

Health, Nutrition & HIV/AIDS Newsletter

A publication of the Uganda Health, Nutrition and HIV/AIDS Cluster December 2007 Volume 1 Issue 3

Editorial

By Dr. Olushayo Olu

Health, Nutrition & HIV/AIDS cluster coordinator

It is amazing how time flies; 2007 which ends in 2 weeks has been a very eventful and busy year for the cluster. The year witnessed many major epidemic outbreaks and natural disasters which include the meningitis outbreak in west Nile region, cholera in Kitgum district (spill over from 2006), Marburg in Kamwenge, floods in Teso, Karamoja and northern Uganda, Hepatitis E in Kitgum and recently Ebola in Bundibugyo districts. The cluster involvement in the coordination, implementation, supervision, monitoring and evaluation of the emergency responses to all these outbreaks and disaster has further strengthened team building, partnerships, joint planning and implementation and improved cohesion among its members. I believe that these and the lessons learned from the emergency response to these health events have laid a solid foundation for more collaborations and joint programming within the cluster in 2008.

In this edition of the cluster newsletter, the lead article is on the ongoing emergency response to the Ebola epidemic outbreak in Bundibugyo district. We also bring you among others, articles on the emergency flood response in Teso, malnutrition situation in the north and malaria control using ITNs in Uganda. Of course we also feature the regular section on news and events within the cluster and provide links to useful websites.

During the year many actors within and outside the cluster including all cluster members too numerous to mention, humanitarian partners, donors, Ministry of Health (MOH) and Uganda AIDS Commission (UAC) contributed immensely to the successful implementation of all cluster activities; to everybody, I say thank you. I also seize this opportunity to welcome Mrs Pauline Ajello, the new Information Assistant for WHO Gulu to the editorial board of the cluster newsletter. Finally, I wish you all a very Merry Christmas and a very Happy and Prosperous New Year!

Epidemic of Ebola Viral Hemorrhagic Fever Hits Bundibugyo District

By Dr. Olushayo Olu



A technical team visits the Ebola isolation unit in Bundibugyo Hospital.

Bundibugyo, a very rural, underdeveloped, and mountainous district of western Uganda has been hit by an epidemic of Ebola viral hemorrhagic fever. Ebola is a very infectious and deadly viral hemorrhagic fever caused by a virus belonging to the filoviridae family.

By the 2nd January 2008, 147 cases and 37 deaths with a Case Fatality Rate (CFR) of 25.3% due to the disease have been reported in 5 sub-counties of the district. Due to the highly infectious nature of the disease, health workers and close con-

tacts of patients are especially at risk of contracting the disease. Of the total 131 cases, 12 are health workers who were attending to the patients of whom 5 have died. Alert (suspected) cases have also been reported in Kasese, Mbarara, Kabarole, Adjumani, Mubende, Kanungu, Masaka, Gulu, Lira and Mbale districts but these have been ruled out by laboratory investigations confining the outbreak to Bundibugyo district. Following the laboratory confirmation of the virus, the Government of Uganda (GoU)

Cont. Page 2

Inside this issue

- The emergency flood response in Teso
- Malnutrition situation in the north
- Malaria control using ITNs in Uganda
- Regular section on news and events within the cluster.



Ministry of Health officials visit Bundibugyo district to assess the ebola situation.

through its Ministry of Health (MOH) officially declared an epidemic of the disease on the 29th of November 2007. A comprehensive epidemic response which focused on establishing infection control at the health facility and community levels, prompt identification of cases and their contacts, establishment of appropriate isolation facilities and effective treatment, community mobilization and education about the disease was immediately mounted in the district.

In neighboring districts and areas where alert cases of the disease have been reported, epidemic preparedness measures were instituted to prevent spread of the epidemic. Sequel to the official declaration of the epidemic, multi sectoral and multi agency national and district taskforces were established and meet regularly to review the epidemic response efforts. The taskforce is chaired and co-chaired by MOH and WHO respectively at the national level and the RDC at the district level and strong partnerships have been built among agencies involved in the response. Tasks were assigned based on comparative advantages of each organization; case management is being supported by MOH, MSF and WHO, social mobilization by MOH, UNICEF, WHO and URCS, epidemiology and laboratory

investigation by CDC, WHO and AFENET, psychosocial support and food supply by UNICEF, URCS, TPO, Butabika Hospital and WFP and medical supplies and logistics are being provided by all these agencies including ICRC, World Vision and IRC.

