



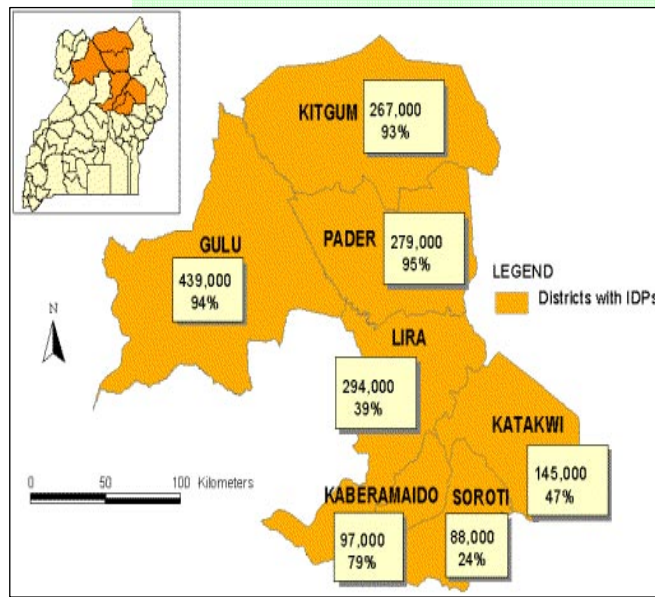
UGANDA WHO Strategy paper for 2006

Present context

Overview

Nearly two decades of conflict have displaced up to 2,3 million people composed of approximately 12.4% (124,000) of which are children under five. About 69% (686,000) persons comprise the sexually active group and an estimated 2.4% (24,000) are pregnant women.¹ An estimated 80 per cent of IDPs are women and children². Homeless and trying to survive, many of whom are subjected to sexual violence and other forms of exploitation. Children are particularly vulnerable; the LRA has abducted 12,000 children since June 2002. An additional 44,000 children travel to towns from outlying areas at night to escape abduction, rape, and/or attack by the LRA. Most of the IDP, 90% are still living in 104 IDP camps without adequate resources. Some of the camps have taken time to be recognized officially which is crucial for emergency aid. The previously affected districts of Gulu, Kitgum, Pader and Katakwi have now been joined by an additional four: Apac, Lira, Kaberamaido, and Soroti. Furthermore 210,000³ refugees were estimated to reside in Uganda, mainly from Sudan.

Uganda, Internal Displacement by District -



Main Public Health Issues and Concerns

In the July 2005, health and mortality survey carried out by WHO, the MoH and other partners in IDP camps in the districts of Gulu, Kitgum and Pader confirmed that the crude and under-five mortality rates are well above their respective emergency threshold (1/10,000 and 2/10,000/day) at 1.54 per 10,000 and 3.18 per 10,000 per day respectively. The resulting estimate of excess mortality is staggering – between 24 000 and 33 000 in the first seven and a half months of 2005, of which 12 000 to 21 000 are under 5 children. The distribution of causes of death consistent across the four survey populations both among all age groups and among under 5s

- Malaria was the first respondent reported cause overall 28.5%, with most malaria deaths 67.8% occurring among under 5s. Plasmodium falciparum transmission, and malaria incidence has generally been increasing. Among under 5 children, bednet

¹ Calculations made from standards population structure.

² Source: UNICEF, 25 May 2004.

³ Source: UNHCR, Global Report 2003.

coverage (28.0%) is far below the current Roll Back Malaria goal (more than 60%), and unlikely to have a significant impact on community malaria transmission

