacancies for them in the district. Wage bill limitations and failure of district service commissions to execute their duties, e.g Lamwo, Pader, Moyo, Koboko, Apac has led to many staff to be in acting positions for more than 2 years. Unconfirmed allegations by some health some district service commissions workers reported that confirmations or promotions if money is not paid to them.

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TABLE 4; TABLE 4; STATUS OF SENIOR CONSULTANT, CONSULTANT

AND MEDICAL OFFICERS AT RRH						H		X	7)				-
	RR	LHs		_		<u> </u>	G	Hs			_		
Cadre	Moroto	Gulu	Arua	Lira	Yumbe	Adjumani	Moyo	Kabong	Nebbi	Abim	Apac	Koboko	
20.14													
Anaesthesiologists	0	0	0	0	0	in the second	Ciln III						
Surgeons	0	0	0		0				a tila i i i Vida i A	1		12.3	
'aediatricians	0	0	0	0	0								121 141 121 131 131 131
Obs/Gynae	1	0	1	0	0							136 64	ر در
hysicians	0	0	0	0	0								
Radiologists	0	0	0	0	0	ا الرسوية بالقامية المراسية ا			in a light of the control of the con			Marian Sanah	
the second						الكالأطبيان والتمانية بعدرة	ali sa Ma	سنبها باز بر با	- or - gard - 2- ab	(I Kurta, Tiers, 19)	Manager Market	t in Controlled a basis on f	10.10.05 (N)
Anaesthesiologists	0	0	0	0	0					I Maria	F: 25 e		
Surgeons	0	0	0		0	O III	100	Habitat See See L				W. Color	
'aediatricians	0		0		0							3 61 3	
hysicians	0		1		0		140	الله الله الله الله الله الله الله الله					
Obs/Gynae	ı		0		0				الاستواد الاستواد الاستواد الاستواد الاستواد الاستواد		M. T	4	
<b>Region State</b>	0		0		0		Dig pr						
10						The Water of the Control of the Cont	t, king pr	a amii 1187 a Mala kabusail — 44	المثلاث المستقدم والمثلاث والمثلاث المستقدم والمثلاث	ar hardrinnal (, ) iic.	i vi	)	11
Surgery	0	ì		0		1	0	1	0	0	0	0	
'aediatrics	1	1	1	1	0	0	0	0	0	0	0	0	
<del></del>		<del>!</del> -	<u> </u>	<u> </u>	<u> </u>	<del></del>	L	<del></del> _	<u> </u>	<u> </u>	<u> </u>	<u> </u>	





	RRHs				GHs							
adre	Moroto	Gulu	Arua	Lira	Yumbe	Adjumani	Moyo	Kabong	Nebbi	Abim	Apac	Koboko
nternal medicine	0		0	0	0	0	0	0	0	0	0	0
)bs/Gynae	0	1	1	0	1	I(MTI)	0	2	0	0	0	1
ublic health Splst	3	3	0	1	0	0	0	0	0	0	0	0

#### NOTE:

- > 9 senior Gulu university staff are working at Gulu regional referral hospital at while the university pay them at 15M per month Government pay 5.5m per month
- ➤ Kabong hospitals has 4 senior medical officers, Moroto has 4 medical officers, Arua has 4 medical officers and 7 seconded by partners like UNICEF and IDI, Abim has 5 medical officers, Kitgum has 4 medical officers, Kabong has 4 medical officers, Moyo has 4 medical officers, Yumbe 7 medical officers, Adjumani 4 medical officers, Nebbi 4 medical officers, Moroto RRH has 14 medical officers on payroll but 5 are on study leave. The orthopaedic surgeon is paid as a medical officer. Apac has 1 senior medical officer and 4 medical officers.

#### RECOMMENDATION

- MOH should review the Policy on hard to reach allowances.
- GOU staff be seconded to PNFP facilities
- MOH should recruit and fill vacancies of especially critical staff in RRHs.
- MOFPED and ministry of Public Service should lift wage bill limitations especially at Local Government.
- The activities and allegations against district service commissions should be looked into by ministry of public services

2.ISOLATION AND COVID TREATMENT CENTRES

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The current ministry of health guidelines limits case management to the national and regional referral hospitals. However, all RRHs and GHs visited and a few HCIVs like Obongi, Packwach and Padibe had improvised either permanent or temporary isolation and treatment centres. Some of the GHs and HCIVs had used support of health partners like UNHCR, UNICEF, World Vision, Plan to be able to achieve.

GHs and some HCIVs were able to provide oxygen for mild to moderately ill patients and referred critical ill patients.

Padibe and Obongi are model HCIVs in terms of case management. It was observed that there was need to empower HC IIIs, HC IVs and district Hospitals to have isolation units. Districts with isolation units showed low positivity rates e.g Obongi and Lira city.

Some HCIVs like Karenga and Nabilatuk in Karenga and Nabilatuk districts need urgent attention by MOH interms of infrastructure, staffing, laboratory and equipment. In Nakapiripirit, Tokora health Centre IV, one room had been reserved within the female ward for management of Covid-19 patients .It did not however, have a dedicated bathroom. A separate facility that had been constructed two years back with a 10 bed capacity was available. However, due to lack of water and power at the facility the infrastructure had remained unutilized. Alebtong health centre IV had handled emergency caesarian cases in which the patients were later on diagnosed to be infected with covid-19 resulting in them being managed at the facility.

The new Yumbe RRH had a new isolation center, fully equipped but the MOH has not accredited it for treatment and isolation or COVID 19 management. The hospital was still receiving funding for a general hospital for both recurrent expenditure and wage bill. This means it cannot function at optimum level.

RECOMMENDATION

Vinistry of health should revise its treatment policy to allow for opening up of covid-19 treatment units at health centre IVs and district hospitals.

Resources to be provided to support their set up and risk allowances to be paid to medical workers at these facilities.



