

Editorial Board

- Dr. Olushayo Olu, Health, nutrition & HIV/AIDS Cluster Coordinator
- Dr Filippo Ciantia, Country Director, AVSI Uganda
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Editorial comments

The health, nutrition and HIV/AIDS cluster has come a long way. From late 2005/early 2006 when it was officially rolled out and we were groping in the dark and grappling with the difficulties of establishing and running a new system which we knew little or nothing about to now when the system is up and running, a lot of achievement has been made. The roll-out of this newsletter marks another major milestone which is aimed at fulfilling one of the cluster's key responsibilities of information sharing and dissemination.

The newsletter will provide priorities, practical experiences, lessons learnt, factual information and data on topical health, nutrition and HIV/AIDS issues on a quarterly basis. We will strive to keep improving the quality and content of the newsletter based on feedbacks we receive from you so please keep the comments coming. An editorial board which will produce the newsletter has been set up and regular sections in the newsletter will include editorial comments, letters from readers, articles on health, nutrition and HIV/AIDS, presentation of health, nutrition and HIV/AIDS data and cluster performance indicators, best practices and innovations, interviews of key partners, donors, top government officials and of course news and events.

During the conceptualization stages of this first edition, the editorial board tinkered with various possible themes and finally agreed on the topic "health coordination" to commemorate what the cluster stands for. Also in this edition we present data on Human African Trypanosomiasis (HAT) in the Lango sub-region to highlight the re-emerging threat of this Neglected Tropical Disease (NTD). Of course we also bring you the latest news and events within the cluster so please sit back, relax and enjoy reading this very first edition of the health, nutrition and HIV/AIDS cluster newsletter!

Health Coordination in Chronic Emergencies: Experiences from Afghanistan, Mozambique and Rwanda; Lessons for Northern Uganda By Dr. Olushayo Olu

What is Coordination?

"Coordination" is one of the words I have heard the most in my years in humanitarian work and it comes in all forms: sector coordination, health coordination, coordination structure, coordination mechanism etc which are often misunderstood, misused and misinterpreted. I often wondered what the meaning of health coordination was and tried several times to define it in my own way. The best I could do was to coin my own definition by combining the Oxford Advanced Learners Dictionary of English definition of coordination and the World Health organization (WHO) definition of health which did not make much sense. This further confirmed to me the difficulties involved in understanding the term itself talk less of what it entails.

Recently, I was opportune to stumble on a few publications which explained the definition of coordination and health coordination to my satisfaction. TMiner et al defined coordination in the UN system as "*the systematic utilization of policy instruments to deliver humanitarian assistance in a cohesive and effective manner*"¹ while the Manager² defined health coordination as "*bringing together, through a common structure (temporary or permanent), groups that are pursuing a common health outcome*". In the case of northern Uganda, this common health outcome is to reduce avoidable mortality and morbidity among the Internally Displaced Persons (IDPs) of the north.

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My deep understanding of the term “bringing together” goes beyond just having coordination meetings but includes so many other activities such as capacity building, standard setting, information sharing, gap identification and filling, monitoring and evaluation all of which are prerequisites for achieving the aim of health coordination which is to synergize efforts and resources, avoid duplication and ensure a more effective health response. The importance of proper coordination of any emergency health response cannot be overemphasized, however it is important to note that health coordination should not be seen as an overall goal of the emergency response but one of the strategies applied to

Although coordination by command is unrealistic in today’s humanitarian world, it is recognized that the availability of some forms of “carrot” (resources especially funds) within a coordinating system facilitates coordination of activities. Donini in his monograph on UN coordination in Afghanistan, Mozambique and Rwanda rightly concluded that coordination by consensus “*may be a process of diminishing returns*”.

This is very much the case especially in acute emergencies and is buttressed by experiences in Rwanda and Afghanistan in which participation of actors was strong at the initial stages of the crises but diminished once actors strongly established themselves in the crises. In the absence of a coordinating system in a humanitarian emergency, at least some minimal forms of information and idea exchange will occur among participating agencies so in reality there is hardly a humanitarian crises situation without some form of coordination.



In Northern Uganda, the advantage of coordination has been best felt during disease outbreaks

ensure the overall goal of reducing mortality and morbidity is achieved. In other words health coordination is not an end in itself but a means to an end.

Three types of coordination styles have been described¹. The first type of coordination is called coordination by command in which leadership is by some kind of authority which can either be carrot or stick. The second type known as coordination by consensus in which the lead agency works to achieve coordination by orchestrating a coherent response and mobilizing key actors around common objectives and priorities. In this case consensus is built through development of relationships which help develop commitment and then consensus. The last type is called coordination by default in which case there is absence of formal coordination system or body and involves informal exchange of information and sharing of tasks by participating actors.

In most humanitarian emergencies, coordination by command may not be acceptable due to the mandate, independence and neutrality of most international humanitarian agencies.

regulate themselves using a coordination by default mechanismⁱⁱⁱ. However the volatile environment in which humanitarian actors operate and often large number of actors who are present during humanitarian crises underscores the need for coordination of humanitarian crises.

Donini wrote and I quote

“Someone must ensure that all the actors—the traditional UN agencies, the ICRC, the myriad NGOs, and the local authorities—know how to read from the same sheet music, even if they do not necessarily dance to the same tune. Put differently, a coordination entity is essential to orchestrate the management of the various inputs and programs so that all the actors can fit into a coherent and effective response”.

