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Health Action in Northern Uganda

Health Newsletter



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Disease Epidemics

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Global epidemics and impact of cholera

Man-made and natural disasters can intensify the risk of epidemics considerably, as can conditions in crowded refugee camps. Explosive outbreaks with high case-fatality rates are often the result. For example, in the aftermath of the Rwanda crisis in 1994, outbreaks of cholera caused at least 48 000 cases and 23 800 deaths within one month in the refugee camps in Goma, the Congo. Although rarely so deadly, outbreaks continue to be of major public health concern, causing considerable socio-economic disruption as well as loss of life. In 2001 alone, WHO and its partners in the Global Outbreak Alert and Response Network participated in the verification of 41 cholera outbreaks in 28 countries.

The 1st Cholera pandemic, or global epidemic, started in 1817 from its endemic area in South-East Asia and subsequently spread to other parts of the world. In 1961, the 7th cholera pandemic wave began in Indonesia and spread rapidly to other countries in Asia, Europe, Africa and finally in 1991 to Latin America, which had been free of cholera for more than one century. The disease spread rapidly in Latin America, causing nearly 400 000 reported cases and over 4000 deaths in 16 countries of the Americas that year.

In 1992, a new sero group— a genetic derivative of the El Tor biotype – emerged in Bangladesh and caused an extensive epidemic. Designated *V. cholerae* 0139 Bengal, the new serogroup has now been detected in 11 countries and likewise warrants close surveillance. While no evidence is available to gauge the significance of these developments, the possibility of a new pandemic cannot be excluded. El Tor, for example, was originally isolated as a virulent strain in 1905 and subsequently acquired sufficient virulence to cause the current pandemic.

Economic and social impact : In addition to human suffering caused by cholera outbreaks, panic and disruption of the social and economic structure may be experienced in affected communities. Unjustified panic-induced reactions include curtailing or restricting travel from countries where a cholera outbreak is occurring, or import restrictions on certain foods. For example, the cholera outbreak in Peru in 1991 cost the country US\$ 770 million due to food trade embargoes and adverse effects on tourism.

The Global Task Force on Cholera Control

WHO Global Task Force on Cholera Control was launched in 1992 by a resolution of the forty-fourth World Health Assembly (WHA 44.6). The aim was to reduce mortality and morbidity associated with the disease and to address the social and economic consequences of cholera.

This partnership brings together governmental and non-governmental organizations, UN agencies, and scientific institutions to coordinate activities against epidemic enteric diseases and develop technical guidelines and training materials for cholera control.

To date, the Task Force has provided technical advice and support for cholera control and prevention at country level; training of health professionals at national, regional and international levels in prevention, preparedness and response of diarrhoeal disease outbreaks; and the dissemination of information on cholera and other epidemic prone enteric diseases to health professionals and the general public.

Currently, priority activities are aimed at:

- encouraging improved surveillance and using data to identify high risk areas and guide intervention.
- providing evidence based support to countries for preparedness and response
- gaining evidence on the use of Oral Cholera Vaccines as an additional public health tool to diminish incidence of cholera in high risk areas and vulnerable groups; linking health and management of the environment in order to improve access to safe water for vulnerable populations and diminish incidence of waterborne diseases.

Displaced populations like those in Palabek, Kitgum district, below, are vulnerable to outbreaks of diseases of epidemic potential



Epidemic and Pandemic Alert and Response : Epidemics and pandemics can place sudden and intense demands on health systems. They expose existing weaknesses in these systems and, in addition to their morbidity and mortality, can disrupt economic activity and development. The world requires a global system that can rapidly identify and contain public health emergencies and reduce unneeded panic and disruption of trade, travel and society in general. The revised International Health Regulations, IHR(2005) provide a global framework to address these needs through a collective approach to the prevention, detection, and timely response to any public health emergency of international concern.

Our vision: An integrated global alert and response system for epidemics and other public health emergencies based on strong national public health systems and capacity and an effective international system for coordinated response.

Core functions : Epidemic and Pandemic Alert and Response (EPR) has six core functions:

- Support Member States for the implementation of national capacities for epidemic preparedness and response in the context of the IHR(2005), including laboratory capacities and early warning alert and response systems;
- Support national and international training programmes for epidemic preparedness and response;
- Coordinate and support Member States for pandemic and seasonal influenza preparedness and response;
- Develop standardized approaches for readiness and response to major epidemic-prone diseases
- Strengthen bio-safety, security and readiness for outbreaks of dangerous and emerging pathogens outbreaks;
- Maintain and further develop a global operational platform to support outbreak response and support regional offices in implementation at regional level.

What about cholera vaccines? Traditional parenteral whole-cell (WC) cholera vaccine has never been recommended by the World Health Organization (WHO) because of its low protective efficacy and its high reactogenicity.