- The Task Force recommend that ICU should be installed in all the Regional Referral Hospitals and staff trained to operate ICU.
- Operational and staff recruitment funds for Yumbe RRH should be expeditiously availed for it to function as a RRH. It's isolation and treatment unit should be operationalized since it has the requisite furniture and should be equipment. This unit can also be earmarked for an ICU or HDU as an immediate measure for critical care.
- Oxygen production in RRHs should be scaled up

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#### 2. INTENSIVE CARE UNITS

All regional referral hospitals had temporary housing for ICUs but they did not function as ICUs. MOH had delivered 10 ICU beds, ventilators, oxygen concentrators and an assortment of ICU equipment but most of these were not operational. This is because of lack of adequate space, inadequate power and lack of intensivists. Lacor hospital has the only functional ICU in northern Uganda and acts as referral point even for critical patients from Gulu RRH. It is headed by two anaesthesiologists and 28 permanent staff dedicated to the COVID management in both the ICU, HDU and isolation ward.

All ICUs in the public RRHs operating as High Dependency Units (HDUs). They were able to monitor and manage moderate patients but referred critical patients to either Lacor or Mulago hospitals if the oxygen saturation dropped beyond 80-85%.5 ICU beds had been installed at Moroto regional referral hospital out of the 10 planned. It was further noted that the ANC ward in Gulu had been remodeled into a COVID ICU and works are expected to be completed by end of July 2021. The Arua ICU, currently being run as an HDU is housed in improvised space on the In-patient building. Of the 10 ICU bed, 8 were to be installed because of space. Funds have been secured by MOH to build a standalone modern ICU complex. Regional power outages will be a huge determinant for operationalization of ICU equipment.

The task force observed that in the grater North, the 1st CT scan was being installed at Aber Hospital, Atapara in Oyam district, previously patients were transferred to Kampala for CT scan. The CT scan was to be operationalised by the end of July, 2021

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## 3. AVAILABILITY OF OXYGEN AND FUNCTIONALITY OF OXYGEN PLANTS

The oxygen plants visited in the 4 RRHs were functional and able to provide optimal amounts of oxygen at stable consumption load. Consumption depends on severity of the patients. Very critically ill patients might exceed the average consumption of 2 to 4 per day and consume upto 6 cylinders per day. A case in point is the week when Soroti RRH had many patients with low saturating oxygen and had to rely on additional cylinders from Moroto RRH. The technician alluded to the fact that production capacity of these plants can be increased by installing a high output compressor as opposed to new procurements in the short term. Some hospitals and lower facilities complained of long turnaround times refill their cylinders from the RRHs while Aber complained that Lira RRH was charging them a small fee for refill. Aber and Apac hospitals have opted to get their refills from Kampala which is very costly.

TABLE 5; OXYGEN PLANT AND NUMBER OF CYLINDERS

Hospital	Functionality	Output	Av daily consumption	No of Cylinders
Moroto RRH	Fully functional	57 cylinders/day	< 20	45
Gulu RRH	Fully functional	40-50 cylinders/day	<30	76
Arua RRH	Fully functional	50 cylinders/day	<30	46
Lira RRH	Fully functional	40-50 cylinders/day	<30	42
Lacor Hospital	Fully functional	14,000cc per hour	14,000cc/patient	42
Matanyi	Fully functional	14,000cc per hour	14,000cc/patient	12
matanyi			14,000cc/patient	12

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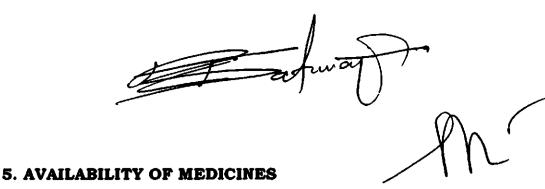
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There is evidence that NMS continues to deliver essential medicines and supplies bimonthly as shown by the delivery notes. In regional referral hospitals, medicines used for treatment of COVID like Azithromycin, Zinc and Vitamin C were delivered but some experienced stock outs before the end of the 2 months delivery cycle. Vitamin D was not delivered to the facilities. This forced patients to go and buy medicines that were out of stock. Zinc was out of

In general hospitals and HCIVs, there was no special addition of the above supplies in the regular bimonthly deliveries. Therefore facilities depended on the essential medicines stock for regular health services and the good will of partners.

stock in both higher and lower health facilities and the pharmacists were

extracting the zinc found in the paediatric homapak kits.

#### 6.HOME BASED CARE

The team noted that in northern Uganda, Home base care had its challenges in rural settings because of the nature of the houses. Self isolation was not practical and this contributed to infection of family members. This situation is worse in refugee settlements where the shelters are very small and congested. The homeless and destitutes cannot also fit into the services of homebased care. This situation has triggered some districts and refugee settlements to start isolation centres in health facilities that have adequate space.

#### Recommendations:

i. MOH should open up its policy on homebased care to allow for isolation centres in hospitals and HCIVs to care for patients who have challenges of adequate housing.

PSYCHO-SOCIAL SUPPORT

Given their distant placement from the main hospital services, the psychiatric units in all the RRHs have been converted into COVID isolation and treatment centres. This has affected the psychiatric services which have had to be relocated to small spaces within the hospitals. There is a lot of stigma attached to COVID patients during and post recovery. Cases of mental depression and aggressive behavior during management of COVID patients have been cited meaning clinical and psychosocial support is vital.

