



HEALTH, NUTRITION AND HIV/AIDS NEWSLETTER

A publication of the Uganda Health, Nutrition and HIV/AIDS Cluster November 2008 Volume 2 Issue 2



Editorial

By Dr. Olushayo Olu,
Health, Nutrition & HIV/AIDS Cluster
Coordinator

Although the signing of the Final Peace Agreement (FPA) has stalled, the relative peace witnessed in northern Uganda since 2006 is still sustained. As a result of this peace, all the IDPs in Lango have now returned to their villages of origin. However, according to UNHCR estimates, as at February this year, only 9% of the IDP populations have made it back to their original homelands in Acholi Sub region. The slow rate of population return in the sub-region (Acholi) is linked to the uncertainty of the outcome of the peace negotiation and unavailability of basic social services such as health, education, water and sanitation in the return areas which should serve as a "pull factor" for the IDPs.

The Peace Recovery and Development Plan (PRDP) which was launched by His Excellency, President Museveni present a golden opportunity for all concerned to support peace building and population return in the north. Members of the health, nutrition and HIV/AIDS cluster should therefore seize this opportunity to embrace the PRDP by supporting the conflict affected districts to effectively implement, supervise, monitor and evaluate the health recovery strategy and district plans which were recently finalized by the MoH and all the 40 PRDP designated districts. To do this effectively, we must ensure that we coordinate, synergize and synchronize our efforts and use durable and context specific solutions to address health recovery issues in northern Uganda.

In this edition of the health, nutrition and HIV/AIDS cluster newsletter; we bring you experiences of some cluster members in providing basic services to returning populations in Kitgum district. Among others, the newsletter also contains articles on linkages between Sexual and Reproductive Health (SRH) and HIV/AIDS and introduction of Kangaroo Mother Care in Pader as well as the regular sections on news within the cluster and district highlights.

Ladies and Gentlemen, please sit back, relax and enjoy yet another edition of the health, nutrition and HIV/AIDS newsletter.

Thank you.

THE IRC MOVES WITH THE POPULATION TO THE RETURN SITES. BY MARTIN NGOLOBE, HEALTH MANAGER, IRC KITGUM



Kinobere Herbert, a Public Health officer, attends to a sick child during an outreach clinic in Akara.

camps face tremendous challenge of building new homes, accessing health care, safe water and access to livelihood.

As of July 2008, 50 percent of the

The current peace process between the Lord's Resistance Army and the Government of Uganda has created an atmosphere of hope in the camps. Lack of an official peace agreement most people do not yet feel secure enough to move all the way back to their original home villages. Those who have left the

internally displaced persons population in Kitgum district are have moved a way from the IDP camps to transit sites located in parishes near their original homes or direct to their original homes.

While this relative peace has enabled population movement
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THE IRC MOVES WITH THE POPULATION.....

BY MARTIN NGOLOBE, HEALTH MANAGER, IRC KITGUM

from IDP camps to transit camps and villages of origin, most of the health services in the district are located in Kitgum town or mothercamp. Few health facilities in return areas have been opened leaving most of the return areas with poor access to health care. However gagging from health facilities supported by IRC staffing level is between 35 and 45 as recommended by HSSP II.

Early 2007 donor partners supported MoH and the districts to provide incentive package to health staff with the aim of attracting and retaining them. This package managed to increase the staffing level by only 1% in the entire district.

The IRC and other humanitarian agencies are providing basic health care to the population in the new sites and return areas through organization of outreach services albeit difficulties. Major challenges being faced in this mode of service delivery is irregularity. The services being accessed by the population in return sites are mostly preventive with only once a week curative services through outreach.

The IRC working within the return and resettlement strategy is following the population it serves with access to basic services like health, clean water, protection of people's rights, livelihoods, recreational activities, and programs for children and youth

so as to facilitate complete return

This has been done through a number of strategies. For instance, support to the District Health Office in provision of health care services in nine health centres of (Palabek Ogili, Palabek Kal, Palabek Gem, Lobarom, Mucwini, Agoro, Padibe, Paloga and Potika), Weekly outreach activities with health facility staff to (*Oboko* in Potika, *Akara* in Mucwini, *Ocettoke* and *Ayoma* in Labuje, *Apyeta* and *Paluda* in Palabek Ogili and *Pawena* in Palabek Gem sub