Currently available oral cholera vaccines (OCV) are safe and offer good protection (over 70%) for at least one year. OCV use is recommended for populations to limit the risk of occurrence of cholera outbreaks in displaced populations in endemic areas and spread and incidence of cholera during an outbreak.

- Currently commercially available OCV contains a live attenuated strain derived from reference classical, O1, Inaba strain presented in a single dose. Protective efficacy was reached 8 days after administration of the vaccine in a volunteer's challenge study, therefore use of the single dose OCV may be possible once an outbreak has started.
- The two-dose OCV, derived from mixtures of WC killed strains, is given in two doses, 10-14 days apart. Protective efficacy is reached 10 days after the second dose. The vaccine is currently not indicated for use once an outbreak has started. Neither of the two vaccines protects against *vibrio cholerae* O139.

Issues to be considered for vaccine use

Population at risk

- Displaced population living in settlements with limited access to safe water and proper sanitation, an area that is endemic for cholera, has experienced cholera outbreaks in the past or is at risk according to seasonality of past data, has limited health infrastructure, has community leaders ensuring involvement of community access to the population at risk possible (individuals >2 years of age), access to same population possible over 3-4 weeks (for the two-dose vaccine)
- Surveillance: data on occurrence of cholera over time predominant strain *V. cholerae* O1 vaccine choice of vaccine will depend on the occurrence of cholera timing of vaccination either pre-emptive (environmental management in the population not satisfactory and outbreak expected in the near future) or reactive (at the early stages of an outbreak to limit its spread). sufficient doses available for total population at risk in given area, vaccine pre-qualified by WHO
- Logistics: cold chain facility and storage capacity available, safe water and cups for vaccine distribution available, human resources health care staff and an Expanded Program on Immunization (EPI)/community vaccination teams
- Prevention Capacity to implement health education during campaign, environmental management activities should continue, there should be political commitment, an agreement to import/license vaccine from manufacturing country should be in place, support and commitment from national/regional & local levels and community leaders/groups

Decision-making process for OCV use/deployment;

- Request for OCV use should be initiated by the Ministry of Health of the country. The decision for deployment of OCV should be taken by an Advisory Panel which will base its decision upon analysis of a set of prerequisites. Terms of reference of the Advisory Panel are similar to the ones of the ICG. The Advisory Panel consists of:
 - WHO Headquarters: Department of Immunization, Vaccines and Biologicals; Global Task Force on cholera control; Communicable Disease Surveillance and Response (CSR)/Alert and Response Operations (ARO)/Epidemic Readiness and Interventions (ERI)
 - WHO Regional Office for Africa and the WHO Representative
 - UNICEF Headquarters and UNICEF Regional Office
 - Advice and guidance for implementation of the mass vaccination campaign using OCV will be provided through the WHO Global Task Force on Cholera Control.
- Systems to be put in place; Disease surveillance/Early Warning and Response Network (EWARN) to be strengthened if already existent, Monitoring and evaluation system, Adverse events following immunization (AEFI) surveillance & Safe waste-disposal system.

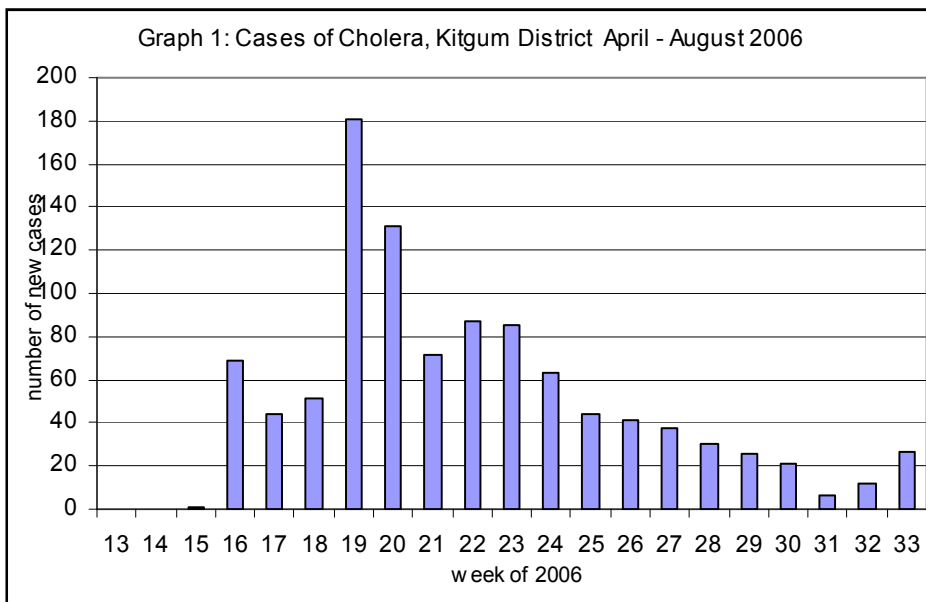
Cholera in Kitgum District: By Dr Barbara Nattabi, WHO Kitgum, Dr John Ntambi, UNICEF Kitgum