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Table 6: Morbidity in General Population and Health Workers

District	Number of positive cases	No of positive health workers
LABILATUK	44	5
GULU	730	86
MOROTO	922	·
KABOONG	36	8
KITGUM	361	05
КОВОКО	103	6
YUMBE	349	55
AMOLATAR	182	10
PAKWACH	125	2
NAKAPIRIPIRIT	67	00
KOTIDO	23	6

Table 7; Mortality in General Population and Health Workers wave 1 and 2

District	Number of deaths	Health worker deaths
YUMBE	7	1
AMOLATAR	3	0
KITGUM	6	1
PAKWACK	1	0
КОВОКО	5	0
NAKAPIRIPIRIT	1	0
GULU	17	2
LABILATUK	0	0
KABOONG HOSP.	0	0
TOKORA HC IV	0	0

Recommendations:

Psycho-socio support and clinical management of COVID psychiatric illness should be identified and

integrated into the management plan.

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iii. Temporary tents be provided to all District Hospitals and HC IV for isolation centers in order to free up the psychiatric units.

### **5.4.8 AMBULANCE SERVICES**

Lack of ambulances for movement of patients between points of care was a general complaint across the region. All the regional Referral Hospitals had received new Landcruiser class B ambulances under the national emergency services fleet. These are compartmentalized from the driver, fitted with first modern aid kits, oxygen cylinders and basic resuscitation equipment like face masks and ambubags. The availability of ambulances varied across districts/facilities visited. No facility had a class C ambulance which is the advanced resuscitation and evacuation vehicle. Most ambulance with in the region were class A ambulances which are vans or land cruisers or Nissan double cabins that are only serve the purpose of transportation. The new ambulance delivered to Arua RRH was stolen in March 2021 and has never been recovered to date. The case was reported to police and investigations are ongoing.

Other lower facilities across the region had received either part of the new ambulances like Pader HCIV and Koboko hospital while other had old fleet or non at all. (Refer to Table 8) A general hospital like Abim does not have a functional ambulance to support referrals to Moroto RRH which is more than 140 km away. In general, the facilities decried lack of sufficient amounts of fuel for the emergency activities. The in-charges of all health facilities visited reported that the running costs like fuel and lubricants were beyond what is provided in the budgets hence sometimes patients and well-wishers have to contribute to referral costs. The standard landcruiser ambulance has a double fuel tank totaling to 180 litres of diesel which is ~ 680,000/. In refugee hosting districts like Arua, Adjumani, Moyo, Lamwo, the ambulance services are slightly better due to health partner support.

**TABLE 8: AMBULANCE SERVICES** 

District	Health facility	Туре А	Source	Туре В	Source	Number
Moroto	Moroto RRH	1	мон	2	MOH ( lnew LC, l Cl9 van)	3
Napak	Matanyihosp	3	Partners	2	Partners	5
Nabilatuk	Nabilatuk HCIV	0	•	0	<del> -</del>	0
Nakapırıpıt	Tokora HCIV	1		<del>                                     </del>	<del>- </del>	1
Amudat	Amudat HCIV	1				1

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Kotido	Kotido HCIV	1	Partners	0	·	1
Karenga	Karenga HCIV	0	·	0	:	0
Kıtgum	Kitgum hospital	1	мон			0
Lamwo	Padibe	1	мон	1	(Partners)	1
Pader	Pajule HCIV	1	MP	1	MOH (New)	2
Gulu	Gulu RRH	1	МОН	2	MOH (1New)	3
Gulu	Lacor	2	Partners	0	<del></del>	2
Omoro		0	<del> </del>			0
Amuru		1	Partners		_ <del>_</del>	1
Adjumanı	Adjumanı hospital	5	2 MOH	3 Partners		5
Moyo	Moyo hospital	0		1	мон	1
Obongi	Obongi HCIV	2	Partners/	0	•	2
			community			
Yumbe	Yumbe Hospital	1	мон	1	MOH (New)	2
Koboko	Koboko hospital	3	MOH/MP	1	MOH (New)	4
Maracha	Maracha HCIV	1				-
Arua	Arua RRH	2	мон	0 (Stolen)	MOH (New)	2
Terego	District	5	Partners			5
MadiOkollo	District	2	Partners	:		2
Nebbi	Nebbi hospital	1	мон	0		1
Zombo	Nyapea hospital	1	Partners	0		1
Packwach	Packwach HCIV	1 (old)	мон	0	<del>-</del>	0
Oyam	Aber hospital	2	Partners	Ō	•	2
Lıra	Lira RRH	2	МОН	ī	MOH (New)	3
Dokolo	Dokolo HCIV	1	мон	0	•	ī
Amolatar	Amolatar HCIV	1	мон	·		1
Otuke	Otuke HCIV	1	мон			1
Allibeong	Aleptong HCIV	1	мон			1
Kelé	Aboke HCIV	1	мон	0	•	1
Apac	Apac GH	1	мон	0	- 1	1
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Recommendations



- Inventory of ambulances which includes their availability and functionality needs to be established.
- Hospitals and HCIVs in dire need of ambulances like Abim, Apac Amudat, Kole, Amolatar, Karenga, Packwach, Aleptong, Nabilatuk should be given priority during distribution
- The national emergency response services with command and dispatch centres at regional level needs to be fast tracked by MOH

#### **5.4.9 OTHER KEY OBSERVATIONS**

#### 1. Risk allowance

The task Force noted that, at the time of their visit, health workers acknowledged that they had started receiving arrears of their risk allowances. They complained of that delays in payment for more than 6 months in some districts was a big motivating factor especially in times of such a pandemic. The 30% tax levied on this allowance was another complaint raised by both health workers and DTF e.g from 80,000/ for the highest category to 56,000/ after taxes after taxes.

It was difficult for health workers who had contracted COVID or families of health workers who had died of COVID to access their compassionate allowance. The processes were very slow and bureaucratic and some had given up.

This allowance is limited to staff working within the COVID isolation, treatment and ICUs/HDUs. However, health personnel in other points of care like OPD and maternity argue that they also come into contact with COVID patients and should also benefit from this allowance. The same concern has been raised by the askaris/gatemen and ambulance driver. Note: some of these ambulance have no partition between the patient compartment and the driver put him at higher risk.