This highlights the strong need for better and more effective health coordination in northern Uganda which is a call to action for those of use working in the area.

I strongly believe that the benefits of coordination far outweigh its pitfalls. We as health actors in the north must try to reap these benefits which I believe will result in reduction in mortality in the north, a success which will be shared by all. However, coordination structures or mechanisms should keep simple, integrated and streamlined to avoid too many parallel structures which may be counter productive. In addition, whatever coordination structure or style we decide to use should have clear, simple and effective mechanism for rapid planning and decision making to eliminate bureaucratic bottlenecks which may delay rapid response.

Although working together to achieve a common health outcome is good in principles, it is often very difficult in practice. With each agency having its distinct mandate and agenda and all of them (humanitarian agencies) competing for funds from the same donors, the task of reconciling them is not easy. The task of coordination is even much more difficult in chronic emergencies such as in northern Uganda where most agencies present are well established on the ground and have established their own norms, standards and information gathering system and thus may be unwilling to participate in a coordination system which they believe will not benefit them. My personal experience working in Africa and Asia has shown that acute emergencies such as disasters and epidemic outbreaks of diseases which last for short periods are much easier to coordinate than chronic ones such as we have in northern Uganda. My rationalization of this trend is that acute health emergencies such as epidemic outbreaks often attract a lot of attention which exerts pressure on humanitarian actors (responding to the crisis) to deliver and ensure that the crisis is brought under control quickly hence they are often "forced" to have to work together.

The Cluster Approach in Uganda

In northern Uganda, coordination of the emergency health response has been a mix of coordination by consensus and coordination by default. Prior to the UN response review and reforms and the application of cluster approach to the northern Uganda crisis, there were existing coordination structures which was led by the OPM and sector Ministries at the national level and the DDMC and sector working groups at the district level. Although this system was functional, many of the health actors in northern Uganda did not participate in it and just did their own thing and only exchanged information on adhoc basis with a few other partners. With the advent of the cluster approach which was initially misunderstood and resisted, coordination of emergency health response in the north has shifted more towards coordination by consensus with better information dissemination and exchange and participation (by health actors) in coordination meetings and other activities of the cluster. Whether this increased quantum will diminish over time as was the experience in Rwanda and Afghanistan is still yet unclear. To prevent the laws of diminishing returns setting in and maintain its relevance, the Ugandan health cluster must adapt to changing coordination needs in the country. Lessons learned from health coordination in northern Uganda have shown that no single style of coordination system (especially in the African context) should be a combination of the three types of coordination.

In other words some form of authority (in this case carrot), commitment and consensus from participating agencies and at least some willingness to exchange information and ideas are prerequisite for a having an effective coordination system. A very important lesson that I learned from the northern Ugandan crisis is that humanitarian actors should always bear in mind early recovery even during the emergency phase as there is a very thin line between emergency response and early recovery especially in the health sector. In other words, humanitarian issues should be integrated into development strategies and vice versa so as to ensure sustainability and capacity development for the next phase.

Health Coordination in Northern Uganda: The Way Forward

Drawing from my personal experiences and lessons learned from coordination in the Afghanistan, Mozambican and Rwandese crisis and of late the Pakistan earthquake¹, I will propose a few suggestions to improve health coordination in northern Uganda. Firstly, the participating and nonparticipating agencies in the cluster mechanism) need to see and reap the benefits of participating in the system. In other words the health cluster must create demand for coordination by demonstrating that its benefits offset its disadvantages. The cluster must do business differently from the coordination system that existed before it and ensure that it effectively performs its roles of information dissemination, capacity building, standard setting and resource mobilization while ensuring that it does not create another layer of bureaucracy or programme implementation. Secondly, the role of Government in health coordination cannot be overemphasized. especially the cluster approach should work with, complement and support the government structures. Even though some may argue that leaving coordination entirely to governments (in crises where they exist) may mean political interference in the aid response, it is imperative that we build upon and safeguard existing local response system to ensure sustainability.

In Uganda, where there are existing coordination structures, all externally led coordination systems especially the cluster approach should work with, complement and support the government structures. Participation of government in coordination will also help to give some authority and legitimacy to coordinating bodies such as the cluster. Thirdly, there is need for more donor cohesion to ensure that some form of "carrot" is available to the cluster coordination mechanism. The lessons learned from the joint emergency health, nutrition and HIV/AIDS response programme in northern Uganda which is funded by DFID and Sida has shown that donors have a big role to play in bringing humanitarian agencies together.

The joint programme has been able to help participating agencies (WHO, UNICEF, UNFPA and WFP) define their mandates and comparative advantages which facilitated allocation of tasks and responsibilities and reduced duplication¹.



Members of the nutrition working group of the Health, Nutrition & HIV cluster in a field evaluation visit to Lacor hospital therapeutic feeding centre

Fourthly, as I earlier mentioned, coordination is a means to an end, so the health cluster should ensure that it keeps the end in focus at all times. Put differently, there should be a balance between time allocated to coordination activities and the actual task of delivering services to the IDPs of northern Uganda. Meetings should be kept to a minimum and they should be short and productive. Fifthly, there is need for better understanding of the international humanitarian system and mandates among humanitarian agencies working in northern Uganda. This is important to ensure that humanitarian agencies understand and respect the mandates of others and that decision making within the cluster is by consensus. In addition development of and adherence to policy and strategic documents and guidelines within the cluster will further facilitate the cluster's tasks of coordination and standard setting.