To support case management, two isolation facilities were established in Kikyo health centre IV (which is the epi-centre of the outbreak) and Bundiguyo hospital while the existing isolation unit in Mulago hospital, Kampala was reactivated to ensure prompt and effective treatment of patients using the best infection control procedure available. Given that the disease is transferred from person-to-person and that most of the cases of the disease cluster around patients and health workers treating them, infection control



The Ebola isolation unit in Bundibugyo hospital

procedures including provision of guidelines, training of health workers and provision of Personal Protective Equipments (PPE) were rapidly put in place in all the isolation units and all Regional Referral hospitals in the country. In addition active listing, tracing and follow-up of patient's contacts using mobile teams, Village Health Teams (VHTs) and Community Medicine Distributors and aggressive

community mobilization is being implemented to reduce risks of transmission of the disease. An Ebola diagnostic laboratory has also been established in the Uganda Viral Research Institute (UVRI) in Entebbe and so far 125 samples have been tested out of which 35 were found to be positive. The establishment of the laboratory greatly facilitated better definition of cases and contributed immensely to improvements in case management. Given the high CFR and traumatic nature of the disease, psychosocial support of affected families and health workers is also being carried out and discharge kits containing essential materials such as cloths, condoms, soap, food ration is being provided to discharged patients

Although the response to the epidemic has so far been very good, there were major challenges which hampered epidemic investigation and initial response efforts. The causative virus responsible for this epidemic is a new strain of Ebola which posed diagnostic challenges and delayed confirmation of the epidemic. This was further compounded by the atypical clinical presentation of the patients with malaria-like symptoms which clouded clinical diagnosis of the disease. Both of these and the highly infectious nature of the disease contributed to the high Attack Rate (AR) of the disease among the health workers which in turn resulted in panic and abandonment of duty by health workers. The resulting shortage of human resources especially nursing staff in terms of numbers and experience in ebola

Cont. to Page 3

Emergency Flood Response Strengthens Health Coordination in Uganda *By Dr. Olushayo Olu*



Joint effort: Cluster members from UNOCHA, UNICEF, WFP, PILGRIM and WHO assess the health situation in Ngenge subcounty, Kapchorwa district, one of the villages that were cut off due to floods.

Unusually heavy rains in the northern, eastern and north eastern regions of Uganda starting from August to November 2007 resulted in the heavy flooding in these areas.

By September about 17 districts, 2 in Acholi sub-region

(Kitgum and Pader), 3 in Lango (Lira, Amolatar and Apac), 6 in Teso (Kumi, Amuria, Katakwi, Bukedea, Kaberamaido and Soroti) and 6 in Bugisu (Bududa, Manafwa, Kapchorwa, Sironko, Mbale and Bukwa) had been affected with Teso sub-region (Amuria and Katakwi districts)

been worst hit. Major consequences of the floods included destruction of crops, houses, population displacement and poor access (many link roads and bridges were washed away).

The floods destroyed many pit latrines and washed the contents into domestic sources of drinking water resulting in widespread contamination of water sources and lack of sanitation facilities; other health consequences of the floods included increases in number of cases of malaria and diarrhea diseases, stock-out of essential drugs and medical supplies, inadequate number of human resources and lack of access to good quality basic health services as many areas were cut-off. To ensure a very effective and well coordinated health response to the

Cont. Page 11

Ebola Fever hits Bundibugyo...*from page 2*

response and inadequate logistics (medical supplies especially Personal Protective Equipments) initially posed the greatest challenges to effective response to the epidemic but these have now be addressed. Underlying weak health systems, poor health infrastructure, equipment and support services such as electricity, water and sanitation and the difficult terrain of the district were also major challenges which hampered response efforts. Although the epidemic is currently under control and the number of cases is reducing, there is cautious optimism about predicting its course. To this end, all hands are on deck to ensure that the current momentum of the epidemic response is sustained over the holiday season. ■

Key points to remember about Ebola

- Ebola is a serious disease, and kills in a short time BUT can be prevented.
- Ebola spreads from one person to another through physical contact with body fluids of an infected person
- **Ebola can be prevented through:**
 - i. Regular washing of hands with soap and water after touching a suspected person
 - ii. Proper protection using gloves, goggles and masks where possible, when handling patients suffering from Ebola.
 - iii. Prompt management of all persons suffering from Ebola, by seeking early medical help.
 - iv. Proper burying of people who have died of Ebola immediately.
 - v. Reporting of any suspected case of Ebola to the nearest health unit
 - vi. Avoid communal washing of hands during funerals.