PNFP hospitals staff were not paid risk allowances by government but in some. for instance Lacor, Matany, Aber and Nyapea, the team observed that Government should provide risk allowances to PNFP Health facilities.

## Recommendations:

MOH should streamline the payment of risk allowances to avoid delays that demotivate staff.

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- ii. The category of beneficiaries of receipients should either be broadened and the amount received based on risk of exposure.
- iii. Given the nature of the pandemic, an amendment by parliament to the tax of this risk allowance will greatly motivate the healthworkers.
- iv. Risk allowances should be distributed to PNFP staff as well and in timely manner

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#### 2. INFRASTRUCTURE

There were various observations in regard to infrastructure for health at the various districts. There is evidence in investment in health infrastructure across the region especially in the areas of maternal child health except in the Karamoja subregion. Some hospitals have received face lifts and new infrastructure in the last 5 years like Yumbe, Moroto, Moyo, Nebbi, Koboko, Anaka and selected HCIIs being upgraded to IIIs with new maternity units. Health partners like IDI, UNHCR, World Visiom, Plan etc have also invested in health infrastructure In Pajule health centre IV in Pader district a new theatre had been constructed by IDI

In Karamoja sub-region, there is a huge challenge with lower level infrastructure in terms of number and the state e.g Nabilatuk HCIV. In Lango subregion, there is only one GH and a RRH. Apac GH hospital though functional has dilapidated structures and needs a face lift. In Kitgum hospital, the OPD unit which had been constructed recently had been put out of use due to the shoddy works. Mortuaries in Kitgum, Arua and Terego Mortuaries are dilapidated.

Housing for staff is a major complaint raised by health workers especially in Moroto where the cost of rent is high. This has led to high turnover of newly deployed staff citing this issue.

deployed staff citing this issue.

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- Ministry of health should come up with a renovation plan for all the district hospitals and health centre IVs to ensure appropriate infrastructure for the facilities.
- Need to build adequate accommodation for staff

3.UTILITIES

The entire northern region though connected to the national or regional grids had challenges of power outages and this affected running of equipment like imaging and laboratory machines. It also destroyed sensitive machines like CBC and chemistry machines. This further puts the future of the yet to be installed ICU machines at risk. Some facilities were also grappling with high bills and arrears. Some hospitals have disconnected staff quarters from the main hospital line and installed self pay meters as a way of cutting down power bills.

There was access to clean and safe water in all RRHs either from the NWSC or from solar driven motorized bore holes in the facility compounds. This was the same for the general hospitals visited but there was break down of the installed submersible pump in Nebbi hospital and they were relying on the NWSC supply. The hospital has arrears of 600 million shillings and has agreed to pay 15 million shillings per month using their PHC nonwage grant. The staff quarters were disconnected and put on self pay metres. HCIVs mainly rely of water harvesting or boreholes but these are broken down in most cases. In Padibe HCIV, World Vision had sunk a solar powered motorized bolehole. There is potential for water harvesting in all health facilities visited but this has not been fully utilized.

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EFFECT OF COVID 19

The population in northern Uganda practices mixed farming, fishing and pastoralism as one of their primary sources of income. Closure of the cattle markets

and weekly food markets has grossly affected their incomes. This was further worsened by the poor crop yields in the first season due to the harsh weather noted in Lango, Acholi and West Nile sub-regions. Closure of cattle markets in Karamoja sub region had rendered many locals unemployed as most rural districts depend on the sale of cattle and other animals.

Among the social impacts observed was increased teenage pregnancies and early marriages. In Karamoja sub region, due to the difficult socioeconomic conditions caused by closure of cattle markets, some parents have married off girls as young as 12 years for dowry and financial gain. In Amudat district the task force visited a shelter at Kalas Girls primary school where 25 victims/ escapees from early marriages where being kept by the school management under the care of the head teachers, Sr. Pross Nantege. The school provides basic needs to the girls. The primary school was found hosting 25 girls of schools going age. These girls were escapees who had run away from their homes to escape from early child marriages which had escalated due to the harsh socio-economic conditions. In Yumbe district a boda boda man had impregnated 13 girls of whom one was under aged. The case was reported to Police and he is on the run.

During all the district task force meetings, it was acknowledged that the COVID relief funds had been received but the number of beneficiaries were inadequate compared to projected figures by districts. Prior to the registration process, there was rural to urban migration for people to access the lists. It has also caused anxiety and complaints by sections of the population who did not benefit.

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#### Recommendations

Closure of cattle markets and food markets during lockdowns should be reviewed and SOPs to provide for their continued operation looked into. Short of this, government needs to provide relief funds to this category of people.

Government needs to intervene among communities that have been affected by the harsh weather conditions in Acholi,Lango,West Nile and Karamoja sub-regions.

Schools providing shelters to young girls to safeguard them from early marriages and teenage pregnancies need to be allowed to emain open and be supported.

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• The number of beneficiaries of the COVID relief fund in municipalities and cities should increased and extended to town councils.

4.1.7 OPERATION, ADMINISTRATION AND MANAGEMENT OF FUNDS AND OTHER RESOURCES APPROPRIATED FOR THEM TO MANAGE THE PANDEMIC;

#### 5.4.10 COVID-19 FUND

The Task Force noted that all districts received COVID-19 funds however the utilization of the funds were provided by the centre and IPFs are given with guidelines on how the funds were to be used with no flexibility on the utilization of the funds and that other districts had more partners contributing towards health care while other districts had no partners at all.

The team noted that each VHT were to receive 400,000 and in the event where VHT are less or more than four and each member were to receive 100,000

The team also noted that only Municipalities and Cities were provided with the relief fund and not all the eligible beneficiaries received the funds and Local Government could not explain who benefited or not because they could not access the systems and that the list of beneficiaries were not published before submission

The Taskforce noted that each district received UGX 165,000,000 as supplementary funding for Covid-19 in the first wave. It was also noted that Districts Municipalities and Cities received varying Indicative Planning Figures (IPFs) for the second wave (see annex for details). These resources were given with the same specific expenditure guidelines across all districts leaving no flexibility to attend to unique needs.