Notes:

- ¹ Minear, L., U. Chellia, J. Crisp, J. Macinlay and T. Weiss (1992). UN Coordination of the International Humanitarian Response to the Gulf Crisis 1990-1992., Thomas J. Watson Institute for International Studies.
- ² Coordinating Complex Health Programs; The Manager, Vol. 12 No. 4, 2003
- ³ Donini Antonio. The Policy of Mercy: UN Coordination in Afghanistan, Mozambique and Rwanda. Thomas J. Watson Institute for International Studies, Occasional Paper No. 22. Providence, RI: Brown University, 1996
- ⁴ Inter-Agency Standing Committee Real-Time Evaluation of the Cluster Approach - Pakistan Earthquake, Islamabad, Pakistan. February 2006
- ⁵ Report of Joint Inter Agency Emergency Health, Nutrition and HIV/AIDS Response in IDP camps in Northern Uganda; August 2006

Lastly, the Ugandan health cluster and its members must respond to the changing environment in which they are working and the changing needs of humanitarian actors as the northern Uganda crises evolves towards transition, return and early recovery. Systems, structures and mechanisms which were useful during the humanitarian response phase may be obsolete during the return and early recovery phases hence the need for the cluster to adapt appropriately. The role of the cluster and its members in early recovery should evolve more towards building the capacity of government to plan for and undertake evidence-based reconstruction within the healthcare system while

gradually disengaging from the crises. To facilitate a hitch-free disengagement from the northern Ugandan crisis, the cluster should articulate an effective exit strategy now.

In conclusion, the importance of health coordination in facilitating effective emergency health, nutrition and HIV/AIDS response, return and early recovery cannot be overemphasized. Health coordination is an important ingredient needed to achieve the shared vision of all humanitarian agencies working in health in northern Uganda. Whatever style of coordination that is used, there is need for participants in the coordination mechanism to see what is in it for them and to understand and respect the individual mandate of each other.

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Health, Nutrition and HIV/AIDS Cluster Roll-out in Uganda - Experiences and Lessons Learned

By Dr. Michael Lukwiya & Ms Ida-Marie Ameda

Background

The perception that humanitarian response does not always meet the basic requirements of affected populations in a timely and predictable manner and that the response provided can vary considerably from crisis to crisis prompted the then Emergency Relief Coordinator (ERC) to launch an independent Humanitarian Response Review (HRR) of the global humanitarian system to better understand and correct the deficiencies. The review covered complex emergencies and natural disasters and emphasis was on preparedness of the international humanitarian organizations to predict crisis, prevent them, mitigate their impact on vulnerable populations and respond effectively to their needs. The response review was conducted between February and June 2005 and assessed the humanitarian response capacities of the UN, NGOs, Red

Cross / Red Crescent Movement and other key humanitarian actors including the International Organization for Migration (IOM). Lessons learned from the review showed that there is a major gap in response capacity in sectors such as health, water, shelter, nutrition, camp coordination and camp management. The

coordination between the coordination structures of the UN, Red Cross and NGOs is poor as each operates as vertical coordinating structure. In addition, the IASC which is the most representative humanitarian body does not represent all humanitarian actors. The review also noted that there is lack of accountability of humanitarian actors towards the beneficiaries however, most of their activities conform with and are supportive of the humanitarian principles and practices. Besides, the way humanitarian agencies respond to challenges differs according to the respective agency mandate. The performance of Humanitarian Coordinators was also found to be erratic and weak and in most cases dependent on the personality of the HC. Lastly, the review concluded that there is low level of preparedness of humanitarian organization especially in terms of human resources.

Based on the recommendations of the HRR, a UN humanitarian reform programme with 4 main pillars was embarked upon by the IASC in 2005. The 4 pillars are:

- *strengthening the humanitarian coordinator system*

- *ensuring predictable funding for emergencies,*
- *strengthening the humanitarian response capacity through the cluster approach and*
- *building more effective partnerships between UN and non-UN humanitarian actors.*

Under the reforms, the humanitarian coordinator system will be strengthened through more rigorous selection and training of HC, development of a pool of pre-certified and experienced HCs who can be deployed at short notice and the use of score cards to assess HCs performances. On the issue of timely and predictable funding, the Central Emergency Response Fund

(CERF) was created to allow for an immediate response to an emergency through a loan component (US \$ 50 million) especially for emergencies where funds have been committed but not yet paid or commitment are thought to be very likely. What's more is that CERF funds can be accessed as grants facilities (US \$

450 million) for rapid response or for under funded crisis. The third pillar of humanitarian reform is the cluster approach which aims at improving the predictability, timeliness and effectiveness of humanitarian response and strengthening of the leadership and accountability in key areas. Nine clusters were designated at the global level. Uganda, Liberia, Somalia and the Democratic Republic of Congo, countries experiencing chronic emergencies were selected to pilot the approach in chronic emergency. In addition, Pakistan, Lebanon, Mozambique and the Philippines who were in acute emergencies were selected as pilot countries for implementing the approach in acute emergency.