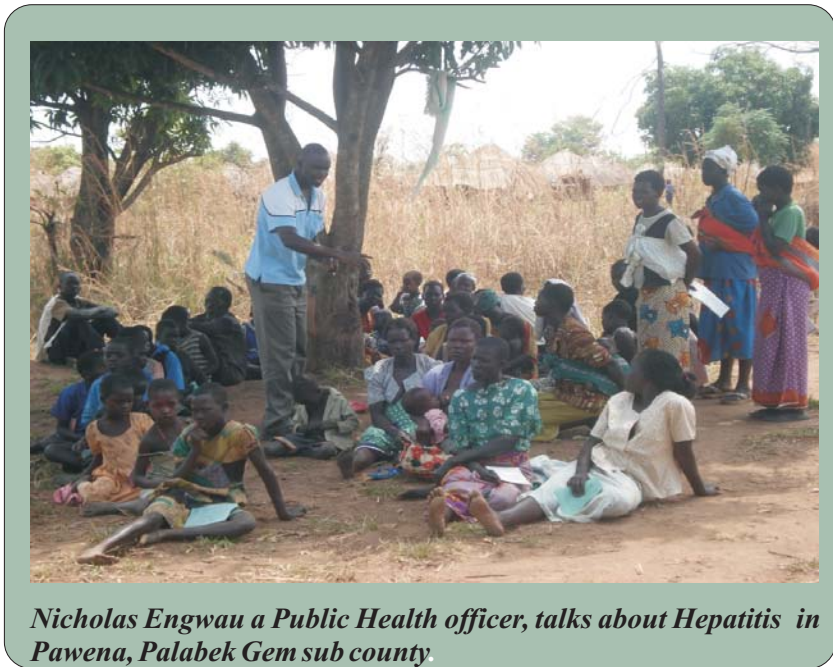
mother to child transmission of HIV/AIDS through counseling and testing of and provision of nevirapine Between January to July 2008 a total of 14,000 people out of which 4,000 are children under 5years of age received curative care, 500 infants vaccinated against meseals, 4,000 pregnant women provided with ANC services, ITNS, counseling and testing for HIV.

Other partners providing outreach services in the district include; International Committee of the Red Cross.

The program works closely with the district health administrative structures through supporting the establishment and training of health unit management committee, Village health teams, Parish development committees and conducting joint support supervision with district and health

Sub district officials.

Challenges faced in improving access to health care in return sites and village of origin include:Low staffing level across all IRC supported health units, frequent absenteeism of health staff, lack of space for consultation at outreach sites and heavy patient case load during outreaches as some of the patients are drawn from the neighboring districts of Gulu.



Nicholas Engwau a Public Health officer, talks about Hepatitis in Pawena, Palabek Gem sub county.

counties).

The basic package of health services delivered during outreaches are health education, clinical services, vaccinations, reproductive health care and referral.

The reproductive health care services are focused on antenatal care, prevention and treatment of sexually transmitted infections, prevention of

CREATING LINKAGES BETWEEN SRH AND HIV/AIDS IN NORTHERN UGANDA. BY MOLLIE FAIR, GRACE LATIGI & PRIMO MADRA

Over twenty-years of armed conflict in Northern Uganda caused a gross disruption of the health system, drastically affecting access to health care and health outcomes for the region's population. One of the vulnerabilities of northern Uganda's population is reflected in poor Sexual and Reproductive Health (SRH) indicators with high HIV sero-prevalence compared to national averages (see chart) below. Although policies and programs often highlight the importance of SRH and HIV/AIDS, they are often treated as two separate intervention areas, and frequently opportunities to create linkages between them are overlooked.

In the last few years, there have been several calls for increased efforts to integrate HIV/AIDS and SRH. In 2004, UNFPA and UNAIDS convened a high-level global consultation and made the "New York Call to Commitment" calling for the integration of HIV/AIDS and SRH; this was followed in June 2005 with a UNAIDS policy position paper "Intensifying HIV prevention." In a resource-constrained health system serving a vulnerable population, as is the case in Northern Uganda, there are multiple benefits that could result from further integration of SRH and HIV/AIDS, accelerating healthy

development in northern Uganda.

Five reasons to link HIV/AIDS and SRH interventions

1. Common root causes: Both HIV/AIDS and poor SRH are driven by many of the same root causes, including gender inequality and poverty and social marginalization of the most vulnerable. Addressing those core issues in northern Uganda would benefit both HIV/AIDS and RH indicators.

2. Common target audience: The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Programming in one area should be mutually reinforcing of the other area.

3. Reduce stigma:

Integrated programs may help to reduce stigma associated with stand-alone HIV Facilities, improving access and uptake of key services.

This is critical for reaching Marginalized, hard-to-reach populations, and high-risk populations.

4. Cost-effectiveness:

Improved integration can mean more relevant and cost-effective programs with greater impact. Along the same lines, integration helps to Address shortages of health care

workers

5. Millennium Development Goals:

Addressing sexual and reproductive health and HIV/AIDS issues are essential to achieving development goals and ensuring reconstruction and development in the north, which Would benefit the entire country.

One of the main reasons for the lack of integration between HIV/AIDS and SRH is that, practical ways to link the services are not clear to most service providers and programming staff. The *Framework for Priority Linkages* developed by IPPF, UNFPA, WHO, and UNAIDS³ provides some guidance (see

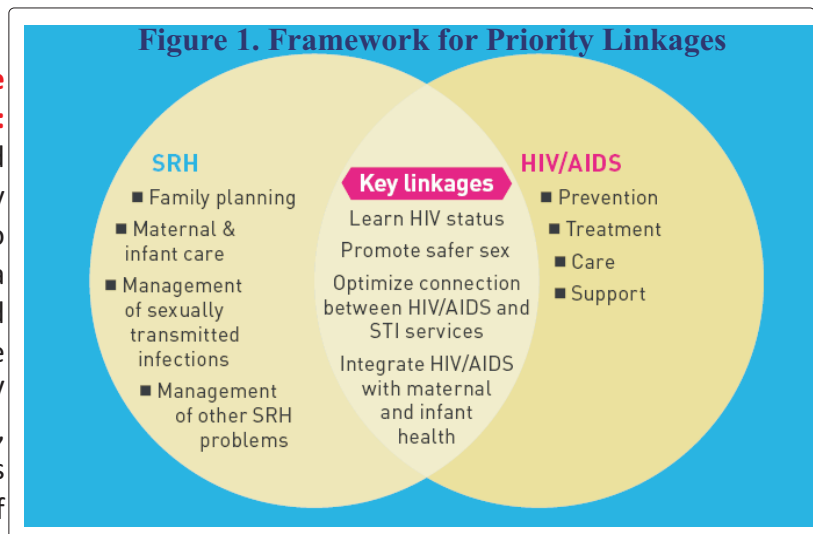


Figure 1) by recommending four priority areas where linkages should be implemented:

