

# How can the health system handle COVID-19 in Kampala slums?

by Hilda Namakula & Gloria Seruwagi

## Urban Health in the Era of COVID-19

Urban healthcare is typically unstructured, with scanty public facilities and a plethora of unregulated private providers. Nearly 75% of the population in the slums seek care from private facilities because they are in closer proximity compared to the public facilities albeit being exorbitant in terms of payment. This has implications for availability, accessibility and utilization of skilled healthcare.

The urban space presents a complexity of health needs and public expectations that require quality health systems to equitably optimize health outcomes and produce greater social value. Poor quality systems are a serious barrier to reducing mortality, especially in precarious times like these of COVID-19.



- Uganda's COVID-19 cases and deaths continue to increase, from its first case in March 2020 and currently at 31,384<sup>1</sup>.
- While COVID-19 has affected all contexts, economies, systems and people; some population categories remain disproportionately affected. These include the residents of informal settlements in urban areas where more than 60% of Uganda's population resides.
- For slums like Ki-Mombasa in Bwaise and Kabalagala-Kataba in Kampala Uganda, residents not only live in crowded conditions but also their Social Economic Status (SES), behavioral lifestyles and access to healthcare generally increase the risk of COVID-19 transmission with even more catastrophic effects.
- Yet the current approach to the prevention and management of COVID-19 points to several missed opportunities in addressing COVID-19 among vulnerable groups like the urban poor living in these slums.

1 <https://www.health.go.ug/covid/>

We conducted research on COVID-19 in slums and assessed health system preparedness with a focus on health workers knowledge and practices in the two slums. We assessed community KAP and implementation experiences of enforcers and frontline workers at the forefront of COVID-19 service delivery.

The [ALERTs study](#) was cross-sectional and mixed methods, with a sample size of 807. Furthermore, 6 health facilities (public and private) in Kampala were assessed on capacity and 135 health workers interviewed. As part of its objectives the study also engaged key multi-level stakeholders, including community health workers, to co-design robust interventions to prevent the rapid spread of COVID-19 as Uganda reaches its “peaking” point with increasing community transmissions.



Mask distribution in informal settlements

## Key Findings

1. Community adherence to COVID-19 guidelines is extremely low. For facemasks the key issues include sharing between people, improper wearing including “chin-masking”, inconsistent wearing and not wearing them at all. Handwashing with soap had dropped by up to 93% within 3 months. Sanitizing is a luxury and physical distancing is not feasible in crowded slum settings.
2. Healthworker capacity for emergency response is limited. 58% of the healthworkers with either a diploma or certificate reported limited knowledge on healthcare response during epidemic outbreaks; while 60% needed refresher training to supplement their knowledge on recommendations for treatment and protection against COVID-19.
3. 77% of healthcare providers reported not receiving capacity building sessions on COVID-19 care. Instead, in the event of a COVID-19 case encounter, they reported their first action to be calling the Ministry of Health or referring people to designated treatment centres. This capacity gap is worsened by limited and inconsistent supportive supervision and clinical mentorship, also severely disrupted by COVID-19. Data from the qualitative arm also confirmed this as shown in the excerpt below:

*... we have never received any training on COVID-19 only what we do is tell people to go to Mulago or call the Ministry to pick the COVID-19 suspect... personally I cannot treat someone with COVID-19 but receive many people with symptoms related to it (KII, healthworker #1)*
4. While some providers in the private sector reported having essential medicines and supplies, service delivery was greatly affected by few and unskilled staff, limited infrastructure, medicine stock outs and supplies.
5. Physical infrastructure such as spacious ICU rooms, patient wards, isolation centers and PPEs for providers in both private and public facilities are inadequate. Only 2 out of the 6 facilities visited had the capacity to manage and treat COVID-19 cases.
6. 55% of the health workers disagreed that practices to ensure staff safety were fully adhered to at their health facility. The practices include mapping out of risk and hazards, staff safety and contingency plans, non-critical staff working from, shift working and enough supply of PPEs, as shown over-leaf:

*...Not really, though they have supplied us with those things, the other gadgets we don't have because ideally, you have to cover yourself properly. When they brought the face shields here they were just for clinical officers and even those ones testing... that means you still lack some equipment for all of us (KII healthworker #2)*

7. In the face of this PPE shortage some policymakers are calling on workers to improvise and get themselves protective gear, instead of waiting for government supplies:

*That is the risk associated with being a health worker... If you lack the hospital mask ... it's just reasonable that you take a step and make sure you buy yourself a mask. (KII policymaker)*



People queue outside a pharmacy in Kampala, Uganda

8. The perceived high cost of services is a key barrier to seeking timely care for suspected COVID-19 victims and other diseases. Moreover, the emergency response system is fragile and not fully functional

*"Concerning the testing of COVID..., I hear some facilities charge a lot of money..., these people in the slum areas don't have money because a test goes for Shs250,000 - 300,000. So, these poor people are going to die they don't have the money." ( FGD community)*

9. The range of COVID-19 services care is limited, and the process slow, at various service points due to functional and/or technical capacity gaps. This contributes to delays for patients seeking urgent care for other diseases especially comorbidities.

## Recommendations

1. Provide targeted & consistent onsite mentorship to support frontline healthworkers and build their capacity to deliver timely and quality care.
2. Rethink & re-design emergency response during epidemic outbreaks in the urban space. This will involve comprehensive mapping to identify and prioritise high volume service points in both the public and private sectors.
3. Ensure affordability of care and awareness on available services, for example for COVID-19 testing. Institute interventions and processes addressing access barriers e.g. subsidization, voucher systems, mass testing and economic empowerment for the urban poor.
4. Empower patients to self-manage chronic conditions, while emphasising health literacy and telemedicine. Collaboratively engage their leaders [political, administrative, cultural and religious] to take lead and ownership of this campaign.
5. Strengthen Community Health Systems for disease prevention and management. Equip community members, leaders, VHTs and lower level facilities with capacity to respond. Invest the required resources to activate and functionalize the Community Health Engagement Strategy (CES) of 2020.

The last two recommendations speak to balancing the demand-supply sides of healthcare and adopting new low-cost, but sustainable, pathways to addressing COVID-19 at community and facility level.

## For More Information Contact

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