Countries are given the liberty to determine the numbers of cluster to adapt depending on the identified needs of that country. For instance, Uganda initially had five clusters and now has seven clusters namely; Health, Nutrition and HIV/AIDS, Protection, Water and Sanitation, Camp coordination and camp management, Education, Food security and lastly Early Recovery cluster. Each cluster has a designated lead.



Inter Agency Standing Committee meeting in Kitgum, 2005

The Health, Nutrition and HIV/AIDS Cluster in Uganda: Major Milestones

The Health, Nutrition and HIV/AIDS cluster became operational in April 2006 and replaced the Health and Nutrition Sector Coordination meetings jointly chaired by Ministry of Health (MOH) and UNICEF. Following the roll out, guiding documents including cluster strategic document, 2006 work plan and modus operandi were developed and shared with members, cluster members were identified, listed and their capacities assessed. The purpose of the assessment of cluster members was to know individual member strengths or comparative advantage and to estimate what the need was regarding capacity building of members. The UN agencies, NGOs and district health teams in northern Uganda were oriented on the cluster approach and the roll out effected in the field. In 2007, a cluster performance report was written, the cluster strategic document was revised and 2007 work plan was developed. Efforts were also made to improve information sharing including the establishment of cluster mailing lists, the cluster Google health group and reference emergency libraries were established in the field. These improved information flow to and from cluster members at field and national level. A set of cluster performance indicators to monitor cluster performance were also identified and data is being collected on them through the HMIS/IDSR system of the country.

To improve coordination, monthly coordination meetings are held at the national and district levels, 3W matrices (who is doing what and where) were jointly developed with UN-OCHA and are being used to facilitate gap identification and filling. A health Services Availability Mapping (SAM) survey was conducted in Acholi sub-region in 2006 and field assessments and supervision of field activities are being jointly carried out by cluster members. This mapping of activities/interventions, joint assessments and supervision greatly facilitated reduction in overlaps and duplication of efforts and encouraged more equitable distribution of services.



Health, Nutrition & HIV/AIDS cluster exhibition at the launch of CAP 2007

Other key achievements of the cluster include a cluster capacity building workshop which was conducted in May 2007, the successful response to cholera, meningitis and measles outbreaks in northern Uganda and Karamoja and resource mobilization through CAP for cluster member were about 60% of funds in the planned budget was realized.

Major Lessons learned: Conclusions, Strengths, Weaknesses, Opportunities and Threats

The cluster built on existing health coordination structures at the national and district levels which made the roll-out smooth and facilitated government involvement.

At the district level, the cluster is co-chaired by the District Health Officers (DHOs) and WHO and works closely with the District Disaster Management Committees (DDMCs) making the task of coordination much easier. The cluster

has also been able to improve information sharing and dissemination among humanitarian actors and has clearly demonstrated the benefits of working together with good participation and collaboration from the NGOs. Participation in cluster activities at national and district level by NGOs that are not traditional members of the cluster at the global level demonstrating the confidence that humanitarian actors have in the cluster.

UN - OCHA's stewardship and support of the cluster roll out through orientation of cluster members, development of the CAP and other strategic plans also contributed to the successful roll out of the cluster at different levels.

The cluster roll out has not been without major challenges. It was planned and implemented using a top-down approach which resulted into misunderstanding of the concept initially. This coupled with lack of information, reference materials and implementation guidelines about the approach caused initial resistance by some humanitarian actors to embrace the approach. The complexity and multiplicity of humanitarian actors present in the country all with different mandates and ways of working often makes joint planning and consensus building difficult.

At the district level, there is still very low capacity, knowledge and skills for health coordination especially within the district health structures. The rapidly evolving humanitarian context also continues to challenge priority setting, planning and coordination of health response. Lack of donor cohesion, communication and information sharing often results in duplication of funding and makes coordination difficult although, the response from the donors to the cluster activities has been very commendable.

Wide dissemination of cluster guidance note among members and the recently conducted cluster capacity building workshop has been done with the aim of improving the understanding of roles, responsibilities and benefits of the cluster by the cluster members and to improve response of the cluster to the humanitarian crisis in the region.

The use of thematic working groups within the cluster has improved the quality of coordination meetings, shortened meeting duration and generally made meetings more productive. Major lessons learned from the health cluster roll out in Uganda include the importance of building on existing structures rather than duplicating them, importance of government participation in coordination in crises where government structures are still intact and the need to create a demand for cluster coordination activities by demonstrating its benefits to humanitarian actors.



Health communication session at the cluster capacity building workshop

A clear exit strategy from northern Uganda also needs to be formulated early in the emergency phase to ensure that the cluster withdrawal is smooth. In the coming months, the cluster will continue to advocate for more funding to address the myriad of gaps in the return areas, scale up capacity building activities for more effective response, strengthen information sharing and dissemination and encourage more joint planning, implementation, supervision, monitoring and evaluation. In addition the cluster will firmly establish itself in Karamoja region, where longstanding conflict has resulted in deterioration in health service delivery and indicators.

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In conclusion, despite the challenges faced initially, the health, nutrition and HIV/AIDS cluster has succeeded in clearly establishing itself as a coordination body within the health sector of Uganda.

It has improved coordination and information sharing within the health sector of the country although there are still many gaps and room for improvement.