1) Improve access and utilization of HIV Counseling and Testing services (HCT), with particular emphasis placed on removing barriers that prevent young people from accessing HCT.

During HIV counseling, information on SRH, particularly dual protection

Continued on page 4

Indicator	Northern Uganda	National Average
HIV sero-prevalence rate ^a	8.2	6.4
Current use of family planning ^b	10.9	23.7
Maternal mortality rate ^b	750 / 100,000	435 / 100,000

a. Uganda national HIV sero-prevalence survey 2006
b. UDHS 2006

CREATING LINKAGES BETWEEN SRH AND HIV/AIDS IN NORTHERN UGANDA. BY MOLLIE FAIR, GRACE LATIGI & PRIMO MADRA

(against HIV/STI and unwanted pregnancies) should be provided. HIV Counseling and Testing (HCT) should be routinely provided in Antenatal care (ANC) as well as Sexually Transmitted Infections clinics, while linking to ART and other post-test care.

2) Promoting safer and healthier sex.

This will not only promote reproductive health, but also prevent HIV. Condom promotion for dual protection especially for PLWHA should be scaled up. Women's empowerment and programs to prevent and respond to GBV also contribute to HIV prevention. There should be a common approach to IEC programs that address both SRH and H I V / A I D S

3) Optimize the connection between HIV/AIDS services and STI Services.

HCT should be a routine test in STD care, and screening for STIs should be part of HCT.

4) Integrating HIV/AIDS services with maternal and infant care.

For Example making PMTCT services part of antenatal care, or utilizing RH clinics as avenues for disseminating information and/or providing services for HIV/AIDS. Effective referral pathways between RH clinics, HCT and chronic car clinics should be established to ensure that a patient utilizing one service is directed to the Other as appropriate.

Uganda's revised HCT policy encourages HIV counseling and testing for young people including

pediatrics. The policy requires both parental and child consent for HCT to be provided to a child of 12 to 17 years. For a child below 12 years only parental consent is required. The HCT policy provides for HIV Counseling and Testing services to be provided routinely in health facilities, particularly in TB, STD, and ANC clinics.

The implementation of this remains limited mainly because most health workers are not trained to provide HIV counseling. Moreover, most health facilities, especially in the war affected northern Uganda, are understaffed and as a result even if the health care providers have the knowledge and skills, providing HCT may not be considered a priority or the quality of counseling may be compromised due to heavy workload. Health workers in ANC clinics do not consider HIV/AIDS care as one of their core functions while providers at HCT clinics consider SRH as none of their business. Therefore, it is necessary to change provider attitudes towards patient management.

Existing Standard Operating Procedures (SOPs) are also weak in helping service providers to practically link HIV/AIDS care with SRH. This is because these SOPs have been developed in isolation, without reference to each other. HCT protocols do not adequately emphasize the need for the provision of information on SRH during HCT counseling sessions while Family Planning (FP) job aides do not provide sufficient guidance on providing

HIV/AIDS care. Patient flows in health facilities are not planned to link the two systems together. Frequently, HCT is provided in one corner of the health facility and ANC at the opposite corner with little communication between the two units; or services are provided on different days of the week, requiring a client to come at least twice to access services from both units.

There is an urgent need for Ministry of Health to revise the existing service guidelines with a view of supporting service providers to link SRH and HIV/AIDS care better. Program managers need to plan with a view of ensuring that HIV/AIDS program benefit from SRH programs and vice versa. Health facility managers should take time to organize patient flows that are conducive for greater linkage. And finally but not least, health care providers need to realize that their role is to provide a holistic care to their patients and not just mechanically doing their component with little concern to the general need of the patient■

From page 2

THE IRC MOVES WITHBy Martin Ngolobe, Health Manager, IRC Kitgum

Across the district, only IRC and International Committee of the Red Cross provide outreach services to new sites yet the demand for this services is high■

GOAL UGANDA INTRODUCES KANGAROO MOTHER CARE IN PADER

BY GOAL TEAM IN PADER

According to UNICEF surveys, 12 % of all infants born in Uganda from 1998 to 2005 were of low birth-weight (LBW) as a result of either preterm birth or impaired prenatal growth. LBW infants contribute substantially to high rate of neonatal and infant mortality, whose frequency and distribution corresponds to those of poverty. Preterm and low birth weight represent more than a fifth of the estimated 47,000 neonatal deaths each year in Uganda, and survivors are at high risk of morbidity. Therefore,



Sister Karin Moore demonstrates the correct application of KMC for midwives of the maternity ward

the care of such infants becomes a burden for health and social systems.

