Special Pathogens
Research Network Limited
(Sppare-net Ltd: Inc. No: 144926)

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"Office of the Director General"

Our Ref: **SPRN/EX/UNGC/COE/2016/001**

January 5, 2016

Communication on engagement covering January 2013 and January 2016 from Special Pathogens Research Network Limited

This communication covers the stated 3 years period from January 2013 to December 2015, a period which has been full of challenges following the global economic down turn and rising aggression by countries, regions, ethnics, religious groups and fanatics, and various individual quest for materialism. The principles of the United Nations Global Compact has guided our network in all its operations and activities and most importantly in maintaining our core principle of not-for-profit network in the midst of emerging complex personal needs and nefarious aggrandizements in our society today.

The Supreme Research Council (SRC), the highest executive board of this network during its end of year annual general meeting for the year 2015, therefore resolved that it will henceforth continue to support the United Nations Global Compact (UNGC) and would therefore wish to renew the on- going commitment of the special pathogens research network limited. It also hopes to incorporate the principles of the UNGC into its long term strategic development goals.

We will continue to support human rights and ethics in all our research efforts. We also support UNGC approach to labor by working against all forms of discrimination in occupation and employment. We support UNGC approach to the environment by advocacy which is aimed at encouraging the society to embrace items that can be recycled and absolutely biodegradable.

Other activities can be found in our website at www.spparenet.us home page

Sincerely

Special Pathogens Research Network
SPPARE-NET
SIGN
DATE
Box 324 Ishaka-Bushenyi (U)

Dr Ezera AGWU, Ph.D, FSAFRI
Director General, SPPARE-NET

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A description of the practical actions that the organization has taken to support the Global Compact principles and to engage with the initiative. Practical actions should relate to one or more of the specific activities suggested to each type of non - business participant in support of the initiative.

Our Ref: **SPRN/EX/UNGC/COE/2016/002**

Annual Medical Camp by Special Pathogens Research Network Limited

In the tropics where we are found and where we operate, avoidable diseases leading to death and great disability has continued to affect the society in great dimension. Disease epidemics has continued to skyrocket to the extent that healthcare providers are awash with confusion about direction and universally accepted treatment principles that will lead to measurable outcome and effective intervention. It is not very clear what exactly the health problem is and therefore many researches have accused all aspects of healthcare management as responsible for the rise in treatment failure. Government intervention strategies are simply not enough to meet the rising demand for healthcare services. All sectors which can augment what the government is doing are therefore welcome to do so.

It is based on this development that the Supreme Research Council (SRC) of the Special Pathogens Research Network Limited, Uganda approved series of activities ranging from capacity building, research and healthcare delivery. One aspect of our activities on healthcare delivery use of standard community based medical camp aimed to set the pace for efficient grassroots healthcare delivery in resource limited settings. It was also aimed at reaching out to community dwellers in hard to reach areas and in communities where there is poor social and health amenities.

Why we engaged in this work:

a. To improve access to health care in communities in hard to reach areas in Uganda
b. **Health education** component of this free access to healthcare was aimed at improving the knowledge; changing the attitude and ultimately transforming the practice of remote hard-to-reach community dwellers about collective and individual response to common diseases like: malaria, typhoid, diarrhoea, pneumonia, tuberculosis, HIV/AIDS, sexually transmitted disease and other tropical diseases
c. **Counselling and diagnosis** component of this free access to healthcare was aimed at improving the coverage, effectiveness and accuracy of diagnosis of common diseases using digitally portable, highly specific and sensitive; easily amenable and reproducible diagnostic tools/kits at the community level without the need for sophisticated standard laboratories.
d. **Clinical consultancy and drug prescription** component of this free access to healthcare was aimed at reducing: avoidable high mortality rate, high disease burden and drug abuse in the community occasioned by self-medication of undiagnosed illnesses, and across-the-counter purchase of drugs and subsequent use of sub-lethal dose for treatment without clinical attention, prescription and lab investigation

Prescription-Drug- dispensing component of this free access to healthcare was aimed at making available the essential prescription drugs to ordinary citizens in hard to reach areas that frequently get sick, suffer from disease scourge and die in their homes without any or adequate healthcare. Absolutely free prescription drug dispensing also targeted those who are living below poverty line and could not afford the available scarce healthcare distance and poor geographical location.

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The exact problems we solved and the magnitude of the problem in this region

1. In this annual program, we are emphasize on HIV/AIDS, diarrhoea, pneumonia, dysentery, febrile illness, malaria and Neglected tropical disease of poverty. We raise awareness, educate villagers about above disease, provide free diagnosis/treatment of uncomplicated disease and refer complicated diseases to our affiliated hospitals.

2. There is high prevalence of the diseases in the target population and the location is endemic for the selected disease. Our absolutely free community outreaches remain unparalleled.