Kitgum, one of the five conflict districts of Northern Uganda, started reporting cases of acute watery diarrhea in mid April 2006. The rising number of cases came against the backdrop of outbreaks of cholera in the bordering Southern Sudan towns of Yei (epidemiological week 4, 2006), Juba (week 6), Torit (week 7) and Ikotos (week 10), heightening the possibility of an outbreak in the district. Several towns and Internally Displaced Persons (IDP) camps in Kitgum district are linked by road to towns in Southern Sudan as traders from southern Sudan travel to them frequently. Ikotos is particularly close to the Uganda border, with a lot of movement between it and Kitgum district. There were also cases of acute watery diarrhea (AWD) in neighboring districts of Koboko and Adjumani in Uganda in week 5 (Sudanese refugees migrated from Yei) and cases of AWD in Moyo (week 6).

Background:

Records show that there were cholera epidemics in Kitgum from 1979-1981 in Padibe, Madi Opei, Agoro and Orom. There were 2 epidemics in 1996; one started in January 1996 with 249 cases and 28 deaths (CFR 11.2%). In 8 weeks the epidemic spread from Padibe Sub County to 15 out of the 24 sub counties. There was another in September-October 2004. In November 2004 an epidemic in Akilok, Orom Sub County which left 2 cases dead was quickly contained as a result of vigorous and well-coordinated humanitarian response. The epidemic immediately followed a general market day where Southern Sudanese and other traders from other regions were present.

The Kitgum DDHS, UN agencies and NGOs set up a response plan in early April 2006. All health centres close to the Kitgum-Sudan border were put on high alert and MSF Holland stocked Agoro, Lokung, Potika, Mucwini and Orom health centres with emergency medical supplies and trained the staff on cholera detection and treatment.



Epidemic evolution

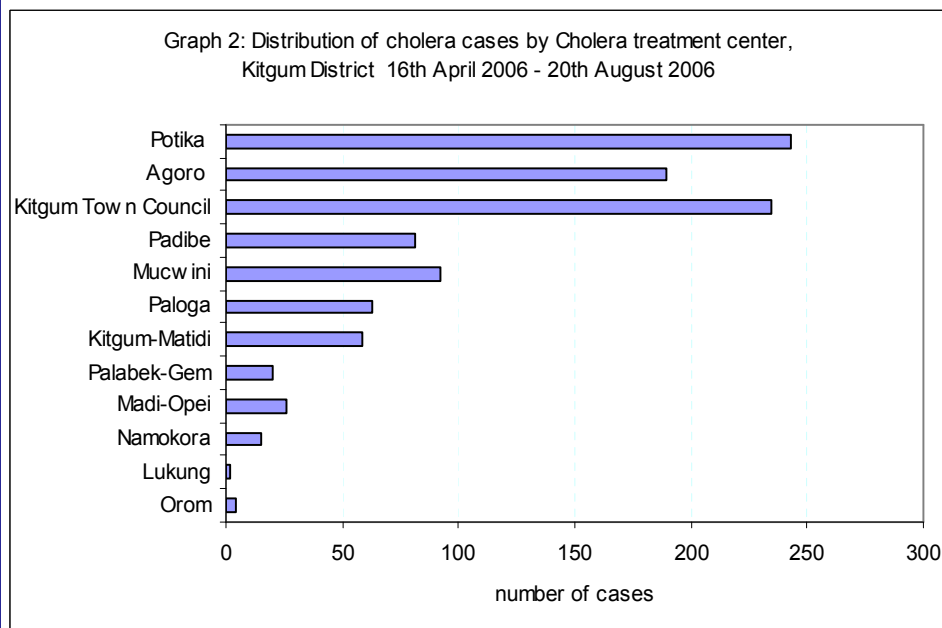
The epidemic started in Agoro IDP camp in the 15th Epidemiological week. In the subsequent two weeks, the epidemic was still confined to Agoro camp, with 69 and 44 admissions for weeks 16 and 17 respectively. During week 18 (4 May 2006), Potika IDP camp reported its first case, who developed acute watery diarrhoea and vomiting after attending a funeral in the same camp. By 7 May 06, Potika had high admissions, with almost 95% of total daily admissions in Kitgum coming from there.

By week 19, cholera had spread to other camps including Kitgum Matidi, Paloga, Palabek Gem, Mucwini, Kitgum Town Council, Padibe and Madi Opei in week 20 and Namukora in week 21. By the end of week 33, 15 out of 22 IDP camps and Kitgum Town Council had registered cases. See graph 1 for the epidemiological curve.

Most cases were registered in Potika (243) followed by KTC (235). See graph 2 for case distribution by camp.