As causes and determinants of impaired foetal growth and preterm birth are largely unknown, effective interventions are limited. Moreover, modern technology is either not available or cannot be used properly in the current context of Northern Uganda. Incubators, for Instance, are often insufficient to meet local needs and purchase of the equipment and spare parts, maintenance and repairs

are difficult and costly. The power supply is intermittent, so the equipment does no work properly. Under such circumstances good care of preterm and LBW babies is difficult: hypothermia and nosocomial infections are frequent, aggravating the poor outcomes due to prematurity. Frequently, and usually unnecessarily, babies are separated from their mothers for medical care, depriving them of necessary contact [Kangaroo Mother Care a practical guide, 2003, World Health Organization, Geneva].

With child survival being a priority area for GOAL Uganda, a programme to reduce infant mortality and morbidity saw the implementation of a Kangaroo Mother Care (KMC) Programme in Pader district. In KMC the baby is continuously kept in skin-to-skin contact with the mother (with help, in some cases, from the father, Grandmother or aunty) and the baby is usually breast-fed exclusively. It is usually initiated in the hospital, but when the infant is stable and the mother is confident it can be continued in the home.

With assistance from Dr Nils Bergman (a world authority on KMC), GOAL located two experts to support the introduction of KMC at Dr Ambrosoli Memorial Hospital, Kalongo, in September 2007. Dr Lucy Linley and Sr Karin Moore, from Mowbray Maternity Hospital in Cape Town, South Africa, facilitated a KMC workshop for doctors, midwives and the Midwifery Tutors of St Mary's Midwifery School.

Representatives from the Ministry of Health also attended the workshop.

With great enthusiasm from the hospital and midwifery school staff, Kangaroo Mother Care was implemented in the maternity ward immediately, much to the delight of the mothers who had been separated from their infants in the special care unit

Prior to the introduction of this programme, premature and low birth weight infants were separated from their mothers and placed in a cot with a hot water bottle in an effort to keep their temperature stable. The infants that survived were slow to recover and weight gain was poor, so mothers and infants remained in hospital for an Extended period of time. The mothers became despondent waiting for the infants to be well enough to go home. Furthermore, these infants were at high risk of nosocomial infection and were deprived of optimal breast feeding, stimulation, safety and love. Mothers, and sometimes their families, are now actively involved in the specialized care required for their low birth weight infants.



A proud mother is happy to be providing KMC for her infant

GOAL UGANDA INTRODUCES KANGAROO MOTHER CARE IN PADER. BY GOAL TEAM IN PADER

The advantages of KMC for the mothers have included encouraging bonding, adequate time for observing the baby, reduced baby crying, and more active participation by the mother regarding baby care (in comparison to the babies being in a cot under the care of the nurse). It has been seen that for the babies, they grow more quickly, spend more time with their mothers, and are kept warm so they sleep for long hours. Additionally, there are advantages to the Midwives, which include a reduced workload, reduced numbers in the nursery, and fewer deaths.

mother and baby were shorter than proposed, but later this improved with encouragement and support for the mothers from the staff in maternity



KMC was a new technology for the mothers and challenges included mothers initially fearing that the babies might suffocate, and mothers complaining a little about the weight of the baby on the chest as they were not used to it. However, these issues were quickly overcome, KMC was implemented with enthusiasm, and the six babies improved and were discharged. Initially hours of contact between

ward. In October a new larger group was admitted to the programme, and by January 2008 KMC became an accepted practice in the hospital.

The duration of stay at the hospital for premature babies has been greatly reduced. KMC babies took an average of 25 days in maternity before being discharged after improving and gaining weight. Babies that had not been on the KMC programme took an

average of 47 Days in maternity before discharge. Deaths of premature babies have reduced considerably. Since January there has been an average of only one death per month, where as prior to the introduction of KMC the hospital staff estimate an average of four deaths per month for premature babies. It is still early days and the midwives and the mothers are continuing to become more familiar with the implementation of KMC, and so this statistic may improve even further. The head of the Kalongo Hospital midwife school has been delighted with the results and says that KMC is here to stay in Kalongo Hospital.

KMC is a powerful, easy-to-use, low-cost and sustainable method to promote the health and well being of infants. It is socially and culturally acceptable in the Uganda context and with such a positive impact on child survival, implementation of KMC should be encouraged throughout the country

[\[Http://www.unicef.org/infobycountry/uganda_statistics.html\]](http://www.unicef.org/infobycountry/uganda_statistics.html)

GULU REFERRAL HOSPITAL STRENGTHENS SKIN CLINIC

BY MICHEAL CHANKARA, WILLIAM ONYAYI AND CELESTINE OLANGO FROM GULU

Dermatology is one of the fields of medicine which is constantly evolving. Different techniques are being incorporated into the field making the service more productive. Genetic studies, the use of immunosuppressive agents and the rapidly expanding laser therapy has

broadened the diagnostic and therapeutic horizon.