- AIDS was the second most frequently reported cause of death with 13.5%;. 71.8% of reported AIDS deaths occurred in 25 to 50 year old adults. A cumulative number of 2 million person has been infected with HIV/AIDS since 1980s of which 900,000 died. Currently, 7% of adult men and women (800,000) are infected with HIV (UHSBS2004-2005). By the end of June 2005, 63,986 patients out of the total of 114,000 estimated needs were receiving ARV treatment in 114 centres, including in the conflict affected north. Resources were provided by Governemnt, UNAIDS-WHO and Global fund
- Violence was the third cause of death with 9.4% .Violence related traumas including killing and abductions in 2005 suggest that the conflict in Acholiland is more widespread and active than is commonly reported. For example, the organization Kacoke Madit, compiling media sources, counts 1450 killed in the first months of since the start of the 2005 . However, the survey estimate is three times higher – about 4400, or roughly 20 killings (plus 6 ‘successful’ abductions) every day throughout the three Districts. Some children of the abducted children have been lucky to escape. However, psychosocial support to address trauma—especially for these former abducted children and their parents—is conspicuously inadequate.
- Specifically among under 5 children, diarrhoeal diseases are mentioned relatively infrequently (around 10%), contrary to published estimates for sub-Saharan Africa Conversely, the illness concept two lango/gimiru (which is the result of chronic diarrhoea and malnutrition) is the second leading reported cause of under 5 death.
- Congested and over-crowded camps provide squalid living conditions. Disease outbreaks caused by limited water supply and poor sanitation contribute to the increased morbidity and mortality rates as proved by the survey. The lack of availability of potable water causes increase rates of water born diseases like diarrhea, dysentery, cholera hepatitis and typhoid.
- Overcrowding also directly affects human health by increasing the transmission potential of most infectious diseases both endemic and epidemic , including but not limited to measles, meningitis, tuberculosis. In the case of measles, it also means that the threshold immunisation coverage required to ensure herd immunity, i.e. interrupt transmission in camps, is higher than in open (ex. village and countryside) settings.
- Recent surveys put both global and severe acute malnutrition rates at 5-8% and 1% respectively in Gulu District (MoH, SCF 2004), 12% and 3% in Kitgum District (IMC), and 4-7% and 1-2% in camps around Kalongo, Pader District (GOAL). These findings suggest that acute malnutrition is probably an important underlying contributor to childhood mortality in the Acholi camps, especially related to diarrhoea. Stunting (chronic malnutrition) is also a serious problem, affecting up to 48% of children in Kitgum District (IMC). There are currently eleven Therapeutic Feeding Centres (TFCs) in northern Uganda and these have, on average, doubled their intake during the last year.

Health system

Currently, the Ministry of Health (MOH) estimates the total number of health service outlets in the country to be 1,738 facilities, of which 1,226 are government-owned/managed, 465 belong to NGOs and 47 belong to the private sector. The facilities include 104 hospitals (57 government, 44 NGO and 3 Private), 250 health centres (179 government, 68 NGO and 3 private), palliative care 2 (1 government, 1 NGO) and others (989 government, 352 NGO and 41 private),. Under the new arrangements, the district health system is used to deliver a package of health services to the population, while the MOH is responsible for policy formulation, standards and guidelines, overall supervision and monitoring

- At the time of independence in 1962, Uganda had one of the best public health care systems in Africa. Health care services were provided free of charge, and access to care was good.
- Following neglect and mismanagement in the 1970s and early 1980s, massive deterioration ensued. Today, only between one-quarter and one-third of those requiring health care used government health facilities because of frequent lack of drugs, poor facilities, absence of qualified health workers, and long waiting times the gap was filled by the private sector
- Repeated complaints that the user fees excluded the poor has provided the basis for abolition of all user charges in the health sector, effective from March 2001.
- Decentralization in Uganda is part of the national policy. There has been a protracted debate as to the level of decentralization most relevant to primary health care.
- Perhaps because of the protracted nature of the crisis in the north, health planning has not shifted to an emergency mode, to address the most urgent needs.
- MOH Staffing levels are insufficient and the finances to enable them to conduct mobile clinics to access the affected populations are not available.
- Less than half of the population of these conflict affected districts lives within 5km of a functional health facility. Many facilities have closed down or are only partially functional. Pregnant women, in particular, lack access to basic maternal health services such as antenatal and emergency obstetric care. In addition, these health services are dependant upon humanitarian foreign assistance (drugs and other supplies).

