Communities Key to EVD Control

Experience from Uganda
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ACHEST is an independent Regional "Think-Do Tank" comprising a Network of Experts with a mission to promote evidence-based and technically sound policies and strategies that are owned and driven by African populations themselves to attain better health outcomes - http://www.achest.org/

ACHEST is registered in Uganda as a NOT FOR PROFIT ORGANISATION and applies internationally accepted governance principles.

Priority work areas: Stewardship & Governance of Health, Health Workforce
Presentation

• Why this presentation? EVD is endemic in Africa and is a global health threat
• Uganda EVD out break of 2000
• Current Prepared Status in Uganda
• Linking Population Health to Governance & Leadership
• Vision for UHC in Africa with Ebola experience
Why this presentation?

- West African epidemic was out of control
- EVD is endemic in Africa and a global health threat
- Panic abroad
- Shared experience: blog, publications, personal contacts, WHO, WB, USAID, AUC
- Key lessons for UHC and Post 2015 SDG
Leading causes of death in Africa
(deaths in thousands)

Source: WHO 2012 (Ebola 2014)
Fig 1 Map of Uganda showing ebola affected districts, 2000-2012
Uganda 2000: Chronology of events

• 8th October 2000 MOH received news of strange illness in Gulu district.
• 9th October 2000 (Independence holiday) Lab. staff dispatched to collect samples.
• Friday 16 October 2000 Ebola confirmed. Week end Ebola meetings at MOH
• Hon MOH and Senior staff fly to Gulu district
• Management structures established
Fig 3: Internally displaced persons (IDP), Gulu municipality, 2000
Figure 2: Camps of 1.3 million internally displaced persons (IDP), Gulu, Uganda, 2000

Source: WHO Report, 2000
Management Structures

• Strong personal leadership of Hon. Minister of Health
• Strong Technical Leadership: Resident Senior staff
• Role of WHO Representative & Hq
• National Task Force
• Strong District leadership with Task Force
• WHO expertise and supplies
• CDC Field lab
Management Process

• Daily morning & evening meetings of NTF
• Daily morning & evening meetings of DTF
• Weekly visits to affected districts from MoH and NTF
• Community mobilization and awareness
• Local leaders: cultural, religious, government
• Media: 3 briefings daily. Personal contact.
• Hotline for conveying and receiving information
Principles of VHF/Ebola management

- Win, maintain Public awareness and trust
- STOP contact with infected animals and eating of their meat
- ISOLATE the sick
- PROMPT and SAFE disposal of remains and waste
- DISINFECT and DECOMTAMINATE homes of dead and infected
- ALWAYS wear PERSONAL PROTECTIVE gear in any Ebola activity

Caring for Ebola patients emphasizes the importance of:
- training,
- practice,
- competence, and
- observation

of healthcare workers in correct donning and doffing of PPE selected by the facility.
Fig. 4: Surveillance flow chart for community cases detection and isolation
Masindi District

• One patient escaped from Gulu District
• Infected 4 staff at the Hospital
• Director relocated to live at district
• Hospital staff deserted
• New staff and burial team volunteered with financial incentives
• Kenyan citizen relatives in contact with deceased patient identified and reported by community and quarantined after return to Kenya
Uganda Health System 2000

• In Post Conflict recovery: implementing new National Health Policy and Strategy
• Affected Gulu district still in conflict with stable strong district leadership
• Two other districts stable
• No previous experience and unprepared
The National Health System

- HOUSEHOLDS / COMMUNITIES / VILLAGES
  - HC II
  - HC II
  - HC II
  - HC II
  - HC II

- HC III
  - HC III
  - HC III

Referral Facility (Public or NGO) (HC IV or HOSPITAL)

District Health Services HQ

Regional Referral
- HOSPITALS

National Referral HOSP

MOH
Headquarters

HSD

District Health Service
Health Sub-District

- Referral Facility General Hospital (District level - 500,000 pop)
- Health Centre IV (County level - 100,000 pop)
- Health Centre III (Sub-country level - 20,000 population)
- Health Centre II (Parish Level – 5,000 population)
- Health Centre I (Village Health Team - 1,000 population)

- The functions and responsibilities of each level of the delivery system have been defined. Minimum service standards and staffing levels have been set for each tier of service delivery.
Village Health Team (Health Centre I)