It was also observed that some districts host refugees and yet received the same funding as those that don't host refugees. The presence of refugees significantly impacts the already meagre budgets.

Some districts taskforces like Nyowa, Gulu received money that was supposed to be returned to the National treasury by area Members of Parliament.

However, money returned to the national treasury by some Members was not

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resent to their respective districts. For instance, Omoro District didn't receive UGX 60,000,000 that was returned by the area MPs.

### Detail on Funding attached as Annex 1

#### RECOMMENDATIONS

- The Task Force recommends that a COVID-19 Fund should be provided to all the eligible vulnerable groups/persons.
- The list of beneficiaries be published for transparency and accountability
- Covid relief funds and donations should be accounted for to obtain public trust

### Contribution by PNFPs in the fight against COVID 19

The team observed that the hospitals of Matanyi (Napak district), Lacor (Gulu district), Nyapea (Zombo district) and Aber (Oyam district) played a significant role in the management against COVID in the greater northern region. They are also part of the district task forces. These hospitals have isolation and treatment units, diagnostic services like RDTs and imaging services like X-rays and a CT-scan in the case of Aber hospital. Their laboratories are operating at full capacity with tests like Chemistry, Microbiology and Haematology which are important for monitoring of clinical parameters. The CT-scan at Aber is the only one in the entire northern region. The administration at Lacor hospital implored the team to follow up on a presidential pledge of a CT-scan made 2 years ago.

Government supports PNFP hospitals with PHC non wage grant of 600 to 700 million shillings per year and general vaccines. In addition, Lacor

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hospital received 10 ICU beds, oxygen concentrators, ventilators and PPEs from MOH. However, some like PNFPs like Lacor hospital are high clinical output hospitals and act as referral points in the entire region. The hospital requested for an increment of PHC non-wage grant to about 2 billion shillings. They also appealed for secondment of staff to cater for this funding gap and an ambulance from government.

As reported in the previous sections, Lacor and Matanyi have piped oxygen for use in their wards and covid treatment units. They charge a compound fee of between 50,000 to 70,000/ for admission, laboratory tests, medicines and related consumables and feeding. Whereas PNFPs run a low cost model of clinical care, they rely on both local and international donors to cushion the cost that would ordinarily be met by the patient. Lacor hospital has an annual budget of 24 billion ugx and this partly financed by PHC grant from GOU, user fee charges and 60-70% is financed by donations.

Recommendations:

MOH should support increase support to PNFPs since they provide a service to Ugandans.

- Human resources for health
- PHC non-wage grant
- Infrastructure & equipment
- Ambulances

The presidential pledge of the CT-scan machine for Locor hospital should be followed up.

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Community Engagement

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The task force noted that there was functionality and representativeness of the district taskforces across different sectors, health partners and it also included political structures. These stakeholders help in transmitting information horizontally and vertically. The task force members acknowledged that the knowledge, attitude and practices toward Covid-19 has improved in wave 2 compared to wave 1. They attributed this to the local down, national wide presidential addresses and locally initiated talk shows

As part of their corporate social responsibility, radio stations routinely or in times of need have a government radio hour given to the office of the RDC once a week. This has helped most task forces to reach out to the community through mass media. The challenge is some of the allocated slots are not prime time. In Kabong district, there is no local FM station meaning the radio programmes have to be conducted in Kotido district which is 70km away on a marram road. In Amudat, because of the terrain, Kenyan radio signals are better meaning the radio shows of the taskforce have to be held in Kenya.

The task force observed Information Education Communication (IEC) materials pinned up in health facilities but these were not enough and most were in the English language.

The task force held radio talks shows on The team as well had radio talk show in Mighty Fire FM in Kitgum, Mega FM in Gulu, Spirit FM in Koboko and Unity FM in Lira districts. It was to explain the objective of the field visits and the findings. Most of the listener feedback was about the need for vaccines and COVID emergency funds not benefitting of the emergency COVID funds.

#### **Recommendations**

• Scale up sensitization and awareness programs on mass media

• MOH should train local FM DJs, news anchors and journalists on the COVID 19 pandemic and avail frequently asked questions on COVID-19

• MOH should increase IEC materials on COVID in the local

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#### **5.4.11 CONCLUSION**

Uganda's health sector like many other sectors has been hit by the COVID-19 pandemic. However, despite its challenges, the health sector has remained resilient and health facilities have continued to deliver key services like outpatients care, in-patients care, general immunization, maternal and child health, reproductive health, surgical and HIV/AIDS services.

The findings in this report do not only attempt to provide redress for COVID-19 related gaps but benefit the general health services. The parameters captured in this report have presented an opportunity for parliament to have a snap shot of the current health services beyond COVID-19. Human resources for health, funding, equipment, medicines and health supplies and health infrastructure should be addressed immediately and long term. Non-health actors like electricity and water augment health services and should be addressed in tandem. Ministry of health's strategy for management of diseases across the board should focus more towards prevention than curative which is more costly in the long term. COVID-19 management should be multisectoral and integrated into mainstream health services as opposed to a vertical programme. The ultimate solution to COVID-19 and future pandemics is vaccination.