The trend in the epidemic showed an overall decrease in the number of daily and weekly admissions, although there was a geographical spread to other camps. The slight increase between weeks 32 and 33 was due to new cases in Kitgum Town Council & Mucwini IDP camp.

Attack rate and mortality: By week 33, 1029 cases had been reported, and the attack rate was 0.3%. This rate may be explained by the con-



gestion in the camps, which in some cases have over 20,000 residents.

WHO estimates attack rates of 10-15% in displaced populations and 1–2% in normal situations. The Case Fatality Rate (CFR) was 1.4% (15 out of 1029 cases), normally around 5% has reached 40% in large outbreaks in refugee camps (e.g. Goma, Democratic Republic of Congo in 1994). With appropriate treatment (oral rehydration in most cases) the case-fatality rate can be reduced to 1% or less.

. Since the cases were adequately treated in the initial 4 weeks of the epidemic there was no registration of deaths during this time period. Most of the patients who died had underlying conditions / co-morbidities. Two patients had pneumonia, and one each sickle cell disease, cardiac disease and psychiatric illness. 4 of the deaths were in Potika, 5 in Kitgum town council, 3 in Mucwini, and 1 each in Palabek Gem, Madi Opei and Kitgum Matidi.

The age range was 1 month to 90 years and is broken down as follows; Under 1 year 3%, 1-4 years 14% , 5-14 years 19% , 15-29 years 14% , 30-44 years 12%, 45 & above 15% and 23% were unknown.

At the start of the epidemic in each camp, rapid tests on stool samples using Cholera SMART® tests for cholera were carried out on the first few cases and then stool samples were forwarded to Central Public Health Laboratory, Kampala, for confirmation, culture and sensitivity. WHO provided Cary Blair medium for the transportation of stool samples. In total 3 samples from Agoro, 3 from Potika, 2 from Palabek Gem, 2 from Kitgum town council and 1 from Paloga were sent to CPHL. Of the 13 samples sent, *Vibrio cholerae* O1 El tor Inaba was isolated from 11 samples. Organisms were sensitive to ciprofloxacin and tetracycline but resistant to Ampicillin, Chloramphenicol, Nalidixic acid and Cotrimoxazole.

Risk factors include;

- ♦ Low water coverage; most camps and Kitgum Town Council have insufficient amounts of safe water, which forces the communities to fetch water from unsafe sources like springs, rivers and streams. The two hundred shilling levy per household for use of borehole water was suspended by a by-law at the start of the epidemic.
- ♦ Low latrine coverage; with an average of 100 persons per stance, the latrine coverage is far below the recommended level of 20 per stance (SPHERE). Many residents of camps defecate in the open and their excreta is washed into springs, streams and rivers, contaminating them.
- ♦ Use of wide mouthed water pots is a major risk factor as a single cup is used for dipping and drinking, potentially contaminating the water. Many of these water pots are not regularly cleaned, and are a potential reservoir of infection. Note that drinking water is almost never boiled.



A wide-mouthed pot in use

- ♦ Poor hygiene practices including not washing hands after defecation and communal washing of hands in one basin-this cultural practice is a major risk factor as the same water is used by a number of people to wash their hands.
- ♦ Public gatherings like funeral ceremonies and animal auctions have contributed significantly to the spread of cholera between camps. The outbreak in Agoro was preceded by an animal auction, while that of Potika occurred after a funeral which hosted residents of Agoro camp.
- ♦ Congestion in addition to the other risk factors makes the population vulnerable to rapid spread of cholera.

The Response ;

- ♦ A cholera preparedness plan was prepared by the district and partners when Southern Sudan declared an epidemic. The cholera taskforce, already in existence, started to meet on a weekly basis.
- ♦ Deployment of emergency supplies for treatment of suspected cases of cholera at camps close to the border with Sudan.
- ♦ Set up of cholera treatment centres and provision of cholera kits and other logistical items needed in cholera treatment.
- ♦ Repair and construction of boreholes and latrines
- ♦ Production and dissemination of health education messages in communities through posters, brochures, radio messages/talk shows, film van and meetings with community/political leaders
- ♦ Assessment of sanitation at schools and education centres. Distribution of cleaning materials, hand washing facilities, latrine & borehole construction was undertaken to improve sanitation in schools. School feeding was suspended until centres had reached a desirable level of sanitation.
- ♦ Political leaders issued by-laws including prohibition of the borehole levy, and open defecation. Note that the chair of the cholera taskforce is the Local Council V Chairman.

Recommendations

- ♦ Strengthening surveillance, particularly early case detection, timely reporting and investigation of suspected cases at both community and health facility level.
- ♦ Establish a community surveillance system –an Early Warning System .
- ♦ An epidemic preparedness & response plan should be improved in order to identify and build core competencies needed to

effect rapid response to outbreaks and diseases of epidemic potential.