WHO actions in 2005

In order to be closer to the affected population to understand their health needs and to implement a defined medium to long-term strategy to prevent excess mortality and morbidity among IDPs in northern Uganda, WHO has opened a sub-office in Gulu and is planning to establish two field offices in Pader and Kitgum districts. Although WHO presence was interrupted for months in Gulu, work continued for surveillance and disease response. WHO re-established its presence late 2005 and is now expanding from Gulu to Pader and Kitgum. In July 2005, An interagency-NGO effort lead by WHO/MOH compiled a mortality study which showed CMR above the emergency threshold, and gave indications of the causes. The Mortality study served as a base for the CHAP of the health sector for 2006. Presently, WHO/MOH /UNICEF are undertaking major efforts to vaccinate against meningitis outbreak in the country.

Main Sector Priorities

The health sectors objectives outlined in the CAP 2006 include:

- Strengthen the delivery of a comprehensive health care package (including immunization, child health, sexual and reproductive health, nutrition, family planning and prevention and treatment of HIV, malaria and tuberculosis,) at district level, lower level health care units and camp level in the conflict-affected districts
- Enhance health and nutrition data collection and analysis for monitoring and effective response
- Strengthen the health system through capacity building, support to retention of qualified staff at all levels, improved availability of drugs and equipments at health facilities

- Support coordination mechanisms at district and camp level including mapping of activities, analysis of gaps, joint planning and monitoring of intervention and impact assessment
- Strengthen epidemic preparedness and response in all conflict-affected districts, with special attention to cholera
- Support continuing camp decongestion process in accordance with the National IDP Policy

Summary key gaps and challenges:

- Ongoing conflict and insecurity;
- Consistent under-estimation of the conflict and its implication for health ;
- Limited access to health services mainly in the north and shrinking local health services;
- Numerous street children in the conflict-affected areas.

Overarching WHO Strategy

Late 2005, WHO reached critical mass needed to move forward and to resume leadership in the health sector.. Following the implementation of the mortality survey, recruitment of two focal points for Kampala and Gulu, and the mobilization of resources from Finland, Norway and DFID, WHO is prepared to reposition itself within the health sector in northern Uganda through :

- a) Tackling causes of mortality and morbidity as shown in the recent mortality survey in the northern districts:
- b) Close collaboration with various levels of MOH (national and district levels) while closely working with health NGOs , bridging between the two parties on various issues where differences may exist
- c) Linking humanitarian assistance in the conflict affected north to the continuing developmental work in other areas of the country through improvement of the information base ;;
- d) Tapping on regional coordination resources using WHO network of country Representative offices in the Great Lakes for early warning, preparedness and response to regional issues like population displacement, HIV and outbreak preparedness measures

WHO Strategic Objectives

Health Response coordination and Monitoring in Northern Uganda

Key strategic points

- Sustain collaboration with District Health Authorities, coordinate regular inter-agency meetings and provide technical guidance on health issues in Kampala, Gulu Pader and Kitgum
- Elaborate, regularly update and disseminate mapping of health actors.
- Produce a monthly newsletter and disseminate it to all health partners.
- Design, develop, and maintain a health databank accessible to all health actors in order to facilitate analysis and decision making.

Improving information management for decision making, planning and advocacy, including upholding the right for health of IDPs

Key strategic points

- Maintain mortality and morbidity surveillance to provide an early warning system for epidemic outbreaks. In addition surveillance will complement district health planning, advocacy and strengthening of the birth and registration system.
- Conduct assessment of public health laboratory capacity in order to ensure provision of training and equipment for adequate sample management, notably for outbreak confirmation purposes.
- Upholding the IDP right for health through information based advocacy work
- Improving local capability for effective disease surveillance and outbreak response

Identifying and filling the gaps in Public health

Improving access of children and pregnant women in IDP Camps to appropriate and effective interventions for prevention and treatment of common illnesses

Key strategic points

- Support provision of preventive and curative services to children including provision of vaccines against childhood vaccine preventable diseases through routine EPI services, polio and measles SIAs, child days
- Support other accelerated disease control activities for polio, measles and neonatal tetanus
- Monitor AFP, neonatal tetanus and measles cases and initiate mop-ups and outbreak response when needed.
- Prompt and effective management of malaria, diarrhoea and pneumonia in children under 5 years of age.