It is time to refocus attention in addressing the nutrition problem in Uganda

By Dr. Eric-Alain Ategbo & Mrs. Brenda Kaijuka Muwaga - UNICEF

Since the mid-1980s, northern Uganda has been trapped in a cycle of violence and suffering due to conflict between the Government of Uganda (GoU) and the Lords' Resistance Army (LRA).

In particular, the people of Acholi land in northern Uganda have been significantly affected, evidenced by the more than one million Acholis who have been forced to flee from their villages of origin to Internally Displaced Persons (IDPs) camps in search of relative peace and security. Thanks to progress made in the peace talks, the situation of the IDPs has evolved with currently massive population movement out of camps, to new settlements or to their original homestead.

Significant reduction in malnutrition rate in northern Uganda has been noted. United Nations Children's Emergency Fund (UNICEF) and other humanitarian partners stepped in to roll out an effective emergency response plan following an elevated prevalence of malnutrition in 2003 which coincided with the peak of the insurgency in northern Uganda.

The Global Acute Malnutrition (GAM) was above the emergency level (15% GAM) in all conflict affected districts from as

high as 30% in Gulu to current rates below 5% in all northern districts except in Kitgum.

Overall, the downward trends in malnutrition can be attributed to the effective humanitarian response in addressing the hunger gap mainly through food aid and emergency feeding programmes on the one hand and the effective management of severe acute malnutrition on the other hand.

However, a reversal in the downward trend is being observed (2006-2007) in Lira

moving out of camps is limited, compared to when they were in IDP camps. Sustaining reduced malnutrition rates requires a change of focus and a change of strategy.

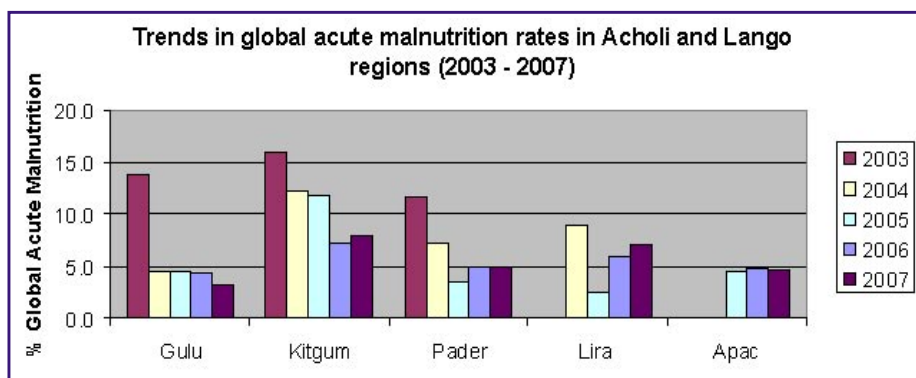
Till date, priority was given to treatment of severe malnutrition through Therapeutic Feeding Centres (TFC) and more recently through the Community Based Therapeutic Care (CTC). This is based in most cases, on VHTs, involved in screening for early identification and referral of children with severe malnutrition. In some cases, moder-

ately malnourished children are referred to Supplementary Feeding Programme (SFP). It is high time to move out of the reactive mode to

adopt a pro-

active way of preventing onset of malnutrition.

With people settling in more or less permanent areas, nutrition programme should be oriented towards community based promotion of adequate nutrition practices which include early initiation of breastfeeding (within one hour after birth), exclusive breastfeeding for the first six months, and timely initiation of adequate (quantity, quality, feeding frequency) complementary feeding with breastfeeding up to two years and beyond. This effort should be comple-



district and to some extent in Pader. This may be as a result of the return process spearheaded there in 2006.

Progress made over the last 4 years in reducing malnutrition rate is significant. The upward trend depicted in Lira and Pader should be seen as warning signs. The situation is still fluid and it is therefore important to put in place relevant plans and actions to sustain the gain.