Lasers are now used for depilation and for removing tattoos without leaving scarring; Photodynamic therapy is increasingly being used to treat skin tumors, narrowband ultraviolet has replaced other forms of phototherapy



for psoriasis and severe atopic dermatitis. The skin clinic in Gulu referral hospital has

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MORE EFFORTS NEEDED TO ERADICATE HEPATITIS E

BY DR.SOLOMON FISSEHA WOLDETSADIK AND PAULINE AJELLO WHO IN GULU

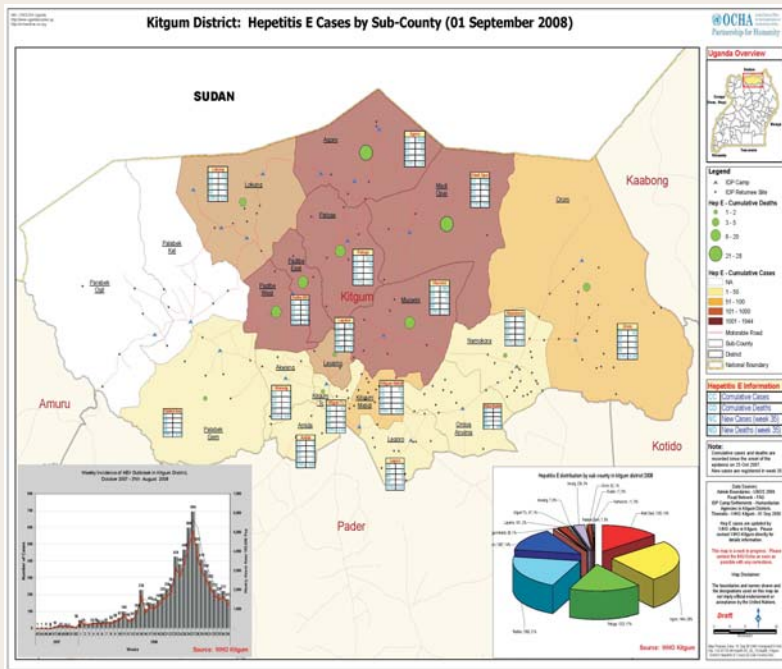
Hepatitis is a general term meaning inflammation of the liver and can be caused by a variety of different viruses such as hepatitis A, B, C, D and E. Since the development of jaundice is a characteristic feature of liver disease, a correct diagnosis can only be made by laboratory analysis of patient's blood (serum) for specific antigen or antibody against a particular virus.

Hepatitis E is caused by infection with the hepatitis E virus (HEV). It is a water borne disease transmitted via the faecal-oral route. Contaminated water or food supplies have been implicated in major outbreaks.

In diseases with oral-fecal transmission, person-to-person secondary transmission can amplify the spread and sustain the outbreak longer. A retrospective cohort study in Saudi Arabia on person to person transmission through oral-fecal route for bacillary dysentery has found that the secondary attack rate (AR%) within families ranged between 7.7% and 80% within households and neighboring villages depending on the exposure to other risk factors especially crowding. Crowding was a major risk factor that amplified transmission of bacillary dysentery within families, Bushira et al (1999)¹. The prevalence of anti-HEV

antibodies, uses of river water for drinking and cooking, personal washing and human excreta disposal were all significantly associated with high prevalence of infection, Corwin et al (1999)². the possibility of multiple factors; the poor environmental hygiene, the communal hand washing from one basin, poor access to safe drinking water and the unsafe storages for drinking water at household level all contributed for the ongoing outbreak. A preliminary report by a team of experts³ has documented an 80% prevalence rate in the most affected communities with only one third reporting clinical signs of jaundice. It was also found that samples from two surface water sources and hand lavage from HEV patients to be weakly positive for HEV.

Given the rampant practice of communal hand washing, the poor sanitation and the crowding in the affected district, contamination of drinking water or food by the patients affected by HEV is likely



1. A family practicing communal hand washing and eating. Communal hand washing is one of the ways through which Hepatitis E is transmitted.
2. A woman lifting the Local brew Kwate to an unknown destination for consumption
3. The woman displays her Kwate after being asked to do by a community health worker
4. Poor hygiene. A family displays Gumboots together with plates in a home made drying rack
5. Community leaders involvement: Community leaders move around homes checking on the household hygiene
6. Experience sharing visit: The District Health Team (DHT) from Gulu on an experience sharing visit in Kitgum district, the first district to report cases of Hepatitis E
7. The DHT team from Gulu meeting with the RDC of Kitgum district
8. The minister of Health, Dr. Stephen Malinga gives a community talk on Hepatitis E at Ogako HC 11
9. The minister of Health, the area MPS with community from Acholi and Karamoja region touring a return site

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GULU REFERRAL HOSPITAL STRENGTHENS.....

been operational since 2006, however not so many people know about how important it is to have a skin clinic but also many are not aware of the skin clinic operations at Gulu Referral hospital.



Tinea Capitis

Managed by 3 Dermatologist patients with skin problems can now access free skin services and treatment once a week as an out patient.

Most patients present with superficial fungal infections like Tinea Capitis,

pityriasis Versicular, Psoriasis and PPE due to HIV.

In total the clinic sees 30 patients, this compared to the target population of the region served by the clinic is extremely insignificant. Dermatologic cases constitute less than 6% of the total OPD attendance.

The skin clinic in Gulu hospital doesn't go without challenges, the patients and the health workers both face a problem of lack of space to enable consultations take place.

The clinic also faces a problem of lack of drugs for the patients as well as equipments and funds to enable the purchase of the above and for

Awareness creation.