- ♦ Risk factors must be addressed to control and end the epidemic. This includes low safe water coverage and low latrine coverage.
- ♦ Good coordination and multi-sectoral collaboration seen between the district and the agencies in control of the epidemic should continue.
- ♦ Cross border consultations with Southern Sudan Health Authorities will support reduction of cross border transmission of cholera.

The epidemic, now running for 21 weeks, with 1066 cases and 15 deaths, continues to persist. Overcrowding, low latrine coverage, grossly inadequate amounts of water and traditional & cultural practices have made it difficult to eradicate. Partners have showed strong support to the district in controlling the epidemic and need to continue this support as the epidemic isn't over.

The **Kitgum Cholera Taskforce** consists of the: LCV, Secretary for Health, DDHS, partners including WHO, UNICEF, OCHA, MSF-Holland, International Rescue Committee, International Medical Corps, OXFAM, AVSI, ICRC/URCS, AMREF, Christian Children Fund, Lutheran World Federation, Feed the Hungry International. Sources:

Cholera in the rest of Northern Uganda

In **Pader district** acute watery diarrhoea was reported in Acholi Bur, 18km from Kitgum Town, during epidemiological week 21. The outbreak persisted through to week 30 and affected other camps including; Acholi bur, Pajula &Atanga. The cumulative number of cases reported was 20, with 0 deaths.

Intervention activities included: establishing cholera treatment centres, provision of cholera treatment kits and transport media for confirmatory tests, increased surveillance activities including contact tracing, provision of training, training materials and technical support to District medical staff and social mobilization activities.

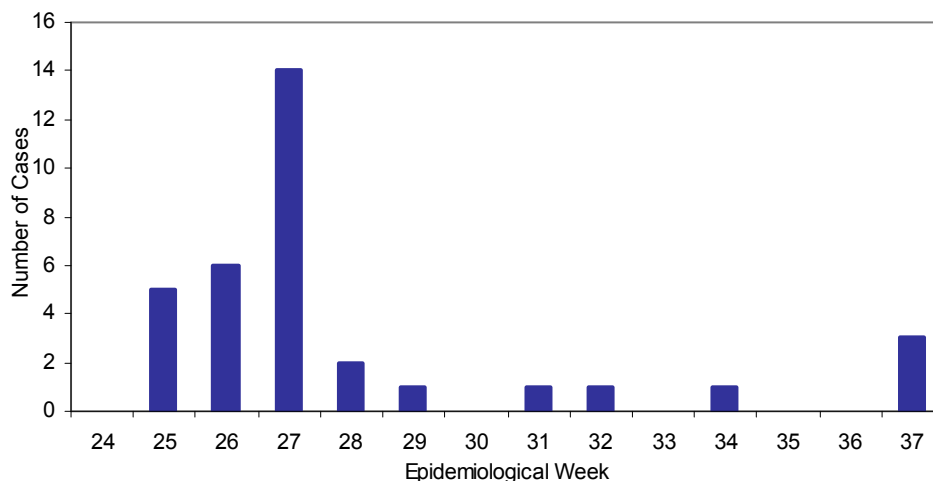
Pader Cholera Taskforce includes: DDHS, WHO, UNICEF, OCHA, CARITAS, MSF-Fr, CESVI, CONCERN, MEDAir, IMC, CCF, AMREF, COOPI, MSF-H, UPDF, ICRC, AVSI, Mercy Corps, Office of the RDC and OPM/UNDP.

Gulu district had been in a state of high alert since the beginning of the rainy season, following the existence of cholera outbreaks in the neighboring districts of Kitgum, Pader and Adjumani; and Southern Sudan. Gulu district had a cholera epidemic that lasted from April to November 2005 with a 861 cumulative cases and a CFR of 1.3%. On 22nd June 2006, Gulu Hospital reported a case of Acute Watery Diarrhea (AWD) originating from Unyama IDP Camp situated about 10 km out of Gulu Town. This case was rapidly followed by a cluster of cases within the camp, and extending to Gulu Municipality. A District Cholera Task Force meeting convened and constituted a rapid response team (RRT) that carried out an outbreak investigation. The investigation confirmed an outbreak of cholera when culture and sensitivity test done at Lacor Hospital isolated *Vibrio cholerae* and epidemiological substantiation was established. In the succeeding week, another cluster of 4 cases in one household occurred in Bibia camp, the source of infection was eventually traced to southern Sudan. Subsequently, sporadic cases of cholera were reported from a number of places.

Progression of Cholera Epidemic in Gulu:

Between 22nd June and 21st August 2006 a cumulative of 34 cases meeting the case-definition of cholera was registered in Gulu. One community and another CTC death occurred. There was a pre-morbid condition in the patient that died from the CTC. Epidemiological investigation identified a multi-focal source of infection in Gulu. The source of infection in the first cluster of cases was traced to Pader District (that was having an ongoing epidemic) from where some guests had traveled to attend the funeral function in Unyama camp. The focus of infection in the second cluster of cases in Bibia Camp originated from Southern Sudan when one member of the family had gone to visit.