Experience has shown that access to basic health and nutrition services by populations

Cont. Page 5

Ministry of Health Consults on a health recovery Strategy and Plan

By Pauline Ajello

Twenty-one years of war, destruction, and displacement of over 1.5 million people has turned northern Uganda into a humanitarian disaster. Health systems have been broken down, abandoned as others are closed for fear of security risks.

With the withdrawal of the LRA to the Congo, security in northern Uganda has improved considerably resulting in population movements close to original homes. With the improvement in security, the Government of Uganda launched the Peace Recovery and Development Plan (PRDP) which sets the pace for return and early recovery in Northern Uganda.

On 2nd November 2007, the Ministry of Health with support from the Health, Nutrition and HIV/AIDS cluster led by WHO,

organized a consultative meeting of stake holders to discuss the modalities for operationalising the Peace Recovery and Development Plan (PRDP) through the development of a health recovery strategy and plan. The half day meeting which was held at Hotel Africana, was attended by Chief Administrative Officers and District Health Officers from Acholi, Lango, Teso and Karamoja regions of Uganda, donor partners, key MOH officials and cluster members drawn from the United Nations and Non-governmental Organisations.

The main objective of the meeting was to reach a common understanding among key health stakeholders on the purpose of the health sector recovery strategy for northern Uganda, its challenges and opportunities. Others

were to identify main linkages with on going relevant planning process and existing coordination mechanisms and to agree on the overall process and the immediate steps/activities and responsibilities for taking the process forward.

During the meeting, Dr. Sam Zaramba the Director General of Health Services urged district leaders to provide a supportive and peaceful environment that would encourage transition from emergency to peace and development. He stressed that this strategy provides an opportunity for all stake holders to participate in the process.

In his speech, the WHO country representative, Dr. Melville George, called for commitment from the districts saying it is very crucial for the success of this program. He commended all stakeholders for showing commitment and interest to this process.

He called on all those present to work together to make the strategy a reality. He said that all stakeholders are learning. He also said that the PRDP will pose more challenges now that WHO and other partners are moving to other districts.

During the meeting, the road map for the health recovery strategy and plan was also presented. The development of the strategy and plan are not one-off activities but a process which will take sometime. The road map started in November 2007 and will be concluded in June 2008. ■

It is time to refocus attention

...from page 4

mented by promotion of healthy behavior including hand washing, use of latrine, use of clean water and promotion of health care seeking behavior.

While significant improvement is being seen in Northern Uganda, malnutrition rate in Karamoja sub-region has increased two folds between 2005 and 2007, increasing from 5 – 10% to above 15%, exceeding the emergency threshold.

Moreover, the recent UDHS (2006) has revealed high prevalence of malnutrition in Kara-

moja and South Western Uganda, with prevalence of stunting reaching 50% in Southwest and 54% in Karamoja.

To significantly influence national indicators and thus, contributing to achieving MDGs 1 and 4, it is imperative for the nutrition community to carefully target areas of high malnutrition and to roll out and support government to roll out relevant strategies/programmes, not only aiming at curbing prevalence of severe malnutrition, but also designed to successfully prevent onset of under nutrition. ■

US \$ 374 million needed for humanitarian and recovery assistance to Uganda in 2008

By Sheila Gashishiri



Health, Nutrition and HIV/AIDS cluster exhibit during the 2008 CAP launch

The Government and humanitarian community in Uganda on 10th December 2007 launched the 2008 Consolidated Appeal for Uganda (CAP 2008), which seeks US\$ 373,943,491 to address emergency life saving needs and facilitate the recovery of vulnerable groups, including displaced and formerly displaced populations, refugees and those affected by natural hazards in Acholi, Lango, Teso, and Karamoja regions.