It is therefore paramount that the Gulu referral hospital administration rethink of availing a permanent and conducive room for both the patients and the clinic staff and purchase Dermatology drugs for the Patients and if support can be provided by



Vericous Vulgaris

partners.

MORE EFFORTS NEEDED TO ERADICATE HEPATITIS E

BY DR.SOLOMON W FISSEHA AND PAULINE AJELLO WHO IN GULU

and hence contributing for the prolonged outbreak and its spread to the neighboring districts. By the mid November 2008 Kitgum district has reported 8975 cases and 134 deaths. However more than 90% of the cases were reported from 5 sub counties which are adjacent and close to the initial point of the outbreak

The number of cases being reported from Kitgum district has started to decline, however there is still a potential for its extension to the other sub-counties and neighboring districts. By the mid November 2008 Pader had reported 57 cases while Gulu and Amuru had reported 8 confirmed cases.

The Government of Uganda, especially the districts in the north and humanitarian partners should consider the current outbreak and the frequent outbreaks of cholera seriously and take measures to address the root causes rather than focusing on treating the symptoms.

The major challenge in the control of communicable disease with oral-fecal transmission is creating the awareness in the community to practice the standard personal and environmental hygiene and providing safe sources for drinking water. An assessment conducted by the district water and Health offices in Gulu in 2007 revealed a dire situation of the

state of safe water sources. It was noted that more than 90% of the sources visited have a sanitation inspection score of less than 5/10 which means the water sources are extremely exposed for contamination. This was further supported by the significant proportion of water sources contaminated with bacteria including faecal coliforms, with only 48% of the house holds and 33% of the shallow wells free from contamination by faecal coliforms-

¹East African Medical Journal [East Afr. Med. J.]. Vol. 76, no. 5, pp. 255-259. May 1999.

²Trans R Soc Trop Med Hyg. 1999 May-Jun;93(3):255-60.

³Hepatitis E epidemic in Kitgum district,

PICTORIAL

The Uganda Health, Nutrition and HIV/Aids Cluster Retreat March 08



A group picture of the Uganda Health, Nutrition and HIV/Aids (HNHA) Partners



Retired WHO Representative for Uganda Dr. George Melville addressing the cluster members before the official opening of the retreat



The Head of OCHA Mr. Tim Pit addressing the Health, Nutrition and HIV/AIDS cluster meeting before he declared the ceremony opened.



The Health working group in a group discussion



The Karamoja group



Dr. Bagambisa - MoH, Dr. Talamoi, Rachael Scotts UNOCHA, Ms. Pamela Komujuni OPM and Dr. Emmanuel Obura-NPO/HAC WHO Lira.



The District Health Officers from Lango, Acholi and Karamoja meet to chart a way forward



The Nutrition working group in a group



The HIV/AIDS working group



The DHOs of Lira and Gulu districts share a light moment with WHO staff



Rechael Goldstein Former Head of UNFPA Gulu chats with other partners



After all its time to relax: Dr. Michael Lukwiya of WHO enjoys his phone conversation, next to him is Pauline from Uganda Aids Commission