As we move from humanitarian response to transition and early recovery phases, the cluster needs to re-adapt its strategies accordingly and reposition itself to respond to the growing demands of return and early recovery in northern Uganda.

Human African Trypanosomiasis epidemic in Lango sub-region:

Is the disease becoming established in North Eastern and Northern Uganda? By Dr. Zabulon Yoti

Human African trypanosomiasis (HAT), or sleeping sickness, is one of the 12 neglected tropical diseases affecting the poorest and most disadvantaged rural communities with the least access to health care. It is a parasitic disease transmitted by the bite of tsetse flies. Cattle are an important domestic reservoir for trypanosomiasis. World-wide, the disease is responsible for an estimated 100,000 deaths yearly.¹ If not treated, sleeping sickness is 100% fatal. The threshold to define an epidemic of sleeping sickness is *one confirmed case in an area previously having no cases*. Two pathogens are responsible for HAT are: *Trypanosoma brucei rhodesiense*, which causes an acute form of disease, and *T b gambiense*, the chronic form. *T b rhodesiense* is found in east Africa, and *T b gambiense* is present in central and West Africa.² *T b rhodesiense* is found in east Africa, and *T b gambiense* is present in central and West Africa.² Uganda represents a region where both types of sleeping sickness exist with a potential of overlap, given the fact that the two focuses are expanding towards each other.³ In Uganda, the West Nile region and Adjumani experience *T b gambiense* while the spread of *T b rhodesiense* has expanded up to Lira district from Eastern Uganda.¹ The overlap of the two forms of the disease will complicate diagnosis and treatment because of the type-specific differences in diagnosis and therapy.

Spread of acute form of HAT in northeast and northern Uganda:

Cases of *T b rhodesiense* sleeping sickness first appeared in Soroti district in 1998 and since then the disease has spread through the districts of Kaberamaido, Dokolo and Lira, putting lives of over 3 million people at risk. The rich vegetation in the affected districts provides the appropriate environment for the vector (tsetse fly) to flourish. Northern Uganda currently is the subject of large-scale livestock restocking activities and, because domestic cattle are important reservoirs of *T b rhodesiense*, movement of infected cattle from northeast to northwest play an important role in the spread of the outbreak. In 2005, a joint study by Edinburgh University and Uganda MOH revealed that up to 18% of the cattle being sold in the major cattle markets of north and northeastern Uganda had *T b rhodesiense*. Community awareness about the disease was found to be very low.⁴



Cattle from other districts are currently being taken to Lango region in early recovery restocking programs may be causing the spread of sleeping sickness there

The further spread of HAT from north-east to north-west, facilitated by population movements and cattle re-stocking, poses a potential threat to the current peace, return and resettlement program in northern Uganda.

There is an urgent need to strengthen targeted public health interventions to control the spread of sleeping sickness and reduce the morbidity and mortality.

Between January 2000 and May 2007, 862 cases of HAT have been treated in the established treatment centres. The majority of these cases presented in 2005. The affected districts include Lira, Dokolo, Kaberamaido and Soroti. While significant progress was realized in controlling the outbreak in 2005, in the last two years the epidemic seems to be stable in most of these districts (see table I and figure 1).

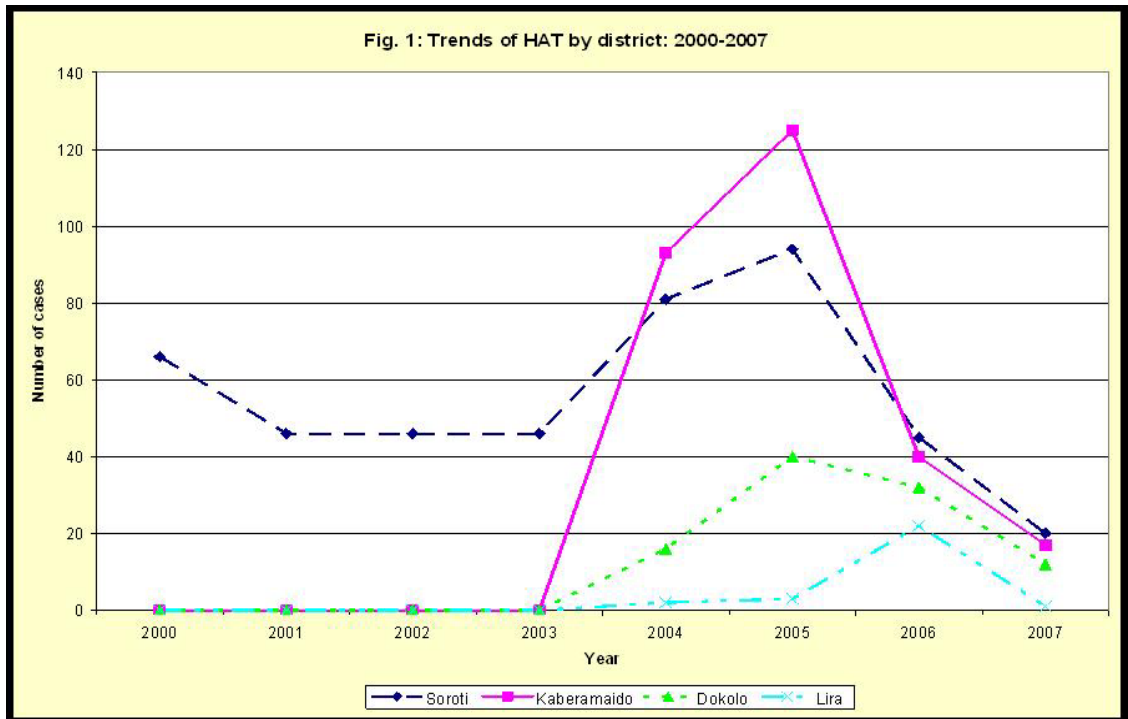
Table I: Cases of acute form of HAT from North & Northeastern Uganda: 2000-2007