“The consolidated Appeal 2008 represents the humanitarian community’s commitment to provide appropriate assistance in four areas: to IDPs and returnees in northern and north-eastern Uganda, those suffering from the insecurity and extreme poverty in Karamoja, those affected by disasters caused by natural hazards and to the refugees seeking shelter in Uganda from conflict in their own countries,” said the United Nations Humanitarian Coordinator Theophane Nikyema, speaking, at the launch of the CAP 2008. The Minister for Disaster Preparedness, Prof. Tarsis Kabwegyere while offici-

ating at the launch at Hotel Africana said that it is hoped that the humanitarian community will provide assistance against the backdrop of the continued improvement in humanitarian access and security resulting from the ongoing peace negotiations between the Lord’s Resistance Army (LRA) and the government. “This improvement has encouraged a steady stream of Internally Displaced Persons (IDPs) to move out of the displacement camps into transit sites or villages of origin.” In order to showcase major highlights of activities that have taken place during the year, humanitarian clusters including the Health, Nutrition and HIV/AIDS (H+N+H/A) cluster exhibited during the launch. The H+N+H/A cluster exhibited documentaries of various activities by cluster members,

gave away Information, Education and Communication materials and showcased interesting pictorials capturing powerful moments of the cluster activities during the course of the year.

The humanitarian community, in cooperation with national and district – level government authorities, has developed the CAP 2008 as a combination of humanitarian and recovery programming that contributes to achievement of the strategic objectives identified within the Peace, Recovery and Development Plan (PRDP) for northern Uganda in order to ensure a smooth transition from crisis to recovery. The Consolidated Appeals Process is the principle



Prof. Tarsis Kabwegyere, Minister of Disaster Preparedness and the Humanitarian Coordinator Mr. Theophane Nikyema inspect stalls of exhibiting clusters during 2008 CAP launch.

tool by which the humanitarian, human rights and development communities’ work in partnership with the Government to plan, coordinate, fund, implement and monitor humanitarian assistance for vulnerable populations. As a planning and programming tool, the CAP promotes a strategic, coordinated, effective and prioritised humanitarian response. ■

WFP empowers youth in northern Uganda with Life skills



Young mothers attend a mobilisation activity

The precarious situation in which many adolescents grow up in the Internally Displaced People's (IDP) camps and return area of northern Uganda contributes to risky behaviours such as; alcoholism, drug abuse, domestic violence, sexual abuse and prostitution. This predisposes the young population in the north and north-eastern Uganda highly vulnerable to STDs/HIV/AIDS and unintended pregnancies among others.

A recently concluded survey among young people out of school conducted by the World Food Programme (WFP) demonstrated that, 67.2% were sexually active and 29.8% were either married or living with their partners. For those young people in school, only 13.6% out of 53.6% sexually active were living with their partners.

To address this problem, WFP

Uganda developed a project in the four northern districts of Uganda to enhance 'Life-Skills' among the youth. The purpose of the project was to build capacity among the youth towards HIV Prevention Programs (CBHP). The program is being implemented by Ma-PLAY with funding from DFID. The districts having the target young people are being provided with food from WFP.

Under this project, youth clubs were formed with the objective of educating young people who remain vulnerable to STDs/HIV and other adolescent health challenges with adequate knowledge, positive attitudes and life skills to assist them understand and appreciate who they are, what they are going through and how better they can achieve their goals and dreams in life.

WFP expects that the project will broadly contribute to the

reduction of HIV/AIDS amongst vulnerable young people in the target areas by creating a supportive environment for the initiation and implementation of the HIV/AIDS interventions in the two districts and enhance the capacity of selected communities to initiate and manage HIV/AIDS behaviour change interventions for the target group.

In order to meet the youths' expectations, WFP plans to carry out mobilization meetings and workshops for key stakeholders. Twenty – four community groups of young people of in and out of school in the districts of Kitgum, Pader, Lira and Amuru will benefit from the life skills development programs.

WFP will also train district youth friendly trainers and equip them with facilities that would enable them support club activities. There is commitment from the district and community leaders as evidenced from the way 24 community clubs voluntarily mobilized themselves and are carrying out activities amongst their peers in the camps and nearby villages.

The gaps in knowledge, attitudes and practices amongst the target group and trained 104 Youth friendly teachers and out of school Volunteers in Training of Trainers have also been assessed. ■

Health Services Availability Mapping Survey concluded in Lango *By Dr. Micheal Lukwiya*

The Ministry of Health with funding from DFID and in collaboration with Uganda Bureau of Statistics (UBoS) and WHO conducted a Health Service Availability Mapping (SAM) survey in all health facilities in the five districts of Lango sub-region from March to August 2007. The survey whose objective was to identify critical gaps in health services delivery with a view to defining priority interventions for health recovery in the area was conducted using a descriptive cross sectional survey methodology with collection of both quantitative and qualitative data.