Malaria response for the IDP in Northern Uganda

Key strategic points

- Support effective treatment of malaria at the health facility and community levels
- Use the anti malarial supplies to advocate the implementation of the new malaria drug policy

Increase access of tuberculosis DOTS treatment in IDP camps in Northern Uganda

Key strategic points

- Support tuberculosis prevention and control services including early detection and successful treatment of infectious cases and community-based directly observed short course treatment (DOTS)

Mental health and psychosocial support in conflict affected population in Northern Uganda

Key strategic points

- Compile assessment reports carried out by partners
- Establish a task force for mental health and psychosocial support
- Support treatment of chronic mental health patients in the area

Strengthening district Epidemic Preparedness and Response

Key strategic points

- Improve the community's capacity to early-detect suspected cases of epidemic prone diseases and report them to health authorities promptly through training of community-owned resource persons (CORPs) and rapid response teams
- Strengthening of supervision mechanisms, and raising awareness and understanding amongst community leaders.
- WHO should facilitate regular meetings of Epidemic Preparedness Committees, and repositioning of outbreak response kits.

Improving maternal and adolescent health services in IDP Camps

Key strategic points

- Strengthen the delivery of comprehensive sexual and reproductive health care services including family planning, emergency obstetrics care, antenatal care, post abortion care and counselling,
- Adolescent friendly health services and SGBV at the district, sub-district and IDP camp levels

Scaling up capacity for the provision of comprehensive HIV care including treatment

Key strategic points

- Strengthen HIV/AIDS prevention and control services through provision of HIV/AIDS counselling and Testing (HCT),
- Prevention of mother to child transmission (PMTCT), care (home and health facility based) and treatment services to the general population

Building Capacity for Epidemic Preparedness and Response

Key strategic points

- Strengthen the capacities of district and sub-district health authorities in collation, analysis and dissemination of routinely collected surveillance data through provision of adequate IT and communication equipment
- Support the MOH for the production/dissemination of a monthly epidemiological bulletin.

Main Health Actors

The conflict has attracted a wealth of local and international non-governmental organisations (NGOs). Their repartition appears geographically biased towards Gulu District, where more than 200 apparently are active compared to Pader District, where only a handful maintain a permanent or sporadic presence. Coordination in the health and other sector implies presence in all these location

Besides the national and district MOH, the UN agencies specially UNICEF , UNHCR and UNFPA, NGOs are providing various range of health services on some of the 104 camps in the north. ⁴ WHO has opened a sub-office in Gulu in December 2004 and; is planning to

⁴ These include Save the Children; Coopi, AVSI, GUSCO, Rachele Rehabilitation Centre, Kitcwa, Concerned Parents Association, Rufou, Noah's Ark, AMREF, MSF, TPO, Norwegian Refugee Council (NRC), DED, LWF, AAH, AVSI, JRS, MSF-France, Maltheser, IRC, Gulu Support the Children Organisation (GUSCO), World Vision, CRS, ACF-USA, CPA, Uganda Red Cross Society (URCS), IMC, GOAL (U), Christian Children's Fund (CCF), Action Aid Uganda (AAU)

establish two antennas in Pader and Kitgum districts. WHO is exploring the possibility to sharing office premises with OCHA in order to favor synergy and good coordination of the agencies respective activities.

.As of November 05 WHO has fielded two international PH coordinators in Kampala an in Northern Uganda

Resources needed for WHO within the CAP 2006

Total Funds Requested: for WHO in the CAP 2006 is USD 8,013,73 out of 33 million for the health sector and 222 million for the entire humanitarian appeal.

Of these 8,013,734 USD proposed by WHO for northern Uganda for 2006 (through the CAP), WHO has been able to raise 4,280,465.69 through DFID, Norway and Finland governments with a shortfall of 3,733,268.31 USD.

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