Affected area	2000	2001	2002	2003	2004	2005	2006	2007	Missing	Total
Soroti	66	46	46	46	81	94	45	20	15	459
Kaberamaido	0	0	0	0	93	125	40	17	0	275
Dokolo	0	0	0	0	16	40	32	12	0	100
Lira	0	0	0	0	2	3	22	1	0	28
Total	66	46	46	46	192	262	139	50	15	862

Figure 1 shows that the epidemic peaked in 2005 and though relatively fewer cases have so far been reported in 2007, this only represents 5 months. Before 2004, the epidemic was only restricted to Soroti where it was noticed to have spread from Busoga.¹

Distribution of cases by sex and age and, treatment outcomes: Both gender and all age groups are affected. Of the 862 cases, 416 (48.3%) are females and 51.7% are males. The youngest patient is a baby less than 1 year and the oldest is 86 years. The mean age of the patients is 29.1 years with standard deviation of 19.4 years.

From table II, the observed case fatality rate is highest among women (10.6%) compared to children (9.8%) and men (4.7%). However, this observed gender and age group specific difference in treatment outcomes is not statistically significant $\chi^2 = 3.98$, $df = 2$, p value = 0.1365).



*Cases in 2007 represent only 5 months of January to May

Table II: Distribution of HAT cases and CFR by age group and gender

CATEGORY	Improved	Died	Total cases	CFR
Children < 18 years	138	15	153	9.8%
Women	126	15	141	10.6%
Men	142	7	149	4.7%
Total	406	37	443	8.4%

Treatment outcomes are significantly influenced by the stage of disease patients present with at the treatment centres. Though the current recommended treatment lasts for the whole month with a long follow up period of 2 years, the outcome of treatment is generally good. The over all case fatality rate is 8.4%. 99.3% of patients who presented for treatment with early disease stage recovered (see table III below). The current MOH WHO supported centres for case management are at Serere HC IV in Soroti, Lwala hospital in Kaberamaido, Dokolo HC IV in Dokolo and Alebtong HC IV in Lira. Dokolo and Alebtong are still not active.

Table III: Treatment outcomes by disease stage at presentation

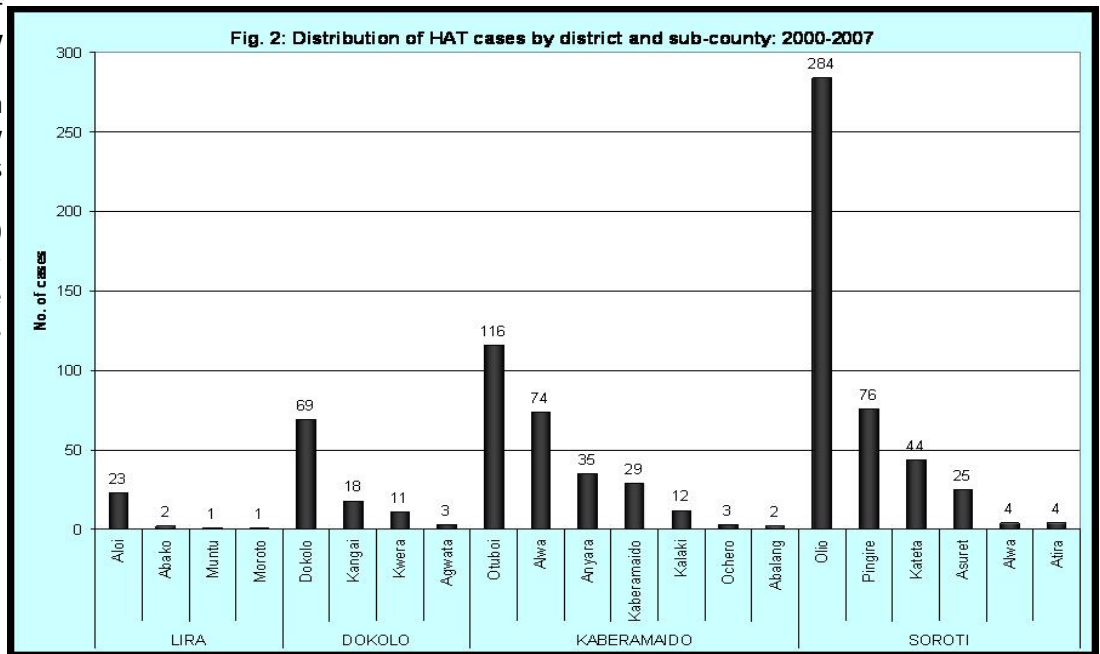
CATEGORY	Improved	Died	Total cases	CFR
Early/haemolympathic stage	138	1	139	0.7%
Late/meningo-encephalitic stage	255	35	290	12.1%
Total	393	36	429	8.4%

$\chi^2 = 15.75$, $df = 1$, p value = 0.00007

Early presentation of patients for treatment under-scores the importance of creating awareness among the affected communities. It has been noted that many patients confuse sleeping sickness with HIV infection/AIDS and therefore, are reluctant to seek early medical attention.