Highlights of the survey results indicate that there are 131 health facilities out of which 18 (13.7%) are non-functional in sub-region, of the 18 non-functional health facilities, 15 (83%) are health centres II and 13 (72%) are located in Lira district. Although all the 113 functional health facilities offer Out-Patient Department (OPD) services, the per-capita utilization is between 0.5 and 0.9 whose figure is below the national average of 1. Almost all health facilities surveyed reported stock-out of at least one of the tracer drug in the last 3 months. More than half of the health facilities in Apac and Dokolo district had infrastructure defect in at least one site in the building. Pope Paul XXIII hospital in Aber had a major crack in the wall, floor and roofing of OPD, maternity and theatre. Access to safe water and latrines was poor in health centres in Lira, Oyam and Apac district. HIV/AIDS counseling and testing services were found to

be low in HC IIIs in Amolatar and Apac and worse in all HC IIs in all districts of the Sub-region. Only 50% of HC IVs were offering ART services and provision of PMTCT services at HC III level is poor ranging from 25% to 54%. The regional hospital, HC IVs and IIIs in Dokolo and Oyam districts and all general hospitals except the one in Amolatar district were found to be offering TB services. However, generally there is a low coverage of TB testing services ranging from 25% to 54% in HC IIIs in Amolatar, Apac and Lira Districts. Less than 80% of HC IIIs were found to be offering in-patient services in the area. The provision of Family Planning (FP) and antenatal (ANC) services is generally poor in all HC IIs in the five districts. All sub-counties in Amolatar, Dokolo and Apac except Ayer sub-county were offering delivery services. In Oyam and Lira district, normal delivery services were available in all except in five (5) sub-counties. Basic Emergency and Obstetric Care (EmOC) services were absent in all HC IVs in Apac, Dokolo and Oyam districts while only fifty percent of HC IVs in Lira district were offering these services.

No HC III in the entire sub-region was offering basic EmOC services. Comprehensive EmOC was lacking in all HC IVs and Lira regional referral hospital. The survey also showed a huge gap in human resources for health with the ratio of doctors to population ranging from 1:25,272 in Lira District to 1:110,617 in Amolatar District. The ratio of population

to nurses/midwives ranges from 1:2,158 in Lira District to 1:5,398 in Oyam District. Distribution of the few doctors available in the sub-region was skewed with most of the doctors, nurses and midwives located either in the regional referral hospital or the general hospitals.

Although data collected at the community level showed that most community interventions like general food distribution, Home based care for AIDS patients, Community based TB-DOTS and Adolescent friendly services were being offered in IDP camps and settlement sites the coverage of these services were very low. For instance, less than 10% of camps in Lira and Oyam had home-based care for AIDS patients while less than 20% of IDP camps had undergone Indoor Residual Spraying (IRS).

Recommendations of the survey include the need to functionalize all health facilities in the area and address the major causes of poor OPD utilization. Vaccination services should also be scaled up in all health facilities especially in HC IIs in Amolatar District where the provision of the above services is 0% for HC IIs. Furthermore there is need to scale up the provision of reproductive health services in all health facilities through deployment of appropriate staff and provision of drugs and equipments. HIV/AIDS services such as HCT, ART and PMTCT must be scaled up appropriately to be able to reach the population in return sites and ensure

Cont. Page 9

Uganda scores higher in consumption of iodised salt

The Uganda Demographic Health Survey (UDHS, 2006) reveals that ninety-six per cent (96%) of households in Uganda are consuming iodized salt as compared to the international cut-off point of 90%. The proportion of households in Uganda therefore consuming iodized salt is higher than the international cut off point. The UDHS-2 (2006), further explains that 96% of newborn

babies in the country are also protected against brain damage caused by lack of iodine in their mother's diet. Iodine deficiency is the largest single cause of irreversible brain damage in the world. It is a problem of public health importance in Uganda and as a result, all edible salt is to be iodized. The Universal Salt Iodization (USI) strategy for the control of Iodine Deficiency Disorders (IDD) has been under

implementation in Uganda since 1994. To support the strategy, a legislation to make production and import of edible salt compulsory was passed in 1997. The effective quality control of salt carried out at major entry points by the Uganda National Bureau of Standards (UNBS) and Uganda Revenue Authority (URA), in collaboration with the Ministry of Health (MOH), technical and financial support from UNICEF has helped make substantial progress in the country.