- Network of functional Village Health Teams (VHTs) to facilitate the process of community mobilization and empowerment for health action.
- VHT comprised of 9-10 people selected by the village (LCI).
- Women’s participation in the VHT is promoted through an affirmative action measure of requiring at least $\frac{1}{3}$ of the team members to be women,
The VHT is responsible for:

• Identifying the community’s health needs and taking appropriate measures;
• Mobilization of additional resources and monitoring of utilization of all resources for their health programs including the performance of health centers;
• Mobilization of communities using gender specific strategies for health programs such as immunization, maternal health, malaria control, sanitation and construction, and promoting health seeking behavior and lifestyle.
The VHT is responsible for:

• Selection of Community Health Workers while maintaining a gender balance;

• Overseeing the activities of Community Health Workers;

• Maintaining a register of members of households and their health status and

• First link between the community and the formal health providers
Uganda Strengths

- Strong political leadership: national, district
- Strong technical leadership: senior staff relocated and lived in affected districts
- Strong community leadership: religious, cultural, civil
- National Health Policy & Strategic Plan
- Strong health partnerships: Swaps, WHO, CDC
- Laboratory support: Uganda Virus research Institute
Uganda Challenges

- Insurgency
  - Lord’s Resistance Army (LRA) rebels;
  - 1.3 million Internally Displaced Persons (IDPs) in camps
  - Societal infrastructure collapsed, no schools, no roads,
- Inaccessible villages close to war-torn Sudan
- First known outbreak in Uganda
  - No preparedness, fear, panic
- Slow to confirm: 6 weeks from index case to confirmation
- Rumours and disinformation by media and political gossip
- Took long to stop: 6 months Sept 2000 - Jan 2001
What are we doing as a country?

• All Districts to have **activate District Task Forces** meeting regularly (Circular and SMS through mTRAC)

• All Health facilities to heighten **Infection, Prevention and Control Practices (IPC)** and be on alert for any suspects using standard case definitions

• **Public Health Emergency Operation Centre (PHEOC)** under ESD is monitoring and responding to all alerts using IDSR - MTRAC & DHIS2.ver2.5 and Hotlines

• **Central Public Health Laboratory and UVRI Lab** are collecting samples using the Hub system countrywide and processing all suspects samples timely
Key elements of Preparedness for VHFs

1. A National preparedness plan (Finalized, Costed and Funded)
2. Human resources (Experienced & Available for training)

3. Equipment (PPEs, Scanners, Thermometers pre-positioned)
4. Treatment centers (Well designed along IPC guidelines)
5. Isolation centers (convenient and with ample capacity)

6. Appropriate Laboratory services (BSL 2enhanced or 3)
7. Data management capacity (Cases, Contacts and Situation reports)

8. Burial arrangements (Teams and Transport)

9. Airport and Ground PoE screening facilities (Multidisciplinary team)

10. Other country specific needs (consider Islands & Hard to reach areas)

3-Apr-15 Presentation at EAC- Ministers of Health meeting
National Coordinating Committee Structure
(National Task Force)

- Surveillance and data management
- Case management and infection control
- Social mobilization psychosocial support
- Communication & Media
- Logistics & supplies

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**Africa’s Economy**  
*The Economist Dec 3-9 2011*

- “Hopeless Africa” May 2000;
- “Rising Africa” Dec 2011
- Africa’s GDP is however projected to keep growing 5-6% for some years to come
- 8/10 fastest growing economies globally
Vision for UHC in Africa

• **Close implementation gap**: Leadership, governance and management; Ownership and accountability, Capacity of local institutions

• Build on positive societal values and practices

• **Integrate health into routine societal governance**, reach every household “leaving no one behind”

• Health Made at Home: **Health Care vs Health Promotion**: Essential Health packages

• Ensuring Quality

• Global solidarity: **Close implementation gap**: international health regulations, **protect essential health packages**, respect local knowledge and evidence
Embed Health in Governance

At its best, the routine governance of society should be the **foundation of the health system** by ensuring that laws, regulations and good practice are complied with by all: that homesteads are hygienic, mothers attend ante natal clinics, children are immunized, the nearest health facility has required personnel and supplies, the referral system is in place, the correct food crops are grown and stored properly, all children are going to school, the rural road network is maintained, law and order is enforced etc. This should be the job description of the **village or community administrator as the very first frontline health worker.** (UHC: Leaves no one behind)
Thank you

- MoH Uganda
- Sam Okware
- CUGH
- MEPI