**Weekly Incidence of Cholera Cases, Gulu District
22 June - 14 Sept. 2006**



The epidemic was characterized by a gradual increase in the number of cases, attaining a peak of 5 cases per day within 10 days before waning to sporadic cases. After 18 days of zero reports, 3 new cases were registered between 9 and 10 September 06. The source of infection of the second cluster of cases in Bibia was in Southern Sudan where a member of the family had gone to visit.

The epi-curve demonstrates a point-source transmission of infection at the beginning of the epidemic, which was followed by a propagated type of transmission. Epidemiological investigation could not establish linkages between the sporadic cases, raising

the likelihood of carrier states or environmental reservoir as the source of the infections.

Alternatively, the sporadic cases could have been imported from neighboring districts but because of poor transmission potential, the infection was interrupted. This epi-curve signifies a well controlled outbreak; this rapid interruption of transmission could partly be attributed to the prompt coordinated intervention by the District Task Force and the fast response of the community that had already been enlightened from previous cholera epidemics.

Distribution of Cases by Location : The cases occurred in 6 camps (Unyama, Bibia, Awer, Patiko, Alokolum & Kati kati) and Gulu Municipality. The cases in Unyama and Bibia camps emerged as clusters following a common source of infection involving family members and relatives. However, the other cases were isolated without any epidemiological linkages established.



An example of an unsafe water source in Bibia camp, Amuru district

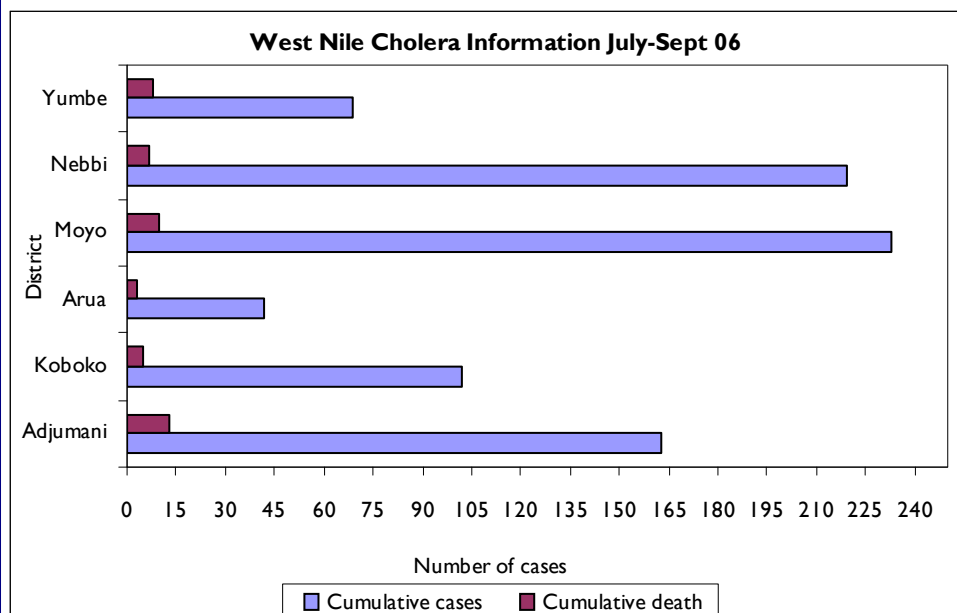
Distribution by Age and Gender: About 58% of the cases were female and 42% male. Age distribution was as follows; 1-4 10%, 5-14 19%, 15-29 35%, 30-44 10%, 45 and above 26%.

Interventions in Gulu/Amuru districts:

Intervention	Action
Coordination	District Cholera Task Force meetings and formation of municipal and lower level task forces at division and camp levels. Lower level taskforces attend district taskforce meetings
Cases management	Establishing CTC in Gulu Hospital and Lacor hospital isolation ward
Surveillance	Active surveillance, active case searches and referral and community follow-up
Social Mobilization	Use of the film van to mobilize and educate the community on diarrhoeal disease prevention, radio spots/messages, radio talk shows, dissemination of brochures/leaflets and posters on cholera prevention in the community

Partners include; The District Health Services, Water Office, Gulu Municipal Council, Secretary for Health, WHO, UNICEF, ACF, AVSI, MSF-E, MSF-CH, Caritas, AMREF, ICRC & CARE Uganda

West Nile: The first case of cholera in West Nile was reported on 12 July 06 in Arua, followed by Moyo on 13 July, Adjumani on 24 July and Koboko on 26 July 06. See the graph below for



Risk factors for the region include;

- ◆ Low latrine coverage, cultural beliefs regarding latrine use and weak soils that don't favor latrine construction
- ◆ Low safe water coverage
- ◆ No hand washing after latrine use
- ◆ Use of wide mouthed water pots
- ◆ Low awareness regarding the safe water chain in communities
- ◆ Poor food hygiene
- ◆ Practice of religious gastric lavage of the dead

The West Nile region was visited by a MoH/WHO team who met with

district taskforces, visited all health facilities where they conducted sensitization and technical support on proper case management & infection control, provided supplies for treatment of cases and health education material for communities.