According to a study carried out in 2005 by the School of Public Health (Mulago Hospital), the Urinary Iodine Excretion (UIE) trend in the country is high. The study indicates that the higher median (UIE) is at 463.8 mcg/l. However, in 1999/2000 the urinary excretion in Uganda was as high as 310mcg/l.

It is therefore necessary to initiate dialogue to revise the iodine content of salt. It is also important to sustain high proportion of households consuming iodized salt. This can be done through awareness creation in poor performing districts by building on the power of school children as effective change agents. ■

Table 1: Table 1 below reveals that in all regions, the proportion of households consuming adequately iodized salt is equal or higher than the international cut off point. However West Nile, Southwest and Western regions deserve special attention.

Nil Iodine	Inadequate (<15 ppm)	Adequate (> 15 ppm)
Central 1	0.0	98.8
Central 2	0.2	98.4
Kampala	0.0	99.6
East Central	0.1	97.9
Eastern 0.0	2.2	97.8
North 0.1	2.7	97.2
West Nile	0.1	91.6
Western	7.2	89.9
Southwest	2.8	91.8
National average	1.5	95.6

Table 2: level of Urinary Iodine Excretion in Uganda (UIE)

Region	Median UIE Mcg/l	% with UIE < 100mcg/l	% with UIE 300 – 500 mcg/l	% with UIE > 500 mcg/l
Central	437.3	3.9	27.0	43.6
Eastern	467.6	2.9	28.8	45.9
Northern	564.2	1.2	25.0	59.2
Western	388.3	7.7	26.9	35.5
National	463.8	3.9	27.0	45.9

* For population iodine nutrition to be considered adequate, the median UIE should be 100 mcg/l.

SAM results ...from page 8

continuity of services especially for those on ARVs. The survey report also recommend the need for the district local government to develop long-term strategies to attract and retain health staff in the area. Lastly, community-based interventions which hitherto focuses on IDP population should be re-designed to follow-up the IDP population to return areas. In this way continuity of service provision will be assured to the IDPs especially during the early phase of return and recovery programmes where provision of services by government to return populations are still lacking.

In conclusion, as an operational plan for the implementation of the health component of the PRDP, is being developed, MoH and the districts must ensure that the recommendations of the SAM survey in Lango sub-region are reflected and addressed in the health recovery plan and strategy. ■

The Commonwealth youth forum provided an opportunity to enhance young people's potential for development



Youths from Commonwealth countries meet during the youth forum at Imperial Botanical hotel in Kampala

The Commonwealth Youth Forum, 2007 (CYF), which was hosted by Uganda between 13 to 20th November 2007 provided an opportunity to enhance young people's potential for development.

The United Nations family participated in the meeting and used the opportunity to exhibit and re-affirm its commitment to ensuring youth development in all aspects of life especially their participation in the social and economic development of

their potential.

The Commonwealth Youth Forum was a great opportunity for the youth in Uganda and East Africa as a whole to share experience and best practices with the youth from the Commonwealth family particularly on how to realize and enable the

potential's of the youth be turned into meaningful reality.

His Excellency, Gen. Yoweri Museveni while opening the conference said that the government of Uganda has since 1986, been encourag-

ing youth development through support to programmes such as Universal Education, Universal Secondary Education, Youth Entrepreneurship Scheme and their representation of youth in all organs of decision-making including the Parliament of Uganda.

The outgoing Secretary General to the Commonwealth, Rt. Hon. Don Mckinnon, said that the Youth Forum



Some of the exhibition stalls at the Commonwealth Youth Forum.

provides the platform for debate and exchange, which offers a vision of active citizenship, as young adults start to play important roles in their communities.

Despite it being a Commonwealth forum for young people, it was attended by representatives from 42 countries out of 52, which signifies that youths' contribution is highly valued. ■



Youths consult at the UN exhibition stall.

In and Out



*Pauline Ajello,
Public Information Assistant*

Pauline Ajello replaces Ida-Marie Ameda as the new Public Information Assistant for Health Action in Crisis program of WHO Uganda. She joined in November 2007. She worked at Straight Talk Foundation for 5 years and holds a bachelor of Mass Communication from MUK. Pauline is a Ugandan



*Francesca Akello
Programme Coordinator*

Francesca Akello has joined Malaria consortium as programme coordinator communicable diseases for northern Uganda, west Nile and Karamoja. Before joining Malaria consortium, Francesca worked with UPHOLD as the Field technical coordinator in Northern Uganda in the areas of HIV/Aids, Education and health. She has a masters in Business Administration and is a Ugandan.