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Annex 01.: Covid 19 funding to districts, Cities and Municipalities

	Entity	Wave One	Wave Two
1	Gulu City		201,200,000
2	Lira City		244,400,000
3	Arua City		338,400,000
4	Kotido Municipal Council		143,200,000
5	Nebbi Municipal Council	•	118,400,000
6	Apac Municipal Council		138,800,000
7	Koboko Municipal Council		114,400,000
8	Kitugum Municipal Council		117,200,000
9	Moroto Municipal Council		104,800,000
10	Terego District	165,530,299	300,400,000
11	Karenga District	165,530,299	241,200,000
12	Madı-Okollo District	165,530,299	264,800,000
13	Obongi District	165,530,299	210,400,000
14	Kapelebwong District	165,530,299	286,400,000
15	Kwania District	165,530,299	328,800,000
16	Nabilatuk District	165,530,299	188,400,000
17	Pakwach District	165,530,299	383,200,000
18	Omoro District	165,530,299	333,200,000
19	Kole District	165,530,299	384,400,000
20	Nwoya District	165,530,299	198,400,000
21	Napak District	165,530,299	288,400,000
22	Albetong District	165,530,299	440,000,000
_ 23	Zombo District	165,530,299	450,800,000
24	Otuke District	165,530,299	360,400,000
25	Lamwo District	165,530,299	360,800,000
26	Amudat District	165,530,299	316,000,000
27	Maracha District	165,530,299	426,400,000
28	Dokolo District	165,530,299	343,600,000
29	Abim District	165,530,299	363,600,000
30	Oyam District	165,530,299	587,600,000
31	Amuru District	165,530,299	231,200,000
32	Amolator District	165,530,299	382,000,000
33	Koboko District	165,530,299	308,400,000
34	Kabong District	165,530,299	331,200,000
35	Yumbe District	165,530,299	613,600,000
36	Pader District	165,530,299	498,400,000
37	NebbiDistict	165,530,299	386,000,000

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	Entity	Wave One	Wave Two
38	Nakapirıpiriti District	165,530,299	233,600,000
39	Moyo District	165,530,299	239,200,000
40	Moroto District	165,530,299	238,400,000
41	Lira District	165,530,299	366,800,000
42	Kotido District	165,530,299	303,200,000
43	Kitgum District	165,530,299	407,600,000
44	Gulu District	165,530,299	216,400,000
45	Arua District	165,530,299	252,800,000
46	Apac District	165,530,299	265,600,000
47	Adjumani District	165,530,299	234,400,000

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#### 6.0 **RECOMMENDATIONS ON CROSS CUTTING ISSUES**

Rt. Hon. Speaker and Hon Members,

The Parliamentary Task Force on the National COVID-19 Response successfully concluded its field activities prepares its final submission to this August House, the following cross cutting issues have been identified for immediate action if the country is to effectively manage the pandemic in the short to medium term.

#### 6.1 THE URGENT NEED FOR MASS VACCINATION

The Task Force was informed by the Ministry of Health that Vaccines are the safest and most cost-effective, proven public health intervention for the prevention, control and even eradication of infectious diseases including COVID-19. This is especially critical for COVID-19 since it has no known cure.

It is far cheaper to vaccinate the 22,000,000 eligible Ugandans above the age of 18 years compared with the direct and indirect costs of COVID-19 management such as cost of care, treatment and loss of lives, implementing control measures countrywide, cost of enforcement of SOPs and the impact of the lockdowns on the economy.

The Ministry of Health informed the Task Force that Uganda had cumulatively received 1,139,260 doses of AstraZeneca vaccine for its target population of 22 million people (44,000,000 doses). Todate, 185,170 persons are fully vaccinated while 687,744 persons has received at least a single dose.

The Ministry of Health is expecting Donations of vaccines as follows;

SN	Donor	Vaccine Type	No. of Doses	Time Period
1.	COVAX Facility	AstraZeneca	18,000,000	2021 and 2022
2.	France	AstraZeneca	175,200	June 2021
3.	Norway	AstraZeneca	286,080	August 2021
4.	Unites States	Pfizer	647,000	August 2021
5.	India	AstraZeneca	100,000	March 2021
6.	China	Sinovac	300,000	July 2021

TOTAL DOSES

19,508,280

Furthermore, according to the Minister of Finance, a budget provision of UGX. 560.84 billion had been availed in FY2021/22 to manage the COVID-19 pandemic of which UGX. 80bn is a GOU resource under National Medical Stores and UGX. 480.84bn is external funding arising from the World Bank to the Ministry of Health.

The Task Force noted that the total budget requirement for AstraZeneca (Vaxzeveria EU) for the 44m doses to cover all the 22m eligible Ugandans amounted to UGX. 875,228,447,000 (USD. 236,548,229) and proposes that funds should be pooled from Government MDAs that have been adversely affected by the pandemic such as the Education Sector and reserved for the purpose of a mass vaccination drive.

#### 6.2 INADEQUATE PERSONAL PROTECTIVE EQUIPMENT

Whereas PPE was the primary guard against infection, often times health workers had attended to COVID-19 patients without adequate protection. Despite National Medical Stores (NMS) indicating the presence of huge consignments of PPE in its stores and pledging to distribute them across the country in the second week of July, 2021, the deliveries made were insufficient to take care of the increasing demand for PPEs forcing health workers to recycle masks and disposable aprons. This comes on the backdrop of adoption of the Home-Based Care strategy and inclusion of the Village Health Teams (VHTs) among the front liners in response to the pandemic by the sector. This ultimately increased the uptake of PPE. However, there was no evidence of a proportional increase in supply to match that demand contrary to the information given by NMS.

The rising number of COVID-19 infections among health workers and the subsequent death of some was attributed to the dire inadequacy of the PPEs such as masks, aprons, goggles, surgical gloves, gum boots and consumables like had sanitizers that leave frontline workers exposed, while on duty leading to infections and hospitalization ultimately affected the confidence of the general public in the public health facilities. For

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example, some health facilities had been shunned by non-COVID-19 patients.