Conclusion:

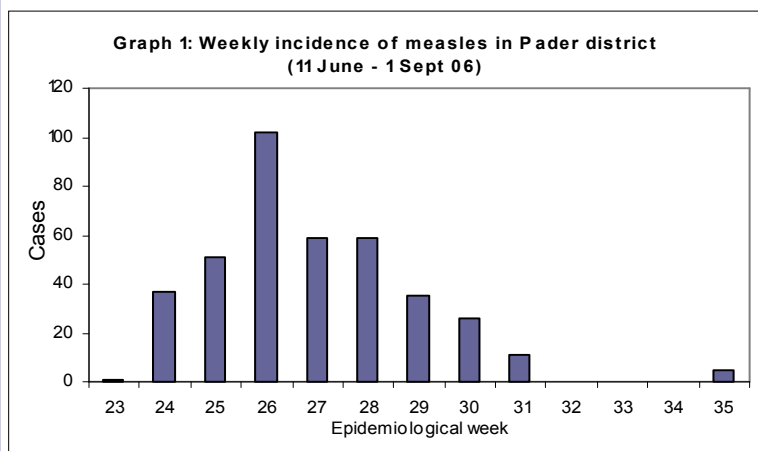
Outbreaks of epidemic prone diseases will continue to occur, more so in places which are congested and have limited latrine & safe water coverage. Long lasting solutions to the problem of disease outbreaks must involve mitigating the risk factors.

Source: WHO-HAC Kampala, Gulu & Kitgum

Measles outbreak response in Northern Uganda

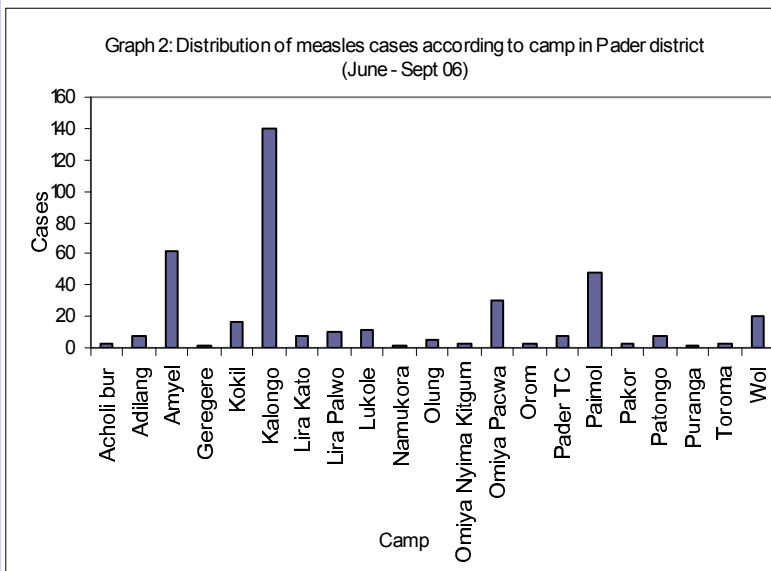
By Innocent Komakech/WHO Pader, Dr Barbara Nattabi/WHO Kitgum & Dr Charles Okot /WHO Gulu

Pader district reported its first measles case during epidemiological week 23 (11 June 06), in Kalongo. In week 24, the weekly incidence rate was up to 37, reaching a peak 95 cases during week 26. The cumulative total was 386 by week 35. The case fatality rate was 1.8%. See graph 1 for weekly incidence rates in Pader.



21 IDP camps were affected, with the 4 most severely affected being Kalongo Township with 140 cases, followed by Amyel with 62 cases, Paimol with 48 cases and Omiya Pacwa with 30. Note that the most severely affected camps are also camps quite close to Kalongo, which was the epicentre of the outbreak. See graph 2 for case distribution by camp.