Distribution of Trypanosomiasis cases by sub-county

The epidemic is worse in selected sub-counties especially those with main cattle markets in the respective districts. In all the 4 districts, about 20 sub-counties are the most affected and would require intensified control activities (see figure 2:). Even within the sub-counties, targeting the worst affected parishes and villages with effective public health interventions will maximize efficiency in resource utilization.



Recommended control measures:

- Public health communication and extension services in affected areas to improve knowledge and reporting of these diseases. Development of simple appropriate easily understood IEC materials for the community will enhance improvement in the level of awareness, community involvement and enhance early case detection and treatment leading to better prevention and treatment outcomes.
- Establishment of effective surveillance system at both community and health facility levels will facilitate uniform reporting, monitoring and evaluation of control interventions.
- Collaboration among various stakeholders: veterinary officials, vector control officers, public health workers, law enforcement officers and the public needs to be improved in order to raise awareness among the community, prioritize control strategies and review disease progress following the different interventions.
- The risk of sleeping sickness spreading by means of the livestock reservoir host needs to be addressed by enforcing the appropriate policies. As part of the national policy for trypanosomiasis control in Uganda, livestock for sale are required to be treated at their point of origin or before sale. This policy needs to be strengthened and its enforcement by district local authorities needs to be emphasized. Farmers should be encouraged to routinely treat/vaccinate livestock.
- Given the high disease burden and the fact that most patients present with advanced stage of disease in the treatment centres, implementing active screening programmes in the most affected villages/sub-counties will improve on treatment outcomes and re.
- Low case fatality rates require continued supply of drugs, supplies and reagents to treatment centres. Regular technical support supervision and continuing professional development in terms of information sharing among the health workers will lead to effective management and follow up of the cases.
- Laying adequate numbers of tsetse fly traps in the most affected places will reduce the number of the vectors (tsetse flies). WHO will support the affected districts by supplying more traps to be placed in the most affected areas.

Measures in place; WHO and partners have undertaken the following

- support to community mobilization and the use of Village Health Teams for prevention
- development of a comprehensive line list and health facility data base at treatment centres
- mass screening at most affected communities
- provision of laboratory supplies and drugs for effective case management

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In and Out



Dr. Purnima Kashyap

Dr Purnima Kashyap, presently the Development and Recovery Coordinator in the United Nations World Food Programme, Uganda will be leaving on a new assignment as Deputy Country Director of WFP in Zambia in July 2007. She has been very active in the Health, Nutrition and HIV/AIDS activities in Uganda. Her portfolio in Uganda covered the above areas in addition to Education, research and partnerships. She has led the nutrition surveys in North and North-eastern regions of Uganda since her arrival in January 2003. Dr Kashyap, who is a Community Nutrition expert, has also been instrumental in increasing awareness and bringing into national policy, nutrition in the HIV/AIDS context. Through the establishment of the Maternal Child Health and Nutrition Programme in the North and north-eastern districts, she has also contributed to the need for greater attention to maternal and child health issues, trying to bring in preventive care and early detection of pregnancy related complications and malnutrition in these populations. She has worked closely with all development partners and forged partnerships with MOH, UNICEF, UNFPA, WHO, ACF, IMC, MSF and many others.



Mr. David Doledec

Mr. David Doledec, the medical and nutrition coordinator for ACF-USA in Uganda has moved on to the organization' New York office as nutrition officer in charge of ACF nutrition programmes in Uganda, Kenya and South Sudan, and international representation. He is replaced by Ms. Uma Palaniappan, who prior to coming to Uganda, worked with ACF-USA in Tajikistan.



Ms. Uma Palaniappan

Dr. Abdikamil Alislad, formerly the Medical Officer in-charge of HIV/AIDS in WHO country office, Kampala has been transferred to the WHO regional office in Congo-Brazzaville as Surveillance and Strategic Information Officer for the Regional AIDS Program under the AIDS, Tuberculosis and Malaria (ATM) Division. To take his position is Dr. Beatrice Crahay, a Belgian who was previously Medical Officer, HIV/AIDS in the WHO country office, Conakry, Guinea. Dr. Crahay has several years of experience working for UNFPA in Africa and America.



Dr. Abdikamil Alislad



Dr. Beatrice Crahay



Dr. Eric Alain Ateqbo

Dr. Eric-Alain Ateqbo, has recently joined UNICEF Kampala Office as Nutrition Specialist. In this capacity, he will play an important role in the Health, Nutrition & HIV/AIDS Cluster especially in the Health and Nutrition Technical Working Group. He is a holder of a Ph.D in Human Nutrition from the Wageningen University (The Netherlands).

Previously, he served as Project Officer Nutrition in UNICEF India Country Office a period of four years. We wish all our colleagues the very best in their new assignments.