*Sascha Von Lieven-Knapp
Field Coordinator*

Sascha Von Lieven-Knapp is the new Field coordinator for MSF Spain in Gulu. She replaces Patricia Parra. Sascha was formerly working in Sudan before she came to work in Gulu Uganda.

Flood Response Strengthens Health Coordination

...from page 3

floods, the health, nutrition and HIV/AIDS cluster was activated in Teso region and a comprehensive emergency response plan focusing on ensuring access to good quality basic health services in the affected areas and epidemic preparedness especially for malaria and diarrhea diseases was jointly developed by cluster members working in the area.

Several joint rapid health assessments were conducted to ascertain the true health situation in the affected areas. In addition, drug stock inventory taking and malaria epidemic risk assessments were conducted in Teso. These assessments identified drug stock-out, inadequate health staff, non-functionality of many health centres II and

III and poor access to the operational health facilities as the immediate health challenges.

To fill these gaps, many partners within the cluster provided drugs, medical supplies, emergency health and cholera kits and logistics support to the affected districts. Technical and financial support was also provided to all affected districts to strengthen Integrated Disease Surveillance and Response (IDSR) and activate active surveillance which resulted in increase in weekly reporting from 68% to 98% in Teso sub-region and IDSR data were used to regularly monitor disease trends.

To address funding gaps, a joint health, nutrition and HIV/AIDS flood flash appeal worth about 3.3m USD was launched by the health cluster and about 880,000 USD (750,000 from CERF and

130,000 from Italian Government) was raised toward this appeal. The flood response provided an excellent opportunity for cluster members to jointly assess, plan, mobilize resources and implement activities together in real time; these contributed immensely to building of partnerships and more cohesion within the cluster which in turn strengthened the coordination capacity of the cluster.

Furthermore, development of collaboration and critical links with other clusters such as WASH guided decision making and response and fostered inter cluster cooperation. The cluster will draw from the lessons learned from this response to ensure more effective collaboration among cluster members in future. ■

Call for Applications

Fourth Public Health Pre-Deployment Course (PHPD4)

The World Health Organisation is organizing the next Public Health Pre-Deployment Course starting from 30 March to 12 April 2008 in Hammamet, Tunisia

The main objective of the course is to prepare professionals with experience in public health and related fields to design, implement, manage and/or coordinate health sector emergency response and early recovery programmes in crises situations effectively, efficiently and safely.

The course will be organized in three modules as follows:

- i. Humanitarian context
- ii. Public health issues: Assessment and planning for health action
- iii. Operational and personal effectiveness

At the end of the course, participants will be expected to participate in a two-day field simulation exercise that will provide them with an opportunity to apply learned knowledge and skills in a series of emergency-like scenarios.

The cost of the course is US\$ 3250 per participant. This includes tuition and all course materials, accommodation and board and the journey from and to the Tunis airport and the course venue. Participants are expected to cover their travel costs from their place of residence or work to Tunis and back, including medical and travel insurance, out-of-pocket and other incidental expenses. WHO will be able to provide some full or partial scholarships to deserving applicants thanks to the generous support of the Swiss and Russian Governments.

Deadline for the submission of applications is 15 January 2008.

For more information and submission of applications, please visit:

<http://www.who.int/hac/techguidance/training/predeployment/phpd4/en/index.html>

Editorial board members

Dr. Olushayo Olu,
Health Nutrition and HIV/
AIDS Cluster
coordinator

Dr. Filippo Ciantia,
Country Director,
AVSI Uganda

Dr. Godfrey Bwire,
Ministry of Health

Dr. Eric Alain Ategbo,
Nutritionist,
UNICEF Uganda

Pauline Ajello,
Public Information Assistant
for Health Action in Crisis
program of WHO Uganda

*For more information regarding the Health, Nutrition and HIV/AIDS newsletter please contact
Dr. Olushayo Olu, WHO Country Office,
P.O. Box 24578 Kampala, Email: oluo@ug.afro.who.int
Mobile: +256 772 721962*

This publication has been made possible by the following partners