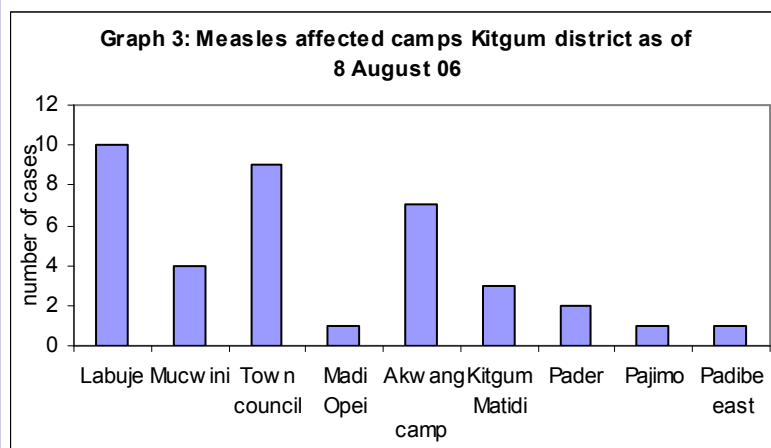
Case distribution by age group was; 0- 5months- 11%, 6-9months-29%, 10-12 months-64%, 13-59months- 41%, over 59 months-2% and those of unspecified age were 1%.



Distribution of cases by vaccination history was as follows; 62% were unimmunised, 19% were immunized according to history, 7% were vaccinated, but no cards were seen, while the vaccination status of 12% was unknown.

During epidemiological week 23 of 2006, Kitgum Town Council reported a case of suspected measles with a history of travel to Kalongo, Pader, three days prior to onset of the illness. Eventually, 7 out of 26 camps in Kitgum district by 27 July 06. A total of 40 cases and 0 deaths were reported by 07 August 06.

In Kitgum, case distribution by age group was; 0-5months- 5%, 6-9months-22.5%, 10-12 months-



20%, 13-59 months-45%, above 59 months-7.5% . 55% of the 40 reported cases had no proof of immunisation. 36% were vaccinated according to history and incidence from the card. 10% presented with unknown immunisation status. The epidemic lasted from week 23 to 32. See graph 3 for areas affected by measles in Kitgum.

A measles vaccination campaign targeting 6-59 months and other antigens including Oral Polio Vaccine 0-59 months (OPV), DPT-HIP-HEB (0-11 months), BCG (0-11 months) & TT (women 15-49 years) was planned for Kitgum, Pader and Gulu/ Amuru districts to enable catch up on immunisation

schedules and provide coverage for those who hadn't received immunisation at all.

Response:

- ◆ Investigation of the suspected outbreak and confirmation by Uganda Virus Research Institute.
- ◆ Case management at health facilities
- ◆ Formation of a Measles taskforce that met on a daily basis and provided regular updates to partners

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WHO Uganda



Child receiving measles vaccination

See the graph 4 for vaccination coverage.

Achievements

- ♦ All sub-counties were covered including hard to reach areas.
- ♦ Vaccines and ice packs were adequate and old chain was well managed.
- ♦ Social mobilization was carried out at all levels

Constraints

- ♦ In some districts micro-planning was done centrally, this caused a few oversights e.g. escort hire.
- ♦ Short period for orientation of health workers, which probably increased vaccine wastage.
- ♦ Funding gaps included escort allowance, training materials and IEC materials for social mobilization, as they were overlooked.
- ♦ Screening for the target group wasn't properly done in some areas. At some posts in Kitgum, vaccinators were put under pressure to vaccinate about 1192 children over 59 months.
- ♦ Disbursement of funds wasn't timely.
- ♦ Discrepancies in population figures was a challenge in estimation of supply requirements & vaccination targets.

Lessons learnt

- ♦ The use of technical working groups such as social mobilization, surveillance, improved the coordination of the campaign.
- ♦ Political involvement at district level is essential for community mobilization.

The Measles Taskforces consisted of District Health Services in Gulu/Amuru, Kitgum & Pader, office of the LCV & District Councilors, WHO, UNICEF, UNEPI, AMREF, MSF-E, MSF-CH, MSF-H & MSF-F.

Recent events:

04/5 Sept 06: Visit of Swedish & Canadian delegations to review plans regarding early recovery, return & protection in Gulu district.

06-07 Sept 06: Health, Nutrition & HIV cluster meeting to discuss emergency plans for return, resettlement & early recovery in the Northern Uganda districts.

09-10 Sept 06: Visit of Jan Egeland, UN Humanitarian Coordinator to Gulu district to discuss peace and plans for return and resettlement of Internally Displaced Populations.

15-16 Sept 06: Visit of the Prime Minister, Hon. Apollo Nsubambi to Gulu & Kitgum districts

20-21 Sept 06: Health, Nutrition & HIV cluster meeting to review district plans for return, resettlement & early recovery, and the Consolidated Appeal for the sector.

- ♦ Formation of technical working groups in surveillance & social mobilization to augment coordination
- ♦ Social mobilization; meetings with leaders and the community, radio talk shows and spot messages,
- ♦ Micro planning for vaccination and an emergency vaccination exercise in 9 camps in Pader
- ♦ Mass measles vaccination campaign that covered Pader, Kitgum & Gulu districts.

Graph 4: Measles/OPV mass vaccination 2006 coverage for Gulu, Amuru, Kitgum & Pader