News:

Cluster Capacity Building Workshop

As part of the activities to strengthen cluster approach in Uganda, a 3-day health, nutrition and HIV/AIDS cluster capacity building workshop took place in Kampala from 7th to 9th May 2007. The goal of the workshop was to further strengthen the capacities of health, nutrition and HIV/AIDS cluster members in Uganda to contribute to improved emergency health action. Forty three participants drawn from the UN (19), NGOs (11), district local government (11), Ugandan AIDS Commission (1) and Office of the Prime Minister (1) attended the workshop which was facilitated by 7 facilitators drawn from WHO offices in Geneva, Brussels, Nairobi and Kampala

Topics covered during the course include the international humanitarian system, humanitarian response review, humanitarian reforms and cluster approach, management of health information during crisis, coordinating health in complex emergencies, communicating effectively during crisis, joint health strategy development, transforming health priorities into action and epidemic preparedness, investigation and response among other topics. At the end of the course, the participants present a joint emergency health, nutrition and HIV/AIDS response plan for Karamoja which will be developed into a full proposal for funding by the cluster.



Participants draw up a health cluster emergency response plan for the Karamoja region

To sustain the achievements of this workshop and strive towards improved emergency health response and coordination in northern Uganda, more of such workshops will be conducted at the national and district levels in the coming months.

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Members of Editorial Board Needed:

The health, nutrition and HIV/AIDS cluster newsletter seeks motivated and committed volunteers among cluster members to join its editorial board. Volunteers will be expected to perform the following tasks and responsibilities along with other board members:

1. Determine the theme/content of each edition of the newsletter
2. Gather relevant articles, reports, news and other materials for the newsletter in a timely manner
3. Review all articles gathered and select the ones to be published in the newsletter
4. Fine tune and prepare all articles selected for publication in the newsletter
5. Participate in writing the editorial comments for each edition of the newsletter
6. Participate in identification and interview of key partners, donors and top government officials and summarize for publication in the newsletter
7. Assist to determine the overall layout and typesetting of the newsletter
8. Ensure that the newsletter is produced and widely disseminated in a timely and well organized manner

Interested volunteers should contact Dr. Olushayo Olu or Ms. Ida Ameda

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Highlights of the Inter Agency Standing Committee (IASC) guidelines on implementation of the cluster approach

In major new emergencies:

At the onset of the emergency (if possible, within the first 24 hours):

1. The Humanitarian or Resident Coordinator (HC/RC) consults national authorities and relevant IASC partners at the country level to determine priority sectors or areas of activity for the emergency; which agencies are best placed to assume the role of sector/cluster lead for each one; what thematic groups are needed to address cross-cutting issues; and what support is needed from OCHA and other actors in terms of common tools and services.
2. Based on these consultations, the HC/ RC draws up a proposed list of sectors with designated sector/cluster leads for each, which may include thematic groups for particular priority cross-cutting issues. The HC (or RC) forwards this list to the Emergency Relief Coordinator (ERC), requesting endorsement within 24 hours from the full IASC at the global level.
3. The ERC shares this proposal with the IASC, requesting endorsement or alternative proposals with 24 hours of receiving the proposal.
4. The ERC ensures agreement is reached within the IASC at the global level. Where agencies at the global level propose arrangements that differ from those initially proposed by the HC (or RC), the ERC consults the HC (or RC) and IASC further in order to reach agreement.
5. The ERC communicates the decision reached to the HC/RC and all relevant partners at global level.
6. The HC/RC informs the host government and all relevant country-level partners of agreed arrangements within the international humanitarian response. Common Humanitarian Action Plans and appeal documents should clearly state the agreed priority sectors and the designated leads for each.

In Ongoing emergencies:

1. The HC ensures that the Humanitarian Country Team, government counterparts, national NGOs and other stakeholders are fully briefed on and familiar with the principles of the cluster approach.
2. The HC facilitates discussions with national authorities/counterparts and a transparent consultative process amongst humanitarian partners to assess needs, operational gaps and response capacities.

3. Based on these consultations and the assessment of needs, operational gaps and response capacities, the Humanitarian Country Team, under the leadership of the HC, determines priority sectors or areas of activity for the emergency; which agencies are best placed to assume the role of sector/cluster lead within the international humanitarian community for each one; what thematic groups are needed to address cross-cutting issues; and what support is needed from OCHA and other actors in terms of common tools and services. In some cases, few or no changes to the existing structure may be needed. In other cases, changes may be needed to address "gap" areas and to enhance predictability and accountability.
 4. The HC informs the ERC of any changes that are made at the country level in the process of introducing the cluster approach. This is to help agencies' Headquarters to plan their activities and undertake the necessary resource mobilization efforts, particularly where major gaps are identified and significant additional response capacity is needed. If in the process of introducing the cluster approach no new sector/cluster leads are designated, the HC should inform the ERC of this, while confirming that the cluster approach will be applied in order to ensure high standards of predictability, accountability and partnership in all sectors.
 5. The ERC shares the proposal with the IASC with a request for endorsement or alternative proposals within one week. The ERC ensures agreement is reached within the IASC at the global level. Where agencies at the global level propose arrangements that differ from those initially proposed, the ERC consults the HC and IASC further in order to reach agreement.
 6. The HC informs the host government and all relevant country-level partners of agreed arrangements within the international humanitarian response. Common Humanitarian Action Plans and appeal documents should clearly state the agreed priority sectors and the designated leads for each.
- For the full documents visit the Health cluster google group at: <http://groups.google.com/group/uganda-health-nutrition-hiv>*