The Task Force noted that there was a communication gap between Ministry of Health, Ministry of Finance and National Medical Stores with regard to planning, budgeting and execution of the budget respectively

#### 6.3 OXYGEN, ICUS AND STAFF FOR ICUS

Health facilities were in dire need of ICU space, assorted equipment such as standard ICU beds, enough Oxygen and oxygen cylinders, oxygen concentrators, humidifiers, Oxymeters among others. Whereas in Mbale RRH works were ongoing to complete part of the surgical complex to create space for ICU, in some facilities, there was need to remodel the facilities to host ICU beds and equipment.

Further there was acute shortage of oxygen for use in Intensive Care Units (ICUs) and High Dependency Units (HDU). Most health facilities had less than 40% of the daily oxygen requirements and less than 50% of the needed oxygen cylinders. Availability of oxygen\_was reported to be between 30-35%.

The situation was worsened by the inability of the RRHs to produce enough oxygen for both themselves and the lower health facilities due to low capacity of the oxygen production plants that cannot match the current need. Hence, RRHs take longer than expected to supply oxygen to lower facilities while in some instances, they completely do not give any oxygen.

Due to high demand for oxygen, some health facilities such as Mbale reported theft of oxygen cylinders by health workers. The said staff were under police investigation by the time of the visit by the Task Force. This comes at a time when the number of severe cases that require regular availability of oxygen are on a steady rise.

The Task Force recommends that the Ministry of Health follows proper planning procedures before haphazard procurement and distribution of equipment. In simple terms, construction of ICU wards should precede procurement and delivery of ICU beds as has been the case in the last year where 143 ICU beds were procured

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and installed in temporary spaces due to lack of standard ICU wards.

#### 6.4 30% TAX ON RISK ALLOWANCE

It was widely reported that health workers had often not received their risk allowances late. In some places, health workers had not been paid their allowances since December, 2020. In addition, the risk allowances were subject to a 30% tax. From UGX 80,000 for the highest category, one ends up wit about UGX 56,000 after taxation and less for those who earn less.

District Health Officers in some districts reported discontent amongst health workers in brought about by differences in risk allowances. They noted that whereas the practice ranked risk, it also served as a disincentive to some and proposed that if possible, the single-spine be adopted to address the issue.

It was observed that the double practice of delay to remit the risk allowances for the gallant health workers and its subsequent taxation served more to demoralize the front liners who were overstretched and working under difficult circumstances to save lives.

#### Recommendations:

- v. Adopt single spine payment for risk allowance to address discontent amongst health workers
- vi. Drop the practice of taxing risk allowances to enable frontline workers feel appreciation from Government

SETTING UP A FUNCTIONAL AMBULANCE SYSTEM

Whereas Ministry of Health indicated that there was a functional Ambulance System at regional level centrally controlled and coordinated, it was only functional in Kampala Metropolitan region.

The Minister for Health informed the Task Force that the country requires 460 ambulances (440 Type B and 20 Type C). Out of the 460, the country has only 121 (116 Type B and 5 Type C). At a performance

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level of 26.3% of the required capacity, this is way below the ideal standard.

The Minister proposed that, subject to availability of funding, the Ministry of Health would scale up the ambulance services annually for the next 5 years until the whole country is covered. To avoid delays in accessing ambulance services, the Ministry would also set up a call and dispatch system at the Regional Referral Hospitals. A pilot of this system is underway in Kampala and Masaka.

The facilities visited neither received any new ambulances nor the facilitation alluded to of the daily UGX 960,000 earmarked for each ambulance.

At present, the field teams found that hospitals continue grappling with old ambulance vehicles as the only alternatives of transporting patients.

Consequently, they attract high costs of maintenance as they breakdown almost routinely. The facilities are forced to use the Primary health Care (PHC) fund for fueling ambulances to transport COVID-19 patients against the increasing demands.

#### Recommendations:

- i. Ministry of Health should urgently functionalize ambulance system to ensure quick evacuation of patients that require urgent medical attention
- ii. The management of the ambulance system should be made transparent and clear to the respective regional referral facilities to ensure proper accountability.

### ENROLLMENT OF TEMPORARY STAFF RECRUITED BY MOH

It was noted that specialists especially in the Intensive Care Units (ICU) such as Intensivists Nurses, Doctors, Anesthesiologists are inadequate to effectively handle the surging numbers of sever COVID-19 cases. This is because COVID-19 causes severe respiratory challenges as the condition advances and usually require specialized services. Average staffing levels across health facilities stagnated at 52%.



Health workers were often drawn from lower health facilities to reinforce services and other COVID-19 related interventions at both testing and treatment centres thereby shrinking the staff number per health facility against the established staffing norms hence affecting service delivery at lower levels.

To address this challenge, the Task Force noted that the Ministry recruited some staff to augment the response efforts but these were engaged temporarily instead of permanent appointments.

Given that it is not clear when the pandemic will end, in alignment with the Presidential Directive to absorb these temporary staff into the main Public Service structure, the Task Force proposes that the staff be engagement on permanent terms.

#### 6.7 ISOLATION UNITS AND PSYCHO-SOCIAL SUPPORT

COVID-19 had contributed immensely to increase in cases of child labour, neglect, physical abuse, gender-based violence (GBV), teenage pregnancy and redundancy in communities. As a result, suicidal tendencies were on the rise.

The movement restrictions imposed to curb the spread of the virus had affected small businesses and increased cost of doing business due to the high cost of transport hence many retails shops run out of business.

The financial /lending institutions have put debtors under immense pressure to meet their loan obligations yet amidst low sales and inability to meet the financing targets. Consequently, programs such as Youth Livelihood Program (YLP). UWEP and Emyooga had been adversely affected due to defaults.

Further, closing of the food and animal markets had rendered many locals unemployed as most rural districts depend on the sale of cattle and other animals.

The offices of District Community Development and Probation and Welfare offices are overwhelmed with cases that require urgent intervention for psycho-socio support, counselling and arbitration.