Health, Nutrition and HIV/AIDS 2009 CAP Project Sheet Summary

Project Title	Appealing Agency/ies	Budget in (USD)						Contact Person
		UNICEF	UNFPA	WHO	WFP	Others	Total	
1 Assistance to Conflict-Affected Populations to Reduce Transmission of HIV in Pader District, Northern Uganda.	Food for the Hungry					490,000.00	490,000.00	Brennen Matthews; phone: 0755988383
2 Assistance to Malaria Endemic Area to Prevent and Control Morbidity and Mortality in Nakapiripiri District.	Food for the Hungry					844,133.00	844,133.00	Brennen Matthews; phone: 0755988383
3 Support to Health Services in Kaabong District	MERLIN					760,000.00	760,000.00	Harriet Fowler, Phone: 0773161790; e-mail: mercduganda@merlin-satcoms.org
4 Improving Reproductive Health Care Service Delivery in Aruu County (Pader District) and Lamwo County (Kitgum District)	CPAR					1,191,905.00	1,191,905.00	Gizaw Shibus, phone: 0414268064; email: gshibus@cpar.ca
5 Uganda Transitional Relief	MTI					355,151.00	355,151.00	Ormodi Felk, phone: 0772514733; email: fomodi@mti-uganda.org
6 Emergency health response and preparedness intervention aimed at supporting local health services and improving reproductive health conditions of at risk communities in North Eastern Uganda	GVC					537,000.00	537,000.00	Simona Mortoro, phone: 0714194940; email: gvcuganda@gvc-italia.org
7 Health, Nutrition and HIV/AIDS Response Coordination in Acholi region	WHO			1,071,070.00			1,071,070.00	Olu, Phone: 0752721962; e-mail: oluo@ug.afro.who.int
8 Health, Nutrition and HIV/AIDS Response Coordination in Karamoja region	WHO			647,350.00			647,350.00	Olu, Phone: 0752721962; e-mail: oluo@ug.afro.who.int
9 Health Emergency Preparedness and Response (EPR) and epidemic disease surveillance in Acholi	WHO & UNICEF	513,600.00		725,032.00			1,238,632.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Claudia Hudspeth, Phone: +256 772 222 345, E-mail: chudspeth@unicef.org
10 Health Emergency Preparedness and Response (EPR) and epidemic disease surveillance in Karamoja	WHO & UNICEF	440,000.00		423,720			863,720.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Claudia Hudspeth, Phone: +256 772 222 345, E-mail: chudspeth@unicef.org
11 Health Emergency Preparedness and Response (EPR) and epidemic disease surveillance in Teso	WHO & UNICEF	176,550.00		506,110.00			682,660.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Claudia Hudspeth, Phone: +256 772 222 345, E-mail: chudspeth@unicef.org
12 Integrated emergency health and HIV/AIDS services delivery in Acholi	WHO & UNICEF	481,500.00		494,340.00			975,840.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Claudia Hudspeth, Phone: +256 772 222 345, E-mail: chudspeth@unicef.org
13 Integrated emergency health and HIV/AIDS services delivery in Karamoja	WHO			682,660.00			682,660.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int
14 Nutrition Response among IDPs and extremely vulnerable populations in Acholi	WHO, UNICEF & WFP	1,717,350.00		235,400.00	513,600.00		2,466,350.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Eric Ategbu, Phone: +256 773 142 741, eaategbu@unicef.org
15 Nutrition Response in Karamoja sub-region	WHO, UNICEF & WFP	2,033,000.00		176,550.00	535,000.00		2,744,550.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Eric Ategbu, Phone: +256 773 142 741, eaategbu@unicef.org
16 Nutrition Response among IDPs and extremely vulnerable populations in Teso Sub-region	WHO, UNICEF	395,900.00		129,470.00			525,370.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Eric Ategbu, Phone: +256 773 142 741, eaategbu@unicef.org
17 Child health in Acholi	WHO, UNICEF	663,400.00		494,340.00			1,157,740.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Claudia Hudspeth, Phone: +256 772 222 345, E-mail: chudspeth@unicef.org
18 Child health in Karamoja	WHO, UNICEF	502,900.00		506,110.00			1,009,010.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Claudia Hudspeth, Phone: +256 772 222 345, E-mail: chudspeth@unicef.org
19 Child health in Teso	WHO, UNICEF	144,450.00		129,470.00			273,920.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Eric Ategbu, Phone: +256 773 142 741, eaategbu@unicef.org
20 Scaling up comprehensive HIV/AIDS care and treatment services in the Acholi region	WHO			323,675.00			323,675.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int
21 Scaling up comprehensive HIV/AIDS care and treatment services in the Teso region	WHO			247,170.00			247,170.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int
22 Scaling up comprehensive HIV/AIDS care and treatment services in the Karamoja region	WHO			253,055.00			253,055.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int
23 Provision of Mental Health and Psychosocial Support in Acholi region	WHO			306,020.00			306,020.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int
24 Strengthening and Consolidation of comprehensive SRH Services for conflict affected populations in Amuria and Katakwi districts	WHO & UNFPA		437,844.00	317,790.00			755,634.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr. Eric Ategbu, Phone: +256 773 142 741, eaategbu@unicef.org, Dr Primo Madra Tel: 0772613482, madra@unfpa.org
25 Strengthening and Consolidation of comprehensive SRH Services for conflict affected populations Acholi sub-region	WHO & UNFPA		670,890.00	341,330.00			1,012,220.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr Primo Madra Tel: 0772613482, madra@unfpa.org
26 Strengthening and Consolidation of comprehensive SRH Services for conflict affected populations in Karamoja sub-region	UNFPA & WHO		569,668.00	317,790.00			887,458.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int, Dr Primo Madra Tel: 0772613482, madra@unfpa.org
27 Support to Health, nutrition and HIV/AIDS Services in Acholland	AVSI					1,450,000.00	1,450,000.00	Dr. Filippo Ciantia, 041 4501604/5, ciantia.kampala@avsi.org, Chiara Savelli, + 39 02 6749881, chiara.savelli@avsi.org
28 Reduction of Acute Malnutrition through Capacity Building Approach in Kaabong and Moroto districts of Karamoja	ACF					180,000.00	180,000.00	Mr. George Petropoulos, Head of Mission PO Box 3177, Plot 4303, Kiwafu Road, Kansanga, Kampala, Uganda (0) 772 713 723 hom.ug@acf-international.org

IN AND OUT



Dr. Moses Ongom recently left WHO office in Moroto for further studies. Moses Joined the WHO/HAC team in February 2007 as the National Professional Officer/Health Action in crisis in Karamoja. Moses has been very instrumental in strengthening the coordination of the Health, Nutrition and HIV/Aids Cluster in Karamoja region ■

Dr. Moses Ongom



Mr. Innocent Komakech has been appointed the National Professional Officer with the WHO Office in Moroto. Before moving to Moroto Mr. Innocent was the National Professional Officer for WHO in Pader district. While in Pader Innocent played a very significant role in ensuring that the Health, Nutrition and HIV/Aids cluster partners were well coordinated ■

Mr. Innocent Komakech



Dr. Isaya Musinguzi has been newly appointed National Professional Officer, Disease Control for WHO office in Pader district. Before joining WHO Pader Dr. Isaya worked as the Assistant District Health Officer for Masindi district in-charge of data management, Human resource and quality of health services. He has also done a number of consultancies with UN agencies and other NGOs. Dr. Isaya holds an MPH ■