3. Barriers to receiving care for selected disease are:

a. Distance to health-care centres, un-official demand for patients to pay or buy certain drugs, consumables, special services restrict access to healthcare in these communities

b. While there is abundant human resources for health in the country, retaining qualified healthcare providers remain a challenge

c. Plan for procuring and distributing all drugs exist but incidences of stock- outs continue to rise because drugs disbursed at the national level are not the same as drugs received at the local level.

d. There is low quality of care because of poor resources

e. Data are generated but storage and retrieval remain a big challenge.

f. There is good management and leadership system but enforcing the system remains a challenge as loop holes militating against good leadership continue to emerge

f. High cost associated with receiving care does not apply because available health services are free

Summary

Improved access to care will provide human resource for health, make medicine available, encourage dis closure to reduce stigma of chronic infections like HIV/AIDS, reduce burden of diarrhoea, pneumonia and neglected tropic al and other febrile illness.
This is because we make available for free medicines for
free medicines for treatment, trained diagnostic experts for disease diagnosis, awareness campaign to increase uptake of health services and reduce stigma by encouraging disclosure at the free testing and Counselling centres

Background of the program activities-The Medical Camp

Mortality and morbidity rate continue to increase till date despite efforts to clamp it down. Cost, poor human resource for health, stock-outs, and poor diagnostic/care
equipments militate against increase uptake of health care services in the local communities. The innovativeness, community attractiveness of our program may be because it is free,

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involvement of local focal persons on the spot diagnosis of disease
by trained andexperienced personnel and free medication to those diagnosed of any un-complicate.

Beneficiaries? All sick people socio-economically and medically incapacitated to use available services at the health centres. Sickness may be HIV/AIDS, febrile illness, malaria, typhoid, pneumonia, malnutrition, diarrhoea, food-poisoning, dysentery, superficial and deep ulcers.

Program access and cost

Community oriented free medical camp is organized at the community square or town halls and trade centre closest to village members. Materials and staff for the camp are transported on rented vehicle. Villagers walk less than 5 minutes to the medical camp, get registered, receive education, and consent for medical attention, grouped according to suspected diseases and available clinicians for diagnosis, treatment and care. Recruited participants do not pay because they cannot pay. Services are delivered to participants randomly as they come until daily resources are spent.

Program implementation approaches

Program implementation committee including research assistants and network members in different countries.

a. **Health education** improves the knowledge; changing the attitude and ultimately transforming the practice of remote hard-to-reach community dwellers about collective and individual response to common diseases like: malaria, typhoid, diarrhoea, pneumonia, tuberculosis, HIV/AIDS, sexually transmitted disease and other diseases
b. **Counselling and diagnosis** improves the coverage, effectiveness and accuracy of diagnosis of common diseases using digitally portable, highly specific and sensitive; easily amenable and reproducible diagnostic tools/kits at the community level without the need for sophisticated laboratories.
c. **Clinical consultancy and drug prescription** reduces: avoidable high mortality rate, high disease burden and drug abuse in the community occasioned by self-medication of undiagnosed illnesses, and across-the-counter purchase of drugs and subsequent use of sub-lethal dose for treatment without clinical attention, prescription and lab investigation

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IMPACT MEASUREMENT:

We measured impact by defining the pre-medical camp burden of disease and after every 3 consecutive medical camps, post-workshop burdens were determined. The difference between the averages gave the impact. We also measured impact by mapping out fresh villages without any medical camps intervention. After one year and six months, we determined the effectiveness of our method by defining the burden in these two villages. Volunteering villages then becomes our next site of medical camp and so on.

Population covered: We have reached over two thousand four hundred people so far in two years from ten villages including: Bassajajbalaba, Byegiragye, katungu, Rwemirokora, Omorushenyi, Kaburenje,

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Katarimwa, Kizinda, Buramba, Rukindo. We still have over twenty four thousand potential participants in villages located around the five districts of old Bushenyi according to our community strategic mapping result.

High uptake of health services: Significant increase in the number of villager's seeking help, filling the outpatients and wards in Kampala International University and the hospitals around the district, attempting to access our free care. Medical student's challenge of lack of patients is now fading.

Outcome on people's health: Evidence of better outcomes includes but not limited to: high awareness of need for medication with prescription; insisting on test before diagnosis; greater participation of community focal persons and improved community involvement in healthcare matters, increased number of locals who have received training on health delivery services, improved practice of referring complicated cases to hospitals or next level health centres, reduced morbidity and mortality of the affected population, high impact of the program on undergraduate training by use of trained undergraduate students for the project, high impact on the retention of healthcare workers by being part of health training program which may influence their decision to work in villages after graduation.

Individual success stories:

a. **Clinical officers:** A group of 20 clinical officers led by Mr Richard Kabagu, testified how the camp gave them the chance to demonstrate their clinical skills in history taking, clinical diagnosis, request for laboratory investigation, interpretation of results, decision on best drug to prescribe based on the lab result and post diagnostic management and counselling of patients and subsequent referral of complicated cases to the affiliated hospitals. Their happiness and testimonies were because these activities are done under close supervision during training. The medical camp gave them the chance to experience professionalism.

b. **Kampala Intentional University teaching hospital KIUTH** once had a free healthcare services paid for by Uganda government in a public-private partnership. Under that scheme patients were given free essential drugs and medical attention but required to pay for investigation and non-essential drugs and hospital utilities. Payment made this scheme unpopular. The surge in the population ready to attend this medical camp was based on the assumption that Hospital free services by KIUTH has been brought home excluding payment for anything. This community-based activity, if scaled up, may supplement existing government hospitals partially free services.

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