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Despite the above socio-economic challenges, no allocation for psychosocio support has been made to support the District Community Development Offices and Probation and Welfare Offices to increase on their outreach activities in response the distress caused by the COVID-19 pandemic.

#### Recommendations:

- Government should require financial institutions to provide a grace period to the borrowers and further reschedule the payment of loans in view of the prevailing circumstances.
- Requisite support and resources be allocated to the Community Development Offices and the Probation/Welfare Offices to reinforce supportive services to the depressed and distressed communities

## ENHANCEMENT OF HOME CARE/NEED FOR MORE SURVEILLANCE

The Task Force noted that while there was a comprehensive surveillance strategy to track and trace contacts of those that tested positive for the Corona Virus in the early days, with the second wave, this has not been the case.

The Task Force further noted that the absence of this surveillance effort has made the containment of the spread of the virus even more difficult especially now that the spread is happening at the community level.

The Task Force recommends that tracking and tracing contacts of confirmed cases as well as surveillance along Uganda's porous borders needs to be stepped up to manage the spread of COVID-19.

#### 6.9 ESTABLISHING A COVID-19 FUND

The Task Force noted that some of the accountability issues raised by the Auditor General on the management of COVID-19 funds resulted from the haphazard management of the funds without a central collection and disbursement point.

The Task Force proposes that a COVID-19 Fund be created to centrally receive and deploy all resources related to the management of the pandemic to avoid leakages, diversions and unclear prioritisation.



#### 6.10 Enhancement of Testing and Diagnostics at all levels

Test Kits for COVID-19 were reportedly inadequate throughout the districts visited. This had reduced the diagnostic capacities of respective districts and border entry points. For example, Malaba which clears over 1,500 vehicles (about 3000 truckers) could only test 50 people every day.

The above was attributed to the inadequacy of test kits and payments required while across Kenya, the testing is free for every trucker. Hence drivers are cleared using the test results they obtain across the border which are not subjected to further checks to ensure authenticity and accuracy.

Additionally, when people test positive for the virus, further investigations into the extent of the damage by the virus to the lungs is hampered by the inadequate diagnostic equipment in most health facilities across the different service delivery levels. The absence of CT-scans and X-ray machines leaves the health workers guessing about the extent of the damage which negatively impacts the patients' outcomes.

### The Task Force recommends that;

- i. the Ministry of Health should budget for the procurement of the required medical equipment including CT Scans, X-ray machines etcetera.
- ii. Parliament should appropriate funds for the procurement of the required diagnostic equipment,

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#### 7.0 CONCLUSION

Rt. Hon. Speaker and Hon Members,

The Country is faced with a challenge unlike any other we have encountered before in our history. The next steps we take as a country, every day for the next few weeks, are crucial to ensuring the difference between endless lockdown measures versus a possible return to normalcy.

H.E. Nana Akufo-Addo, President of the Republic of Ghana, is quoted to have said, in relation to the pandemic, that, "while we know how to bring the economy back to life, we do not know how to bring people back to life".

It is therefore important to prioritise saving lives by prioritizing mass vaccination of 21,900,000 eligible Ugandans over the course of the next few months.

Rt. Hon. Speaker and Hon Members, I beg to submit.

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## SIGNATURES OF ASSENT TO THE REPORT OF THE PARLIAMENTARY TASK FORCE ON THE NATIONAL COVID-19 RESPONSE – JULY 2021

SN	NAME	ROLE	SIGNATURE
1.	Hon. Abdu Katuntu	Chairperson	M
2.	Hon. Dan Atwijukire Kimosho	D/Chairperson	Anne
3.	Hon. Agnes Kunihira	Member	
4.	Hon. Bernard Odoi	Member	
5.	Hon. Anna Adeke	Member	Alexander
6.	Hon. Dicksons Kateshumbwa	Member	Dat-1.
7.	Hon. Abed Bwanika	Member	Bucurea
8.	Hon. Victoria Nekesa (Dr.) (Col.)	Member	1
9.	Hon. Dr. Charles Ayume	Team Leader	
10.	Hon. Dr. Samuel Opio Acuti	Member	
11.	Hon. George Didi Bhoka	Member	Het
12.	Hon. Dr. Lilian Aber	Member	
13.	Hon. Charles Onen	Member	
14.	Hon. Jonathan Odur	Member	<u></u>
15.	Hon. Ojara Mapenduzi	Member	- (Thomas
16.	Hon. Faith Nakut Loru	Member	-
17.	Hon. Emmanuel Ongiertho	Member	
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19.	Hon. Dr. Emmanuel Otaala Otiam	Team Leader	Minnotaatu.
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24.	Hon. Margret Makhoha	Member	Mineral
25.	Hon. Karim Masaba	Member	
26.	Hon. Jonathan Ebwalu	Member	



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27.	Hon. Dr. Michael Iga Bujenya	Team Leader	
28.	Hon. Dr. Lulume Bayiga	Member	
29.	Hon. Nakazibwe Hope	Member	Mark.
30.	Hon. Pauline Kemirembe	Member	Alemaenke
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32.	Hon. Michael Kakembo	Member	All the second
33.	Hon. David Kabanda	Member	Manual Control
34.	Hon. Charles Tebandeke	Member	JAM S
35.	Hon. Joseph G. Ssewungu	Member	
36.	Hon. Ruyonga Joseph	Team Leader	,
37.	Hon. Mwijukye Francis	Member	
38.	Hon. Dr. Asiimwe Florence Akiiki	Member	TASUMVE
39.	Hon. Bebona B Josephine	Member	
40.	Hon. Kamara Nicholas	Member	Harm
41.	Hon. Nyakato Asinansi	Member	(1)
42.	Hon. Rutahigwa Elisa	Member	
43.	Hon. Atwijukire Dan Kimosho	Member	
44.	Hon. Dickson Kateshumbwa	Member	750 Vo. P

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