Dr. Isaya Musinguzi



Lucy Kachapila (Mrs.) Has been newly appointed Child Survival and Development Specialist Health and Nutrition with UNICEF Gulu Zonal Office. Lucy holds RCNM, DPeads, Bcur letA, Msc, MBA. Before joining UNICEF she worked as a registered nurse and midwife and as a clinical pediatrician, the MoH headquarters as a Community Health Manager and as Deputy Director of Nursing services for Malawi. Lucy retired from civil service and joined UNICEF Malawi country office as a Project officer for IMCI/ECD. She later became a Child Survival Specialist and a Coordinator for all Child survival issues in the country office and Government ■

Lucy Kachapila



Dr. Asmamaw Bezabeh has been newly appointed HIV/AIDs Program Manager with Visions in Action (VIA). Prior to joining VIA, Dr. Asmamaw was working in Ethiopia as Care and Treatment Officer for Family Health International in provision of comprehensive HIV/AIDS prevention and care packages in a resource limited settings. Dr. Asmamaw has a Medical Degree (MD) from Addis Ababa University ■

Dr. Asmamaw Bezabeh



Carol Elliott has been newly appointed Visions in Action Country Director. Carol is a British citizen who has worked as a consultant for World Vision, VSO, Save the Children and UNESCO in Cambodia and Mozambique. She has also provided technical support in the development and implementation of national strategic plans and policies including (but not limited to): Education, Good governance, HIV/AIDS, OVC, Child protection, Youth, land mine survivors and people with disability. Carol holds a Masters in Management and Professional Studies in Education from the University of Southampton ■

Carol Elliott

From page 10	Project Title	Appealing Agency/ies	Budget in (USD)					Contact Person	
			UNICEF	UNFPA	WHO	WFP	Others		Total
29	Support the Scale up of Malaria Control in Acholi Sub-region	WHO			341,330.00			341,330.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int.
30	Support the Scale up of Malaria Control in Teso Sub-region	WHO			249,250.00			249,250.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int.
31	Support the Scale up of Malaria Control in Karamoja Sub-region	WHO			341,330.00			341,330.00	Dr. Olushayo Olu, Phone: +256 752 721 962, oluo@ug.afro.who.int.
32	Improving access to health care for the refugees	UNHCR					976,000	976,000.00	Dr. Ibrahima Diallo, diallci@unhcr.org
	Total		7,068,650.00	1,678,402.00	9,260,362.00	1,048,600.00	6,784,189.00	25,840,203.00	

DISTRICT HIGHLIGHTS

A GLANCE AT GULU AND AMURU DISTRICTS IN ACHOLI SUB REGION

Demographic characterizes	Achievements	Major Health indicators: Immunization		Constraints										
Gulu Total Population: 362,147 Estimated under 5 years: 88,036 (25% of population)	VHT programme coverage of 50% 44 Functional health units Human resource coverage 24% A very active health, Nutrition and HIV/Aids Cluster	<table border="1"> <thead> <tr> <th>Indicator</th> <th>Achievements 2008</th> </tr> </thead> <tbody> <tr> <td>DPT 3</td> <td>112%</td> </tr> <tr> <td>Measles</td> <td>116%</td> </tr> <tr> <td>Deliveries in H.U</td> <td>65%</td> </tr> <tr> <td>OPD Utilization per Capita</td> <td>1.7</td> </tr> </tbody> </table>	Indicator	Achievements 2008	DPT 3	112%	Measles	116%	Deliveries in H.U	65%	OPD Utilization per Capita	1.7		Human resources for health is still poor
Indicator	Achievements 2008													
DPT 3	112%													
Measles	116%													
Deliveries in H.U	65%													
OPD Utilization per Capita	1.7													
Amuru Total Population: 22,161,9 Estimated under 5 years: 44,767(20.2% of population)	VHT programme coverage of 31.5% 34 Functional health units Human resource coverage 65% A very active health, Nutrition and HIV/Aids Cluster	<table border="1"> <thead> <tr> <th>Indicator</th> <th>Achievements 2008</th> </tr> </thead> <tbody> <tr> <td>DPT 3</td> <td>115%</td> </tr> <tr> <td>Measles</td> <td>116.2%</td> </tr> <tr> <td>Deliveries in H.U</td> <td>26%</td> </tr> <tr> <td>OPD Utilization per Capita</td> <td>1.5%</td> </tr> </tbody> </table>	Indicator	Achievements 2008	DPT 3	115%	Measles	116.2%	Deliveries in H.U	26%	OPD Utilization per Capita	1.5%		Human resources for health is still poor
Indicator	Achievements 2008													
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Deliveries in H.U	26%													
OPD Utilization per Capita	1.5%													

IMPORTANT WEBSITE AND RESOURCE MATERIALS

Disaster Management Centre. Resourceful information on educational, training courses <http://epdwww.egr.wisc.edu/dmc>

UN Web and Gopher Servers. Information about the UN: jobs, conferences and news <http://www.un.org/textindex.html>

David Baldwin's Trauma - very extensive site on trauma related issues <http://gladstone.uoregan.edu/~dub/trauma.html>

Emergency Medicine - Medical resources http://galaxy.einet.net/galaxy/Medicine/Medical_Specialities/Emergency.Medicine

Global Health Disaster Network <http://www.pitt.edu/HOME/GHNet/GHNet.html>

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This publication has been made possible by the following

